

**Title:** Over 20 Years of ‘Assisted Dying’ in Oregon: Learning from Oregon Health Authority’s Annual Data Reports

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**Abstract:**

**Main text:**

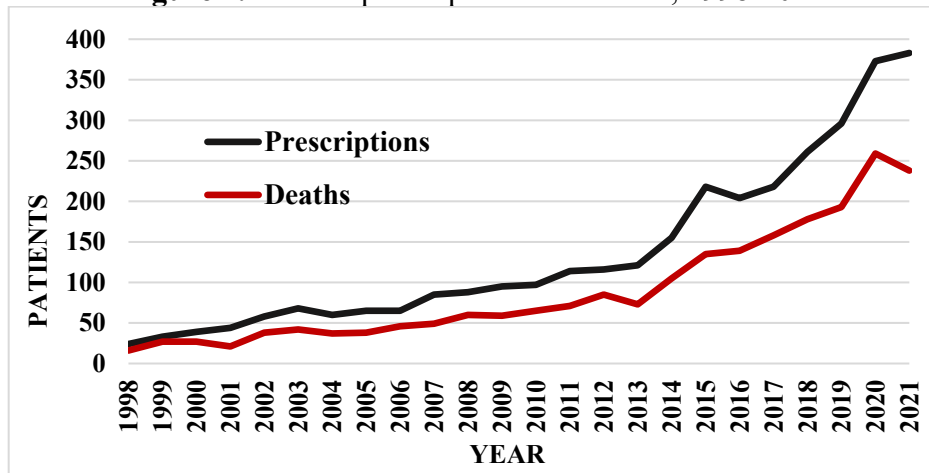
In 1997, Oregon enacted the Death with Dignity Act, becoming the first US state to practice physician-assisted suicide. This legislation allows residents who are at least 18 years of age, capable of making and communicating health care decisions, and have been diagnosed with a terminal illness that will lead to death within six months to end their lives through the voluntary self-administration of lethal drugs prescribed by a physician for that purpose. Annually, the Oregon Health Authority publishes a report which contains data regarding the use of assisted suicide in the state, including the number of lethal drugs prescribed under the DWDA, the number of patients who have died by ingesting these drugs, and a variety of participant data such as insurance status, motivations for hastening death, and the underlying illness which qualified them for assisted suicide.

The Oregon Health Authority recently published the annual data report for 2021, making 23 years of data available for over 2,000 adults in Oregon who have died under the DWDA; what was once a ‘bold experiment’<sup>1</sup> is now a practice of longevity. This short report aims to collate data found in Oregon Health Authority’s reports on assisted suicide from 1998 to 2021 with the aim of revealing data trends from over 20 years of practice. A few trends are brought to particular attention: an exponential increase in the number of assisted suicide prescriptions and deaths, a transition in the sociodemographic traits and end-of-life concerns of participants, and the expansion of patient eligibility to typically non-terminal and psychological disorders.

*Exponential increase in assisted suicide prescriptions and deaths*

Oregon’s Death with Dignity Act was initially proposed to provide a dignified end-of-life care option for a small minority of patients experiencing unbearable suffering which could not be alleviated by palliative care, and this sentiment is well reflected in the first few years of its practice. In 1998, only 24 prescriptions were written for lethal drugs under the DWDA and just 16 patients died from ingesting these drugs. However, what began as an option for extreme cases has become an increasingly attractive end-of-life care decision. On average, the number of lethal drugs prescribed under the DWDA has increased by 13.6% each year and the number of patients who die by ingesting these drugs by 14.7%. In 2021, nearly 400 lethal prescriptions were written and 238 patients died by assisted suicide.<sup>2</sup> This is over a 1,000% increase since the first year of its practice. Based on these trends, it can be estimated that by 2031 over 900 patients could die by assisted suicide each year.

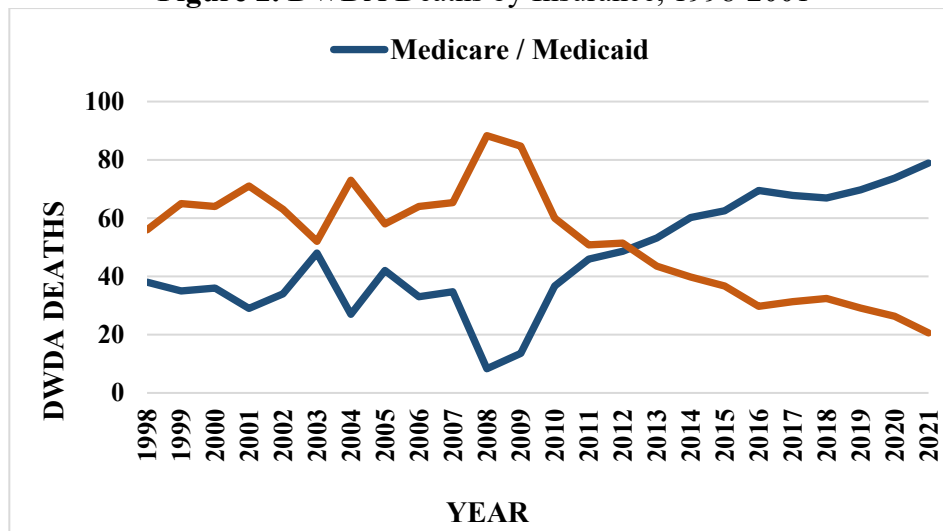
**Figure 1. DWDA prescriptions and deaths, 1998-2021.**



*Transitions in the sociodemographic traits and end-of-life concerns of participants*

With an increasing number of patients drawn toward physician-assisted suicide, close attention must be paid to who is participating in this practice and their motivations for doing so. Throughout the past 20 years, there have been a few notable transitions in the sociodemographic traits and end-of-life concerns of participants. The first of these is insurance status. Throughout the first ten years of ‘Death with Dignity’ in Oregon, the large majority of participants (up to 88%) were privately insured.<sup>3</sup> In the past eight years, however, this is no longer the case. In 2021, only 21% of those who died by assisted suicide had private insurance and the vast majority, 79%, had government insurance, Medicare or Medicaid.<sup>2</sup> This is double the state average of adults with government insurance.<sup>4</sup>

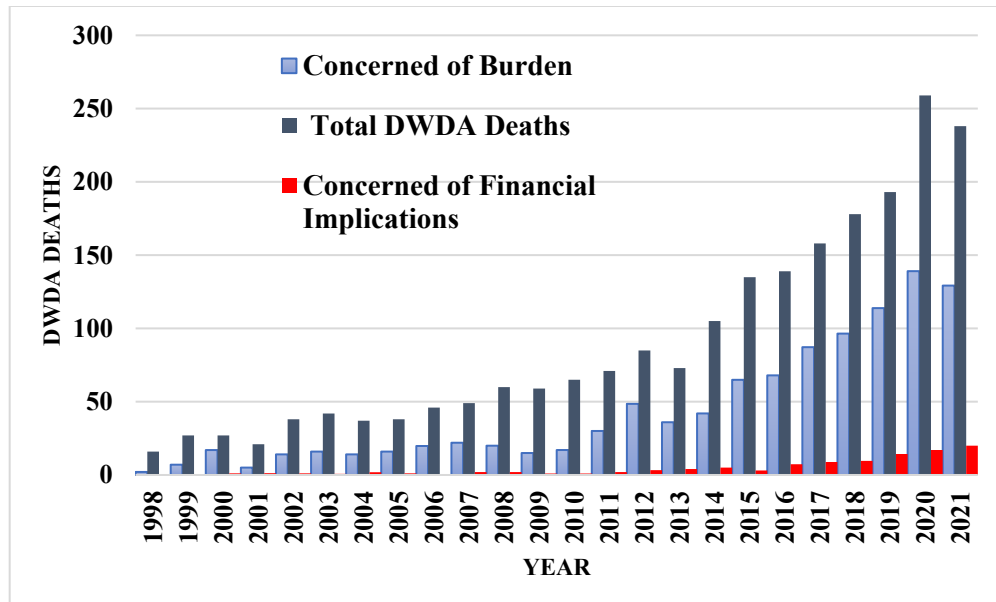
**Figure 2. DWDA Deaths by Insurance, 1998-2021**



Concern about being a burden on caregivers and loved ones has long been a reported concern of those who die by assisted suicide. However, what was once true for an average of 30% of participants in the first five years of its practice is now shared among over half of those who die by assisted suicide; in 2019, nearly 60% of those who died by ingesting lethal drugs under the DWDA were concerned about being a burden on their caregivers and loved ones. Additionally, there has been a significant increase in the number of participants who are

concerned about the financial implications of treatment. This reached a record high of 8.5% in 2021.<sup>2</sup>

**Figure 3. DWDA Participant Concerns, 1998-2021**

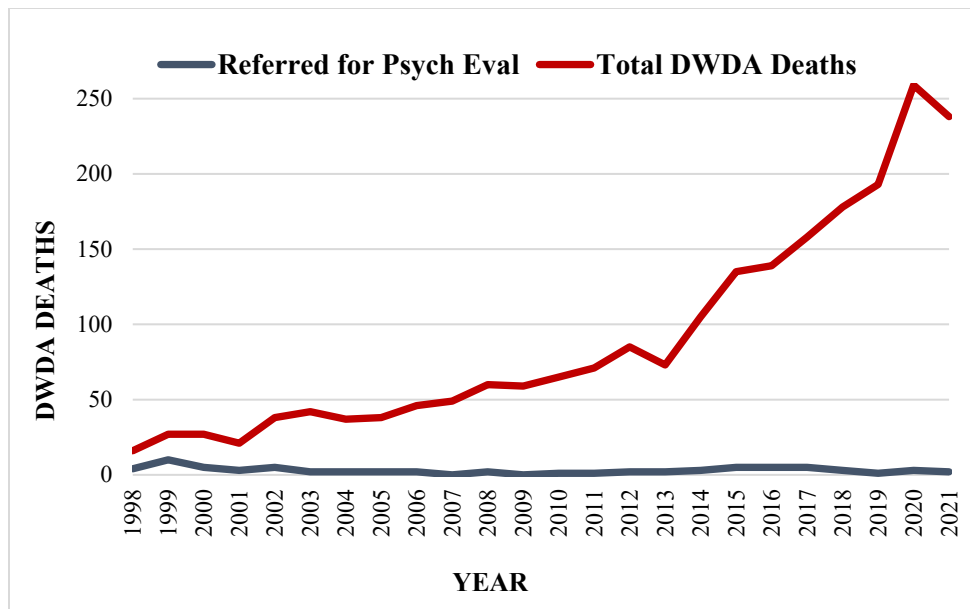


*Expansion of patient eligibility to typically non-terminal and psychological disorders*

In order to be eligible for assisted suicide, the Death with Dignity Act requires that patients be diagnosed with an illness that will reasonably lead to death within six months. While this seems a simple criterion, determining which diseases qualify as a ‘terminal’ has proven complex. Questions have arisen as to whether ‘terminal’ illnesses include diseases that would lead to patient death within six months if no medical treatment was given to slow down the course of the disease, and in 2017 the Oregon Health Authority confirmed that any patient is eligible for assisted suicide as long as their condition will reasonably lead to death in the absence of any medical intervention.<sup>5</sup>

The latest Death with Dignity Act Data Summary confirms this interpretation, as it includes cases of patients qualifying for assisted suicide due to typically non-terminal diseases, including arthritis, arteritis, complications from a fall, hernia, sclerosis, and stenosis. Most significantly, the data summary also reports that in 2021 patients with anorexia, a psychological illness, died by assisted suicide under the DWDA for the first time.<sup>2</sup> Although the number of patients who have died under the DWDA has increased exponentially, the number of patients referred for psychiatric evaluation has decreased. This is particularly concerning as research shows that one in six patients who receive lethal drugs meet the criteria for treatable mental, emotional, psychological conditions such as anxiety and depression.<sup>6</sup> Additionally, there is no mandate to assess if patients have adequate decision-making capacity nor reporting mechanisms in place to reveal whether such an assessment was conducted prior to prescribing the drugs. When the practice was first legalised, psychiatric referrals were as high as 37%. By 2003, however, this percentage dropped to 5% and now less than 1% of patients who die by ingesting lethal drugs under Oregon’s DWDA undergo psychiatric evaluation.<sup>2</sup>

**Figure 4. DWDA Deaths Referred for Psychiatric Evaluation, 1998-2021**



### Conclusion

Oregon Health Authority’s annual reports contain data from 23 years of assisted suicide legislation and over 2,000 patients who have died by ingesting lethal drugs under the DWDA. This short report reveals some concerning trends, including an exponential increase in the number of assisted suicide prescriptions and deaths, changes in the sociodemographic traits and end-of-life care concerns of participants, and a widening criterion of ‘terminal’ illnesses which qualify patients for assisted suicide. We are concerned that, in Oregon, assisted suicide may be an increasingly attractive end-of-life care decision for low-income individuals who may struggle to access quality end of life care, fear the financial implications of care, or feel like a burden on their loved ones and caregivers. Additionally, patients with typically non-terminal and psychological diseases are becoming increasingly eligible for assisted suicide without any requirements of psychiatric evaluation. Most notably, in 2021 cases of assisted suicide for anorexia were reported for the first time.

These trends are not unique to Oregon. In other jurisdictions where ‘assisted dying’ is practiced, expansion of eligibility criterion has also been experienced. In Canada, the Superior Court of Quebec recently declared that requiring patients to be near death in order to access ‘assisted dying’ is unconstitutional, and the Senate has introduced an amendment to allow patients with mental illnesses to qualify for participation.<sup>7</sup> A physician in Colorado recently published an article which details her rationale for helping two young women with anorexia access assisted suicide drugs under Colorado’s End-of-Life Options Act.<sup>8</sup> Clinicians in Belgium have revealed that patient safeguards are increasingly ignored, many patients hasten their deaths because they feel like a burden on their loved ones or cannot access quality end-of-life care, and patients are routinely euthanised for psychological suffering.<sup>9,10</sup>

This short report calls for in-depth analysis of assisted suicide data from Oregon, with particular attention paid to the participation of financially disadvantaged patients who may hasten death out of fear of the financial implications of care, burden, or inability to access quality end-of-life care as well as the participation of those with typically non-terminal illnesses. There is also a need for the state to keep comprehensive records of patients who have request and received assisted suicide drugs under the DWDA, and the implementation of a more thorough reporting process so that more detailed data may be collated. Currently, clinicians are not required to keep chart notes after a certain period of time and the record of names and identity of those who have sought assisted suicide is destroyed by the Oregon Health Authority after one year. This makes comprehensive data analysis or postmortem investigation impossible.

Jurisdictions throughout the world considering ‘assisted dying’ legislation look to Oregon as an example of a safe precedent of practice. Because of this, it is significant to take seriously some of the concerning data trends in a state with more than 20 years of such practice.

#### Authorship Contribution:

The conception for this article was a collective effort between Ilora Finlay and Ana Worthington. AW wrote the first draft and IF contributed to the methodology of this draft. Satya Chandragiri and Brick Lantz contributed comments and suggestions on subsequent drafts, and AW managed the process of reviews and edits.

#### Conflict of Interest:

Ilora Finlay is on the board of Living and Dying Well. Ana Worthington declares paid employment with Living and Dying Well for whom she works as a temporary researcher.

#### Funding:

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