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Oregon's Assisted Suicide Law: 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 in 1997. Supporters later closely modeled Washington's new law on the law in Oregon, saying that its "safeguards" are operating well and have prevented abuse. The facts suggest otherwise.

Reporting or Concealing?

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

The Oregon Health Division noted in 1999: "There are several limitations that should be kept in mind when considering these findings [about doctor-assisted suicide]…. 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.

In Oregon these doctors are usually members of, or close collaborators with, "Compassion & 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 12 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 what happens at the time patients actually ingest the lethal overdose, as nothing in the law requires them to be present. In 2010, only 9% of doctors were present at this time, compared to an average of 20% in previous years. See Oregon Public Health Division, "Oregon's Death with Dignity Act – 2010," at http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year13.pdf.

These patients' deaths are not allowed to be considered suicides or assisted suicides for any legal purpose. Ore. Rev. Stat. § 127.880. In Oregon, doctors list patients' underlying illness as the cause of death on death certificates; in Washington this 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. 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); Wash. Rev. Code § 70.245.040 (2).

A Free Choice?

Despite medical literature on the frequent role of depression and other psychological problems in choices for suicide, the prescribing doctor (and the doctor he selects to give a second opinion) are free to decide whether or not to refer suicidal patients for any psychological counseling. Even if such counseling is provided, its goal is to determine that the patient is not suffering from "a psychiatric or psychological disorder or depression *causing impaired judgment*." Ore. Rev. Stat. § 127.825. 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.

From 1998 to 2009, on average only 8.4% of patients were referred for counseling to check for "impaired judgment." In 2010 this declined to 1.5% (one patient out of 65). Oregon Public Health Division, op. cit., at 2 and Table I.

Physicians are to encourage patients requesting a lethal prescription to notify their next of kin, but may not require this. Ore. Rev. Stat. § 127.835.

Physicians are to certify that the patient is "capable" and "acting voluntarily." Ore. Rev. Stat. § 127.855. 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). See Hendin and Foley, op. cit., at 1629-30.

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

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

- One woman with cancer received doctor-assisted suicide 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.

From Assisted Suicide to Homicide

Can others take an active role in ending the patient's life? This is less clear than most people realize, since regulation of the process essentially ends once the patient obtains the "medication to end his or her life." The Oregon and Washington laws do not authorize anyone "to end a patient's life by lethal injection, mercy killing or active euthanasia," but they do not define the latter terms – and in any case, action taken in accordance with the new laws may *not* be seen legally as assisted suicide *or* "homicide." Ore Rev. Stat. § 127.880; Wash. Rev. Code § 70.245.180. A doctor must even counsel the patient beforehand about "the importance of *having another person present* when the patient takes the medication." Ore. Rev. Stat. § 127.815 (1)(g); Wash. Rev. Code § 70.245.040 (1)(g) (emphasis added). Oregon's law mentions the patient's "ingesting" the drugs, Ore. Rev. Stat. §127.875, but the common meaning of "ingest" is to swallow or absorb, which may not exclude active involvement by others. Washington law states explicitly that patients will "self-administer" the drugs, but then defines "self-administer" to mean "ingesting" and so leaves the same ambiguity. Wash. Rev. Code §§ 70.245.020; 70.245.010 (12). See M. Dore, op. cit., 391-3.

After an Oregon patient with physical disabilities was "helped" by a relative to take the lethal overdose, the Oregon deputy attorney general opined 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; quoted in USCCB Secretariat for Pro-Life Activities, *Life at Risk*, Feb./March 1999, www.usccb.org/prolife/publicat/liferisk/febmar99.shtml.

An Oregon emergency room physician was asked by a woman to end the life of her mother who was unconscious from a stroke. He tried to stop the older woman's breathing or heartbeat in several ways, finally giving her a lethal dose of a paralyzing drug; she 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 a case of "assisted suicide" -- and he later resumed medical practice. See PCCEF, op. cit.

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