

is much more secure. Moreover, the assumption underlying this concern is that patients are eager to die and will act prematurely if given the chance. The opposite is true. For example, cancer patients want as dearly to live as anyone. They want to live so long as life has the barest quality and meaning. They wait until death is imminent and suffering severe before taking action, and natural death often overtakes them before they make that choice (as demonstrated by the fact that between 30% and 50% who obtain the life-ending medication do not use it).¹

The Concern about Risk to Vulnerable People

This concern stands in stark contrast to demographic characteristics of those who access aid in dying. Overwhelmingly, these individuals are older (median age 71 years), white (97.6%), highly educated (71% college educated) residents of urban areas, enrolled in hospice (90.4%) and covered by medical insurance (98.5%). Research by Battin *et al* (2007) found no evidence of heightened risk to groups of potentially vulnerable adults (including those aged 85+, people suffering from a physical disability, people with psychiatric illnesses including depression) in Oregon.¹¹

In 2010, Baroness Finlay (a Director of Living and Dying Well) and Professor George wrote a response which called the methodology of this research into question.¹² Since then the original authors have responded to Finlay and George's paper, by stating that a number of their allegations are flawed.¹³ For example, claims that they omitted the deaths of those aged between 65-84 years in the analysis are wrong. This data was in fact presented in an accompanying table and supports that there is no evidence of heightened risk of assistance in dying among older adults. Battin *et al* summarized by saying:

"We welcome further attempts to examine what really happens where physician assistance in dying is legal... However, we do not welcome the seemingly ideologically biased assumption evident in the Finlay and George critique that requesting or receiving such assistance is itself a symptom of vulnerability... there is no current evidence for the claim that legalized physician-assisted suicide or euthanasia will have disproportionate impact on patients in vulnerable groups."

Conclusions

This briefing has directly addressed concerns raised by Living and Dying Well. However, there is also a wealth of evidence which I would encourage you to read, which further demonstrates that assisted dying is working safely, providing terminally ill patients in Oregon with genuine choice. This includes evidence that Oregon is a national leader in palliative and end-of-life care as a whole,^{14,15} that people are not driven to request assisted dying because of poor pain relief or palliative care,^{1,16} and that family members are more emotionally prepared for, and accepting of, their loved one's death when wide choices are available.¹⁷ Yearly reports on the Washington Death with Dignity Act are also available.¹⁸

Data from the 15 years since assisted dying was legalized in Oregon demonstrates that it has worked safely, that optimal palliative relief makes assisted dying a last resort and, crucially, it gives tangible comfort and peace of mind to dying adults.

Barbara Coombs Lee

12. Finlay I, George R (2010) *Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon's data* *Journal of Medical Ethics* doi:10.1136/jme.2010.037044

13. Battin MP, van der Heide A, Ganzini L, van der Wal G and Onwuteaka-Philipsen BD (2011) *Legal physician-assisted dying in Oregon and the Netherlands: The question of "vulnerable" groups. A reply to I.G. Finlay and R. George* Published online 27 July 2011

14. Quill T (2007) *Legal regulation of physician-assisted death – the latest report cards* *New England Journal of Medicine* 356(19): 1911-1913

15. *The Guardian* (2008) *Hospice and palliative care in Oregon*. Thursday 23 October 2008

16. Lindsay R (2009) *Oregon's experience: evaluating the record* *The American Journal of Bioethics* 9(3): 19-27

17. Ganzini *et al* 2009 *Mental health outcomes of family members of Oregonians who request physician aid in dying* *Journal of Pain Management* 38(6): 807-815

18. <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.aspx>



compassion & choices
www.compassionandchoices.org



compassion & choices

Support. Educate. Advocate. Choice & Care at the End of Life

February 2013

Compassion & Choices is a non-profit organization dedicated to expanding and protecting the rights of terminally ill people in the USA. Part of Compassion & Choices' campaigning work is to legalise aid in dying for terminally ill, mentally competent adults in the States of the USA.

Barbara Coombs Lee is the President of Compassion & Choices. She practised as a nurse and physician assistant for 25 years before beginning a career in law and health policy. She was a Chief Petitioner for Oregon's Death with Dignity Act.



PHYSICIAN-ASSISTED DYING IN OREGON AND WASHINGTON: THE FACTS

Introduction

A recent briefing from the organization Living and Dying Well (a group opposed to the legalization of assisted dying), *'Physician-Assisted Suicide in Oregon and Washington'*, articulated its concern over the numbers of patients who have received assistance to die, the numbers of doctors who take part in the process, the relationship between doctor and patient, and the potential risk to vulnerable populations.

The evidence arising from fifteen years of practice and the exhaustive academic research on that experience does not validate those concerns.

Wide consensus exists within Oregon that the choice of assisted dying for mentally capable, terminally ill adults has benefited patients and their families and improved end-of-life care. The Death with Dignity Act is enormously popular among Oregonians, who view it as a desirable, yet infrequently used, option. Elected officials receive essentially no public pressure to revise or repeal it.

Annual reports from the Oregon Health Authority, combined with independent academic research, provide solid data that this law is working as intended. Eligibility criteria and procedural safeguards are workable and effective. Only a small percentage of Oregon's dying patients choose assisted dying. Washington State adopted the same law in 2008 and its data replicates the findings in Oregon – however there are only three years of data. Therefore, this briefing will focus on data from Oregon where a terminally ill, mentally competent adult, after a series of checks and safeguards, may choose to self-administer doctor-prescribed, life-ending medication in order to abbreviate extraordinary suffering and control the manner and timing of his or her imminent death.

The Concern about Assisted Dying Numbers

Since the law became effective in 1997, 1,050 terminally ill Oregon residents have had a life-ending prescription written and 673 have died taking the medication. Death as a result of assisted dying remains rare, at 0.24% of all deaths in 2012.¹ It is important to note that even with an initial increase in cases (due to awareness of the choice of assisted dying increasing during the early years), this proportion has not risen above 0.24% and has stayed consistent since 2008. Crucially, we know that many more people benefit from the law than use it.² One in six dying Oregon residents speak openly with their loved ones about whether assisted dying might comfort them and then one in fifty begins the eligibility process by speaking with their doctors about it. These upfront and honest discussions are a direct result of the legislation, and have played a huge role in easing anxieties, calming fears of future suffering and prompting effective treatment of troublesome symptoms. Most of the conversations do not result in a formal assisted dying request and only one in 500 ingest the life-ending medication. Between 30% and 50% of even those patients who complete the exhaustive eligibility process and receive a life-ending prescription do not use it; rather they take comfort in knowing the choice is there.^{1,3}

Consideration of assisted dying as a palliative measure, intended to comfort the patient, control fears and improve the quality of life, is widespread among participating Oregon physicians.

The Concern about Numbers of Participating Doctors

62 doctors wrote 114 life-ending prescriptions in 2011 and 61 doctors wrote 115 prescriptions in 2012.⁴ The experience of Compassion & Choices is that most doctors write one prescription or less per year, and only a handful of doctors specializing in cancer care are likely to write five or more in any year. These physicians are well-established and respected among their peers and in the communities they serve, and the nature of their practice means they care for many dying patients. Importantly, all doctors are trained to assess mental capacity and if they receive a serious request for assisted dying they must follow strict guidelines published by the Oregon Health Authority. Doctors in Oregon participate in the process voluntarily and those who decline to participate for any reason can opt out. Giving doctors this freedom to opt out inevitably means some of their patients will seek other doctors, who may, after careful consideration, determine that the patient meets the eligibility criteria for a life-ending prescription. Therefore the law respects the choices of both dying patients and their doctors.

The Death with Dignity Act requires that two doctors assess the patient, with the second doctor being knowledgeable in treating the patient's disease. Both physicians must file attestations that the patient is terminally ill, capable of making health care decisions, and not acting under any form of duress, coercion or undue influence. Witnesses to the patient's signed request form make the same attestations and patients who fill their prescriptions also receive counselling from the pharmacist on the voluntary nature of the act of ingestion.

The Oregon Death with Dignity Act does not specify a time that the patient and prescribing physician must know each other. To do so would deprive patients of freedom of contract and association and

1. *Summary of Oregon's Death with Dignity Act (1998-2012)* Oregon Health Authority
2. *Susan Tolle et al (2004) Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide* *Journal of Clinical Ethics* 15(2): 111-122
3. *Ganzini L, Beer TM, Brouns M et al (2006) Interest in physician-assisted suicide among Oregon cancer patients* *Journal of Clinical Ethics* 17: 27-38
4. *2012 Summary of Oregon's Death with Dignity Act (2013)* Oregon Health Authority
5. *2011 Summary of Oregon's Death with Dignity Act (2012)* Oregon Health Authority
6. *Ganzini L, Goy E, Dobscha S (2008) Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey* *British Medical Journal* 2008;337:a1682 doi:10.1136/bmj.a1682

render their choices bound to the specific moral or religious tenets of their doctors. In 2012 the median duration of the patient-physician relationship was 19 weeks, with many relationships extending to decades. Median duration between the first request and death was 47 days, far more than the required 15 day 'cooling off' period (where the individual must wait a little over two weeks before obtaining the life-ending prescription). Physicians have no incentive to abbreviate the eligibility or deliberation processes.

The Concern about Depression

Living and Dying Well's observation that only a small percentage of those who ended their lives by assisted dying are referred for specialist psychological assessment is certainly true. However, there is nothing sinister behind this. Complete psychological assessment is done when the attending physician discerns the possibility of mental impairment, yet also believes the patient may still qualify for aid in dying. This almost never happens. If the physician perceives any mental health condition or depression that might impact on their decision making, the patient is usually deemed ineligible and the request does not proceed.

Thus the small number of psychological evaluations reported in the annual reports actually reflects a high degree of expertise and caution among attending physicians, who screen out ineligible patients prior to any psychological evaluation. In other words, those patients who fail the attending physician's initial psychological screening are deemed ineligible for an assisted death, and are therefore neither sent to a psychiatrist nor recorded in the annual figures. Patients who see a psychiatrist and are deemed ineligible are also not recorded in annual figures. We can apply statistical information to discern that approximately 655 patients in 2011 talked with their doctors about assisted dying (2% of 32,731, the total deaths in Oregon in 2011, the latest year for which this figure is available).^{2,5} With only 114 prescriptions written that year under the Act, it is clear the number screened out is high. Overall, since 1998, 6.2% of patients who have had an assisted death underwent full psychological assessments.¹

Ganzini *et al* (2008) published a study that attributes symptoms of depression to 1 in 6 patients who had an assisted death. The investigators acknowledge, however, that a majority of the indicators they used to measure the presence of depression may actually reflect the physical effects of terminal illness. These measures included weight loss, reduced appetite and sleeplessness.⁶ If a cancer patient had lost weight, these researchers attributed it to depression only. Furthermore, symptoms of depression do not necessarily mean a person lacks mental capacity or exhibits impaired judgment. Indeed, a level of 'appropriate sadness' is considered normal in terminally ill patients approaching the end of their life.⁷

The Concern about Prognosis

Opponents of assisted dying have argued that it can be difficult to deliver accurate prognoses for terminal illness. This may be true, but the evidence is that where errors occur, they are far more likely to be overestimates in life expectancy than underestimates, particularly in cases of cancer. Studies reveal that between 63% and 71% of predictions are too optimistic.^{8,9,10}

It is also important to appreciate that a request for assisted dying generally takes place within weeks of a person's death, when prognosis

7. *Ganzini L, Dobscha S (2003) If it isn't depression... Journal of Palliative Medicine* 6(6): 927-931
8. *Stiel S et al (2010) Evaluation and comparison of two prognostic scores and the physicians' estimate of survival in terminally ill patients* *Supportive Cancer Care* 18: 43-49
9. *Gripp S, Moeller S, Bolke E et al (2007) Survival prediction in terminally ill cancer patients by clinical estimates, laboratory tests, and self-rated anxiety and depression* *Journal Clinical Oncology* 25:3313-3320. doi:10.1200/JCO.2006.10.5411
10. *Christakis NA, Lamont EB (2000) Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study* *British Medical Journal* 320:469-472. doi:10.1136/bmj.320.7233.469
11. *Battin MP, van der Heide A, Ganzini L, van der Wal G and Onwuteaka-Philipsen BD (2007) Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups* *Journal of Medical Ethics* 33: 591-97