THE RISE OF PHYSICIAN-ASSISTED DYING AND THE EVOLUTION OF DEATH WITH DIGNITY IN OREGON

by

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Physician-assisted dying is when a physician provides, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life. The question of whether and under what circumstances terminally ill patients should be allowed to access life-ending medications with the aid of a physician is receiving increasing attention as a matter of public policy. While public policy related to physician-assisted dying may be a relatively recent development, it is the result of a much longer effort to provide the best possible end-of-life care to patients. The hospice movement shifted the focus from providing treatment to patients for physical ailments, to caring for patients holistically. In 1994, Oregon became the first state in the country to legalize physician-assisted dying policy. Since then, Oregon's policy has been used as an example for other states when crafting their own physician-assisted dying policies. Several issues have arisen since the creation of the policy 25 years ago, and there are many ongoing discussions about ways the law should be applied differently or altered, proving the relevance and importance of the law to lawmakers and Oregonians alike.

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Introduction:

In recent years, much of the developed world has seen an increase in end-of-life debates and an intensification of pressure for legalization of **physician-assisted dying** (PAD). The question of whether and under what circumstances **terminally ill** patients should be able to access life-ending medications with the aid of a physician is receiving increasing attention as a matter of public policy because of a rise in aging population, prevalence of chronic decision and a growing movement in patients' rights to refuse or accept medical treatment.

In the US, nine states -- California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington DC have legalized physician-assisted dying through legislation. In addition, Montana has legalized physician-assisted dying through a court ruling (the State Supreme Court essentially ruled that there are no laws prohibiting aid-in-dying in Montana). In 40 states, physician-assisted dying remains illegal. The federal government and all 50 states prohibit euthanasia under general homicide laws. The federal government does not have aid-in-dying laws (Brittanica, 2022).

Growing Interest in PAD

The increase in interest in end-of-life care options is related to both the increasing number of older adults, and the expectation people have of **medical choice**. "Between 2015 and 2050, the proportion of the world's population over 60 years old will nearly double from 12% to 22%" (World Health Organization [WHO], 2022). Coincidentally, there is also intensified interest in the concept, concept of "choice" also known as **patient autonomy**.

In the health care setting, autonomy means a patient has the right to determine which medical interventions to elect or forgo. This notion can also extend to assisted dying: Patients accustomed to making their own health care decisions throughout life should also be permitted to control the circumstances of their deaths.

Whether an assisted death is warranted is inexorably linked to our understanding of what it means to be healthy; often, that translates into the absence of illness. Most of Western medicine subscribes to the **medical model of health**, which treats the human body as a complex mechanism and advocates the treatment of symptoms using medical intervention and procedures. At its core, this approach is about seeking out the cause of illness and providing curative remediation.

While the medical model of health works to a certain extent, it fails when a patient cannot be cured, and treatments are no longer effective. The World Health Organization (WHO) offers a different definition of health: a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2022). This more holistic approach to health includes all the different areas of our lives that affect our health and well-being. Where the medical model does not consider patients who are diagnosed with terminal and incurable diseases, the World Health Organization's model advances an all-encompassing vision of a high quality of life.

It was during the early 1990s that the end-of-life care movement focused national attention on quality of life at the end as well as the need for a more open discussion surrounding end-of-life options. As a result, in 1994 Oregon was the first state in the country to legalize physician-assisted death policy. The successful campaign

of the Oregon Death with Dignity Act in November 1994 passed and defeated a repeal effort in November 1997. Oregon has since been an example to other states when drafting their own legislation and has the most comprehensive data on physician-assisted dying of any state in the country. Oregon continues to be a leader in the assisted dying movement.

In the forthcoming chapters, I will discuss the origins of the hospice movement and how Cicely Saunders had a vision for a different kind of end-of-life care. This movement then made its way to the US thanks to people like Florence Wald and Elisabeth Kubler-Ross. Now, hospice and palliative care are some of the most rapidly growing areas of healthcare. Next, I will discuss the distinct terminology differences when referring to physician-assisted dying, followed by an examination of what a "good death" means. Oregon was the first state in the US to legalize physician-assisted dying policy, and I will explain how that policy came to be, and how it exists in society today. There are many different ongoing issues related to assisted dying, and I will consider a few of the most prevalent in Oregon currently.

What is Hospice and Palliative Care?

Today, with demand for end-of-life care increasing due to an aging population with more chronic illnesses, hospice and palliative care are a quickly growing area of healthcare. The primary difference between hospice and palliative care is the timeline in which they are offered. The World Health Organization stresses that palliative care should start from the diagnosis of life-threatening illness (Connor, 2018). Thus, palliative care is for any patient with a chronic illness that is experiencing a decreased quality of life because of symptoms related to their disease, not just the dying. The

National Hospice and Palliative Care Organization (NHPCO) defines **palliative care** as treatment that enhances comfort and improves the quality of an individual's life during the last phase of their life (Connor, 2018).

Hospice care, in contrast, has a defined timeline, which begins with a physician's diagnosis. In healthcare today, hospices are dedicated to those with a terminal illness whose doctor believes have six months or fewer to live if the illness runs its natural course (National Institutes of Health, 2022). Derived from the Latin **hospes/hospit**, the word shares its origins with both hospital and hospitality. In medieval times, it referred to a place of shelter for all in need: ill travelers on long journeys, the poor and women in labor, i.e., not only the dying (Tatum, 2014).

Today, the concept is more narrowly defined: Patients can only be transitioned to hospice care once their physician diagnoses them with six months or less to live. Of course, some patients may outlive that estimate and have the flexibility to move in and out of hospice care as their condition changes. In addition, hospice is "primarily a concept of care, and not a specific place of care" (Milicevic 2002, 30). Hospice patients *can* be cared for in a facility, but they can receive hospice treatment from hospitals, other healthcare providers and at home. In fact, patients often prefer to be cared for and die at home (Baldwin, 2011).

While distinct, hospice and palliative care share similar objectives: to improve overall quality of life, increase level of comfort, and provide emotional support to the patient and their family. In addition:

- Provide relief from pain and other distressing symptoms
- Affirm life and regard dying as a normal process

- Intend neither to hasten nor postpone death
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients live as actively as possible until death
- Offer a support system to help the family cope during the patient's illness and in their own bereavement
- Use a team approach to address the needs of patients and their families, including bereavement counseling
- Enhance the quality of life and attempt to positively influence the course of the illness (Connor 2018).

Physician-assisted death is a delicate, and a deeply personal subject, and each dying person, their family members and loved ones may have their own sense of what a "good death" would be.

Good Death

The hospice movement has brought with it the concepts of **palliative care** and **good death**. Empirical research on what constitutes a good death only began a few decades ago, likely a result of the growing end-of-life care movement. What constitutes a good death will differ from person to person but will "contain common factors such as being free from pain and discomfort and dying in a venue of choice" (Baldwin 2011, 42). While a good death has no universal definition, one's perception of a good death is unique to each person and dying situation. A good death is a dynamic concept for patients, families, and healthcare providers alike (Baldwin 2011, 77).

The common elements in many people's definition of a good death are controlling pain, maintaining individual dignity, remaining autonomous, choosing the

location of dying, and feeling spiritually, emotionally, and psychosocially supported. Others hold notably different ideas about what a good death is, with some being potentially contentious. Being able to exercise control over one's death has introduced ethical dimensions to the meaning of good death which has rendered it a contentious issue for contemporary palliative care (Baldwin 2011, 78).

In 2016, researchers published a literature review to the *American Journal of Geriatric Psychiatry* which investigated the core themes of a good death. Their findings identified ten major themes, each with sub-themes. Table 1 summarizes the results of the review.

Table 1: Core Themes and Subthemes of a Good Death and/or Successful Dying, *American Journal of Geriatric Psychiatry*

Core Theme	Subtheme
Preferences for dying process	Death scene (how, who, where, and when)
	Dying during sleep
	Preparation for death (e.g., advanced directives, funeral arrangements)
Pain-free status	Not suffering
	Pain and symptom management
Emotional well-being	Emotional support
	Psychological comfort
	Chance to discuss meaning of death
Family	Family support
	Family acceptance of death
	Family is prepared for death
	Not be a burden to family
Dignity	Respect as an individual
	Independence
Life completion	Saying goodbye
	Life well lived
	Acceptance of death
Religiosity/spirituality	Religious/spiritual comfort
	Faith
	Meet with clergy
Treatment preferences	Not prolonging life
	Belief that all available treatments were used
	Control over treatment
	Euthanasia/physician-assisted suicide
Quality of life	Living as usual
	Maintaining hope, pleasure, gratitude
	Life is worth living
Relationship with HCP	Trust/support/comfort from physician/nurse
	Physician comfortable with death/dying
	Discuss spiritual beliefs/fears with physician
Other	Recognition of culture
	Physical touch
	Being with pets
	Healthcare costs

Writer Amy Neuman suggests that there is no such thing as a “good death.” The death always hurts, both the dying and the grief left behind. Neuman poses an alternative, that while no death is a good death, a “good enough death” is possible. There are many kinds of good enough death, specific to each dying person. A good enough death could include any number of the themes in Table 1 or elsewhere. A good enough death is when the individual dying person’s requests are met and they feel comforted. However, there is only one kind of bad death, one characterized by pain, denial, prolongation, and loneliness. It was perhaps appropriate that the person who first introduced physician-assisted dying policy in Oregon uniquely understood this dilemma.

Chapter 1: An Evolutionary Path

The end-of-life care that we are familiar with today is the result of a decades-long movement which advocated for compassionate and holistic treatment at the end of one's life. in the first modern hospice was founded in England in 1967 by a nurse named Cicely Saunders, who created a different way to care for the dying, by treating them as a whole person rather than a set of symptoms. Saunders, who first trained as a nurse, then as a social worker and finally a physician, envisaged a team approach, or a center for excellence in care of the dying patient. Her vision was of an atmosphere that was truly patient-centered, with specific mental, physical and emotional needs cared for (Roberts, 2018). Her legacy, St. Christopher's, continues to serve as a beacon for hospice development worldwide. The research and education center has continued to promote improvement in palliative care and to share knowledge of palliative care methods gained from its 50 years of experience (Connor, 2018).

The US Hospice Movement

The US hospice movement is based on the hospice model developed in Great Britain and widely disseminated by St. Christopher's Hospice in London. The British model is distinguished by control of physical, sociological, psychological, and spiritual symptoms; coordinated home/inpatient care with a central hospice administration; inclusion of the family in the unit of care; provision of care by an interdisciplinary team; structured staff supporting communication systems; and acceptance of the patient based on need rather than ability to pay (Osterweis 1979, 494).

Hospice first came to North America in 1971. Hospice Inc., in New Haven, Connecticut was founded by **Florence Wald**, dean of nursing at Yale University. Wald was inspired by a lecture at Yale given by Dame Saunders in 1963 as part of a six-week tour of the US. Saunders quickly developed contacts in the US and spreading the lessons of hospice learned in the UK.

In the mid-1970s, a small but committed hospice movement begun to take shape throughout the United States and Canada (St. Christopher's Hospice, 2020). The National Hospice Organization was founded in 1978 in the US and began holding annual educational conferences. There was little doubt that palliative care and hospice care was appropriate and necessary. The importance of establishing a more responsible end-of-life care system was valued in terms of relieving suffering during the last days of life and during bereavement (Osterweis, 1979).

One of the pioneers from the United States in care of the dying is **Elisabeth Kubler-Ross**. In the 1960s, she interviewed dying patients in general hospitals in Chicago and wrote a book, *On Death and Dying*. This book had a heavy influence and caused much public reaction in the US. The publication of *On Death and Dying* was one of the factors that brought end-of-life issues to public awareness. Kubler-Ross, Wald, and Saunders accelerated the spread of the hospice movement in the UK, USA and the entire world (Milicevic, 2002).

After making waves in the UK, Saunders' teachings reached the US, beginning with the 1974 establishment of the first hospice in Branford, CT. Its popularity was enhanced by post-WWII desire in America for a more compassionate way to care for

the dying. The US hospice movement really took off with the help of notable advocates Florence Wald and Elisabeth Kubler-Ross.

The United States and Western Europe in the 1970s were undergoing rapid social change. Many institutions were being challenged, and people were experimenting with new ways of solving old problems. Those involved in the treatment of the dying began hearing about a new approach to care being used in the United Kingdom called hospice (Connor, 2018).

Throughout the twentieth century in the United States, modern medicine transformed the experience of dying from part of daily life to a highly depersonalized event. Before the widespread use of antibiotics following the Second World War, people died at a younger age and with less forewarning. The dying were less apt to rush to the hospital; rather they convalesced at home with the help of their families. Physicians could do little but visit and attend to the dying by relieving their suffering (Tatum, 2014).

Health care professionals and family members of the dying were frustrated with callus, insensitive medical care. Physicians, nurses, psychologists, and social workers were not trained to care for the dying and tended to visit dying patients less often (Connor, 2018). In addition to caregivers being ill-equipped to care for the dying, unrealistic optimism led to “a conspiracy of silence” where family and medical staff knew the truth but withheld it from the patient. There was a widespread belief that to tell a patient they were dying would cause harm and lead to premature demise. Many caregivers were dissatisfied in this atmosphere of denial. There had to be a better way to treat the dying.

When they first came to the fore in the late 1970s, hospice programs in the US were very individualized. Although they shared a basic conceptual approach, they differed in terms of setting, service components, reimbursement arrangements and staffing. Each one seemed to evolve out of the needs and resources of its own community. Cooperative planning within and among communities was relatively limited in the early stages of the US hospice movement. Leadership and coordination to the movement was later provided by The National Hospice and Palliative Care Organization (Osterweis, 1979).

After the Second World War, great advances were made in pharmaceuticals and medical techniques. Antibiotics and other life-sustaining methods made seeking hospital treatment more beneficial to quietly dying at home. As a result, patients died in institutions more often than they died at home. However, the attitude was that they did not die, but rather "expired." At the time, their deaths were seen as a failure in the context of the curative model of healthcare.

The US hospice movement has a slant distinctly toward home care. Most Americans surveyed showed a preference for dying in their own homes. There is also a greater emphasis on use of volunteers and more of a focus on psychological preparation for death than in the British hospice model.

In the early 1990s, as hospice began to grow, it became clear that many patients with life-threatening conditions would not qualify for hospice care due to having an uncertain prognosis, and an overall resistance to the idea of acknowledging the likelihood of death. Many of these patients were dying in hospitals and other institutions without the resources to be cared for at home by hospices. To expand the reach of end-

of-life care, healthcare professionals and some hospices began to develop care programs, usually hospice based, that provided many of the same services delivered by hospices but without any requirements for prognosis or treatment limitations (Connor, 2018).

Modern Hospice and Palliative Care

Over the past decade, palliative care has been one of the most rapidly growing fields of healthcare within and outside of the United States due to a combination of better quality of life, better quality of care and the provision of care at an affordable cost (Hughes, 2014). These three elements are now referred to as the **triple aim** of improving healthcare in the US. By improving the healthcare experience, improving the health of the community, and reducing costs, healthcare organizations can identify and address problems more efficiently.

The need for palliative care is expected to rise substantially in the next few decades. Over the 40 years that the field of palliative care has developed in the United States, the US population has grown from 228 million to 330 million people. America's population is getting older as well; in 1980, 11% of the population was 65 years old or older, whereas in 2020, this figure rose to 16%. With the aging of baby boomers and the increased longevity of earlier generations, 14 million more people were 65 years and over in 2020 (54.1 million) compared with a decade earlier (40.3 million).

Coupled with the aging of America's population is the fact that more people are living with chronic disease. In 2020, 133 million Americans, nearly half the population, suffered from at least one chronic disease (Hughes, 2014). Considering that 63% of patients in hospice and palliative care are more than 85 years old, and the principal

diagnosis of these patients are chronic illnesses such as cancer, heart disease, and dementia, the need for quality hospice and palliative care programs is only increasing (Vietta, 2001).

Today, palliative and hospice care continue to provide and promote quality of life for people who have life-limiting illnesses. The early modern hospices provided care for people diagnosed with a cancer, whereas contemporary palliative care includes care for people of all ages and their families in which the patient has any number of diagnoses of terminal illnesses. Palliative care has evolved to "enable quality of life, quality of living, and quality of dying across a range of health, social, and home care settings, provided by a multi-disciplinary team including professionals, volunteers and lay carers" (Baldwin 2011, 94). Changes in health and social care policy and, subsequently, the organization of care delivery over the years, have seen palliative care being introduced into a variety of care settings. Palliative care has spread from the hospice building into hospitals, community, nursing, and residential homes, so that today it is delivered in urban, rural and remote settings. The palliative care team has similarly evolved to incorporate a range of health and social care professionals whose responsibility is to work and learn together to provide responsive comfort and care for their clients. The palliative care team's focus is to provide holistic care. This way, the team remains faithful to the philosophy of palliative care that was envisioned by the pioneers of the modern hospice movement (Baldwin, 2011).

The concept of modern hospice, which can be simply described as principles or a philosophy of care for the dying person, has gathered momentum to such an extent that today it is a movement incorporating palliative care across the world. The concept

of hospice resulted from the recognition of the neglect of terminally ill people being cared for in a health service that tended to abandon the dying. The early and enduring definition of hospice was captured by Saunders's 1978 philosophy of enabling people to live with a degree of quality to their life until they died and, when the time came, to die peacefully and in dignity. Between Saunders's published philosophy and the World Health Organization's well-known holistic definition were other notable characterizations of hospice care, embracing individuality in living through a humanistic approach to care that addressed the bio-psycho-social needs of the person with a life-limiting illness, and including care of the patient's family. Death is recognized as an inevitable part of life, and there is a willingness to discuss issues relating to dying and death. The modern hospice and palliative care movement, initially considered to be care required when cure was no longer possible, has evolved into a continuum from the time of the patient's diagnosis and inevitable death to the family's care in their grief and bereavement (Baldwin, 2011).

A relatively recent development of the modern hospice and palliative care movement is the growing push to legalize physician-assisted dying policy. The fundamental values of the hospice movement are whole-person healthcare and patient-driven treatment. The growth of end-of-life care services and hospice resources over the last few decades is a direct result of the hospice movement, one of those services is assisted dying. Physician-assisted dying affords dying people autonomy and compassion during the most difficult time, which is directly in line with the values of the hospice movement.

Chapter 2:

There are several terms used to describe medical aid-in-dying. While often used interchangeably, the correct terminology is crucial to describing the situation accurately and without political bias. Physician-assisted suicide has become an antiquated and inherently negative way of describing medical aid-in-dying. Each person's definition of a good death is unique and subjective, but many core similarities can be extracted. Factors such as choosing the location of your death, and the people you wish to be comforted by are common threads when examining what a good death means. Physician-assisted dying has introduced an ethical dimension into what a good death means, as some patients perceive a good death to be one that they control. Oregon began the effort to legalize physician-assisted dying in 1991, with the Oregon Death with Dignity Act passing in 1994. The policy has endured legislative challenges, lawsuits, and even a ballot attempt to repeal. The policy remains strong to this day, and Oregon lawmakers demonstrate its relevancy as they continue to make amendments based on the best interest of the public.

Distinction in Terminology

There are many different terms to refer to a person ending their own life with the aid of a physician. Often used interchangeably, **death with dignity, aid-in-dying**, **assisted dying**, **assisted suicide**, and **euthanasia** all have slightly nuanced meanings. The term that a person uses often indicates their position on legalization. Without context, the terms assisted suicide and euthanasia are often seen as immoral. Those words hold connotations of corruptness and inhumane treatment. Assisted suicide is tainted with the negative stigma surrounding suicide and is often used by those who

oppose assisted dying as a policy. Euthanasia has a different meaning from all the other terms. Whereas assisted dying, aid-in-dying, and death with dignity refer to a person taking their own life with the assistance of another person, euthanasia describes a situation where a person asking for assistance in dying has another person take the action which leads to their death. The crucial difference is who performs the fatal action. Aid-in-dying laws across the country have made it legal for the dying person to perform the action themselves. However, another person taking the action to end the dying person's life is considered murder and is strictly prohibited almost everywhere in the world.

The hospice and palliative care movements are only expanding as the need for quality end-of-life care grows. Dying patients not only want hospice and palliative care available to them, but they are also demanding *quality* care, and more options. The field is relatively new to modern medicine, and new methods of providing comfort through end-of-life care are being developed constantly. Regardless of the availability of optimal palliative care, palliative care cannot fully relieve all people's suffering, and it is likely that assisted dying will continue to be chosen by some.

Physician-Assisted Dying in Oregon

In 1991, Oregon Senator Frank L. Roberts proposed the first aid-in-dying law in the nation. Roberts was widely known as the "conscience of the Oregon Senate" at the time. He had advanced prostate cancer, and as a complication of the radiation therapy he had sustained a spinal cord injury and used a wheelchair. Senator Roberts was married to the governor, Barbara Kay Roberts, and he knew that the prostate cancer was going to kill him. One might think that all these elements would have allowed him to

get his bill through the legislature, but quite the opposite occurred -- it didn't even get a serious hearing. The bill received what is called a courtesy hearing which is when witnesses testify on the bill, but a vote is not held. There was no one representing patients, let alone dying patients. Just about everyone who attended the hearing were clergy members and had to come to the Capitol Building to testify against the bill. Following the hearing the bill quietly disappeared. About a year and a half later, Roberts died in the governor's mansion with his wife by his side. The senator unfortunately had exactly the kind of death that he'd hoped to avoid, drifting in and out of consciousness for several weeks.

It was two years later in a church bulletin that Oregon Senate Healthcare and Bioethics committee member Barbara Coombs Lee learned that people were gathering to draft an initiative to place on a state ballot (Cohen 2019, 278-279). Coombs Lee spent the next 10 months laboring on the initiative. She campaigned on behalf of the initiative throughout the State of Oregon. Coombs Lee went on to spend 10 years defending Oregon's Death with Dignity Act in both judicial and legislative arenas. She would also be a major help in crafting of the state of Washington's assisted dying law (Cohen 2019, 280).

Physician-assisted dying was officially legalized in Oregon in 1994 through the citizen's initiative that Coombs Lee campaigned for and helped write (See Appendix B). The Death with Dignity Act (DWDA), as it is called, is a "permissive law that allows terminally ill Oregonians to end their lives through the voluntary self-administration of a lethal dose of medication, expressly prescribed by a physician for that purpose" (Oregon Health Authority, 2022).

The DWDA was passed twice by Oregon voters. The first time was in a general election in November 1994 when it passed by a margin of 51% to 49%. An injunction delayed implementation of the Act until it was lifted on October 27, 1997. In November 1997, a measure was placed on the general election ballot to repeal the DWDA. Voters chose to retain the DWDA by a margin of 60% to 40%. There is no state "program" for participation in the DWDA. People do not "make an application" to the State of Oregon or the Oregon Health Authority. It is up to qualified patients and licensed physicians to implement the DWDA on an individual basis. No one is compelled to participate. The DWDA requires the Oregon Health Authority to collect data about DWDA participation and to issue an Annual Report, which is where all published data on the DWDA is found (OHA, 2022). The 25 years of aid-in-dying data from Oregon is the most comprehensive collection in North America.

Oregon Death with Dignity Act Requirements and Regulations

The DWDA states that, to participate, a patient must be:

- 18 years of age or older
- A resident of Oregon
- Capable of making and communicating health care decisions for themselves
- Diagnosed with a terminal illness that will lead to death within six months

These requirements all come with certain exceptions. The Oregon legislature has made several amendments to the DWDA in the last few years, indicating how relevant and alive the law is today. One of these changes came on January 1, 2020, allowing patients to be exempt from any waiting period that exceeds their life expectancy. Patients with less than 15 days to live are exempt from the 15-day waiting period

between the first and second oral requests for medication. Patients with less than 48 hours to live are exempt from the 48-hour waiting period between the patient's written request and the writing of the DWDA prescription.

In March 2022, a major change was made when Oregon reached a settlement with an Oregon physician that wanted to provide aid-in-dying to his patients across the state line in Southwest Washington. As a result of the settlement, the Oregon Health Authority, the Oregon Medical Board, and the Multnomah County District Attorney ordered their staff to stop enforcing the residency requirement in Oregon's Death with Dignity Act. In practice, that means that people who wish to use Oregon's law will not need to obtain an Oregon driver's license or lease to prove long-term residency before seeking medical help to end their lives (Templeton, 2022). The Oregon Health Authority has also agreed to propose legislation in the next regular session, officially removing the residency requirement from the Death with Dignity Act. This decision was made quite recently, and while the state is no longer enforcing the residency requirement, the law itself will not be officially changed until the legislation is passed in the Oregon Congress. Oregon will be the first state in the nation to allow physicians to prescribe lethal drugs to out-of-state patients (Templeton, 2022).

A primary motivator for this lawsuit was the difficulty in finding doctors in Southwest Washington who offer aid in dying. The largest healthcare organization in Clark County, Peacehealth, is a Catholic health system that does not prevent its patients from seeking medical aid in dying but will not participate in it. In situations like this, where the discussion of whose conscience is more important—that of the Church, hospital doctors, staff and administrators, or patients—is still ongoing as it relates to

physician-assisted dying. Neuman describes this complicated web of opinions as a "hierarchy of conscience" (Neuman 2016, 75). Society lets corporations and institutions interject their own beliefs into the personal patient-doctor relationship and allows these groups to deny patients the care they want. Despite this, or perhaps in response to this, the aid-in-dying movement continues to grow and gain momentum. Maybe the intensified interest in the aid-in-dying movement is because patients fear the loss of control over their own dying experience, as institutions and organizations such as these attempt to dictate the most intimate decisions in a person's life.

In Oregon, assisted dying is provided under strict rules that govern the decision of the procedure itself. The Oregon Health Authority, a governmental body, regularly publishes a documentation of the practice, which includes a list of the reasons patients give for wanting to end their lives. Among these reasons, loss of dignity is highly ranked. The other most important life ending concerns being loss of autonomy, and the decreasing ability to participate in activities that make life enjoyable (Weber-Guskar, 2019). Physicians and patients that follow the DWDA requirements are protected from criminal prosecution and the choice of legal physician-assisted dying cannot affect the status of the patient's health or life insurance policy (Norman-Eady, 2002). Under the act, ending one's life in accordance with the law does not constitute suicide. The Death with Dignity Act "legalizes physician-assisted dying, but specifically prohibits euthanasia, where a physician or other person directly administers the medication to end another's life" (Norman-Eady 2002, 1).

A variety of safeguards limit conditions under which the prescription can be written. A physician will write the prescription after confirming that the patient has a

terminal illness likely to cause death within six months and is competent to make the decision and is doing so voluntarily. Individuals must be informed of the options of hospice and comfort care. "In order to minimize risk of impulsive decisions, individuals must make one written request, and two oral requests over the period of 15 days" (Ganzini 2016, 77).

The patient must be referred to a psychiatrist or psychologist if there is a concern that a request for a lethal prescription stems from impaired judgment resulting from mental illness such as depression. The physician must request but may not require that the patient inform their family of their decision to end their life. Physicians who do not comply with the law's requirements may be subject to action from the state licensing board (Ganzini, 2016, 77).

Prescribing physicians are required to report information to the state on patients who receive prescriptions. They however are not required to report any information on requests that do not result in a prescription, therefore less is known about the reasons why patients are denied prescriptions (Ganzini 2016, 77).

Physician-Assisted Dying Within Hospice

Throughout the United States, individuals become eligible for hospice care at the time they have less than six months expected life and are no longer pursuing life-sustaining treatment. At the time of passage of Oregon's Death with Dignity Act, there was a concern that legalized physician-assisted dying may undermine support for hospice and palliative care, both of which were early in their development. In fact, "physician-assisted dying became an option within hospice, with 90% of physician-assisted dying decedents hospice enrolled" (Ganzini 2016, 79).

Concerns that legalization of physician-assisted death would undermine efforts to develop and improve palliative care programs in target vulnerable groups such as the elderly population, the uninsured, or the poor have not been realized. In fact, in Oregon the availability of hospice and palliative care has expanded substantially, although the increased availability cannot necessarily be attributed to legalization of physician-assisted death. Compared to people with other causes of death, Oregon residents who have died after taking a prescription for lethal medication have more years of education and are most likely to be white. “It is unclear if these traditional measures of privilege confer greater interest in physician-assisted death, or more success in obtaining a prescription for lethal medication” (Ganzini 2016, 427).

Another challenge to care providers at the end of life is that individuals who request physician-assisted dying services often are motivated by concerns that are not easily ameliorated by hospice care. Although many of the arguments around legalization focused on pain, a surprising finding is that most patients of the at the time of their first request for physician assisted dying have minimal pain. “The fear of future pain is a more important reason for their requests” (Ganzini 2016, 80). For hospices, physician-assisted dying patients can present a variety of challenges both at a policy level, and for individual practitioners. Individual practitioners opposed to physician-assisted dying may believe that they have failed as a physician when their patient chooses to take the lethal medication and denying a dying patient their request for lethal drugs typically prompts them to look for another physician.

Among the hospice organizations in Oregon, policies on physician-assisted dying vary. All hospices share core values of not hastening death, not abandoning

patients, and respecting both physician-patient and inter-disciplinary team relationships, but they differ in how they balance these values. Oregon hospices will not discharge a patient who entertains the goal of physician-assisted dying, but no hospice will provide the patient with the lethal medication or assist in the self-administration.

Within these boundaries, hospices vary on the degree to which they allow staff to discuss physician assisted dying with the patient, notify the attending physician of the patient's interest in physician-assisted dying, refer the patient to an advocacy organization for more information, or allow hospice staff presence before or during ingestion of the medication (Ganzini 2016, 81).

For example, on one side of the spectrum there are religiously based hospices where physician-assisted dying is incompatible with their hospice care. They will not provide information about patient choices, and they ask patients to respect their hospice position. On the other side of the spectrum, there are hospices that "emphasize respect for patient self-determination, allow hospice personnel to openly discuss assisted-dying as an option, refer the patient to advocacy organizations for information, and allow staff attendance when patients end their life" (Ganzini 2016, 81).

The Oregon Death with Dignity Act has been criticized as both inadequate in safeguards and lacking in enforcement for safeguards. Oregon does not require that the primary or the consulting physician have expertise in palliative care. Assisted dying laws require two doctors to independently evaluate a patient's request for medical assistance in dying. But patients must be physically able to ingest the life-ending medication themselves, a safeguard that ensures they are acting voluntarily. Patients are evaluated to make sure they have the decision-making capacity when they receive the

prescription, but there are no safeguards to ensure that they are of sound mind at the time they take the prescription. Safeguards are written into the law to make sure that patients are competent and not requesting physician assisted dying because of treatable mental illness. Mental illness alone does not exclude patients from obtaining lethal prescriptions. Physicians assess that any mental illnesses are not impacting the patient's judgment to hasten death, but this decision does not require evaluation by a psychiatrist or a psychologist. A small number of people with depression do access the law, further supporting the need for improving the screening process for mental illnesses (Ganzini 2016, 83). Patients become eligible under the law at the time they have less than six months life expectancy, yet some patients who have prescriptions outlive this life estimate bringing into question the accuracy of physician prognoses.

The Reality of Physician-Assisted Dying in Oregon

As of January 21, 2022, 238 people had died in 2021 from ingesting the prescribed medications, including 20 who had received prescriptions in previous years. Demographic characteristics of DWDA patients were similar to those of previous years: most patients were aged 65 years or older (81%) and white (95%). The most common diagnosis was cancer (61%), followed by neurological disease (15%) and heart disease (12%). Since the law was passed in 1997, a total of 3,280 people have received prescriptions under the DWDA and 2,159 people (66%) have died from ingesting the medications. During 2021, DWDA deaths accounted for an estimated 0.59% of total deaths in Oregon. People who die with a physician’s assistance are more likely to be members of groups enjoying comparative social, economic, educational, and professional privilege.

Since 2020, the DWDA provides an exemption to the statutory waiting periods for patients expected to live fewer than 15 days after the time of their first oral request for medication. In 2021, 81 patients (21% of DWDA prescription recipients) were granted exemptions. Prescribing physicians were present at time of death for 36 (15%) of the patients who ingested DWDA medications. Forty-one patients (17%) had other health care providers present, and volunteers were present for 43 deaths (18%). Data on time from ingestion to death are available for 155 DWDA deaths (65%) during 2021. Among those patients, time from ingestion until death ranged from two minutes to 24 hours, with a median time of 32 minutes.

Medical aid-in-dying has gone through several changes since its legalization in Oregon in 1994. It is important to use the accurate terminology when referring to different aspects of assisted dying procedures. What it means to have a good death is distinct to each person but there are many similarities that researchers can use when developing more effective end-of-life care. Physician-assisted dying introduced a new factor into what a good death means, as some patients perceive a good death to be one that they control. Oregon began the effort to legalize physician-assisted dying in 1991, with the Oregon Death with Dignity Act passing in 1994. The policy remains one of Oregon's landmark pieces of legislation, however it does not exist without flaws. Discussions and debates are ongoing about the feasibility of requiring psychological evaluations for patients requesting physician-assisted dying.

Chapter 3:

Oregon legalized the Death with Dignity Act in 1994, and it has remained Oregon law ever since. However, a topic as contentious as physician-assisted dying is not without its complications. One of the major issues currently being discussed is whether every patient that shows interest in physician-assisted dying should undergo psychological evaluation to rule out mental disease or disability. Another concern that presented itself around 2015 is which prescription drugs should be utilized for the purpose of ending a person's life peacefully. There is a lot of research on the medications that heal ailments and treat diseases, but until recently there hasn't been any research on which drugs should be used to most humanely kill someone. As physician-assisted dying continues to become more available across the country and around the world, perhaps the most difficult problem is how to equitably serve people with physical or mental disabilities that preclude them from participating in their own death. This question is especially relevant as we ask whether those sick with COVID-19 will have physician-assisted dying as an option.

Ongoing Challenges and Issues with Assisted Dying in Oregon and Beyond

Under the Oregon law, the prescribing and consulting physicians must determine that the patient requesting a lethal prescription is "capable." If either believes the patient has a psychiatric or psychological disorder that might impair judgment, then "either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or

psychological disorder or depression causing impaired judgment" (Oregon Revised Statute (ORS) 127.825 s.3.03).

In 2008, researchers from the Oregon Health and Science University (OHSU) reported in the *BMJ* (formally, the *British Medical Journal*) that 1 in 4, or 25%, of those seeking assisted suicide in Oregon were depressed. "The current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legalized aid-in-dying are needed" (Ganzini 2008).

In 2009, officials with the Oregon Health Department called the ongoing decline in requests for psychiatric evaluation for those seeking assisted suicide a "worrisome trend," noting that "[t]he decline in formal evaluation raises concerns that depression remains undiagnosed in some patients who request and receive a prescription under the DWDA" (Oregon Health Authority 2009).

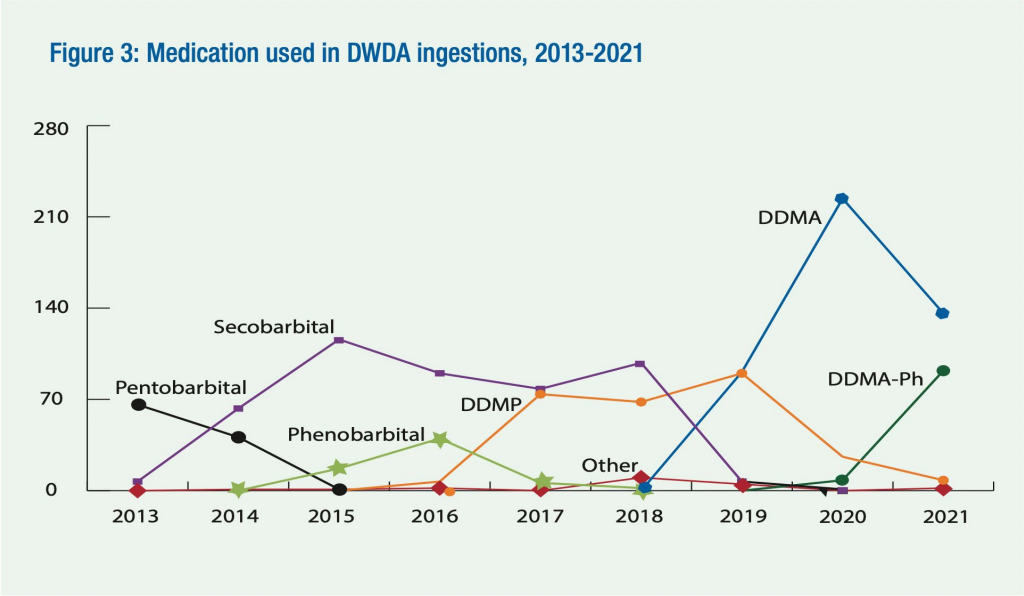
Yet despite the warning of a "worrisome trend" of declining psychiatric evaluation requests, and despite all the evidence for the linkage between depression and a desire to hasten death, out of the patients that died from a lethal prescription, only two patients were referred for psychological or psychiatric evaluation in 2021, three in 2020, and 66 total from 1998 to 2019. A total of 2,159 patients died from 1998 to 2021, and a mere 3.2% have been evaluated by a psychologist or psychiatrist.

Another ongoing issue is which drug to prescribe to patients that participate in aid-in-dying. In 2016 the two lethal medications used by most patients for decades had suddenly become either unavailable or prohibitively expensive. For years, the two barbiturates widely considered the best drugs for hastening death in terminally ill

patients were pentobarbital and secobarbital. These medications were painless, fast-acting, and relatively affordable. But since 2015, they've been largely unavailable. US pharmacies stopped carrying pentobarbital approved for human use, and the price of secobarbital doubled from an already historic high after Valeant Pharmaceuticals (today known as Bausch Health) bought the manufacturing rights. A few years ago, a lethal dose cost about $200 or $300; now it can cost $3,500 or more. Scientists required a new drug that would: first, put a patient to sleep and keep them asleep; and second, make sure there was no pain involved; and third, ensure that they would die, and, hopefully, die relatively quickly. It also needed to be affordable, hoping for $500 a dose. The new drug contains high doses of four medications: digoxin—a cardiac drug, diazepam—also known by its early brand name, Valium—morphine, and propranolol, a beta-blocker that slows the heart. The mixture is called DDMP2. Another version of the drug, DDMA was developed using amitriptyline instead of propranolol. Currently, DDMP2, DDMA, and DDMA-Ph (DDMA with phenobarbital) are the most commonly used drugs for physician-assisted dying in Oregon (See Figure 1) (OHA, 2022).

Figure 1: Medication used in DWDA ingestions in Oregon, 2013-2021

This figure shows the changes in the preferred prescription drugs for assisted dying in recent years.



Ethical and Legal Debates

Those who would deny patient's legal right to euthanasia or assisted suicide typically appeal to two arguments: a **slippery slope argument** and argument about the **dangers of abuse**. Both are scare tactics, the rhetorical force of which exceeds their logical strength (Benatar 2011, 206).

The slippery slope argument is regularly invoked in a variety of practical ethical contexts make the claim that if some specific kind of action is permitted, then society will be inexorably we lead down the slippery slope to permitting other actions that are morally wrong. It is of course easier to assert the existence of a slippery slope and prove that it exists (Benatar 2011, 206). At the heart of a slippery slope claim, therefore, is pessimism about our capacity to regulate effectively, and to locate and police

boundaries between acceptable and unacceptable conduct. A slippery slope argument against assisted dying does not involve the claim that there is something wrong with doctors helping their patients to die. In practice, people who use slippery slope arguments against assisted dying often also believe that it is intrinsically wrong, but this is not the claim that they are making when they invoke the slippery slope. Rather, the slippery slope claim is that, even if we were to accept that doctors might sometimes act reasonably when they comply with a patient's request for assisted dying, we should nevertheless prohibit it because, if assisted dying were to be legalized, it would be impossible to prevent abuse.

This leads into the second argument invoked by opponents of a legal right-to-die, the argument that such a right will be abused and that no legal safeguards can prevent that abuse. For example, it has been said that where written voluntary consent is a legal requirement, that consent has not always been obtained. It has also been said that euthanasia or assisted suicide are often not reported, even in jurisdictions in which reporting is obligatory. Citing many examples of abuse of a legal right is not sufficient to justify withholding that right. If the likelihood for abuse were thought to be grounds for withholding a right, then much more than assisted dying would have to be banned. Driving, for example, would have to be prohibited on the grounds that the right is abused and none of the safeguards we have against such abuse are completely effective. People still drive faster than they should, drive without a license, and drive under the influence. There is no reason to withhold from some people are legal right to reasonable activity merely because other people will abuse that right. The appropriate response is regulation imperfect though that may be. Opponents of the legal right to die often say

that freedom has its limits, however, just because freedom has its limits does not mean a right to die falls beyond those limits. Although society may restrict a person's freedom to prevent the infliction of harm on others, it is very difficult to justify restricting a person's freedom when that restriction will result in immense personal harm.

As we continue to legalize physician-assisted dying, we as a society will still have to contend with the suffering of large groups of patients who are presently excluded from any consideration of aid in dying. Children, the mentally and developmentally disabled, the mentally ill, those with Alzheimer's disease or acquired dementia, and those who are paraplegic, or any others who are unable to participate in the suicidal act without help, are specifically excluded from proposals to legalize assisted suicide. To prevent abuses of assisted suicide, their particularly vulnerable status merits such exclusion. However, these people all have the potential for suffering and if we are to continue legalizing physician-assisted dying, it is inevitable that society will have to find a way to extend the service to them as well. If aid-in-dying is deemed a right of persons who are dying, then on what basis and for how long will society be able to deny that right to children, people who are paralyzed, and those who are mentally, or physically disabled (Byock 2013, 245).

Physician-Assisted Dying and COVID-19

Amid a pandemic, questions have arisen regarding physician-assisted dying and how it applies to COVID-19. Is COVID-19 considered a terminal illness? Can one be guaranteed death with dignity if a severe COVID-19 infection develops? There are numerous qualifications to be considered for aid in dying. The first requirement is that a patient must be diagnosed with a terminal illness with a prognosis to die within the next

six months. Then, the patient must be fully coherent and place an oral and written statement of their wishes. After the initial request, the patient must wait 15 days before being asked again by a physician for verbal consent. The patient must remain coherent and be able to self-medicate themselves with the lethal dose. If at any time the patient becomes incapacitated, they no longer qualify for aid in dying and must consider other end-of-life care. In a patient with a severe coronavirus infection, the 15-day waiting period could be detrimental. In Oregon, patients can be exempted from this 15-day waiting period if a physician decides that the patient could pass within that amount of time, be placed on a ventilator, or incapacitated, which would forfeit their eligibility. The controversy continues because COVID-19 is not lethal to all patients. Thus, a physician cannot be certain that a patient who acquires COVID-19 will die from the infection in the next six months. Therefore, access to death with dignity is likely not an option for many patients facing a severe coronavirus infection.

The COVID-19 pandemic has exposed the tragedy of patients dying in isolation, separated from family and friends to limit infection in hospital settings. The process has altered the experience of serious illness for patients and their loved ones, including their ability to grieve, share important words and feelings, and provide comfort. The ongoing pandemic has been a reminder of the importance of having human connection and support at any time, but especially when faced with serious illness, and the essential contribution palliative care makes in supporting human connection while reducing patients' physical, emotional, and spiritual suffering. Globally, the pandemic has exponentially increased awareness of the importance of—indeed the essential role of—palliative care in taking care of people with serious illness.

Conclusion:

This paper has explained the rise of physician-assisted dying and the revolution of Death with Dignity in Oregon. After a thorough review of the existing literature and analysis of available documents, this paper has provided a historical account of the beginnings of the hospice movement, and how their values of holistic care differ from the medical model of healthcare. Cicely Saunders had a vision of a different kind of end-of life care and began the hospice movement in the UK. Florence Wald was essential to bringing the hospice movement to the US in the 1970s. The US was primed for a new way to care for the dying after enduring World War II. Since then, the hospice and palliative care fields have grown massively within and outside the US, with demand only increasing as the world's population grows older with more chronic illnesses. Oregon was the first state in the US to legalize physician-assisted dying policy in 1994 and has been a leader in the assisted dying movement nationwide and internationally since then. The policy is not without its complications and struggles. There are many ongoing discussions about ways the law should be applied differently or altered, proving the relevance and importance of the law to lawmakers and Oregonians alike. Physician-assisted dying policy is a result of the earlier work of the hospice movement to establish the importance of holistic, patient-driven, end-of-life care. The primary arguments against physician-assisted dying policy were discussed and refuted as being largely fear-mongering with little logical basis.

The main findings from this study are as follows:

- Relatively recent physician-assisted dying policy is the result of a much longer hospice and end-of-life care movement, which focuses on caring for the patient holistically, not just medically.
- Most arguments against physician-assisted dying are scare tactics, the rhetorical force of which exceeds their logical strength.
- Physician-assisted dying is a humane and patient-centered option for terminally ill patients seeking to end their life on their own terms.

A potential avenue for future research and inquiry is examining whether the psychological evaluation step of the assisted dying process should be required for all patients or remain up to the physician's discretion. Very few Oregon physicians refer their assisted-dying patients for psychological evaluation, causing concern that mentally ill patients are passing undetected when they could benefit from psychological treatment. The Oregon Legislature has proven that the Death with Dignity Act is an alive and relevant piece of policy to Oregonians as they continue to make necessary changes as recent as this year, 25 years after its implementation.

The significance of Oregon being the first state in the US to pass physician-assisted dying legislation cannot be overstated. It placed Oregon at the forefront of the physician-assisted dying conversation, and Oregon will forever be the example in which others look to for guidance. Oregon's Death with Dignity policy has served as a national and international model and remains an inspiration for other states across the nation that

are developing similar policies. Physician-assisted dying policies in other states are heavily modeled after the Oregon Death with Dignity Act. Washington's policy is almost the same as Oregon's. As a result, it is imperative that Oregon continues to innovate, ask questions, and strive to deliver the best physician-assisted dying care possible, as not only Oregonians are affected but policy across the country could be influenced. Researching how to prioritize the mental health of the patients and ensure their psychological competence in making such a large decision is a part of that goal.

More pathways for possible future research include investigating the connection between the individuals who access the Oregon DWDA and the demographic make-up of Oregon as a whole. According to the US Census Bureau, as of July 2021 approximately 89% of Oregonians are white. Looking at the 2021 OHA Annual Report Data, approximately 96% of those that accessed the DWDA were white as well. Further study is required into whether the large percentage of white people who access the law is related to Oregon being a predominantly white state. Is there an equity issue with the DWDA that excludes minority groups from accessing it as easily as white Oregonians?

An area that also demands further research is why Oregon legalized assisted-dying policy first. What were the circumstances that made Oregon unique? Essentially, why did Oregon pass this law first, and where does Oregon lead the nation with other policies? Oregon has also legalized marijuana and possesses one of the most inclusive and protected abortion laws in the country. What are the factors that allow these policies to exist?

While briefly mentioned previously, the discussion of assisted dying within religious and spiritual spheres is understandably very active. Spiritual and ethical

debates about the efficacy of physician-assisted dying continue alongside policy debates. It was not my intention to examine these ideas in this paper as I was more focused on policy. A further examination into the connection between religiosity and assisted dying laws is required.

Looking to the future, physician-assisted dying continues to be legalized across the US (See Figure 3), and the world (See Figure 2). Policies vary greatly between the US and other counties, and even state-to-state within the US. Currently, new physician-assisted dying policies are being actively discussed in New South Wales, Australia, and England. In the US, New Jersey is considering passing a law very similar to Oregon's Death with Dignity Act.

Figure 2: Physician-assisted dying policy across the world

This map shows the state of different assisted-dying laws around the globe.

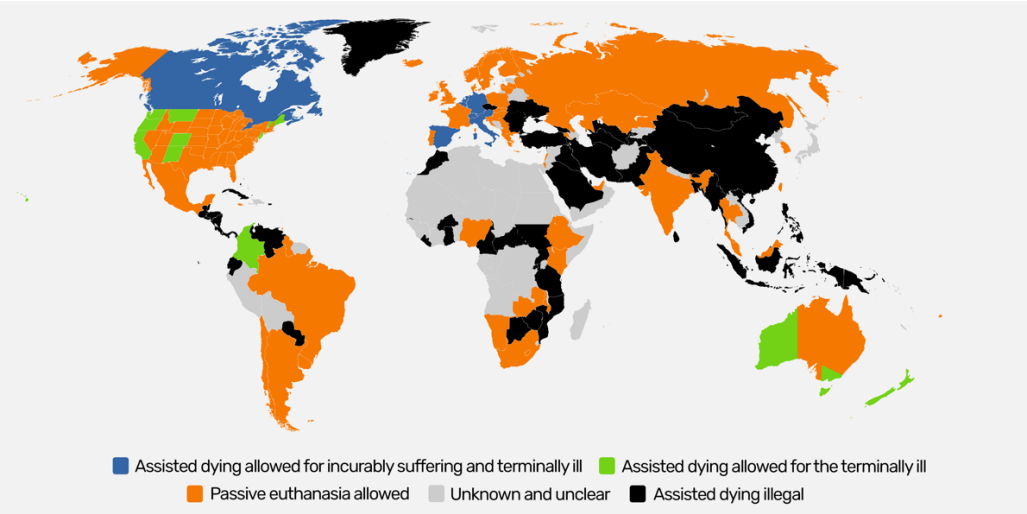
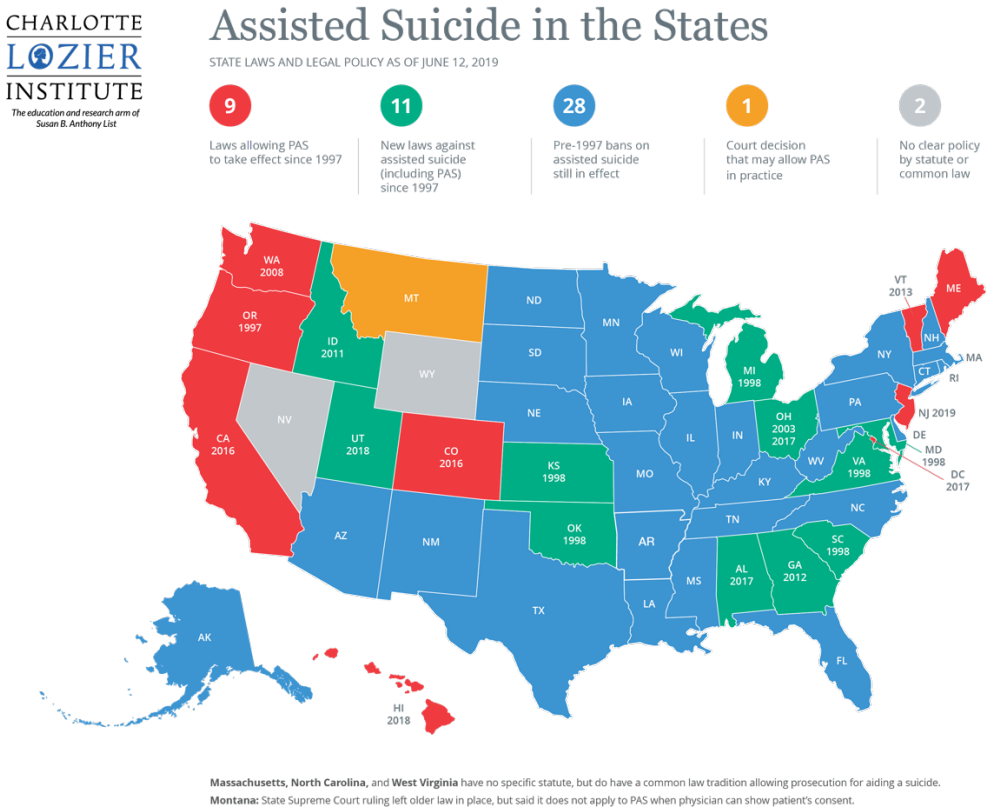


Figure 3: Differences in assisted-dying policy in the US

This map shows the differences between state-to-state assisted dying policy in the US



Appendix A: Practical Instructions When Ingesting Life-Ending Medications

Starting 12 hours prior to taking the medications (End of Life Washington)

1. Discontinue regular medicines, except those for pain or comfort. Do not take laxatives or stomach-coating medications like Maalox, Pepto-Bismol, and Carafate (sucralfate).
2. For the 5 hours prior to taking the medications
    a. Do not eat any food.
    b. Drink only water or clear juice during this period; no carbonated beverages.
3. One hour prior to taking life-ending medications
    a. Take the anti-nausea medications:
    b. 2 mg of Haldol (haloperidol) or 8 mg of Zofran (odansetron), AND
    c. 20 mg of Reglan (metoclopramide)
4. DDMP2 and DDMA mixtures:
    a. Just prior to swallowing the lethal medication, gradually, and quickly, stir one of the following into the DDMP2 or DDMA powder to make a smooth, non-clumpy solution:
        a. 2-4 oz. of a strong liquor such as vodka, whiskey, or Grand Marnier
        b. 4 oz. of warm (not hot) water, OR
        c. 4 oz. of clear juice or Gatorade, OR
        d. For those who have trouble swallowing, 4 oz. of non-fat pudding, yogurt, or applesauce. Please note that mixing the medication with soft food might result in a longer time to death.
    e. NOTE: Alcohol helps dissolve the powder and if used, can minimize the amount of liquid to be ingested (as little as 2 oz.). Strong liquor enhances the effect of the medications and can assist in absorption. It is a preferred option, but not required.
5. Swallow the lethal medication
    a. Swallow all of the liquid lethal medication within 2-3 minutes. It will taste bitter.
    b. Immediately after swallowing the life-ending medication, quickly also take a spoonful of sorbet, jam, honey, or anything that may help to cleanse the palate (no carbonated
    beverages).
    OR
    c. 2-4 oz of strong liquor, such as vodka, whiskey, or Grand Marnier
    d. (Creamed liqueurs should be avoided); alcohol enhances the life-ending medication’s effects. Do not use alcohol if there is any nausea.

Appendix B: Hospice Movement Historical Timeline

1948 - Cicely Saunders, a nurse at Archway Hospital London, falls in love with a man with only weeks to live. Helping people to get the most out of their final days became her calling.

1963 - Dame Cicely Saunders introduces the idea of specialized care for the dying to the United States in a lecture at Yale University.

1965 - Florence Wald, Dean of the Yale School of Nursing, invites Dame Cicely Saunders to become a visiting faculty member.

1967 - Cicely Saunders established St. Christopher Hospice in the UK

1968 - Florence Wald takes a sabbatical from Yale to work at St. Christopher's Hospice.

1969 - Elizabeth Kubler-Ross publishes *On Death & Dying*, a landmark book advocating for patient choice and at home hospice care which altered the public perception of hospice and assisted dying. The book identifies the five stages through which many terminally ill patients progress.

1972 - Elisabeth Kubler-Ross testifies at the first national hearings on the subject of death with dignity, conducted by the US Senate Special Committee on Aging.

1974 - America's first hospice, Connecticut Hospice in Branford, CN is founded by Florence Wald, along with two pediatricians and a chaplain.

1975 - The first National Symposium on Hospice Care is convened in New Haven, Connecticut.

1978 - US Department of Health, Education, and Welfare provides federal support for hospice movement. National Hospice Organization (NHO) is established to promote the concept of hospice care.

1979 - The Health Care Financing Administration (HCFA) initiates demonstration programs at 26 hospices in 16 states to assess the cost effectiveness of hospice care and to help determine what a hospice is and what it should provide. Cicely Saunders is made a Dame of the British Empire.

1983 - Reagan signs Medicare hospice benefit law, covering care for 80-85% of hospice beneficiaries

1989 - Oregon introduces first assisted dying bill.

1993 - Hospice is included as a nationally guaranteed benefit under Clinton's healthcare reform, hospice now an accepted part of US healthcare

1994 - Oregon voters approve Measure 16, a Death with Dignity Act ballot initiative. U.S. District Court Judge Hogan issues a temporary restraining order against Oregon's Measure 16, following with an injunction to bar the state from putting the law into effect.

1997 - Growing end-of-life care movement focuses national attention on quality of life at the end, the need for increased awareness, and physician education on end-of-life matters. The Oregon Death with Dignity Act takes effect on October 27 after attorneys from Death with Dignity successfully argue in front of the Ninth Circuit Court to overturn an injunction against implementation. The Act serves as the first-of-its kind legislation in the world, allowing patients with terminal illness in Oregon the right to assisted-dying.

2004 - More than 1 million Americans with a life-limiting illness are served by the nation's hospices, the first time the million-person mark has been crossed.

2005 - Cicely Saunders dies from cancer at St. Christopher's Hospice at age 87

2006 - Inaugural World Day held October 1st to focus global attention on hospice and palliative care, celebrated in 70 countries

2009 - The Accreditation Council for Graduate Medical Education, a private, non-profit organization responsible for the accreditation of post-MD medical training programs within the United States, adds hospice and palliative medicine to its list of accredited programs. The Washington Death with Dignity Act goes into effect in March, the second state to pass death with dignity legislation.

2013 - Vermont becomes the third US jurisdiction with a death with dignity law, the first law to pass by legislative action.

2014 - Forty years after the creation of Connecticut Hospice, National Hospice and Palliative Care Organization and its affiliates celebrate 40 years of hospice care in the US.

2015 - The California legislature passes the End-of-Life Option Act, the 4th jurisdiction to pass a death with dignity law.

Appendix C: Glossary

Aid-in-Dying: refers to a practice in which a physician provides a competent, terminally ill patient with a prescription for a lethal dose of medication, upon the patient's request, which the patient intends to use to end his or her own life. In practice, it is the same thing as physician-assisted dying (University of Washington Medicine).

Cicely Saunders: Cicely Saunders founded the first modern hospice and, more than anybody else, was responsible for establishing the discipline and the culture of palliative care. She introduced effective pain management and insisted that dying people needed dignity, compassion, and respect, as well as rigorous scientific methodology in the testing of treatments (British Medical Journal).

Dangers of Abuse Argument: A common argument cited by those against physician-assisted dying policies. The argument claims that vulnerable populations, lacking access to quality care and support, may be pushed into assisted death. This argument also claims that assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage loved ones to opt for assisted death and the protections in legislation can never catch all instances of such coercion or exploitation (University of Washington Medicine).

Death with Dignity: Death with dignity is an end-of-life option, governed by state legislation, that allows certain people with terminal illness to request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified manner voluntarily and legally. The phrase is synonymous with physician-assisted dying. Oregon also enacted the Death with Dignity Act in 1997 which allows terminally ill individuals to end their lives through the voluntary self-administration of lethal medications, leading to the widespread use of the phrase (Death with Dignity National Center, Oregon Health Authority).

Elizabeth Kubler-Ross: was a Swiss-born psychiatrist, a pioneer in Near-death studies and the author of the groundbreaking book *On Death and Dying* (1969), where she first discussed what is now known as the Kübler-Ross model. In this work she proposed the now famous Five Stages of Grief as a pattern of adjustment (Elizabeth Kübler-Ross Foundation).

Euthanasia: Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering (American Medical Association).

Florence Wald: Florence Wald was an American nurse, former Dean of Yale School of Nursing, and largely credited as "the mother of the American hospice movement". She led the founding of Connecticut Hospice, the first hospice program in the United States (American Sentinel).

Good Death: A good death is highly subjective but is generally considered to be one that is free from avoidable distress and suffering, for patients, family, and caregivers; in general accord with the patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards (National Institutes of Health).

Hospice Care: Focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life. Provides comprehensive comfort care as well as support for the family but attempts to cure the person's illness are stopped. Care begins after treatment of the disease is stopped and when the person is not going to survive the illness (National Institutes of Health).

Medical Choice: A decision by a patient about a diagnostic or therapeutic procedure, based on choice, which requires the decision to be voluntary and that the patient has the capacity for choice, which rests on 3 elements: possession of a set of values and goals, ability to understand information and communicate decisions, and the ability to reason and deliberate (Free Medical Dictionary).

Medical Model of Health: The medical model presumes the existence of illness or disease. It therefore emphasizes clinical diagnosis and medical intervention in the treatment of disease or its symptoms. Under the medical model, health is defined as the absence of illness or disease (Oxford Medicine).

Palliative Care: Specialized medical care for people living with a serious illness. Intended to enhance a person's current care by focusing on quality of life for them and their family. Can begin at diagnosis, and at the same time as treatment (National Institutes of Health).

Patient Autonomy: acknowledging that patients who have decision-making capacity have the right to make decisions regarding their care, even when their decisions contradict their clinicians' recommendations (American Medical Association Journal of Ethics).

Physician-Assisted Dying: A physician providing, at the patient’s request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life (American Academy of Hospice and Palliative Medicine).

Physician-Assisted Suicide: A now outdated term to refer to when a physician provides a patient with the resources for a patient to take their own life. See Physician-Assisted Dying.

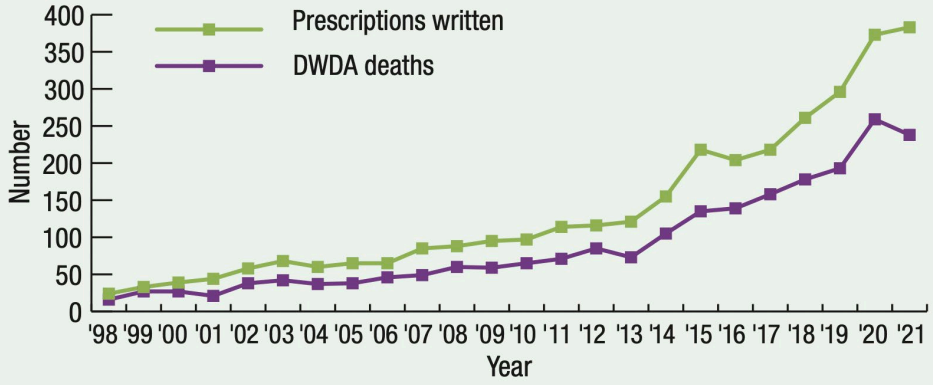
Slippery Slope Argument: A common argument invoked by those opposed to physician-assisted dying policy. This argument claims that if some specific kind of action (such as physician-assisted dying) is permitted, then society will be inevitably led down the slippery slope to permitting other actions that are morally wrong.

Terminal Illness: A terminal condition or illness is one that is life-limiting. In the near future it is expected the illness will result in permanent unconsciousness from which the person is unlikely to recover or death. As it relates to assisted dying policies, terminal illness is defined as a disease that will cause death within six months (American Cancer Association).

Triple Aim of Healthcare: Created by the Institute for Healthcare Improvement, improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care (Institute for Healthcare Improvement).

Appendix D: Oregon Health Authority 2021 Annual Report Data

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998–2021



**As of January 21, 2022*

See Table 2 for detailed information

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2021, as of January 21, 2022

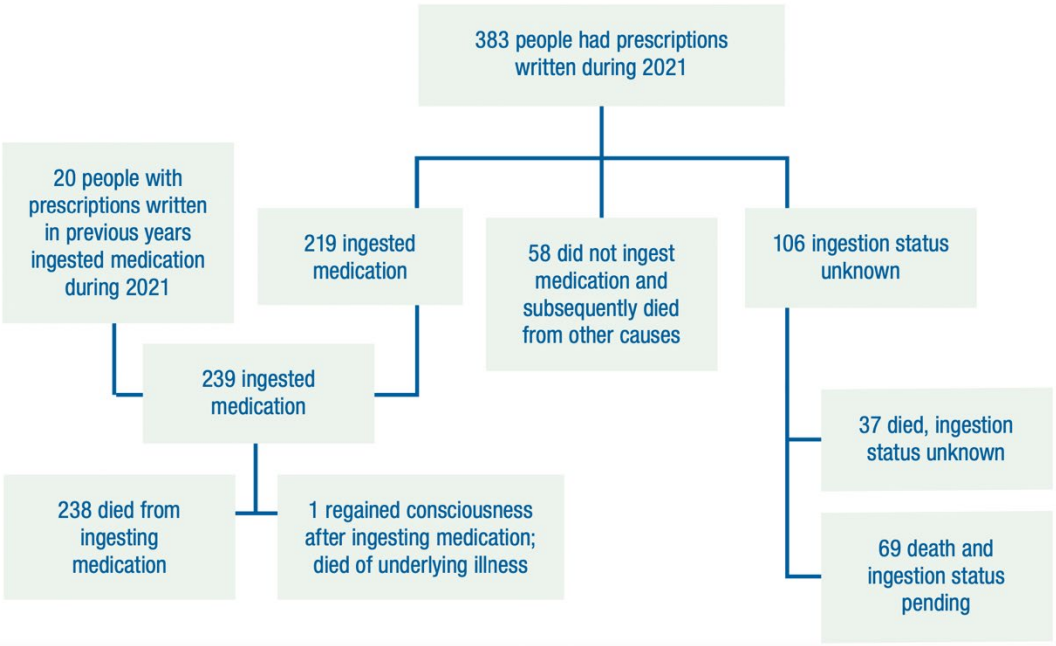


Table 1. Characteristics and end-of-life care of 2,159 DWDA patients who have died from ingesting a lethal dose of medication as of January 21, 2022, Oregon, 1998-2021

Characteristics	2021 (N=238)		2020 (N=259)		1998–2019 (N=1,662)		Total (N=2,159)	
Sex	**N (%)[1]**		**N (%)[1]**		**N (%)[1]**		**N (%)[1]**	
Male	133	(55.9)	131	(50.6)	881	(53.0)	1,145	(53.0)
Female	105	(44.1)	128	(49.4)	781	(47.0)	1,014	(47.0)
Age								
18–34	1	(0.4)	1	(0.4)	10	(0.6)	12	(0.6)
35–44	2	(0.8)	4	(1.5)	32	(1.9)	38	(1.8)
45–54	13	(5.5)	13	(5.0)	96	(5.8)	122	(5.7)
55–64	30	(12.6)	31	(12.0)	309	(18.6)	370	(17.1)
65–74	71	(29.8)	87	(33.6)	499	(30.0)	657	(30.4)
75–84	76	(31.9)	69	(26.6)	453	(27.3)	598	(27.7)
85+	45	(18.9)	54	(20.8)	263	(15.8)	362	(16.8)
Median years (range)	75	(28-101)	74	(33-99)	72	(25-102)	73	(25-102)
Race and ethnicity								
White	226	(95.0)	252	(97.3)	1,597	(96.4)	2,075	(96.3)
African American	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.0)
American Indian	0	(0.0)	0	(0.0)	3	(0.2)	3	(0.1)
Asian	6	(2.5)	3	(1.2)	23	(1.4)	32	(1.5)
Pacific Islander	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.0)
Other	0	(0.0)	1	(0.4)	5	(0.3)	6	(0.3)
Two or more races	0	(0.0)	1	(0.4)	7	(0.4)	8	(0.4)
Hispanic (any race)	6	(2.5)	2	(0.8)	20	(1.2)	28	(1.3)
Unknown	*0*		*0*		*5*		*5*	
Marital status								
Married (including Registered Domestic Partner)	112	(47.5)	118	(45.6)	763	(46.2)	993	(46.2)
Widowed	46	(19.5)	62	(23.9)	361	(21.8)	469	(21.8)
Never married	21	(8.9)	20	(7.7)	138	(8.3)	179	(8.3)
Divorced	57	(24.2)	59	(22.8)	391	(23.7)	507	(23.6)
Unknown	*2*		*0*		*9*		*11*	
Education								
8th grade or less	1	(0.4)	4	(1.5)	19	(1.2)	24	(1.1)
9th–12th grade, no diploma	7	(3.0)	9	(3.5)	70	(4.3)	86	(4.0)
High school graduate/GED	58	(24.7)	59	(22.8)	348	(21.1)	465	(21.7)
Some college	48	(20.4)	47	(18.1)	340	(20.7)	435	(20.3)
Associate degree	14	(6.0)	27	(10.4)	148	(9.0)	189	(8.8)
Bachelor's degree	56	(23.8)	57	(22.0)	403	(24.5)	516	(24.1)
Master's degree	32	(13.6)	38	(14.7)	194	(11.8)	264	(12.3)
Doctorate or professional degree	19	(8.1)	18	(6.9)	124	(7.5)	161	(7.5)
Unknown	*3*		*0*		*16*		*19*	

Characteristics	2021 (N=238)		2020 (N=259)		1998–2019 (N=1,662)		Total (N=2,159)	
Residence county/region[2]								
Multnomah	54	(22.7)	53	(20.5)	361	(21.9)	468	(21.8)
Deschutes	26	(10.9)	16	(6.2)	69	(4.2)	111	(5.2)
Lane	26	(10.9)	27	(10.5)	180	(10.9)	233	(10.8)
Clackamas	20	(8.4)	22	(8.5)	170	(10.3)	212	(9.9)
Washington	17	(7.1)	25	(9.7)	168	(10.2)	210	(9.8)
Jackson	12	(5.0)	23	(8.9)	110	(6.7)	145	(6.8)
Marion	10	(4.2)	17	(6.6)	168	(10.2)	195	(9.1)
Other northwest counties	44	(18.5)	47	(18.2)	246	(14.9)	337	(15.7)
Southern Oregon	19	(8.0)	20	(7.8)	124	(7.5)	163	(7.6)
Central Oregon / Columbia Gorge	6	(2.5)	4	(1.6)	27	(1.6)	37	(1.7)
Eastern Oregon	4	(1.7)	4	(1.6)	29	(1.8)	37	(1.7)
Unknown	*0*		*1*		*10*		*11*	
End-of-life care								
Hospice								
Enrolled	232	(97.5)	245	(94.6)	1,468	(90.2)	1,945	(91.5)
Not enrolled	6	(2.5)	14	(5.4)	160	(9.8)	180	(8.5)
Unknown	*0*		*0*		*34*		*34*	
Insurance								
Private	36	(20.6)	56	(26.3)	712	(47.1)	804	(42.3)
Medicare, Medicaid or Other Governmental	138	(78.9)	157	(73.7)	781	(51.7)	1,076	(56.7)
None	1	(0.6)	0	(0.0)	18	(1.2)	19	(1.0)
Unknown	*63*		*46*		*151*		*260*	
Underlying illness								
Cancer	**146**	**(61.3)**	**172**	**(66.4)**	**1,248**	**(75.1)**	**1,566**	**(72.5)**
Lip, oral cavity, and pharynx	3	(1.3)	7	(2.7)	34	(2.0)	44	(2.0)
Digestive organs	33	(13.9)	44	(17.0)	334	(20.1)	411	(19.0)
Pancreas	*8*	*(3.4)*	*14*	*(5.4)*	*111*	*(6.7)*	*133*	*(6.2)*
Colon	*7*	*(2.9)*	*6*	*(2.3)*	*92*	*(5.5)*	*105*	*(4.9)*
Other digestive organs	*18*	*(7.6)*	*24*	*(9.3)*	*131*	*(7.9)*	*173*	*(8.0)*
Respiratory and intrathoracic organs	23	(9.7)	35	(13.5)	268	(16.1)	326	(15.1)
Lung and bronchus	*22*	*(9.2)*	*33*	*(12.7)*	*251*	*(15.1)*	*306*	*(14.2)*
Other respiratory and intrathoracic organs	*1*	*(0.4)*	*2*	*(0.8)*	*17*	*(1.0)*	*20*	*(0.9)*
Melanoma and other skin	5	(2.1)	4	(1.5)	40	(2.4)	49	(2.3)
Mesothelial and soft tissue	6	(2.5)	3	(1.2)	31	(1.9)	40	(1.9)
Breast	12	(5.0)	15	(5.8)	114	(6.9)	141	(6.5)
Female genital organs	12	(5.0)	17	(6.6)	89	(5.4)	118	(5.5)
Prostate	16	(6.7)	13	(5.0)	76	(4.6)	105	(4.9)
Urinary tract	7	(2.9)	8	(3.1)	46	(2.8)	61	(2.8)

Characteristics	2021 (N=238)		2020 (N=259)		1998–2019 (N=1,662)		Total (N=2,159)	
Eye, brain, central nervous system	4	(1.7)	5	(1.9)	54	(3.2)	63	(2.9)
Brain	*4*	*(1.7)*	*4*	*(1.5)*	*49*	*(2.9)*	*57*	*(2.6)*
Eye and central nervous system	*0*	*(0.0)*	*1*	*(0.4)*	*5*	*(0.3)*	*6*	*(0.3)*
Thyroid and other endocrine	1	(0.4)	0	(0.0)	7	(0.4)	8	(0.4)
Ill-defined, secondary, and unspecified sites	5	(2.1)	6	(2.3)	44	(2.6)	55	(2.5)
Lymphoma and leukemia	16	(6.7)	10	(3.9)	76	(4.6)	102	(4.7)
Other cancers	3	(1.3)	5	(1.9)	35	(2.1)	43	(2.0)
Neurological disease	**35**	**(14.7)**	**21**	**(8.1)**	**186**	**(11.2)**	**242**	**(11.2)**
Amyotrophic lateral sclerosis	22	(9.2)	11	(4.2)	135	(8.1)	168	(7.8)
Other neurological disease	13	(5.5)	10	(3.9)	51	(3.1)	74	(3.4)
Heart/circulatory disease	**29**	**(12.2)**	**29**	**(11.2)**	**76**	**(4.6)**	**134**	**(6.2)**
Respiratory disease [e.g., COPD]	**15**	**(6.3)**	**17**	**(6.6)**	**91**	**(5.5)**	**123**	**(5.7)**
Endocrine/metabolic disease [e.g., diabetes]	**5**	**(2.1)**	**6**	**(2.3)**	**13**	**(0.8)**	**24**	**(1.1)**
Gastrointestinal disease [e.g., liver disease]	**1**	**(0.4)**	**5**	**(1.9)**	**12**	**(0.7)**	**18**	**(0.8)**
Infectious disease [e.g., HIV/AIDS]	**0**	**(0.0)**	**1**	**(0.4)**	**13**	**(0.8)**	**14**	**(0.6)**
Other illnesses[3]	**7**	**(2.9)**	**8**	**(3.1)**	**23**	**(1.4)**	**38**	**(1.8)**
DWDA process								
Outlived 6-month prognosis	9	(3.8)	8	(3.1)	69	(4.2)	86	(4.0)
Referred for psychiatric evaluation	2	(0.8)	3	(1.2)	66	(4.0)	71	(3.3)
Patient informed family of decision[4]	221	(95.7)	246	(97.2)	1,485	(95.7)	1,952	(95.9)
Patient died at								
Home (patient, family or friend)	226	(95.0)	239	(92.3)	1,534	(92.6)	1,999	(92.8)
Assisted living or foster care facility	11	(4.6)	15	(5.8)	77	(4.6)	103	(4.8)
Nursing home	1	(0.4)	0	(0.0)	18	(1.1)	19	(0.9)
Hospital	0	(0.0)	0	(0.0)	4	(0.2)	4	(0.2)
Hospice facility	0	(0.0)	0	(0.0)	3	(0.2)	3	(0.1)
Other	0	(0.0)	5	(1.9)	20	(1.2)	25	(1.2)
Unknown	*0*		*0*		*6*		*6*	
Lethal medication[5]								
DDMA	136	(57.1)	224	(86.5)	91	(5.5)	451	(20.9)
DDMA-Ph	92	(38.7)	8	(3.1)	0	(0.0)	100	(4.6)
DDMP-2	7	(2.9)	26	(10.0)	168	(10.1)	201	(9.3)
DDMP-1	1	(0.4)	0	(0.0)	71	(4.3)	72	(3.3)
Secobarbital	0	(0.0)	1	(0.4)	859	(51.7)	860	(39.8)
Phenobarbital	0	(0.0)	0	(0.0)	65	(3.9)	65	(3.0)
Pentobarbital	0	(0.0)	0	(0.0)	386	(23.2)	386	(17.9)
Other	2	(0.8)	0	(0.0)	22	(1.3)	24	(1.1)

Characteristics	2021 (N=238)		2020 (N=259)		1998–2019 (N=1,662)		Total (N=2,159)	
End-of-life concerns[6]								
Losing autonomy	222	(93.3)	241	(93.1)	1,499	(90.2)	1,962	(90.9)
Less able to engage in activities making life enjoyable	219	(92.0)	244	(94.2)	1,484	(89.3)	1,947	(90.2)
Loss of dignity[7]	162	(68.1)	188	(72.6)	1,132	(73.8)	1,482	(73.0)
Burden on family, friends/caregivers	129	(54.2)	139	(53.7)	775	(46.6)	1,043	(48.3)
Losing control of bodily functions	112	(47.1)	101	(39.0)	730	(43.9)	943	(43.7)
Inadequate pain control, or concern about it	64	(26.9)	87	(33.6)	443	(26.7)	594	(27.5)
Financial implications of treatment	20	(8.4)	17	(6.6)	71	(4.3)	108	(5.0)
Health care provider present (collected since 2001)	**(N=238)**		**(N=259)**		**(N=1,590)**		**(N=2,087)**	
When medication was ingested								
Prescribing physician	45		30		257		332	
Other provider, prescribing physician not present	36		60		373		469	
Volunteer	46		46		56		148	
No provider or volunteer	32		36		130		198	
Unknown	*79*		*87*		*774*		*940*	
At time of death								
Prescribing physician	36	(15.1)	30	(11.6)	235	(15.0)	301	(14.6)
Other provider, prescribing physician not present	41	(17.2)	56	(21.6)	383	(24.4)	480	(23.3)
Volunteer	43	(18.1)	46	(17.8)	65	(4.1)	154	(7.5)
No provider or volunteer	118	(49.6)	127	(49.0)	884	(56.4)	1,129	(54.7)
Unknown	*0*		*0*		*23*		*23*	
Complications[8]	**(N=238)**		**(N=259)**		**(N=1,662)**		**(N=2,159)**	
Difficulty ingesting/regurgitated	5		3		30		38	
Seizures	0		1		2		3	
Other	1		1		15		17	
None	69		69		708		846	
Unknown	*163*		*185*		*907*		*1,255*	
Other outcomes								
Regained consciousness after ingesting DWDA medications	1		0		8		9	
Timing of DWDA event								
Duration (weeks) of patient-physician relationship								
Median	5		9		12		11	
Range	0 - 940		0 - 1085		0 - 2138		0 - 2138	
Patients with information available	*236*		*252*		*1,651*		*2,139*	
Patients with information unknown	*2*		*7*		*11*		*20*	

Characteristics	2021 (N=238)	2020 (N=259)	1998–2019 (N=1,662)	Total (N=2,159)
Duration (days) between first request and death				
Median	30	34	47	43
Range	1 - 1095	0 - 1080	14 - 1503	0 - 1503
Patients with information available	*236*	*257*	*1,662*	*2,155*
Patients with information unknown	*2*	*2*	*0*	*4*
Duration (minutes) between ingestion and unconsciousness				
Median	5	5	5	5
Range	1 - 45	1 - 45	1 - 240	1 - 240
Patients with information available	*146*	*130*	*875*	*1,151*
Patients with information unknown	*92*	*129*	*787*	*1,008*
Duration (minutes) between ingestion and death				
Median	32	50	30	30
Range	2min-24hrs	6min-8hrs	1min-104hrs	1min-104hrs
Patients with information available	*155*	*143*	*900*	*1,198*
Patients with information unknown	*83*	*116*	*762*	*961*

1 Unknowns are excluded when calculating percentages.

2 **Other northwest counties:** Benton, Clatsop, Columbia, Lincoln, Linn, Polk, Tillamook, and Yamhill.
Southern: Coos, Curry, Douglas, Josephine, Klamath, and Lake.
Central/Columbia Gorge: Crook, Gilliam, Hood River, Jefferson, Sherman, Wasco, and Wheeler.
Eastern: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, and Wallowa.

3 Includes deaths due to anorexia, arthritis, arteritis, blood disease, complications from a fall, hernia, kidney failure, medical care complications, musculoskeletal system disorders, sclerosis, and stenosis.

4 First recorded in 2001. Since then, 84 patients (4.0%) have chosen not to inform their families, and 35 patients (1.7%) have had no family to inform. Information is unknown for 18 patients.

5 **DDMA** is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.
DDMP-Ph is a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital
DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.
Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.

6 Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive.

7 First asked in 2003. Data available for 2,030 patients.

8 Information about complications is reported only when a physician or another health care provider is present at the time of death.

Table 2. Number of DWDA prescription recipients, DWDA deaths, and attending physicians, 1998-2021

Year	Prescription recipients	DWDA deaths	Attending physicians
1998	24	16	n/a
1999	33	27	n/a
2000	39	27	22
2001	44	21	33
2002	58	38	33
2003	68	42	42
2004	60	37	40
2005	65	38	40
2006	65	46	41
2007	85	49	46
2008	88	60	60
2009	95	59	64
2010	97	65	59
2011	114	71	62
2012	116	85	62
2013	121	73	62
2014	155	105	83
2015	218	135	106
2016	204	139	101
2017	218	158	92
2018	261	178	108
2019	296	193	113
2020	373	259	142
2021	383	238	133
Total	**3,280**	**2,159**	

Table 4. Duration between ingestion and death, DWDA deaths, 2001–2021

Drug(%)	Total	Unknown duration	Known duration	<1hr	1– 6 hours	>6 hours	Median (minutes)	Mean (minutes)	Range	Regained consciousness[6]
Secobarbital[1]	792	403	389 (100.0)	293 (75.3)	69 (17.7)	27 (6.9)	25	137	2min - 83 hrs	5
DDMA[2]	451	166	285 (100.0)	166 (58.2)	114 (40.0)	5 (1.8)	45	74	1min - 19 hrs	1
Pentobarbital[1]	384	156	228 (100.0)	188 (82.5)	31 (13.6)	9 (3.9)	20	97	1min - 104 hrs	0
DDMP-2[3]	201	96	105 (100.0)	46 (43.8)	36 (34.3)	23 (21.9)	85	254	2min - 47 hrs	2
DDMA-Ph[4]	100	34	66 (100.0)	46 (69.7)	19 (28.8)	1 (1.5)	31	58	5min - 7 hrs	0
DDMP-1[3]	72	47	25 (100.0)	12 (48.0)	7 (28.0)	6 (24.0)	77	223	10min - 21 hrs	0
Phenobarbital[5]	65	43	22 (100.0)	4 (18.2)	13 (59.1)	5 (22.7)	73	439	20min - 72 hrs	0
Other	24	6	18 (100.0)	7 (38.9)	8 (44.4)	3 (16.7)	71	237	10min - 24 hrs	1
TOTAL	**2,089**	**951**	**1,138 (100.0)**	**762 (67.0)**	**297 (26.1)**	**79 (6.9)**	**30**	**129**	**1min - 104 hrs**	**9**

1 Pentobarbital has been unavailable for DWDA use since 2015; secobarbital since 2019.

2 DDMA is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.

3 DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.

4 DDMA-Ph is a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.

5 Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.

6 Patients who regained consciousness after ingestion are not considered DWDA deaths, and are not included in the other columns in this table.

NOTE: Table includes all reported durations, not just those from licensed providers. Complete information not available before 2001. Unknown values are excluded when calculating percentages.

Table 3. Primary location of practice, DWDA physicians, 2021

Region[2]	Attending physicians		Consulting physicians	
	N	(%)[1]	N	(%)[1]
Metro counties (Clackamas, Multnomah, Washington)	70	(52.6)	100	(51.0)
Northwest Oregon (excludes metro counties)	38	(28.6)	57	(29.1)
Southern Oregon	18	(13.5)	26	(13.3)
Central Oregon / Columbia Gorge	4	(3.0)	11	(5.6)
Eastern Oregon	3	(2.3)	2	(1.0)
Unknown	*0*		*2*	

1 Unknowns are excluded when calculating percentages.

2 **Northwest Oregon**: Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill.
Southern Oregon: Coos, Curry, Douglas, Jackson, Josephine, Klamath, and Lake.
Central / Columbia Gorge: Crook, Deschutes, Gilliam, Hood River, Jefferson, Sherman, Wasco and Wheeler.
Eastern Oregon: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union and Wallowa.

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