Living and Dying Well

Keeping the law safe for sick and disabled people

Physician-Assisted Suicide in Oregon and Washington

By Catherine Simon

Catherine Simon has been Research Officer at Living and Dying Well since September 2011. In this article (the first of two on the experience of jurisdictions which have legalised 'assisted dying') she updates our 2010 research report on Oregon's experience of physician-assisted suicide since 1998 and includes the first three years of Washington State's experience, which legalised PAS in 2008.

Living and Dying Well is a public policy research organisation established in 2010 to promote careful analysis of the issues surrounding the subject of 'assisted dying' - the current euphemism for physician-assisted suicide. Living and Dying Well takes the view, based on the evidence, that legalisation of 'assisted dying' would pose serious risks to public safety and that debate needs to focus on rigorous analysis of the evidence rather than on campaigning spin.

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INTRODUCTION

In October 2010 *Living and Dying Well* published an analysis[i] of how Oregon's physician-assisted suicide (PAS) law was operating in practice. That analysis covered the years 1998 (the first complete year of the law's operation) to 2009 (the last year for which records were then available). This report updates that analysis, including official data for 2010 and 2011. It also extends the analysis to cover the neighbouring State of Washington, which legalised physician-assisted suicide in 2008 and which has published official data for the years 2009 to 2011.

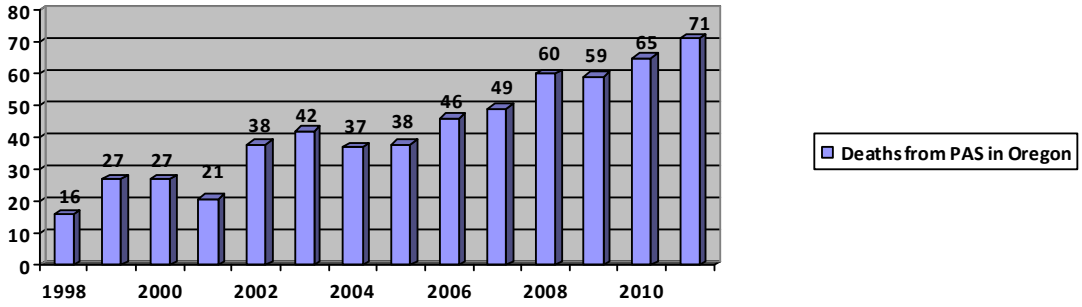
Oregon's and Washington's PAS laws permit a doctor to supply lethal drugs to a requesting patient if that patient has been diagnosed as having a terminal illness with a prognosis of six months or less and if the assessing doctor, and a second doctor, judge the request to be voluntary and the patient to be mentally capable. If it is considered that a patient requesting PAS may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, he or she must be referred for specialist assessment. Lethal drugs supplied to qualifying patients must be self-administered.

OREGON - THE LATEST POSITION

(a) Incidence of Physician-Assisted Suicide

Our 2010 analysis concluded, from the evidence of official reports from the Oregon Public Health Department (OPHD), that between 1998 and 2009 there had been nearly a fourfold increase in the incidence of deaths from PAS. As Table 1 (below) shows, this rising trend has continued: by 2011 the number of deaths from PAS in Oregon had risen to four and a half times the 1998 level.

TABLE 1: Deaths from PAS in Oregon, 1998-2011



The death rate from PAS in Oregon in 2011 was recorded by the OPHD as 22.5 per 10,000 deaths. Oregon is a very small jurisdiction: its population is less than half that of Greater London. To understand the impact of an Oregon-style PAS law here, it is necessary to apply Oregon's 2011 death rate to the number of deaths registered in England and Wales in that year[ii]. This indicates that an Oregon-style

law here could be expected to result in 1,090 PAS deaths a year. This estimate assumes that any PAS law in Britain would be limited by the same conditions as those in force in Oregon - in particular, that PAS should be available to those with a prognosis of six months or less. In fact, it has been suggested in some quarters[iii] that lethal drugs for PAS should be available to persons with a prognosis of life of 12 months. On this basis the annual number of deaths from assisted suicide could be expected to be considerably higher than 1,090.

(b) Multiple Prescribing

Our 2010 analysis drew attention to the phenomenon of multiple prescriptions for lethal drugs being issued by a small number of physicians and it cited the OPHD report on 2005 that eight such prescriptions in that year had been issued by one doctor. The latest reports show that the trend of multiple prescribing is continuing: the report on 2011 states that there was a range of between 1 and 14 prescriptions issued per physician in that year. In other words, at least one physician issued prescriptions for lethal drugs to 14 patients.

The growth of multiple prescribing is indicative of the presence of 'doctor shopping' - of patients seeking PAS from doctors who are not their regular physicians and who are unlikely to have any in-depth knowledge of their psychological states and personal or family circumstances. The OPHD report on 2011 reveals that the median length of the doctor-patient relationship for those who died by PAS between 1998 and 2011 was just 12 weeks within a range of 0 to 1,905 weeks. It is clear that some applicants for PAS have received lethal drugs from doctors whose knowledge of them as patients has been of short duration.

(c) Mental Capacity

In our 2010 report we commented on the low rate of referral of PAS applicants for specialist psychological or psychiatric assessment. This trend appears to be continuing. The latest OPHD report shows that just 1.4 per cent of those who ended their lives by PAS in 2011 had been referred for such specialist assessment. The reports do not tell us how many unsuccessful applicants for PAS were so referred: such data would certainly help to shed more light on the process of mental capacity assessment. Nonetheless, as we observed in our 2010 report, Professor Linda Ganzini's 2008 study[iv] discovered that 1 in 6 out of a sample of patients who had been supplied with lethal drugs for PAS had been suffering from clinical depression which the assessing doctors had not diagnosed.

(d) Prognosis of Terminal Illness

The limitation of 'assisted dying' to terminally ill patients with a specified prognosis of life remaining is presented by those who wish to see the law changed to license physician-assisted suicide as a key safeguard of their proposals. This raises the question: how reliable is prognosis itself? Professor Sir Mike Richards, the Department of Health's National Director for End of Life Care, described

prognosis of terminal illness to Lord Falconer's 'commission on assisted dying' as "*fraught with difficulty*"[v]. The Royal College of General Practitioners told Lord Mackay's House of Lords Select Committee in 2004 that "*it is possible to make reasonably accurate prognoses of death within minutes, hours or a few days. When that stretches to months, then the scope for error can extend into years*"[vi].

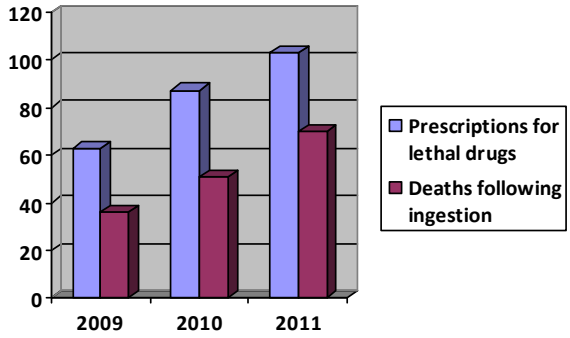
These professional assessments are corroborated by Oregon's own experience. The 2011 OPHD report tells us that, for those who took their own lives by PAS in the period 1998 to 2011, the mean interval between requesting lethal drugs and death as a result of ingesting such drugs was 46 days. What we cannot know from the report is how long those who took their own lives would have lived if they had not ingested the drugs. The report does, however, tell us that the 46-day mean was within a range of 15 to 1,009 days. In other words, some people in Oregon (we are not told how many) who have ended their lives prematurely with lethal drugs supplied by doctors on the basis of a six-months-or-less prognosis have lived for much longer (in at least one case for nearly three years) before swallowing those drugs. How long these people would have lived if they had not ingested the drugs is impossible to tell. What is clear is that lethal drugs are being supplied to some people diagnosed as terminally ill who have turned out not to be terminally ill as defined by the law. This is not to suggest any malpractice on the part of the assessing physicians. It does, however, illustrate the fallibility of prognosis as a safeguard in the licensing of PAS.

This is more than just a clinical technicality. Most doctors are familiar with the question asked by patients diagnosed as terminally ill: how long do I have? A doctor's prognosis of the course of a terminal illness is likely to be a key ingredient of any decision to seek legalised assisted suicide: patients who are told that they have less than six months to live may be more inclined to want to 'end it all' than if they believed there might be another year or two years of life remaining. Supporters of legal change may argue that prognosis can be adrift in both directions, with doctors over-estimating the time remaining. That is true, but the undeniable fact, as Oregon's experience indicates, is that under-estimation in prognosis is far from uncommon and qualifying criteria framed in terms of several months are too unreliable to be considered as a safeguard.

WASHINGTON

Washington State legalised PAS in 2008 on the same terms as Oregon, its neighbour on the north-west coast of the USA. There have been three annual reports published since the 2008 law came into force, covering the last 10 months of 2009 and the calendar years 2010 and 2011. Table 2 shows the numbers of prescriptions for lethal drugs issued and the number of persons who died after swallowing those drugs in the period 2009 to 2011:

Table 2: Prescriptions for lethal drugs issued and deaths following ingestion in Washington State 2009 -2011



The official report for 2011 records that 70 of the 103 persons who received lethal drugs legally in that year died after ingesting them and that a further 19 died of natural causes. It was not known, at the time the report was published, whether the remaining 14 recipients of lethal drugs had died and, if so, whether or not they had died as a result of PAS. The figure of 70 deaths from PAS in 2011 is, therefore, a minimum figure. Even at this level, however, it represents a 37 per cent increase on the figure for 2010 and a 94 per cent increase on 2009. While the rising trend is reminiscent of what was seen in Oregon a few years previously, the increase is steeper and, if Oregon's experience is anything to go by, it is reasonable to suppose that Washington's death rate from PAS will continue to rise for some years yet.

The official annual reports from Washington State indicate that the characteristics of those receiving lethal drugs for PAS are similar to those in neighbouring Oregon - ie predominantly elderly, with relatively short relationships with the assessing and prescribing doctors, and with a low rate of referral for psychological or psychiatric examination.

DISCUSSION

The situation in Oregon and Washington, as revealed in the latest official reports, contains a number of worrying features which cannot be reconciled with claims by campaigners for legalisation of 'assisted dying' in Britain that the laws in these two States are working well.

Foremost among these is the adequacy of the assessment process by which applicants for PAS are judged to qualify for receiving lethal drugs. To be effective, any assessment system has to be objective and knowledge-based. In the case of PAS it has to rest on knowledge not only of the patient's clinical condition but also of his or her mental capacity, including such things as susceptibility to mood swings and depression. It must also embrace an awareness of circumstances in the patient's personal or family background which could be influencing the request.

Yet what we are seeing in Oregon and Washington is assessments that are being carried out in some cases by doctors who have only recently been introduced to the patient and who, by reason of their willingness to participate in PAS, may possibly be inclined to see such requests as a rational and reasonable response to terminal illness. The fundamental problem here is that many doctors are unwilling to participate in PAS. Given the opposition to these practices of most doctors in Britain (and of the principal medical professional bodies[vii]), it would be reasonable to expect that the 'doctor shopping' that we see taking place in Oregon and Washington would be replicated here if a law licensing physician-assisted suicide were ever to be enacted.

It is sometimes claimed that research has shown that there is no evidence of heightened risk to vulnerable groups of people in Oregon from legalisation of PAS. The research[viii] on which this claim rests was published in 2007 and was based on a methodology which has since been called into question[ix]. To take one example, the researchers compared death rates from PAS among elderly people in Oregon with death rates from PAS among younger people. They concluded that there was "*no evidence of heightened risk"* to the elderly on the basis that "*persons aged 18-64 years were over three times more likely than those over age 85 years to receive assisted dying".* However, the calculations on which this conclusion was based took no account of deaths of persons aged 65-84, an age group which is generally regarded as coming within the term 'elderly'. If deaths from PAS among 65 to 84-year-olds are included, it can be seen that there are more than twice as many such deaths among the elderly as among younger persons. While this does not of itself mean that the elderly are necessarily at risk, it should make us pause for thought over confident assertions that this is not the case.

We need to think carefully also about the year-on-year increases in the incidence of PAS in these two jurisdictions. While such increases are to be expected in the wake of legalisation, in Oregon they are persisting after 15 years. Some argue that even the latest numbers are small in percentage terms and that what they show is that there is a demand for PAS. While this may possibly be so, the data coming out of Oregon and Washington tell us something else. It is easy to make the mistake of assuming that licensing PAS would simply allow a very small number of cases that attract media attention to proceed without legal objection. The rising death rates in Oregon and Washington illustrate that licensing an act by law does not simply replicate the status quo in legal form: it changes the dynamic. We have to ask ourselves whether we are prepared, bearing in mind the evidence of Oregon and Washington, to see a substantial rise in the incidence of assisted suicide in place of the handful of cases which currently cross the desk of the Director of Public Prosecutions.

There are also challenging questions surrounding the assessment of mental capacity in those seeking PAS. One of these is whether psychological or

psychiatric evaluation should not be a mandatory part of any assessment process for PAS rather than being left to the discretion of the assessing doctor - as is the case in Oregon and Washington and as is being proposed by campaigners here. A suicide wish is normally regarded as grounds for psychological assessment: it is difficult to see why a wish for assisted suicide should be treated differently. It is sometimes argued by supporters of legalised 'assisted dying' that mandatory assessments would be burdensome to those concerned and perhaps distressful to an applicant who is clear in his or her own mind about wanting assisted suicide. It is necessary to remember, however, that the purpose of the criminal law is to protect the vulnerable (in this case persons who may be less than wholehearted about ending their lives or may be suffering from transient feelings of despair and depression or subtle pressure from others) rather than to smooth the path of the fully resolute.

Another question is whether a balanced and considered psychological assessment can be carried out in the course of a single consultation either with an assessing doctor or with a psychiatrist or psychologist to whom an applicant for PAS has been referred. This issue was raised in evidence to Lord Falconer's 'commission on assisted dying' - namely, that reliable psychological assessment cannot be based on what a patient may say on one day and in one set of circumstances[x]. Proper capacity assessment takes time. It may be argued that people who are terminally ill do not have time (though this argument itself begs some interesting questions), but the decision here is surely of a gravity that cannot be addressed simply by an interview with an assessing doctor or by a single session with a specialist.

There are lessons to be learned from Oregon's and Washington's experience of licensing PAS. These are too important to be brushed under the carpet with assurances that all is well.

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[i] 'What's happening in Oregon', October 2010

[ii] Registered deaths in England and Wales in 2011 were 484,367: 'Deaths Registered in England and Wales in 2011, by Cause', Office of National Statistics

[iii] See 'Safeguarding Choice', a consultation document published in July 2012 jointly by the campaigning group Dignity in Dying and the All-Party Parliamentary Group for Choice at the End of Life

[iv] "The prevalence of depression and anxiety in terminally ill patients pursuing aid in dying from physicians", British Medical Journal 2008; 337:a1682

[v] Oral Evidence to the 'commission on assisted dying' 23 February 2011

[vi] House of Lords Report 86-I (Session 2004-05), Paragraph 118

[vii] Specifically, the British Medical Association, the Royal College of Physicians, the Royal College of General Practitioners and the Royal College of Surgeons.

[viii] "Legal physician-assisted dying in Oregon and The Netherlands: evidence concerning the impact of patients in 'vulnerable' groups", Journal of Medical Ethics 33, No. 10, 2007, Pages 591-597

[ix] "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 37, 2011, Pages 171-174

[x] Oral Evidence to the 'commission on assisted dying' 25 May 2011