

Special Report

LEGALIZED PHYSICIAN-ASSISTED SUICIDE IN OREGON —
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AND DAVID W. FLEMING, M.D.**ABSTRACT**

Background and Methods On October 27, 1997, Oregon legalized physician-assisted suicide. We collected data on all terminally ill Oregon residents who received prescriptions for lethal medications under the Oregon Death with Dignity Act and who died in 1998. The data were obtained from physicians' reports, death certificates, and interviews with physicians. We compared persons who took lethal medications prescribed under the act with those who died from similar illnesses but did not receive prescriptions for lethal medications.

Results Information on 23 persons who received prescriptions for lethal medications was reported to the Oregon Health Division; 15 died after taking the lethal medications, 6 died from underlying illnesses, and 2 were alive as of January 1, 1999. The median age of the 15 patients who died after taking lethal medications was 69 years; 8 were male, and all 15 were white. Thirteen of the 15 patients had cancer. The case patients and controls were similar with regard to sex, race, urban or rural residence, level of education, health insurance coverage, and hospice enrollment. No case patients or control patients expressed concern about the financial impact of their illness. One case patient and 15 control patients expressed concern about inadequate control of pain ($P=0.10$). The case patients were more likely than the control patients to have never married ($P=0.04$) and were more likely to be concerned about loss of autonomy due to illness ($P=0.01$) and loss of control of bodily functions ($P=0.02$). At death, 21 percent of the case patients and 84 percent of the control patients were completely disabled ($P<0.001$).

Conclusions During the first year of legalized physician-assisted suicide in Oregon, the decision to request and use a prescription for lethal medication was associated with concern about loss of autonomy or control of bodily functions, not with fear of intractable pain or concern about financial loss. In addition, we found that the choice of physician-assisted suicide was not associated with level of education or health insurance coverage. (N Engl J Med 1999;340:577-83.)

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ON October 27, 1997, Oregon legalized physician-assisted suicide.¹ Although there have been many studies of physician-assisted suicide, there are no data on the experiences of patients and physicians when the practice is legal.²⁻⁸ Physician-assisted suicide is practiced in the Netherlands but is subject to criminal prosecution, even though such prosecutions are rare. We report on the first year of experience with legalized physician-assisted suicide in Oregon.

The Oregon Death with Dignity Act allows terminally ill state residents to receive prescriptions for self-administered lethal medications from their physicians.¹ It does not permit euthanasia, in which a physician or other person directly administers a medication to a patient in order to end his or her life. To obtain a prescription for a lethal medication, the law requires that the patient be an adult resident of Oregon who is "capable" (able to make and communicate decisions about his or her health care) and who has an illness that is expected to lead to death within six months. The patient must make one written and two oral requests to his or her physician. The two oral requests must be separated by at least 15 days. The patient's primary physician and a consultant are required to confirm the diagnosis of a terminal condition and the prognosis, determine that the patient is capable, and refer the patient for counseling, if either believes that the patient's judgment is impaired by depression or some other psychiatric or psychological disorder. The primary physician must also inform the patient of all feasible alternatives, such as comfort care, hospice care, and pain-control options. To comply with the law, physicians must report all prescriptions that they write for lethal medications to the Oregon Health Division.⁹ Reporting is not required if patients begin the process of requesting a prescription but do not actually receive it. Physicians and patients who adhere to the requirements of the act are protected from criminal prosecution.¹

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METHODS

Although the Oregon Death with Dignity Act states that actions taken in accordance with the law do not constitute suicide, we use the term “physician-assisted suicide” rather than “death with dignity” to describe the provisions of this law. Physician-assisted suicide is the term used by the public and in the medical literature to describe the voluntary self-administration of lethal medications prescribed by a physician expressly for the purpose of ending one’s life.

Data Collection

Physicians who write prescriptions for lethal medications are required by law to report specific information to the Oregon Health Division.^{1,9} We matched the death certificates for all patients who requested and received prescriptions for lethal medications with the physicians’ reports on the prescriptions and abstracted data on the dates of the requests, consultations, and demographic characteristics of the patients. The physicians were contacted to obtain any missing data or clarify discrepancies.

We contacted each physician who had prescribed lethal medications and determined whether the patient used them. We then asked the physician a series of questions about the patient’s illness, insurance status, end-of-life care, prescribed medications, and medical and functional status at the time of death. Functional status was coded with the use of the scale developed by the Eastern Cooperative Oncology Group.¹⁰ The physician was asked, both specifically and in an open-ended fashion, whether the patient had expressed concern about end-of-life issues. If the patient took the lethal medications, we collected data on the rapidity of their effect and on unexpected adverse reactions. We also collected data on each physician’s age, sex, number of years in practice, and medical specialty. We did not interview the patients, their families, or other physicians who provided care at the end of life. Reporting forms and the questionnaire used to interview the physicians are available on the World Wide Web (at www.ohd.hr.state.or.us/cdpe/chs/pas/pas.htm) or from the National Auxiliary Publications Service.*

Cohort and Case–Control Analyses

We compared the patients and physicians who participated in physician-assisted suicide with those who did not. For this analysis, a case patient was defined as a person who had died between January 1, 1998, and December 31, 1998, after ingesting a lethal dose of medication prescribed under the Death with Dignity Act. (No prescriptions for lethal medications were written under the act in 1997.)

We calculated mortality rates using death-certificate data for 1996 from the Oregon Health Division (1996 was the most recent year for which final mortality data were available). We compared the demographic characteristics of the case patients with those of the cohort of Oregon residents who had died in 1996 from similar underlying illnesses (e.g., lung cancer, breast cancer, and chronic obstructive pulmonary disease).

We also performed a matched case–control study comparing the case patients with control patients who died from similar underlying illnesses but who did not receive prescriptions for lethal medications. Using Oregon death certificates issued in 1998, we matched up to three control patients to each case patient according to the underlying illness, age (within 10 years of the case patient’s age), and date of death (within 30 days of the case patient’s death).

We collected data on the demographic characteristics and end-of-life care and concerns of the control patients, as well as the characteristics of their physicians, from death certificates and interviews with the physicians, using the same methods as those described for case patients. The physician who signed the death certificate was interviewed, unless he or she specifically referred us to another

physician. Control patients were considered ineligible for the study if their physicians refused to be interviewed, could not be contacted after three attempts, or were unavailable for an interview within seven days after the first attempted contact or if we were unable to identify a physician responsible for the patient’s end-of-life care. Only control patients who would have met the requirements of the Death and Dignity Act were included in the analysis.

The institutional review board of the Oregon Health Division and the Human Subjects Research Office at the Centers for Disease Control and Prevention both determined that the reporting system and study design were part of the routine surveillance and evaluation required by the Oregon Death with Dignity Act and, as such, were not subject to formal review by the institutional review board of either institution.

Statistical Analysis

Univariate analyses were performed with use of the Mantel–Haenszel chi-square test and Fisher’s exact test. The results of matched analyses are expressed as Mantel–Haenszel odds ratios and summary chi-squares. The Mann–Whitney U test was used to compare continuous variables. Two-tailed P values that were less than or equal to 0.05 were considered to indicate statistical significance. Statistical calculations were performed with Epi Info, version 6.04b.¹¹

RESULTS

Patients Who Received Lethal Prescriptions

Information on 23 persons who received prescriptions for lethal medications in 1998 under the Death with Dignity Act was reported to the Oregon Health Division. Of the 23, 15 died after taking their lethal medications, 6 died from their underlying illnesses, and 2 were alive as of January 1, 1999. The characteristics of the 21 prescription recipients who died in 1998 are shown in Table 1. Their age ranged from the 3rd to the 10th decade of life. Twenty of the patients had been residents of Oregon for longer than six months when they received their prescriptions. One patient had moved to Oregon four months before her death so that her family could care for her, not because physician-assisted suicide was legal in the state. All the reports submitted by the physicians who prescribed lethal medications were in full compliance with the law. Eighteen of the 21 prescription recipients had cancer; 12 of the 18 had lung, ovarian, or breast cancer.

Twenty of the 21 patients received prescriptions for 9 g of secobarbital or pentobarbital; 1 received a prescription for 1 g of secobarbital to be used in conjunction with an oral narcotic. The patients also received prescriptions for a number of nonlethal medications to be used concurrently with the lethal medication (Table 1).

The Process of Physician-Assisted Suicide

Among the 15 case patients who died after ingesting the prescribed lethal medication, the median time from ingestion to unconsciousness (available for 11 patients) was 5 minutes (range, 3 to 20 minutes), and the median time from ingestion to death (available for 14 patients) was 26 minutes (range, 15 min-

*See NAPS document no. 05504 for 17 pages of supplementary material. Order from NAPS, c/o Microfiche Publications, 248 Hempstead Tpke., West Hempstead, NY 11552.

TABLE 1. CHARACTERISTICS OF PATIENTS WHO RECEIVED PRESCRIPTIONS FOR LETHAL MEDICATIONS AND TIMING OF EVENTS.

CHARACTERISTIC	PATIENTS WHO DIED AFTER INGESTING LETHAL MEDICATION (N=15)	PATIENTS WHO DIED FROM TERMINAL ILLNESS (N=6)	TOTAL (N=21)
Demographic characteristics			
Median age (yr)	69	47	69
White (no. of patients)	15	6	21
Male sex (no. of patients)	8	3	11
Oregon resident for more than 6 mo (no. of patients)	15	5	20
Resident of Portland area (no. of patients)	7	4	11
Legal requirements (no. of patients)			
Psychiatric or psychological consultation obtained	4	0	4
Physician's report in full compliance with law	15	6	21
Underlying illness (no. of patients)			
Cancer (all types)	13	5	18
Lung, ovarian, or breast cancer	9	3	12
Acquired immunodeficiency syndrome	0	1	1
Congestive heart failure	1	0	1
Chronic obstructive pulmonary disease	1	0	1
Medications prescribed (no. of patients)			
Secobarbital (9 g)	13	6	19
Pentobarbital (9 g)	1	0	1
Secobarbital (1 g) and morphine (1 g)	1	0	1
Antiemetic agent	14	5	19
Agent that promotes gastric motility	6	5	11
Chlorpromazine	1	0	1
Beta-blocker	3	3	6
Timing of events (days)			
Interval between first and second oral requests			
Median	18	30	20
Range	15-68	16-83	15-83
Interval between first oral request and death			
Median	20	93	26
Range	15-75	26-101	15-101
Interval between receipt of prescription and death			
Median	1	28	4
Range	0-22	8-66	0-66

utes to 11.5 hours). No complications, such as vomiting or seizures, were reported.

Mortality Data

The 15 physician-assisted suicides accounted for 5 of every 10,000 deaths in Oregon in 1998, with the 28,900 deaths that occurred in 1996 (the most recent year for which final data were available) used as the denominator.¹² The rate of physician-assisted suicide among persons who died from cancer was 19 per 10,000 (13 of 6784 deaths). In the cohort of case patients and the 5604 Oregon residents who died from similar underlying illnesses in 1996, age, race, sex, level of education, and rural or urban residence were not associated with the likelihood of physician-assisted suicide (Table 2). As compared with persons who were married, those who were divorced or had never married were more likely to choose physician-assisted suicide (risk ratio for divorced persons, 6.8; 95 percent confidence interval,

1.3 to 37.2; $P=0.03$; risk ratio for persons who had never married, 23.7; 95 percent confidence interval, 4.4 to 128.9; $P<0.001$).

Case-Control Study

We were unable to obtain information for 17 of 81 potential control patients (21 percent): we could not contact the physicians who cared for 12 patients, and it was not clear who provided care at the end of life for 5. Of the 64 potential control patients for whom physician-interview data were available, 21 (33 percent) would not have been eligible for a prescription under the Death with Dignity Act: 10 were not capable of making decisions about their health care, 2 were not Oregon residents, 2 could not take oral medications, and for 7 patients, the time between the physician's determination that the patient had less than 6 months to live and death was less than the required 15-day waiting period. We successfully collected data on 3 matched control pa-

TABLE 2. CHARACTERISTICS OF CASE PATIENTS AND OREGON RESIDENTS WHO DIED FROM SIMILAR ILLNESSES IN 1996.

CHARACTERISTIC*	OREGON RESIDENTS WHO DIED IN 1996 (N=5604)	CASE PATIENTS (N=15)	RATE OF PHYSICIAN-ASSISTED SUICIDE (PER 10,000 DEATHS)	RISK RATIO (95% CI)†	P VALUE
Median age (yr)	74	69	—	—	0.40
Race (no.)					
Nonwhite	116	0	0.0	1.0‡	
White	5450	15	27.4	Undetermined	1.00
Sex (no.)					
Female	3026	7	23.1	1.0‡	
Male	2578	8	30.9	1.3 (0.5–3.7)	0.57
Residence (no.)					
Rural	3582	8	22.3	1.0‡	
Urban (Portland area)	2022	7	34.5	1.6 (0.6–4.3)	0.39
Education (no.)					
Did not graduate from high school	1540	3	19.4	1.0‡	
High-school graduate§	3901	12	30.7	1.6 (0.5–5.6)	0.58
College graduate	614	4	64.7	3.3 (0.8–14.8)	0.11
Marital status at death (no.)					
Married	2703	2	7.4	1.0‡	
Widowed	1868	5	26.7	3.6 (0.7–18.6)	0.13
Divorced	789	4	50.4	6.8 (1.3–37.2)	0.03
Never married	224	4	175.4	23.7 (4.4–128.9)	<0.001

*Data on race were available for 5566 Oregon residents who died in 1996 from illnesses that were similar to the case patients' underlying illnesses, data on education were available for 5441, and data on marital status were available for 5584.

†CI denotes confidence interval.

‡This was the reference category.

§This category includes college graduates.

tients for each of 14 case patients, with a single control patient matched for 1 case patient.

As in the analysis of mortality data for Oregon in 1996, the case patients and control patients did not differ statistically according to race, sex, rural or urban residence, or educational level (Table 3). The case patients were more likely than the control patients to have never married ($P=0.04$).

End-of-Life Issues

None of the case patients or control patients expressed concern to their physicians about the financial impact of their illness. We found no significant differences between case patients and control patients with respect to insurance coverage at the time of death. One of the case patients (7 percent) and 15 of the control patients (35 percent) expressed concern about pain at the end of life ($P=0.10$). Similar proportions of case patients and control patients were receiving hospice care at the time of death, had advance medical directives, and died at home. The proportions of patients who expressed concern about being a burden to family members, friends, or other care givers or about the inability to participate in activities that made life enjoyable did not differ significantly between the two groups. However, the case patients were more likely than the control patients to

express concern about loss of autonomy (odds ratio, 7.3; 95 percent confidence interval, 1.5 to 35.9) or loss of control of bodily functions (e.g., incontinence or vomiting) as a result of their illness (odds ratio, 9.0; 95 percent confidence interval, 1.6 to 51.4). At the time of death, the case patients had a higher functional status than the control patients; 21 percent of the case patients, as compared with 84 percent of the control patients, had a score of 4, indicating that they were completely disabled ($P<0.001$).

Characteristics of the Physicians

Fourteen physicians wrote prescriptions for lethal medications for the 15 case patients. Forty physicians provided care at the end of life for the 43 control patients. The physicians for the case patients were similar to the physicians for the control patients with regard to sex, specialty, age, and number of years in practice, although there was a trend for the case patients' physicians to be older and in practice longer (Table 4).

Six case patients requested lethal medications from one or two physicians before finding a physician who would begin the prescription process. Five of these six case patients were specifically referred for discussion of physician-assisted suicide to the physicians who eventually wrote their prescriptions.

TABLE 3. CHARACTERISTICS OF CASE PATIENTS AND MATCHED CONTROL PATIENTS.

CHARACTERISTIC*	CASE PATIENTS (N=15)	CONTROL PATIENTS (N=43)	MATCHED ODDS RATIO (95% CI)†	P VALUE
Demographic characteristic				
Median age — yr	69	74	—	0.70
White race — no. of patients (%)	15 (100)	43 (100)	1.0	1.00
Male sex — no. of patients (%)	8 (53)	15 (35)	4.5 (0.6–32.1)	0.30
Oregon resident for more than 6 mo — no. of patients (%)	15 (100)	43 (100)		
Resident of Portland area — no. of patients (%)	7 (47)	16 (37)	1.4 (0.4–4.9)	0.87
Education — no. of patients (%)				
Did not graduate from high school	3 (20)	11 (27)	1.0‡	
High-school graduate§	12 (80)	30 (73)	1.4 (0.3–9.7)	0.90
College graduate	4 (27)	7 (17)	Undetermined	1.00
Marital status — no. of patients (%)				
Married	2 (13)	20 (47)	1.0‡	
Widowed	5 (33)	14 (33)	1.7 (0.1–24.7)	0.93
Divorced	4 (27)	7 (16)	7.5 (0.7–354.5)	0.12
Never married	4 (27)	2 (5)	Undetermined	0.04
Insurance coverage — no. of patients (%)				
Private insurance	8 (53)	28 (65)	1.0‡	
Medicare only	4 (27)	7 (16)	6.0 (0.3–288.4)	0.41
Oregon Medicaid	2 (13)	7 (16)	0.8 (0.1–7.7)	0.81
No insurance	1 (7)	0	Undetermined	0.56
Unknown	0 (0)	1 (2)	Undetermined	0.56
Functional-status score of 4 — no. of patients (%)¶	3 (21)	32 (84)	0.1 (0.0–0.4)	<0.001
Hospice care or advance directives — no. of patients				
Enrolled in hospice program	10 (71)	32 (74)	0.8 (0.2–4.2)	1.00
Written advance directives	11 (79)	37 (92)	0.4 (0.1–3.3)	0.55
Died at home — no. of patients (%)	12 (80)	29 (67)	3.5 (0.4–29.7)	0.55
Concern about end-of-life issues — no. of patients (%)				
Cost of treating illness or prolonging life	0	0	—	
Burden on family, friends, or other care givers	2 (13)	15 (35)	0.2 (0.0–1.5)	0.21
Inability to participate in activities	10 (67)	26 (60)	1.2 (0.3–4.3)	1.00
Inadequate pain control	1 (7)	15 (35)	0.2 (0.0–1.4)	0.10
Loss of autonomy due to illness	12 (80)	17 (40)	7.3 (1.5–35.9)	0.01
Loss of control of bodily functions	8 (53)	8 (19)	9.0 (1.6–51.4)	0.02
Duration of patient–physician relationship — days				
Median	69	720	—	0.03
Range	15–3780	35–7284		

*Data on education were available for 15 case patients and 41 control patients, functional-status scores were available for 14 case patients and 38 control patients, hospice data were available for 14 case patients and 43 control patients, and data on advance directives were available for 14 case patients and 40 control patients.

†CI denotes confidence interval.

‡This was the reference category.

§This category includes college graduates.

¶A score of 4 indicated complete disability.

||Percentages do not sum to 100 because some patients expressed concern about more than one issue.

Physicians for 29 of the 43 control patients (67 percent) would have refused to write a prescription for lethal medication had the patient requested it; physicians for 9 control patients (21 percent) would have provided prescriptions, and physicians for 5 control patients (12 percent) were unsure how they would have responded to such a request. Six control patients (14 percent) had discussed physician-assist-

ed suicide with their physicians, but none had begun the formal request process. In one instance, the patient discussed physician-assisted suicide with her physician in early 1998 but did not want to be a “test case.” In another instance, the patient’s primary physician was an employee of a health care system that did not allow its physicians to participate in assisted suicide.

TABLE 4. CHARACTERISTICS OF PHYSICIANS WHO PRESCRIBED LETHAL MEDICATIONS AND PHYSICIANS WHO PROVIDED CARE AT THE END OF LIFE FOR CONTROL PATIENTS.

CHARACTERISTIC	PHYSICIANS OF CASE PATIENTS (N=14)	PHYSICIANS OF CONTROL PATIENTS (N=40)	ODDS RATIO (95% CI)*	P VALUE
Male sex — no. (%)	11 (79)	35 (88)	0.5 (0.1–3.4)	0.41
Primary care specialty — no. (%)†	9 (64)	22 (55)	1.5 (0.4–6.6)	0.55
Age — yr				0.07
Median	51	44	—	
Range	37–69	30–62		
Years in practice				0.11
Median	18	12	—	
Range	1–45	1–36		

*CI denotes confidence interval.

†Primary care specialties included family practice, internal medicine, obstetrics, and gynecology.

DISCUSSION

Many people feared that if physician-assisted suicide was legalized, it would be disproportionately chosen by or forced on terminally ill patients who were poor, uneducated, uninsured, or fearful of the financial consequences of their illness.^{13–16} In our study of physician-assisted suicides in Oregon in 1998, we found no evidence to support these fears. The case patients and the larger cohort of patients with similar terminal illnesses did not differ statistically with respect to age or education. In addition, the case patients did not differ from the matched control patients with respect to insurance status, and neither the case patients nor the control patients expressed concern about the financial impact of their illness. Our conclusion, however, is based on a relatively small number of patients. Ongoing surveillance is needed.

Considerable debate over physician-assisted suicide has focused on the lack of data on the lethal medications prescribed and on the rapidity of their effect and adverse reactions.^{17–20} We found that the lethal medications prescribed to the case patients were similar, perhaps as a result of information available through advocacy groups. With one exception, all prescriptions were for 9 g of a fast-acting barbiturate and an antiemetic agent. The time to unconsciousness was fairly uniform. The majority of the patients for whom data were available were unconscious within 5 minutes after taking the lethal medication, and all were unconscious within 20 minutes. Although the majority of the patients died within 1 hour, four patients died more than 3 hours after taking the prescribed medications, and one died 11.5 hours afterward. This last patient was reported to have taken all 9 g of the prescribed barbiturate and to

have been unconscious within five minutes. Thus, the time to death is not always rapid or predictable.

Do patients request lethal prescriptions because of inadequate care at the end of life? Our data do not support this hypothesis. The proportions of case patients and control patients with advance medical directives were similar, and similar proportions of case patients and control patients (71 percent and 74 percent, respectively) were enrolled in a hospice program. Oregon ranks third nationally in the rate of hospice admissions.¹⁶ Three case patients who were not receiving hospice care had repeatedly declined offers of such care. Only one case patient expressed concern to her physician about inadequate control of pain at the end of life. The fact that 14 of the 15 patients did not express concern about pain control at the end of life may reflect advances in palliative care in Oregon, which ranks among the top five states in per capita use of morphine for medical purposes.²¹

We found that the case patients were significantly more likely than the control patients to have expressed concern to their physicians about loss of autonomy and loss of control of bodily functions. Seventy-nine percent of the case patients were not completely disabled when they took their lethal medications. This suggests that controlling the time of death was important to them. Many physicians reported that their patients had been decisive and independent throughout their lives or that the decision to request a lethal prescription was consistent with a long-standing belief about the importance of controlling the manner in which they died. Thus, the decision to request and use a prescription for lethal medications during the first year of legalized physician-assisted suicide in Oregon was associated with views on autonomy and control, not with fear of intractable pain or concern about financial loss.

In 1998, many physicians and some hospital systems in Oregon did not participate in physician-assisted suicide. Forty percent of the case patients were unable to initiate the prescription process with the first physician they approached and had to request a prescription from a second or third physician. This is probably an important reason why the case patients had shorter relationships with their physicians than the control patients did with their physicians. Fewer than one quarter of the control patients' physicians would have written a prescription for a lethal medication if it had been requested. In an anonymous survey of Oregon physicians in 1995, fewer than 50 percent stated that they would provide a lethal prescription if physician-assisted suicide were legal.³ Several hospital systems in Oregon (e.g., the Veterans Affairs hospitals, the Indian Health Service, and at least one Catholic hospital system) specifically prohibit participation in physician-assisted suicide by patients or staff in their facilities.²² The absence of participation in physician-assisted suicide

on the part of some physicians and hospital systems may have influenced our findings with respect to the characteristics of the case patients.

The Oregon Health Division is charged with collecting information under the Death with Dignity Act but is also obligated to report any cases of noncompliance with the law to the Oregon Board of Medical Examiners.^{23,24} Our responsibility to report noncompliance makes it difficult, if not impossible, to detect accurately and comment on underreporting. Furthermore, the reporting requirements can only ensure that the process for obtaining lethal medications complies with the law. We cannot determine whether physician-assisted suicide is being practiced outside the framework of the Death with Dignity Act.

The 14 physicians who wrote prescriptions for lethal medications represented a variety of specialties and a wide range of ages and years in practice. For some of these physicians, the process of participating in physician-assisted suicide exacted a large emotional toll, as reflected by such comments as, "It was an excruciating thing to do . . . it made me rethink life's priorities," "This was really hard on me, especially being there when he took the pills," and "This had a tremendous emotional impact." Physicians also reported that their participation led to feelings of isolation. Several physicians expressed frustration that they were unable to share their experiences with others because they feared ostracism by patients and colleagues if they were known to have participated in physician-assisted suicide. The legitimacy of these fears and their influence on the willingness of physicians to participate in physician-assisted suicide under the Oregon Death with Dignity Act are likely to affect the ability of otherwise eligible patients to choose physician-assisted suicide.

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