



## Secretariat of Pro-Life Activities

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### **Assisted Suicide Laws in Oregon and Washington: What Safeguards?**

Oregon's law allowing doctors to prescribe lethal overdoses for some patients' suicides was first approved in 1994; after a court challenge it took legal effect late in 1997. Supporters later modeled Washington's 2008 law on Oregon's law, saying that its safeguards are operating well and have prevented abuse. In fact the data suggest that the "safeguards" are largely meaningless, and the death toll in both states has greatly increased over the years.

In Oregon, 1,749 lethal prescriptions have been written and at least 1,127 patients have died from ingesting the drugs. In 2016 there were 133 deaths -- about the same as in 2015, but a 26% increase over 2014 and almost eight times the deaths in the law's first full year. In Washington, in less than seven years, 938 prescriptions have been written and at least 751 patients died from the drugs; these numbers rise each year, so the number ingesting lethal drugs in 2015 (166 patients) is over three times the number in 2010 (51), the first full year of the law's operation.

*Note: Unless noted otherwise, all data are from the official annual reports of Oregon's and Washington's health departments, referenced at end of this document; each year's report also provides a summary of past years' data for comparison. Note that Washington's most recent report is for 2015.*

### **Reporting or Concealing?**

All reporting about doctor-assisted deaths is self-reporting by the doctors prescribing lethal drugs. Or. Rev. Stat. §§ 127.855(7) and 127.865; Wash. Rev. Code §§ 70.245.120 and 70.245.150.

The Oregon Health Division noted in 1999: "There are several limitations that should be kept in mind when considering these findings.... For that matter, the entire account [by prescribing physicians] could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves." Center for Disease Prevention & Epidemiology, Oregon Health Division, *CD Reports*, March 16, 1999, at 2.

These doctors have often been members of, or close collaborators with, "Compassion and Choices" (formerly The Hemlock Society), which adamantly supports assisted suicide and promoted the new law. By C&C's own figures, in the law's first twelve years the group played an active role in 78% of Oregon's assisted deaths; in 2009 they were involved in 97%. See K. Stevens, "The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization," March 4, 2010, at [www.patientsrightscouncil.org/site/oregon-assisted-suicide-deaths/](http://www.patientsrightscouncil.org/site/oregon-assisted-suicide-deaths/).

Doctors cannot report reliably on the situation when patients actually ingest the lethal overdose and die, as nothing in the law requires them to be present – and no one else who may be present is required to report. In Oregon, the prescribing physician was present at the time of death in only 10% of known cases in 2016 – compared to 11% in 2013 and 2015, 14% in 2014, and an average of 16.5% in previous years. In all four of the years mentioned here, *no* health care

provider was present in about 80% of the known cases (40% in previous years). The real figure could be much higher: In 2016, for example, whether any health care provider was present is “unknown” in 100 of the 133 cases because the physician, the only person who can report this, was not present. In Washington in 2015, the prescribing physician was present in only 5% of cases (9 out of 166); in at least 24% of cases (compared to 16% the previous year), *no* health care provider was present when the drugs were ingested. Who else may have been present, what role they played in causing the patient’s death, and what motives they were acting on, are never reported.

These deaths are *not allowed* to be considered suicides or assisted suicides for any legal purpose. Or. Rev. Stat. § 127.880; Wash. Rev. Code § 70.245.180. In Oregon, doctors list patients’ underlying illness as the cause of death on death certificates; in Washington this falsified report is explicitly *required* by law. See M. Dore, “‘Death with Dignity’: A Recipe for Elder Abuse and Homicide (Albeit Not By Name),” 11.2 *Marquette Elder’s Advisor* 387-401 (Spring 2010) at 395; <http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=1027&context=elders>. The death certificate may be signed by the doctor who prescribed lethal drugs, completing this closed system for controlling and hiding information. Or. Rev. Stat. § 127.815(2); Wash. Rev. Code § 70.245.040(2).

### **A Free Choice?**

Despite medical literature on the frequent role of depression and other psychological problems in choices for suicide, the prescribing doctor (and the doctor he selects to give a second opinion) are free to decide whether or not to refer suicidal patients for any psychological counseling. Even if such counseling is provided, its goal is to determine that the patient is not suffering from “a psychiatric or psychological disorder or depression *causing impaired judgment*.” Or. Rev. Stat. § 127.825; Wash. Rev. Code § 70.245.060. The doctors or counselor can decide that, since depression is “a completely normal response” to terminal illness, the depressed patient’s judgment is not impaired. See H. Hendin and K. Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective,” 106 *Michigan Law Review* 1613-45 (2008) at 1623-4; available at <https://docs.google.com/file/d/0BwDPETL1NpNAmMfjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhIMjA2OTFj/edit?hl=en&pli=1>.

From 1998 to 2012, on average only 6.2% of patients who died under the Act in Oregon had been referred for counseling to check for “impaired judgment.” In 2013-2016 this declined to less than 4%. Of 108 patients who died under the Act in 2007 and 2009, *none* was referred for psychological evaluation. In Washington, in 2014 and 2015, only 4% of patients who died from any cause after receiving the prescription are known to have been referred for such counseling; the state does not report whether *any* of those who actually ingested the lethal drugs had been referred for counseling.

Physicians are to encourage patients requesting a lethal prescription to notify their next of kin, but they are to proceed even if this does not occur. Family notice is optional. Or. Rev. Stat. § 127.835; Wash. Rev. Code § 70.245.080.

Physicians are to certify that the patient is “capable” (or in Washington, “competent”) and is “acting voluntarily.” Or. Rev. Stat. § 127.855; Wash. Rev. Code § 70.245.040. But only “good faith” compliance with these and other requirements of the Act is necessary, ignoring physicians’

usual obligation not to act negligently. Or. Rev. Stat. § 127.885(1); Wash. Rev. Code § 70-245-190(1). See Hendin and Foley, *op. cit.*, at 1629-30.

Once lethal drugs have been prescribed the Act has *no* requirements for assessing the patient's consent, competency, or voluntariness. No witnesses are required at the time of death.

Despite the law's efforts to prevent public scrutiny, a few cases have become known in Oregon:

- One woman with cancer received doctor-assisted death although she had dementia, was found mentally incompetent by some doctors, and had a grown daughter described as "somewhat coercive" in pushing her toward the lethal prescription. See Hendin and Foley, *op. cit.*, 1626-7.

- A man received the prescription although he was well known to have suffered from depression and suicidal feelings for decades; guns had been removed from his house because he was so prone to suicide, but authorities left the lethal prescription in his home. He had already arranged to take the lethal overdose when other physicians averted this outcome by offering to address his pain and other concerns; he died comfortably of natural causes a few weeks later after reconciling with his daughter. See Physicians for Compassionate Care Education Foundation (PCCEF), "Five Oregonians to Remember," at [www.pccef.org/articles/art60.htm](http://www.pccef.org/articles/art60.htm).

### **Terminal Illness?**

In Oregon, fewer patients had cancer in 2013, 2014 and 2015 (65%, 69% and 72% respectively) than in past years (80%); this figure went back up to 79% in 2016. Other patients chiefly had chronic conditions with a less predictable future, such as chronic lower respiratory disease (2% of patients in 2016), ALS or "Lou Gehrig's disease" (7%), heart disease (7%), and "other" (6%). The state of Oregon says "other" includes "benign and uncertain neoplasms," suggesting that the doctor only thought the condition *might* shorten life but still prescribed the drugs. Since 1998 there have been three Oregon patients whose illnesses were "unknown" – that is, the physician named no illness at all, but the case was still listed as meeting the law's requirements. In Washington, 72% of patients who died after receiving the lethal drugs in 2015 had cancer (76% the previous year).

Many of these conditions other than cancer are associated with aging. In 2016 the median age of those dying under the Oregon law was 73. Despite the publicity surrounding Brittany Maynard, a 30-year-old cancer patient who moved to Oregon to use the law, fewer than 1% of those receiving the lethal drugs are under 35 years old; in 2014 Ms. Maynard was the *only* person under 35. In Washington in 2015, 73% of the patients were aged 65 or over.

Of the 133 patients in Oregon who took the lethal drugs and died in 2016, *nineteen* had been diagnosed as having less than six months to live *in previous years* and given the lethal prescription. The same is true of *seven* of the 132 patients who died in 2015 and *eleven* of the 105 who died in 2014. In 2016 in Oregon, the time between prescribing the drugs and the patient's death ranged from 15 to 539 days; in past years it has been as long as 1009 days. In Washington in 2015, 16% (compared to 9% the previous year) died more than 25 weeks after their initial request for the drugs, living as long as 95 weeks. Of the patients who received prescriptions in 2016 but did not take the drugs, only 40% (36 out of 90) subsequently died that year of other causes. Clearly these six-month predictions are not reliable. How unreliable they

are, of course, cannot be determined for those who took the drugs less than six months after being diagnosed.

### **From Assisted Suicide to Homicide**

Can others take an active role in ending the patient's life? Oregon law speaks of the patient as "ingesting" medication to end his or her life. Or. Rev. Stat. § 127.875. Washington law says patients will "self-administer" the drugs, but defines "self-administer" to mean "ingesting." Wash. Rev. Code §§ 70.245.020 and 70.245.010(12). But "ingesting" ordinarily means absorbing or swallowing; so this does not seem to bar others from administering the drugs. If such action is in accord with the Act, it may *not* be treated as a homicide. Or. Rev. Stat. § 127.880; Wash. Rev. Code § 70.245.180(1). See M. Dore, *op. cit.*, 391-3.

After an Oregon patient with physical disabilities was "helped" by a relative to take the lethal dose, the state's deputy attorney general wrote that if the law does not allow such active assistance it may violate laws guaranteeing equal access to health care such as the Americans with Disabilities Act. Letter of Oregon deputy assistant general David Schuman to state legislator Neil Bryant, March 15, 1999.

An Oregon emergency room physician was asked by a woman to end the life of her mother who was unconscious from a stroke. He tried to stop her breathing or heartbeat in several ways, finally giving a lethal dose of a paralyzing drug to the older woman who died minutes later. The state board of medical examiners reprimanded the doctor but he faced no criminal charges for this direct killing -- which news reports called an "assisted suicide" -- and he later resumed medical practice. See PCCEF, *op. cit.*

### **Troubling Trends**

Most of those dying under these laws are not married or in another formally committed relationship. In Oregon, 53% in 2016 (and 60% in 2015) were divorced, widowed or never married. Increasingly, those dying under the law have no or only governmental health insurance -- 56% in 2013, 60% in 2014, 71% in 2015, and 70% in 2016 (compared to an average of 35% in previous years).

Consistently, untreated pain is *not* among the top reasons for taking lethal drugs; in 2016, 90% said they were "less able to engage in activities making life enjoyable" and were "losing autonomy," and 49% cited being a "burden" on family, friends or caregivers (compared to 48% in 2015 and an average of 40% in previous years). It seems solitary, dependent and chronically ill seniors are prime candidates for assisted suicide in Oregon. Similar trends are seen in Washington, where 53% were widowed, divorced or never married in 2015 (up from 42% the previous year), and 71% of those for whom the information is known were dependent solely on Medicare or Medicaid (up from 57% the previous year). In Washington, 52% cited being a "burden," while only 35% cited a concern about pain.

In all, at least 30 patients in Oregon are known to have regurgitated some of the lethal dose (three of them in 2016), and six regained consciousness after taking the drugs and died later, apparently from their underlying illness (see Oregon Report for 2012, Table 1 and note 13). In 2016, patients are known to have taken as long as 9 hours to die, with this figure unknown for

81% of the cases (108 out of 133). In Washington there have been at least 9 cases of regurgitation and 2 cases of waking up after ingesting the drugs. In Washington in 2015, at least 20% of patients took over an hour and a half to die from the drugs, taking as long as 30 hours (compared to a maximum of 18 hours the previous year); in another 17% of cases the time period is unknown.

### *Primary Sources*

For Oregon data, including archived annual reports from past years, see Oregon Health Authority, “Death with Dignity Act Annual Reports,” at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>.

For a direct link to the two most recent years:

Oregon Public Health Division, “Oregon Death with Dignity Act: Data summary 2016,” at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>

Oregon Public Health Division, “Oregon Death with Dignity Act: 2015 Data Summary,” at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>

For Washington data, see Washington State Department of Health, “Death with Dignity Act,” at <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>

A direct link to the Department’s “2015 Death with Dignity Act Report,” with comparisons to the previous year:

<http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf>