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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 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, 2,518 lethal prescriptions have been written and at least 1,657 patients have died from ingesting the drugs. In 2019 there were 188 drug-induced deaths – 10 more than the previous year, a 79% increase over 2014, and *over twelve times* the deaths in the law's first full year. In Washington, in less than ten years, 1,667 prescriptions have been written and at least 1,210 patients died from the drugs. The number reported to have died from ingesting lethal drugs in 2018 (at least 203 patients) is almost three times as many as in 2011 (70) and over five times as many as in 2009 when the law took effect (36).

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. Washington has not yet reported data from 2019.

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 others who may be present are not authorized to report. In Oregon, the prescribing physician was present at the time of death in only 18% of cases in 2019, with an average of 15% for all years. *No* health care provider was present in 67% of cases in 2019 and 62% of cases in 2018 (with an overall average of 61%).

Whether *any* health care provider was present when the drugs were ingested is “unknown” in about half of all cases (770 of the 1,585 cases occurring since 2001, when this question began being asked of prescribing physicians).

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. 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 (as well as the doctor he selects to give a second opinion) is 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 the counselor can decide that, since suicidal 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; <https://docs.google.com/file/d/0BwDPETL1NPnAMmFjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhlMjA2OTFj/edit?hl=en&pli=1>.

From 1998 to 2017, less than 5% of patients who died under the Act in Oregon were even referred for evaluation to check for “impaired judgment.” In 2018 this declined to 1.7% (3 out of 178) and in 2019 to 0.5% (1 out of 188). Of 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. (For 2017 this figure was initially reported as 2%, but the number was so small that the latest report has “redacted” it to a blank.) Washington does not report whether *any* of those who died from ingesting the lethal drugs were referred for psychological evaluation.

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 are prescribed, neither state’s law 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 the lethal drugs are ingested. Supporters of such laws have long said that requesting a prescription is not the same as choosing to ingest the drugs – the patient may only seek the comfort of knowing they are available. And to be sure, at least 62 (or as many as 120) of the 290 patients who received prescriptions in Oregon in 2019, and at least 64 (or as many as 83) of the 267 who received them in Washington in 2018, did not ingest the drugs. But this means there are *no* “safeguards” 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 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.

- 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.” T. Bannow, “Redmond doctor avoids losing license despite complaints,” *The Bulletin* (Bend, OR), Oct. 7, 2016; <https://www.bendbulletin.com/localstate/4718319-151/redmond-doctor-avoids-losing-license-despite-complaints>. 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>.

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/1xOZfLFrvuQcaZfFudEncp2b18NrUo/view>. This helps explain the data below. Washington has not said how it interprets its identical definition.

In Oregon, 68% of the patients who died from the lethal drugs in 2019 had various forms of cancer (compared to 63% in 2018 and 75% overall). Increasingly the patients have chronic conditions with a less predictable future, such as respiratory disease (7%), neurological conditions such as ALS or “Lou Gehrig’s disease” (14%), cardiac and circulatory disease (5%), endocrine/metabolic diseases such as diabetes (1%), and “other” including arthritis and sclerosis (3%). 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, 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, 75% of patients who died (from any cause) after receiving the lethal drugs in 2018 had cancer. Other illnesses included neurological conditions (10%), respiratory disease (5%), cardiac conditions (6%), and “other” (4%). Washington does not report how this profile may differ for those who actually ingest the drugs.

Many of these conditions other than cancer are commonly associated with aging. In 2019 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, only one patient in 2019 (and no patient in 2018) was under 35; overall, fewer than 1% of those receiving the lethal drugs have been younger than 35, and Ms. Maynard was the *only* person under that age in 2014 when she died. In Washington in 2018, 79% of the patients who died were aged 65 or over.

Of 188 patients in Oregon who died from the prescribed drugs in 2019, *eighteen* were diagnosed as having less than six months to live “*in previous years*” and given the lethal prescription. This is true of *eleven* patients in 2018, *fourteen* in 2017, *nineteen* in 2016, *seven* in 2015 and *eleven* in 2014. In 2019 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 1503 days, over four years; in 2018 it was 807 days, in 2017 it was 603 days, and in 2016 it was 539 days. So the time from request for lethal prescription to an induced death has been over *eight times* the patient’s alleged natural life expectancy.

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.

Clearly these six-month predictions are not reliable. How unreliable they are, of course, cannot be determined for the majority who take the drugs less than six months after being diagnosed. The falsified death certificates, reporting death from natural causes, discourage any autopsy that might have determined how long the patient could otherwise have lived.

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). 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 did 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, 51% in 2019 (as well as 57% in 2018, 48% in 2017, 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, 69% in 2017, 68% in 2018, and 70% in 2019 (compared to an average of 36% in previous years).

Consistently, untreated pain or a concern about future pain are *not* among the top reasons for taking lethal drugs. In 2019, 90% of those ingesting the drugs in Oregon said they were "less able to engage in activities making life enjoyable" and 87% said they were "losing autonomy"; 59% cited being a "burden" on family, friends or caregivers (compared to 54% in 2018, 55% in 2017, 49% in 2016, 48% in 2015 and an average of 41% in previous years). In 2019 only 33% cited a concern about current or possible future pain (26% in 2018). Seven percent cited financial

concerns about treatment, compared to an average of 2% in the first five years of the law's operation. It seems solitary, dependent and chronically ill seniors are prime candidates for assisted suicide in Oregon.

Similar trends are seen in Washington: as many as 56% of those obtaining the drugs were widowed, divorced, or never married in 2018, and were a majority in the three previous years as well (up from 42% in 2014). At least 66% were dependent solely on Medicare or Medicaid in 2018 (up from 54% in 2017). In Washington, 85% cited loss of autonomy, 84% cited less ability to engage in enjoyable activities, 69% cited "loss of dignity," 51% cited being a "burden" and 9% cited financial concerns, while 38% cited a concern about pain.

Humane and Dignified Death?

In all, at least 47 patients in Oregon (including six in 2019, seven in 2018, four in 2017 and three in 2016) have experienced complications such as seizures or regurgitating some of the lethal dose, and eight (one in 2018) regained consciousness after taking the drugs and died later, apparently from their underlying illness. For a total of 903 patients, 127 of them in 2019, it is simply *not known* whether these things occurred because no health care professional was present to report them. In 2019, Oregon patients are known to have taken as long as *47 hours* to die (18 hours in 2018, 21 hours in 2017), with this figure *unknown* for 32% of cases in 2019 (61 out of 188), 44% in 2018 (79 out of 178) and 46% overall (758 out of 1,657). Overall, Oregon patients are known to have taken as long as 104 hours (over four days) to die.

In Washington there have been at least 35 cases of "complications" (8 cases in 2018 alone), and the complication rate for another 97 patients is unknown. Reports for previous years showed 15 cases of regurgitation (2 in 2017 and 7 in 2016), 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." 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 to die (35 hours in 2017, 22 hours in 2016, 72 hours in 2015). In another 15% of cases in 2018 the time period from ingestion to death 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:

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

A direct link to the 2019 report, with overall data from past years:

<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.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 2018 report, with comparisons to the previous two years:
<https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>

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