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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, 3,712 lethal prescriptions have been written and at least 2,437 patients have died from ingesting the drugs. In 2022 there were 431 prescriptions, and at least 278 drug-induced deaths – more than twice the number in 2016, and almost *eighteen times* the drug-induced deaths in the law's first full year. For 58 patients in 2022, whether they died (from any cause) or ingested the drugs is unknown.

In Washington, in fourteen years, 3,158 prescriptions have been written (452 in 2022) and at least 2,341 patients died from the drugs (at least 363 in 2022). The number reported to have died from ingesting lethal drugs in 2022 is over four times as many as in 2012 (83) and is *ten* times as many as in 2009 when the law took effect (36). For another 39 patients who died in 2022, it is *not known* whether they died from the drugs, so as many as 402 may have done so.

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. Its 2022 report does not include data on the time from drug ingestion to death.

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. The Department issued its report on 2019 cases eight months after the end of that year, its report on 2020 cases after ten months, its report on 2021

cases after 11 months, and its report on 2022 cases after six months. Yet it reports that for these four years it has not received a patient's written request for 147 patients (41 in 2019, 45 in 2020, 46 in 2021, and 15 in 2022) and has not received the physician's form for 116 patients (39 in 2019, 34 in 2020, 35 in 2021, and 8 in 2022). Over the 14 years of the law's existence, the health department has not received a patient's written request in 279 cases or the attending physician's compliance form in 230 cases – with about half these cases occurring in the last four 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 as cases where lethal drugs were provided "under the terms of the law" (2019 and 2020 reports, p. 5; 2021 and 2022 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 the similar group "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 13% of cases in 2022 and, on average, 14% in all years. *No* health care provider was present in 68% of the deaths in 2021 and 2022, with an overall average of 62%. Whether *any* health care provider was present when the drugs were ingested is "unknown" in almost half of all cases (1,049 of the 2,365 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*, and as of 2019 it no longer reports even 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 51 cases in 2022 (18% 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 that person 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 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 2022, only 3% of patients who died under the Act in Oregon were even referred for evaluation to check for "impaired judgment." In 2020 this declined to 1.2% (3 out of 259), in 2021 to 0.8% (2 out of 238), and in 2022 to 1.1% (3 out of 278). Of the108 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 no evaluations are reported, allegedly "to protect participant confidentiality." In five of the last six years, then, Washington does not report that *any* of those who died from ingesting the lethal drugs, or any who received the drugs, is known to have received a psychological evaluation.

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. 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).

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 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 84 (or as many as 185) of the 431 patients who received prescriptions in Oregon in 2022, and at least 45 (or as many as 89) of the 452 who received them in Washington in that year, did not ingest the drugs. (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:

- One 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." 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. 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, 64% of the patients who died from the lethal drugs in 2022 had various forms of cancer (compared to 61% in 2021, 66% in 2020, and 73% overall). Increasingly the patients have chronic conditions with a less predictable future, such as respiratory disease (10%), neurological conditions such as ALS or "Lou Gehrig's disease" (10%), cardiac and circulatory disease (12%), endocrine/metabolic diseases such as diabetes (1%), and so on. Over 1% 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 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, 73% of patients who died (from any cause) after receiving the lethal drugs in 2022 were reported to have cancer. Other illnesses included neurodegenerative conditions (8%), respiratory disease (7%), cardiac or vascular conditions (6%), "other" (4%), or "unknown" or "missing" (3%). As noted above, in 8 cases in 2022 (227 cases overall) the physician never submitted the legally required compliance form that would list any illness.

Many of these conditions other than cancer are commonly associated with aging. In 2022 the median age of those dying under the Oregon law was 75. 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* person under that age in 2014 when she died. In Washington, in 2020, 2021, and 2022, about 80% of the patients who died were aged 65 or over.

Of 278 patients in Oregon who died from the prescribed drugs in 2022, *32* were diagnosed as having less than six months to live and given the lethal prescription "*in previous years.*" This is true of 20 patients in 2021, 22 in 2020, 18 in 2019, 11 in 2018, 14 in 2017, and 19 in 2016. 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 1,095 days (over three years) in 2021, 1,080 days in 2020, 1,503 days in 2019, 807 days in 2018, and 603 days in 2017. The time from request for lethal prescription to a drug-induced death is most recently over *ten 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. In 2020, at least 17% of patients lived more than 120 days, among the 295 patients (out of 340 total) for whom a Pharmacy Dispensing Report was submitted; for another 45 patients this figure is unknown. In 2021, at least 67 (19%) of the 346 patients with a Pharmacy Dispensing Report lived more than 120 days, with this figure unknown for another 44 patients. Beginning in 2019 Washington *stopped reporting* a *maximum* survival time.

In Washington, there are 61 patients over the past 12 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. The falsified death certificates, which report 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). "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, 53% in 2022 and 2021 (and on average, 54% throughout the 1998-2022 period) were divorced, widowed, or never married. *Most* of those dying under the law have no or only governmental health insurance –71% in 2015, 70% in 2016, 69% in 2017, 68% in 2018, 70% in 2019, 74% in 2020, and 80% in 2021 and 2022 (with an overall average of 60%).

Consistently, untreated pain or a concern about future pain are *not* among the reasons for taking lethal drugs for most patients. In 2022, 89% of those ingesting the drugs in Oregon said they were "less able to engage in activities making life enjoyable" and 86% said they were "losing autonomy"; 46% cited being a "burden" on family, friends or caregivers (compared to 54% in 2021, 53% in 2020, 59% in 2019, 54% in 2018, and an overall average of 48%). In 2022, only 31% cited a concern about current or possible future pain (27% in 2021 and 33% in 2020). Six percent in 2022 and 2020, and 8% in 2021, cited financial concerns about treatment, with an overall average of 5%. It seems solitary, dependent and chronically ill seniors are prime candidates for assisted suicide in Oregon.

Similar trends are seen in Washington. Fifty-three percent of those obtaining the drugs were widowed, divorced, or never married in 2022. In 2021 "<10" percent of those known to have died were never married and another 43% were divorced or widowed. 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 2022, 83% cited loss of autonomy, 83% cited less ability to engage in enjoyable activities, 69% cited "loss of dignity," 59% cited being a "burden" on others, and 10 percent cited financial concerns, while 46% cited a concern about present or possible future pain.

Humane and Dignified Death?

In all, *at least* 64 patients in Oregon (including six in 2022, five in 2021, five in 2020, six in 2019, and seven in 2018) have experienced complications, such as seizures or regurgitating some of the lethal dose. Nine (including one in 2021 and one in 2018) regained consciousness after taking the drugs and died later, apparently from their underlying illness. For a total of 1,476 patients, 206 of them in 2022, it is simply *not known* whether these things occurred because no health care professional was present to report them. In 2022, Oregon patients are known to have taken as long as *68 hours* or about three days to die (24 hours in 2021, 8 hours in 2020, *47 hours* in 2019, 18 hours in 2018, 21 hours in 2017). This figure is *unknown* for 41% of cases in 2022 (113 out of 278), and 45% overall (961 out of 2,159). Oregon patients are known to have taken as long as 104 hours, over four days, to die.

In Washington, from 2009 to 2018, there were at least 35 cases of "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 (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." *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 (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. 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, a maximum time from ingestion to death is unknown because Washington stopped reporting it. In 2022, it stopped reporting how many patients took more than two hours to die.*

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 2022, almost all drug-induced deaths (98%) 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%); in 2017, 66% of cases used morphine and 34% used secobarbital. *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 2,000 lethal drug overdoses that have been prescribed but not ingested by patients under these 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 2022 report, with overall data from past years:
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.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 2022 report:
https://doh.wa.gov/sites/default/files/2023-10/422-109-DeathWithDignityAct2022.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 2022 data.)

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