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**Oregon's Assisted Suicides:
The Up-to-Date Reality
in 2017**

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Thomas M. Messner, J.D., *Oregon Lawmakers Promote Abortion, Crush Civil Liberty, and Hate on Social Justice*, On Point Series 16
Richard Doerflinger, M.A., *A Reality Check on Assisted Suicide in Oregon*, On Point Series 15
Moira Gaul, M.P.H., *Ad Campaign Ruling Highlights Needs for Outreach and Healing*, On Point Series 14
Richard Doerflinger, M.A., *The Effect of Legalizing Assisted Suicide on Palliative Care and Suicide Rates: A Response to Compassion and Choices*, On Point Series 13
Michael J. New, Ph.D., *Hyde @ 40: Analyzing the Impact of the Hyde Amendment*, On Point Series 12
Michael J. New, Ph.D., *An Analysis of How Medicaid Expansion in Alaska Will Affect Abortion Rates*, On Point Series 11
Elizabeth Johnson, M.D., *The Reality of Late-Term Abortion Procedures*, On Point Series 10
Thomas M. Messner, J.D., *The Constitutional Viability of Five-Month Abortion Laws*, On Point Series 9
Maureen L. Condic, Ph.D., *A Scientific View of When Life Begins*, On Point Series 8
Gene Tarne, *Ethical Stem Cells: Back to Basics*, On Point Series 7
Susan Wills, *The Overlooked Key to the Drop in U.S. Abortions*, On Point Series 6
Susan Wills, *New Studies Show All Emergency Contraceptives Can Cause Early Abortion*, On Point Series 5

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In February 2018 the Oregon Health Authority released its latest annual report on legally authorized physician-assisted suicides, covering deaths that occurred in 2017.¹ This provides a renewed opportunity to test the constantly repeated claim of the advocacy group “Compassion & Choices” that its flagship assisted suicide law in Oregon, the model for laws in other states, has been working well for 20 years with no “abuses.”

The first problem with that claim is how difficult it is to determine what would constitute an “abuse” under this law. As previously documented, the Oregon statute and its imitators are artfully filled with loopholes.² Physicians, witnesses, and others involved in the process need not comply objectively with the law’s requirements, but only show “good faith” compliance, exempting physicians from their usual obligation not to be negligent. The prescribing physicians need not refer a patient for psychological evaluation even in a clear case of clinical depression -- such referral is required only if the doctors think the patient’s depression causes “impaired judgment.” So if they agree with the patient’s judgment that he or she is better off dead, there is no referral. And so on.

The second problem is that the Oregon system is tailor-made to conceal, not reveal, abuses. The physicians involved in prescribing the drugs are the only people allowed to file reports on these cases. The Oregon Health Authority itself says it has no legal warrant to do anything but take this self-reporting at face value. If other doctors found that the patient is *not* eligible for assisted suicide, patient or family can simply keep trying other doctors until they find one ardently committed enough to assisted suicide to sign the forms – and it is only that last doctor who files a report. So the very cases that *most* cry out for investigation – in which other doctors had concluded that this patient is *not* eligible to receive lethal drugs – are those in which the only report is most likely submitted by ideologically committed physicians inclined to ignore or conceal problems. Those physicians are then told by the state to falsify the death certificate, listing the underlying illness as cause of death, so there will be no autopsy or independent scrutiny. And after filing an annual report from which all identifying information has been removed, the state destroys the original reports.

Yet even these deliberately uninformative annual reports provide some indication of how the law is working in practice.

¹Oregon Public Health Division, “Oregon Death with Dignity Act: Data Summary 2017,” available at <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>

² Richard Doerflinger, M.A., “A Reality Check on Assisted Suicide In Oregon,” On Point Series 15, The Charlotte Lozier Institute, April 2017, available at <https://lozierinstitute.org/a-reality-check-on-assisted-suicide-in-oregon/>

Annual body count

In 2017, there were 218 lethal prescriptions written and 143 patients died from these drugs. The annual increase in deaths has accelerated in the last four years, with almost twice as many assisted suicides in 2017 (143) as in 2013 (73).³ Since 1998, these drugs have claimed 1,275 lives. Because the law does not allow these deaths to be recorded as suicides, they are in addition to other suicides, which by 2014 (the last reported year) had given Oregon a suicide rate 43% higher than the national average.⁴

Fourteen of the 2017 deaths were from drugs prescribed in previous years. So of the 218 prescriptions filled in 2017, as many as 89 lethal barbiturate overdoses (with instructions on how to use them to take a life) are in the population, and the state that authorized their distribution has no idea what became of them. In all, 1,967 lethal prescriptions have been written and at least 1,275 patients have died from these drugs, leaving a total of 692 lethal overdoses unaccounted for.

Checking for mental health?

Despite the medical consensus that most suicidal feelings among seriously ill patients, like such feelings among others, are influenced by depression or other conditions that compromise voluntariness, fewer and fewer patients receive a psychological evaluation.⁵ From 1998 to 2012, only 6% of patients on average were referred for evaluation; this went down to just under 4% in 2013-2016, then 3.5% in 2017. The state has not cited a single case out of 1,275 in which a patient was found ineligible for assisted suicide because an evaluation found depression or other mental condition impairing judgment.

Proponents of the Oregon law claim that a request for a lethal prescription is, in any case, no sign of a definite wish to take one's life. They say many patients simply want to have the drugs available later in case things go so badly that they see no other solution. The essential question, then, is this: What checks are there against depression or other mental condition, misuse of the drugs by others with their own agendas, subtle or overt coercion, etc., *at the time of death?*

The answer is: There aren't any.

³Oregon Health Authority, Death with Dignity Act Annual Reports, available at <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/index.aspx>

⁴ Oregon Health Authority, "Oregon Vital Statistics Annual Report 2015, Volume 2," available at <https://digital.osl.state.or.us/islandora/object/osl%3A94197>

⁵ "Suicide and Assisted Suicide: The Role of Depression," USCCB Secretariat of Pro-Life Activities, June 1, 2017, available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/end-of-life/euthanasia/upload/Suicide-and-Assisted-Suicide-The-Role-of-Depression.pdf>

The only person who can report on the circumstances at that time is the prescribing physician, and that person was only present 16% of the time in 2017 (an average of 15% for all years). In past years, a health care provider other than the prescribing physician was present 27% of the time on average; in 2017 that is down to 13%. Thus in 2017 no health care provider was present 71% of the time. The prescribing physician nevertheless steps back into the process to certify a death from natural causes (though that physician knows, and reports confidentially to the state, that the opposite is true).

“Incurable and irreversible” terminal illness?

Oregon’s law allows a lethal prescription 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.” This is slippery even on its face, since (as stated above) this “reasonable medical judgment” is governed by a “good faith” standard (“I really thought he was sick”), and the only person “confirming” the judgment is a second physician hand-picked by the first one. But it turns out that the phrase “incurable and irreversible” does not even mean what it says. It does *not* mean “cannot be cured” or “cannot be reversed.”

This was uncovered in January 2018 by Fabian Stahle, a Swedish investigator who contacted a state health official in Oregon to clarify how the phrase “terminal disease” is interpreted by those who monitor the law’s implementation.⁶ He found that patients are eligible for assisted suicide if the two doctors think they are likely to die in six months *without* any treatment -- even if they could have been cured by treatment, or could live for years or decades if treated. If the patient refuses potentially curative treatment (as a suicidally depressed patient, for example, may well do), or treatment is *denied* by someone else like the physician or a health insurance company, that patient becomes “terminal” and can receive lethal drugs. Essentially you are terminal if, by withholding treatment, you can be made terminal.

Stahle published his findings online with extensive quotes from the Oregon official – including a quote that this is how the state health department has always interpreted the law’s reference to “terminal” disease. This helps explain the gradually expanding profile of those receiving lethal prescriptions in Oregon.

As noted above, 14 patients dying from the drugs in 2017 received them, based on a six-month prognosis, *in previous years*. This was true of 19 patients in 2016, 7 in 2015, and 11 in 2014. Overall, the time from first request for the drugs, to death from those drugs, has

⁶ Fabian Stahle, “Oregon Health Authority Reveals Hidden Problems with the Oregon Suicide Model,” Sater, Sweden, January 2018, available at <https://drive.google.com/file/d/1xOZfLFrvuQcaZfFudEncpzp2b18NrUo/view>

been as long as 1,009 days (over five times the projected life expectancy); in 2017 it was as long as 603 days.

In 2017, some 77% of the patients had various forms of cancer. Others had chronic conditions with a less predictable trajectory toward death, such as cardiac and respiratory conditions found in many seniors, neurological conditions like ALS (Lou Gehrig's disease), and even metabolic conditions like diabetes. In 2016 the list included "benign and uncertain" growths; overall, three patients have been found eligible for the lethal drugs although doctors listed no illness at all.

Uncontrollable pain vs. "humane and dignified" death?

The prospect of patients dying in excruciating, intractable pain has long been cited by assisted suicide advocates to win public sympathy and support for their agenda.

The reality is that pain, or even concern about future pain, ranks low on the reasons that patients cite for getting the lethal drugs. In 2017, only 21% cited this concern (compared to an average of 26% in past years). The most common reasons are being "less able to engage in activities making life enjoyable" (88%), "losing autonomy" (87%), and "loss of dignity" (67%), all of which could be cited by someone with a chronic illness or long-term disability that is not terminal. The most significant change is that in 2017, some 55% of patients (compared to an average of 42% in past years) say they are obtaining the lethal dose because they are a "burden on family, friends or caregivers" – a feeling easily communicated to patients by those other parties, and by the existence of a government policy singling them out for "assistance" in suicide.

Can the Oregon policy itself promise a "quick and painless" end to life? In 2017, at least two patients had seizures after ingesting the drugs. Overall, at least 25 patients (including one in 2017 and three in 2016) regurgitated some of the dose, and seven overall have regained consciousness and died later of natural causes. (Interestingly, there is no record of anyone choosing to go through this a second time.) For 638 patients, 101 of them in 2017, it is not known whether such complications occurred, presumably because the prescribing physician who filed the report was not present. The time period from ingesting the drugs to death is unknown in most cases; in the 40 cases where it is known in 2017, patients took as long as 21 hours to die, compared to nine hours in 2016, with an overall maximum of 101 hours (over four days). In 2017 it took as long as four hours for the patient to lose consciousness, compared to a maximum of one hour previously; this figure is not known for 105 of the 143 patients in 2017.

Demographics

In 2017, the demographic profile of people receiving the lethal drugs did not radically change in most respects. Patients are generally seniors (median age 74); about half are married or in another committed relationship; 94% are white; about half have a college

degree; the percentage that is male rose somewhat in 2017 (58%, compared to an average of 52% in the past).

One significant change: In 2017, only 31% of the patients had private health insurance (compared to 54% in 2016), and 68% had only governmental insurance such as Medicaid and/or Medicare (compared to 45% the previous year). This is troubling in light of Oregon’s Medicaid rationing plan, which has been known to deny potentially life-prolonging treatment to patients while highlighting the availability of assisted suicide.

Not that private health insurance is a guarantee against rationing. In 2017, Nevada physician Brian Callister revealed that he had sought approval from insurance companies in Oregon and California (the latter also having an Oregon-style law) for two patients he thought could be cured by a treatment available in those states – in both cases, he says, the companies refused coverage for the treatment but suggested that he consider assisted suicide.⁷

Conclusion

This is the updated reality of physician-assisted suicide in the state whose law is seen as a model for the nation. Chronically ill seniors, potentially victims of untreated depression and the impression that they have become a “burden” on others, are nudged to a premature death that may be more gruesome than they’ve been led to believe, with no one usually present at the time of death to check whether they are competent, badgered by others, or overtly coerced toward that death. This is what has become known as “death with dignity” in Oregon, and advocates are working to spread it to far more states.

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⁷ Kelsey Harkness, “Doctor: Insurance Wouldn’t Pay for Patients’ Treatments, but Offered Assisted Suicide,” Daily Signal.com, June 28, 2017, at <http://dailysignal.com/2017/06/28/doctor-says-health-insurance-wouldnt-pay-for-patients-treatments-but-offered-assisted-suicide-instead/>