



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, 1,967 lethal prescriptions have been written and at least 1,275 patients have died from ingesting the drugs. In 2017 there were 143 deaths – ten more than the previous year, a 36% increase over 2014 and over nine times the deaths in the law's first full year. In Washington, in less than eight years, 1,186 prescriptions have been written and at least 943 patients died from the drugs. These numbers rise each year, so the number dying from the lethal drugs in 2016 (192 patients) is 14% higher than in 2015 (169) and almost four 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 generally provides a summary of past years' data for comparison. Note that Washington's most recent report is for 2016.

Reporting or Concealing?

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

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 16% of the cases in 2017, with an average of 15% for all years. In 2017, *no* health care provider was present in 71% of cases (with an overall average of 59%). For some years the real

figure could be higher: In 2016, for example, whether any health care provider was present is “unknown” in 23 of the 138 cases -- presumably because the prescribing physician, the only person who can report this, was not present and did not know.

In Washington in 2017, the prescribing physician was present when the drugs were ingested in only 9% of cases (17 out of 192); in at least 13% of cases *no* health care provider was present when the drugs were ingested, and this is unknown for another 28%. Washington does not report on whether a health care provider was present at the time of death. In both states, who else may have been present at either time, what role they played in causing the patient’s death, and what motives they were acting on, are never reported or investigated.

These deaths are *not allowed* to be considered suicides or assisted suicides for any legal purpose. Ore. Rev. Stat. 127.880; Rev. Code Wash. 70.245.180. In Oregon, doctors list the 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. Ore. Rev. Stat. 127.815 (2); Rev. Code Wash. 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*.” Ore. Rev. Stat. 127.825; Rev. Code Wash. 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/0BwDPETL1NpNAmMfjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhlMjA2OTFj/edit?hl=en&pli=1>.

From 1998 to 2016, on average only 5% of patients who died under the Act in Oregon had been referred for counseling to check for “impaired judgment.” In 2017 this declined to 3.5% (5 out of 143). Of 108 patients who died under the Act in 2007 and 2009, *none* was referred for psychological evaluation. In Washington in 2016, only 5% of the 240 patients who died from *any* cause after receiving the prescription were referred for such counseling; the state does not say whether *any* of those who died from ingesting the lethal drugs were referred for counseling.

Physicians are to encourage patients requesting a lethal prescription to notify their next of kin, but family notice is optional. Ore. Rev. Stat. 127.835; Rev. Code Wash. 70.245.080.

Physicians are to certify that the patient is “capable” (or in Washington, “competent”) and is “acting voluntarily.” Ore. Rev. Stat. 127.855; Rev. Code Wash. 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. Ore. Rev. Stat. 127.885 (1); Rev. Code Wash. 70.245.190 (1). See Hendin and Foley, *op. cit.*, at 1629-30.

Once lethal drugs have been prescribed the Act has *no* requirement 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.

Terminal Illness?

In theory these laws allow the prescribing of lethal drugs only for patients with a "terminal disease," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Ore. Rev. Stat. 127.800 §1.01 (12); Rev. Code Wash. 70.245.010 (13). But a Swedish investigator has found that the Oregon Health Division has always interpreted "terminal" to include conditions that can be reversed or even cured, but will likely lead to death in six months *without treatment*. If the patient refuses life-saving treatment, or treatment is withheld by others such as a physician, insurance company or government agency, that makes the treatable condition "terminal" and the lethal drugs can be prescribed. See F. Stahle, "Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model," January 2018, at <https://drive.google.com/file/d/1xOZfLFrvuQcazZfFudEncp2b18NrUo/view>. This helps explain the data below. Washington state has not said how it interprets its identical definition.

In Oregon, 77% of the patients who died from the lethal drugs in 2017 had various forms of cancer. Other patients had chronic conditions with a less predictable future, such as respiratory disease (1.4%), neurological conditions such as ALS or "Lou Gehrig's disease" (7%), cardiac and circulatory disease (6%), endocrine/metabolic diseases such as diabetes (1%), and "other" (1%). In 2016 Oregon reported that "other" can include "benign and uncertain neoplasms," suggesting that the doctor only thinks the condition *might* shorten life but still prescribes 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 listed as meeting legal requirements.

In Washington, similarly, 77% of patients who died after receiving the lethal drugs in 2016 had cancer. Other illnesses included neurological conditions (8%), respiratory disease (8%), cardiac conditions (6%), and "other" (2%).

Many of these conditions other than cancer are commonly associated with aging. In 2017 the median age of those dying under the Oregon law was 74. Despite widespread publicity by “Compassion and Choices” about Brittany Maynard, a 30-year-old cancer patient who moved to Oregon to use the law, no patient in 2017 was under 35; overall, fewer than 1% of those receiving the lethal drugs are younger than 35, and Ms. Maynard was the *only* person under that age in 2014 when she died. In Washington in 2016, 71% of the patients were aged 65 or over.

Of 143 patients in Oregon who died from the prescribed drugs in 2017, *fourteen* were diagnosed as having less than six months to live *in previous years* and given the lethal prescription. This is true of *nineteen* of the patients in 2016, *seven* in 2015 and *eleven* in 2014. In 2017 in Oregon, the time from a request for lethal drugs (supposedly by a patient with less than six months to live) to the patient’s death from those drugs has been as long as 603 days; in 2016 it was 539 days, and has been as long as 1009 days (*over five times* the patient’s alleged life expectancy).

In Washington in 2016, 10% of patients died 25 weeks or more after their initial request for the drugs, living as long as 112 weeks (over two years); in 2015, 16% died 25 weeks or more after the request, living as long as 95 weeks.

Clearly these six-month predictions are not reliable. How unreliable they are, of course, cannot be determined for the majority 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. Ore. Rev. Stat. 127.875. Washington law says patients will “self-administer” the drugs, but defines “self-administer” to mean “ingesting.” Rev. Code Wash. 70.245.020; 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. Ore. Rev. Stat. 127.880; Rev. Code Wash. 70.245.180 (1). See M. Dore, *op. cit.*, 391-3.

After an Oregon patient with physical disabilities was “helped” by a relative to ingest 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.

One 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

Many dying under these laws are not in a committed relationship. In Oregon, 48% in 2017 (as well as 53% in 2016 and 60% in 2015) were divorced, widowed or never married. Most of those

dying under the law have no or only governmental health insurance – 56% in 2013, 60% in 2014, 71% in 2015, 70% in 2016, and 69% in 2017 (compared to an average of 35% in previous years).

Consistently, untreated pain or a concern about future pain are *not* among the top reasons for taking lethal drugs. In 2017, 88% said they were “less able to engage in activities making life enjoyable” and 87% said they were “losing autonomy”; 55% cited being a “burden” on family, friends or caregivers (compared to 49% in 2016, 48% in 2015 and an average of 40% in previous years). Only 21% cited a concern about current or possible future pain. It seems solitary, dependent and chronically ill seniors are prime candidates for assisted suicide in Oregon.

Similar trends are seen in Washington: 54% were widowed, divorced or never married in 2016 (up from 53% in 2015 and 42% in 2014). At least 46% were dependent solely on Medicare or Medicaid. In Washington, 51% cited being a “burden,” while 41% cited a concern about pain.

In all, at least 34 patients in Oregon (including four in 2017 and three in 2016) have experienced complications, such as regurgitating some of the lethal dose, and seven regained consciousness after taking the drugs and died later, apparently from their underlying illness. For a total of 638 patients, 101 of them in 2017, it is simply *not known* whether this happened. In 2017, Oregon patients are known to have taken as long as 21 hours to die (9 hours the previous year), with this figure unknown for 72% of the 2017 cases (103 out of 143). Overall, Oregon patients have taken at least as long as 101 hours (over four days) to die, with this figure unknown for over half the total patients (673 out of 1,275).

In Washington there have been at least 13 cases of regurgitation (7 in 2016) and 2 cases of waking up after ingesting the drugs. In Washington in 2016, at least 30% of patients took over an hour and a half to die from the drugs (21% the previous year), taking as long as 22 hours (72 hours the previous year); in another 17% of cases the time period is unknown.

Primary Sources

For the text of the Oregon law see:

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx>

For Oregon’s annual reports, see:

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/index.aspx>

A direct link to the 2017 report, with overall data from past years:

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

For Washington data, including the text of the law and annual reports, see:

<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>

A direct link to the Department’s 2016 report, with comparisons to the previous two years:

<https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2016.PDF>