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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 effect late in 1997. Supporters later modeled Washington's 2008 law on Oregon's law, saying that its safeguards were operating well and had 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, 4,881 lethal prescriptions have been written and at least 3,243 patients have died from ingesting the drugs. In 2024 there were 607 prescriptions, and at least 376 drug-induced deaths – more than twice the number in 2019, and *over twenty times* the drug-induced deaths in the law's first full year. For 87 patients in 2024, whether they died (from any cause) or ingested the drugs is unknown.

In Washington, in fifteen years, 3,703 prescriptions have been written (545 in 2023) and at least 2,768 patients died from the drugs (at least 427 in 2023). The number known to have died from ingesting lethal drugs in 2023 is over twice as many as in 2016 (192) and about *twelve* times as many as in 2009 when the law took effect (36). For another 56 patients who died in 2023, it is *not known* whether they died from the drugs, so as many as 483 may have done so. In 2023, assisted suicide advocates persuaded the Washington legislature to weaken or eliminate "safeguards" against abuse that these advocates had once sponsored, claiming that they were restricting "access." Changes include: reducing the waiting period for lethal drugs from 15 days to 7 days, allowing a nurse practitioner or physician's assistant to assume the roles previously requiring a physician, allowing a social worker to conduct any mental health evaluation, providing for delivery of lethal drugs by mail or messenger, etc.

Note: Unless noted otherwise, all data are from the official annual reports of Oregon's and Washington's health departments, cited at end of this document; some annual reports provide a summary of past years' data for comparison. Beginning in 2019 Washington stopped reporting on key facts -- Duration of the physician/patient relationship; maximum time between first request and death; percentage of patients dependent solely on government insurance (Medicaid or Medicare); complications from taking the drugs; and the drugs used to cause death. As of May 2025, Washington had not yet issued its report on 2024 cases.

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; Current (CD) Disease Summary: an epidemiology publication of Oregon DHS.

In Washington the physician must submit the Attending Physician's Compliance Form and the patient's signed and witnessed request for lethal drugs to the Department of Health *within 30 days*

after writing the lethal prescription. From 2019 to 2023, the Department has taken from six to eleven months after the end of the year in question to issue its annual report. Yet it reports that during these five years it has not received a patient's written request for 175 patients (28 in 2023) and has not received the physician's compliance form for 151 patients (35 in 2023). Over the 15 years of the law's existence, the health department has not received a patient's written request in 309 cases or the attending physician's compliance form in 262 cases – with well over half these cases occurring in the last five reported years. By law, these cases do not enjoy the immunity from prosecution granted by the Death with Dignity Act; so they are subject to the state law under which it is a felony to assist a suicide, as well as to civil and professional liability. Yet the Department lists these among cases where lethal drugs were provided "under the terms of the law" (2019 and 2020 reports, p. 5; 2021, 2022, and 2023 reports, p. 1). See R. Doerflinger, "Lethal Non-Compliance with Washington's 'Death with Dignity Act'," Charlotte Lozier Institute, December 20, 2022, at https://www.printfriendly.com/p/g/9MNFaW.

These doctors are often members of, or close collaborators with, "Compassion and Choices" (formerly The Hemlock Society), which adamantly supports assisted suicide and promoted the state laws. By C&C's own figures, in the Oregon law's first 12 years the group played an active role in 78% of the state'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/. The president of "End of Life Washington" has claimed that "95% of the people who use the law work through" his organization. Testimony of March 17, 2021, before the Senate Health & Long Term Care Committee, watch – TVW, Washington State's Public Affairs Network, at 49:35.

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 others who may be present are not authorized to report. In Oregon, the prescribing physician was present at the time of death in only 16% of cases in 2024 and, on average, 14% in all years. *No* health care provider was present in 65% of the deaths in 2024, with an overall average of 64%. No health care provider was present when the drugs were *ingested* in over half of all cases (54%) in 2024.

In Washington in 2018, the prescribing physician was present when the drugs were ingested in less than 10% of cases (20 out of 203); in at least 8% of cases *no* health care provider was present at this time, and this is unknown for another 15%. Washington does not report on whether a health care provider was present at the *time of death*, and as of 2019 it no longer reports on whether one is present for *ingestion of the drugs*. Oregon reports that a non-medical "volunteer" (presumably from assisted suicide groups) was present at the time of death in 94 cases in 2024 (32% of all cases). In Washington, 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 the death certificate; 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 (as well as the doctor this person selects to give a second opinion) is free to decide whether or not to refer suicidal patients for any psychological evaluation. Even if this 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 the psychologist can decide that, since suicidal thoughts are "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; https://docs.google.com/file/d/0BwDPETL1NPnAMmFjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhlMjA2OTFj/edit?hl=en&pli=1.

From 1998 to 2024, on average, only 2.5% of patients who died from the drugs in Oregon were referred for evaluation to check for "impaired judgment." In recent years, this was down to 0.8% in each of 2024 (3 out of 376), 2023 (3 out of 367), and 2021 (2 out of 238), and 1.0% in 2022 (3 out of 304). Of the 108 patients who died under the Act in 2007 and 2009, *none* was referred for psychological evaluation.

In Washington in 2018, only 4% of the 251 patients who died from *any* cause after receiving the prescription were referred for evaluation, compared to 5% in 2016. In 2017, 2019, and 2020, the number is so small that it is posted as blank; in 2021 it is listed only as "<10"; and in 2022 and 2023 no evaluations are reported, allegedly "to protect participant confidentiality." In at least five of the last seven years, then, Washington does not report that *any* of those who died from ingesting the lethal drugs, or who obtained them, received a psychological evaluation. Neither state has ever reported that a patient requesting lethal drugs was rendered ineligible by depression or other source of impaired judgment.

In January 2020, a new change to the Oregon law took effect: If the attending physician thinks a patient may die before the end of the usual 15-day waiting period, that period is waived. In 2020, 75 of the 370 patients given lethal prescriptions (20%) received the waiver, and some (it is not reported how many) died from the drugs on *the same day* as that first oral request. In 2021, 81 of the 383 patients given the prescriptions (21%) received the waiver, and some died from the drugs the day after the first request. In 2022, some patients (it is not reported how many) received the waiver, received a lethal prescription within a week of first meeting the doctor, and died the day after first requesting the drugs. In 2024, 29% of patients obtaining the prescription (179 out of 607) received the waiver, and some died the next day. This is same-day or next-day suicide assistance, with no time to reconsider, receive a meaningful second opinion or psychological evaluation, or verify the prognosis. If all patients given this waiver died from the drugs, they made up *over one-third* of all patients dying from that cause in 2021 (81 of 238). Because it qualifies the patient for immediate provision of the drugs, the prediction of an imminent death becomes a self-fulfilling prophecy.

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. As noted above, in hundreds of cases, Washington physicians have not submitted their compliance forms claiming the patient was competent.

Once lethal drugs are prescribed, neither state requires *any* assessment of the patient's consent, competency, or voluntariness. No witness, and no protection against subtle or overt coercion, is provided for at the time when lethal drugs are ingested. Supporters of such laws have long said that requesting a prescription is not the same as choosing to die from the drugs – the patient may only seek the comfort of knowing they are available. And to be sure, at least 96 (or as many as 274) of the 607 patients who received prescriptions in Oregon in 2024, and at least 41 (or as many as 97) of the 545 who received them in Washington in 2023, did not ingest the drugs the year they received them. (This variance in numbers is due to both states listing the ingestion status of so many patients as unknown). But this means there are *no* "safeguards" whatever for the time when the actual decision to ingest lethal drugs is made.

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

- An Oregon 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.

- An Oregon 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 https://www.pccef.org/articles/pcceffive-oregonians-to-remember2007pdf.

- Similarly, in 2019, End of Life Washington publicized the case of cancer patient Robert Fuller, having arranged for a reporter and photographer to accompany him through the "death with dignity" process. It turned out Fuller had been suicidal for many years and tried to take his own life when physically healthy; yet he was deemed competent and without any depression impairing his judgment in order to qualify him for the lethal drugs. See Assisted Suicide: A Tale of Two Narratives - The Catholic Thing.

- The Oregon Health Authority reports that in 2018 "two physicians were referred to the Oregon Medical Board for failure to comply with DWDA [Death with Dignity Act] requirements." No details are provided on exactly how they violated the Act, or on why there is no mention of criminal charges – in theory, if the Act is violated it should no longer protect the physician from criminal prosecution under Oregon's longstanding law against assisting a suicide. The identity of one physician is unknown. Oregon Medical Board records show that the other is Dr. Rose Kenny, who in 2016 agreed to serve five years' medical probation after the Board found evidence of "dozens of legal violations, including unprofessional or dishonorable conduct, gross or repeated negligence and prescribing controlled substances without a legitimate medical purpose." Yet in less than two years she was allowed to prescribe lethal overdoses of controlled substances to vulnerable patients. See A. Schadenberg, "Exposing abuse of the Oregon assisted suicide law. Two doctors accused of alleged abuse of the Oregon assisted suicide law," Euthanasia Prevention Coalition, March 6, 2019;

https://alexschadenberg.blogspot.com/2019/03/assisted-suicide-abuse-cover-up-in.html. In 2021 a third physician was referred to the Oregon Medical Board for noncompliance with the law. In Washington, despite the many well-documented violations of reporting requirements noted above, the state health department has not reported any physician being referred for such action.

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 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 it 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/1xOZfLFrvuQcazZfFudEncpzp2b18NrUo/view. This helps explain the data below. Washington has not said how it interprets its identical definition.

In Oregon, 57% of the patients who died from the lethal drugs in 2024 had various forms of cancer (compared to 69% overall). Increasingly the patients have chronic conditions with a less predictable future, such as respiratory disease (8%), neurological conditions such as ALS or "Lou Gehrig's disease" (15%), cardiac or circulatory disease (11%), endocrine/metabolic diseases such as diabetes (3%), and so on. Over 4% are "other" (unspecified) conditions. In 2021, qualifying conditions included arthritis, sclerosis, anorexia (a psychiatric condition), "complications from a fall," and "medical care complications" (3%). In 2016 Oregon reported that "other" can include "benign and uncertain neoplasms," suggesting that the doctor only thinks the patient *might* have a life-shortening condition but still prescribes the drugs. Since 1998, three Oregon patients' illnesses were listed as "unknown" – the physician named no illness at all, but the case apparently met legal requirements.

In Washington, similarly, 70% of patients who died (from any cause) after receiving the lethal drugs in 2023 were reported to have cancer. Other illnesses included neurodegenerative conditions (9%), respiratory disease (7%), cardiac or vascular conditions (9%), unspecified "other" (6%), or "unknown" or "missing" (3%). As noted above, in 35 cases in 2023 (262 cases overall), the physician never submitted the legally required compliance form listing any illness.

Many of these conditions other than cancer are commonly associated with aging. In 2024 the median age of those dying under the Oregon law was 75, and 83% were aged 65 or over. Despite widespread publicity by "Compassion and Choices" about Brittany Maynard, a 30-year-old cancer patient who moved to Oregon to use the law, only one patient in 2022 (and one patient in 2021) was under 35; overall, fewer than 1% of those receiving the lethal drugs have been younger than 35, and Ms. Maynard was the *only* such person under that age in 2014 when she died. In Washington each year, 2020 through 2023, about 80% of the patients who died were aged 65 or over.

Of 376 patients in Oregon known to have died from the prescribed drugs in 2024, *43* were diagnosed as having less than six months to live and given the lethal prescription "*in previous years.*" This is true of 30 patients in 2023, 32 in 2022, 20 in 2021, and 22 in 2020. 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 1,859 days, over *five years* (in 2022); it was 727 days (two

years) in 2024, 1633 days (about four and a half years) in 2023, 1,095 days (over three years) in 2021, and 1,080 days (3 years) in 2020. The time from request for lethal prescription to a drug-induced death has been over *ten times* the patient's predicted survival time.

In Washington in 2018, 12% of patients died 25 weeks or more after their initial request for the drugs, living as long as 115 weeks (over two years). In 2017 the time from prescription to death was as long as 81 weeks and in 2016 as long as 112 weeks; in 2015, 16% died 25 weeks or more after the request, living as long as 95 weeks. Beginning in 2019, however, Washington stopped reporting a maximum survival time, noting only the percentage of patients who survived "more than 120 days." In 2020, that was true of at least 17% of the patients for whom a Pharmacy Dispensing Report was submitted; in 2021 it was true of at least 67 (19%) of the 346 patients with such a report, with this figure unknown for another 44 patients.

In Washington, there are 82 patients over the past 15 years who received the drugs based on a six-month prognosis but for whom the health department has no evidence that they have died.

Clearly these six-month predictions are not reliable. *How* unreliable they are, of course, cannot be determined for those who take the drugs, as they might have lived much longer. The falsified death certificates, reporting death from natural causes, discourage any autopsy that might have determined whether the patient had a terminal condition.

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 it defines "self-administer" to mean "ingesting." Rev. Code Wash. 70.245.020; 70.245.010 (12). "Ingesting" ordinarily means absorbing or swallowing; so this may not 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 did not allow such active assistance it may violate laws guaranteeing equal access to health care (sic) 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 in 2024, at least 60% in 2024 (and for all years an average of 55%) were divorced, widowed, or never married. *Most* of those dying under the law have no or only governmental health insurance – 77% in 2024, as high as 80% in

2021 and 2022, and an overall average of 64%).

Consistently, untreated pain or a concern about future pain are *not* among patients' chief reasons for taking lethal drugs. In 2024, 88% of those ingesting the drugs in Oregon said they were "less able to engage in activities making life enjoyable" and 89% said they were "losing autonomy"; 42% cited being a "burden" on family, friends or caregivers (with an overall average of 47%). In 2024, 34% cited a concern about current or possible future pain (overall average of 30%). Nine percent in 2024 cited financial concerns about treatment, with an overall average of 6%. It seems solitary, dependent and chronically ill seniors are prime candidates for assisted suicide in Oregon.

In 2023, Oregon amended its law to remove the residency requirement. Lethal prescriptions were provided to 29 patients from other states in 2023 and 23 in 2024, providing for what some call "suicide tourism."

Similar trends are seen in Washington. At least 57% of those obtaining the drugs were widowed, divorced, or never married in 2024. At least 66% were dependent solely on Medicare or Medicaid in 2018 (up from 54% in 2017); beginning in 2019 Washington *stopped reporting* this figure. In Washington in 2023, 81% cited loss of autonomy, 83% cited less ability to engage in enjoyable activities, 57% cited "loss of dignity," 51% cited being a "burden" on others, and 10 percent cited financial concerns, while 41% cited a concern about present or possible future pain.

Humane and Dignified Death?

In all, *at least* 84 patients in Oregon, including at least nine in 2024, have experienced complications, such as seizures or regurgitating some of the lethal dose -- with the presence of complications "unknown" for another 2,037 patients (255 of them in 2024), presumably because the physician authorized to report was not present. In all, nine (including one in 2021 and one in 2018) regained consciousness after taking the drugs and died later, apparently from their underlying illness. Oregon patients are known to have taken as long as 26 hours to die in 2024, and 137 hours (almost 6 days) in 2023. Time from ingestion to death is *unknown* for 115 patients in 2024, and 1,355 overall.

In Washington, from 2009 to 2018, there were at least 35 "complications" (8 cases in 2018 alone), and the number of complications for another 97 patients is unknown. Reports for years before 2018 showed 15 cases of regurgitation, and two cases of waking up after ingesting the drugs; in 2018 these events were not listed separately but included in a generic listing for "regurgitation, seizures, awakening, other." *Beginning in 2019 the state stopped reporting on complications altogether*.

In Washington in 2018, at least 31% of patients took over an hour and a half to die from the drugs, taking as long as 30 hours. The maximum time was 35 hours in 2017, 22 hours in 2016, and 72 hours in 2015. In another 15% of cases in 2018 the time from ingestion to death is unknown. In 2019, 25% took over two hours (with another 16% reported as unknown); this was true of 19% in 2020 (with another 18% unknown), and 16% in 2021 (with another 14% unknown). *Beginning in 2019, Washington stopped reporting a maximum time from ingestion to death. In 2022, it did not report how many patients took more than two hours to die. In 2023, 13% of patients (63) took more than two hours, with another 29% (144) unknown.*

These complications and lingering deaths, as well as the sharply rising cost and limited availability of the barbiturates commonly used in the past, have led physicians to experiment with lethal doses of other drugs. See J. Aleccia, "Docs in Northwest Tweak Aid-in-Dying Drugs To Prevent Prolonged

Deaths," *Kaiser Health News*, Feb. 21, 2017, https://khn.org/news/docs-in-northwest-tweak-aid-in-dying-drugs-to-prevent-prolonged-deaths/.

In Oregon in 2024, almost all drug-induced deaths were caused by a combination of morphine and various other drugs. In Washington, in 2018, the drugs most commonly used were morphine sulfate, an opioid (78%), or secobarbital, a barbiturate (22%). *Beginning in 2019, Washington stopped reporting which drugs are used.*

Neither state has reported, or claimed knowledge of, the location or ultimate use of the more than 2,500 lethal drug overdoses that have been prescribed but are not known to have been ingested by patients under these two laws.

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:
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx
A direct link to the 2024 report, with overall data from past years:
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf

For the text of the Washington law see:
Chapter 70.245 RCW: THE WASHINGTON DEATH WITH DIGNITY ACT
For Washington's annual reports, see:
https://doh.wa.gov/data-and-statistical-reports/health-statistics/death-dignity-act/death-dignity-data
A direct link to the Department's 2023 report:
https://doh.wa.gov/sites/default/files/2025-01/422-109-DeathWithDignityAct2023.pdf

(NOTE: These online texts of the laws have been updated to reflect changes approved by the legislatures in 2023, further weakening their "safeguards" against abuse. These changes do not affect data from previous years.)

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