Why Assisted Suicide Must Not Be Legalized

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INTRODUCTION

While many people know that Oregon, Washington State, and Montana have legalized assisted suicide, it is less well known that approximately half the states in the U.S. have either defeated bills to legalize it, or have passed laws explicitly banning it.¹

In many cases, the bills or referenda were defeated due to the efforts of an opposition coalition spanning the political spectrum from left to right. These coalitions typically represent disability rights organizations, physicians and other health care workers, hospice organizations, and Catholics and other right-to-life organizations. In some cases, they also include organizations representing the Latino community, poor people, and workers.

The opposition to the legalization of assisted suicide is often mischaracterized as driven exclusively by religious conservatives, but most current opposition coalitions include many persons and organizations whose opposition is based on their progressive politics. Among those are disability rights groups; many nationally prominent disability rights organizations oppose the legalization of assisted suicide.²

Other key opponents include the World Health Organization, the American Medical Association and its state affiliates, the American College of Physicians, the National Hospice and Palliative Care Organization, the American Cancer Society, many other medical organizations, and the League of United Latin American Citizens (LULAC). Many prominent Democrats and liberals also oppose legalization, including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff.

Assisted suicide strikes many people, when they first hear about it, as a cause to support. But upon closer inspection, there are many reasons why legalization is a serious mistake. Supporters focus on superficial issues of choice and self-determination. It is crucial to look deeper. Legalizing assisted suicide would not increase choice and self-determination, despite the assertions of its proponents. It would actually augment real dangers that negate genuine choice and control.

The disability community’s opposition is based on the dangers to people with disabilities and the devaluation of disabled peoples’ lives that result from assisted suicide. Further, this opposition stems from factors that directly impact the disability community as well as all of society. These factors include the secrecy in which assisted suicide operates today, even where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangers of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms.

In view of this reality, we address many of the disability-related effects of assisted suicide, while also encompassing the larger social context that inseparably impacts
people with disabilities as well as the broader public. First, after addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. By detailing significant problems with Oregon’s supposed safeguards, we raise some of its real dangers, particularly for people with depression and other psychiatric disabilities. Third and finally, we explore the ways that so-called “narrow” assisted suicide proposals can easily expand. This article focuses primarily on conditions in the United States, though much of our discussion also applies in other countries.

In short, we must separate our private wishes for what we each may hope to have available for ourselves some day—a hope that often fails to understand how assisted suicide actually operates—and, rather, focus on the significant dangers of legalizing assisted suicide as public policy in our society today. Assisted suicide would have many unintended consequences.

A note about terminology: The words used in this policy debate are controversial. We use the term “assisted suicide” because it is understood by the public and is used in the legal and medical literature. A clear, specific term is needed. “Aid in dying” could mean anything done to help a dying person, while “death with dignity” has many meanings. The politicization of this terminology is discussed below.

I. FEW HELPED, MANY HARMED: DISABILITY PREJUDICE AND THE DAMAGE TO SOCIETY

Legal Alternatives Available Today

The movement for the legalization of assisted suicide is driven by anecdotes of people who suffer greatly in the period before they die. But the overwhelming majority of these anecdotes describe either situations for which legal alternatives exist today, or situations in which the individual would not be legally eligible for assisted suicide.

It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn. It is legal to receive sufficient painkillers to be comfortable, and we now know this will not hasten death. And perhaps least understood, for anyone who is dying in discomfort, it is currently legal in any U.S. state to receive palliative sedation, wherein the dying person is sedated so discomfort is relieved during the dying process. Thus, there is already a legal recourse for painful deaths. These alternatives do not raise the serious difficulties of legalizing assisted suicide.

Moreover, anyone with a chronic but non-terminal illness is not eligible for assisted suicide in either Oregon or Washington State. Anyone with depression that affects his or her judgment is also ineligible. Consequently, the number of people whose
situations would actually be eligible for assisted suicide is extremely low, yet its harmful consequences would be significant.

Even assisted suicide’s proponents acknowledge that a very small number of people would utilize it. They will tend to be affluent, white, and in possession of good health insurance coverage. At the same time, large numbers of people, particularly among those less privileged in society, would be at significant risk of harm.

Perhaps for these reasons, the World Health Organization (WHO) has recommended that governments not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for all their citizens. As Herbert Hendin, noted international expert on suicide prevention, explained, “All U.S. states and all countries have a long way to go to achieve this goal.”

**Fear, Bias, and Prejudice against Disability**

Fear, bias, and prejudice against disability play a significant role in assisted suicide. Who ends up using assisted suicide? Supporters advocate its legalization by suggesting that it is needed for unrelievable pain and discomfort at the end of life. But the overwhelming majority of the people in Oregon who have reportedly used that state’s assisted suicide law wanted to die not because of pain, but for reasons associated with disability, including the loss of autonomy (89.9 percent), the loss of the ability to engage in activities that make life enjoyable (87.4 percent), the loss of dignity (83.8 percent), and the loss of control of bodily functions (58.7 percent). Furthermore, in the Netherlands, more than half the physicians surveyed say the main reason given by patients for seeking death is "loss of dignity."  

This fear of disability typically underlies assisted suicide. Janet Good, an assisted suicide advocate who worked with Jack Kevorkian in bringing about the deaths of several people with disabilities, said:

> Pain is not the main reason we want to die. It's the indignity. It's the inability to get out of bed or get onto the toilet ... [People] ... say, ‘I can't stand my mother – my husband – wiping my butt.' [It's] about … dignity.

But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will abet suicides because people need help using the toilet?

Diane Coleman, president and founder of Not Dead Yet, a grassroots disability organization opposed to legalizing assisted suicide, has written that the "public image of severe disability as a fate worse than death … become[s] grounds for carving out a deadly exception to longstanding laws and public policies about suicide intervention services … Legalizing assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The
difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death to the socially devalued group.9

And as Paul Longmore, Professor of History at San Francisco State University and a foremost disability advocate on this subject, explained that the legalization of assisted suicide would “take place within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities.”10 This prejudice and discrimination often plays out in deadly ways, including pressure by hospital staff members on people with disabilities to sign “Do Not Resuscitate” forms:

“Yvonne Duffy had hospital personnel constantly urging and demanding that she sign the order,” while Robert Powell, a wheelchair rider, was denied admittance to a hospital when he refused to sign a DNR. The disability rights magazine Mouth related that a New Mexico subscriber went to a hospital emergency room during a severe asthma attack. While she struggled to breathe, a social worker carefully took the time to explain that she had a right to reject medical treatment. At last, the disabled woman demanded that the staffer summon a doctor. As she departed, the social worker insistently informed her: “It’s not too late. The Right to Die is on the hospital channel 6 twenty-four hours a day. You can watch it in your room!” Mouth writer Joe Ehman entered a Rochester, New York, hospital for back surgery. Both before and after the operation, a squad of hospital, county, and home-health social workers pressured him to sign a Do Not Resuscitate order. Ehman shot back at them, “I’m only 30 years old! I don’t want to die!”11

Additional linkages between assisted suicide and the danger it poses to people with disabilities are made below, particularly in The Danger to People With Depression and Psychiatric Disabilities, and The Questionable Circumstances of Oregon Deaths.

A Deadly Mix: Managed Health Care and Assisted Suicide

An Ailing System Made Worse

A significant problem with legalization is the deadly interaction between assisted suicide and profit-driven managed health care. Again and again, health maintenance organizations (HMOs) and managed care bureaucracies have overruled physicians’ treatment decisions because of the cost of care. These actions have sometimes hastened patients' deaths.12 Financial considerations can have similar results in non-profit health plans and government-sponsored health programs such as Medicare and Medicaid, which are often under-funded.

The cost of the lethal medication generally used for assisted suicide is about $300, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment already poses a significant danger. This danger is far greater where assisted suicide is legal. Direct coercion is not necessary. If patients are denied necessary life-sustaining health care treatment, or even if the treatment they need is delayed, many will, in effect, be steered toward assisted suicide.
A 1998 study from Georgetown University's Center for Clinical Bioethics underscores the link between profit-driven managed health care and assisted suicide. The research found a strong link between cost-cutting pressure on physicians and their willingness to prescribe lethal drugs to patients, were it legal to do so.\(^\text{13}\)

The deadly impact of legalizing assisted suicide would fall hardest, whether directly or indirectly, on socially and economically disadvantaged people who have less access to medical resources and who already find themselves discriminated against by the health care system. As the New York State Task Force on Life and the Law notes, assisted suicide:

... will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered ... [T]here [is no] reason to believe that the practices, whatever safeguards are erected, will be unaffected by the broader social and medical context in which they will be operating. This assumption is naïve and unsupportable.\(^\text{14}\)

Longmore underscored this point, stating, "Poor people, people of color, elderly people, people with chronic or progressive conditions or disabilities, and anyone who is, in fact, terminally ill will find themselves at serious risk."\(^\text{15}\)

**Deteriorating Health Care in Oregon**

Longmore and other disability rights activists have long made the point that Oregon’s adoption of assisted suicide must be critically examined in relation to its curtailment of Medicaid spending. As Longmore explained, Oregon instituted “health care rationing for the poor” in the same year that the State’s assisted suicide initiative became law in 1994.\(^\text{16}\) That year, the Oregon Medical Assistance Program (OMAP) ranked over 700 health services and terminated funding for 167 of these services. Four years later, when the assisted suicide law went into effect, OMAP directors put lethal prescriptions on the list of “treatments,” categorized as “comfort care.” At the same time, OMAP slashed Medicaid funding for more than 150 services crucial for people with disabilities, people with terminal illnesses, and older adults, while further trimming already limited funding for in-home support. In the same year, OMAP attempted, but failed, to limit the funded doses of a powerful pain medication and successfully put barriers in the way of funding for a path-breaking anti-depressant.

Longmore demonstrates, moreover, that the chronological link between assisted suicide and the attacks on health care services for Oregon’s most vulnerable residents are neither accidental nor well disguised:

A newspaper profile revealed that Barbara Coombs Lee [author of Measure 16, Oregon’s assisted suicide initiative] was “closely involved in passage” of
Oregon’s health plan. Oregon’s governor John Kitzhaber, a former emergency room physician and the chief architect of this health care rationing system, admitted—or perhaps he was boasting—that “only three states spend less per person on health care for the poor.” The British magazine The Economist praised Kitzhaber “for rationing health care in the face of limited resources” and observed that “Oregon no longer pays for such treatments as ‘efforts to fight the final stages of AIDS.’” Politicians’ and bureaucrats’ implementation of these cost-cutting measures while they willingly fund assisted suicide amounted to a declaration of class warfare against the poor, many of whom are sick or disabled.17

The impact of the Oregon Health Plan’s drastic limitations became very real to Oregon Medicaid recipients Barbara Wagner and Randy Stroup. Wagner, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients’ one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment “but it would cover … doctor-assisted suicide.” Stroup was prescribed mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication’s benefit has been shown to be “not huge, but measurable”; while the drug may not extend a patient’s life by very long, it helps make those last months more bearable by decreasing pain.18 Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of physician-assisted suicide.19

These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five-year survival. H. Rex Greene, M.D., former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center and currently a member of the AMA Ethics Council, called this rule “an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria.”20

It is also often alleged that legalized assisted suicide has improved end-of-life care in Oregon. While it is true that Oregon has shown some improvements, similar improvements have occurred in other states that have not legalized assisted suicide.21 And research strongly suggests that Oregon has seen a reduction in the quality of end-of-life palliative care during the years since the Oregon law went into effect. A 2004 Journal of Palliative Care Medicine study showed that dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the Oregon law took effect.22 An article in The Oregonian about the study stated, “The findings call into question the widespread view that pain control at the end of life has improved markedly in Oregon.”23 And in 2008, authorities on end-of-life care and suicide prevention Herbert Hendin, M.D., and Kathleen Foley, M.D., discussed a number of studies that show inadequate palliative and end-of-life care in that state.24
The Broad Indirect Impacts on Health Care

Addressing the negative impact of the legalization of assisted suicide on the practice of medicine, the two professional associations representing oncologists in California wrote in 2007 that legalization “strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship.” Legalization, they concluded, undermines the “physician’s primary directive … to first, do no harm”; “destroys the trust between the patient and doctor”; and, “[u]nder the pretense of providing compassion,” relieves a physician “of his or her primary responsibility … to safeguard [patients’ lives] and to provide comfort to the suffering. It is the ultimate patient abandonment.”

It has been argued that concerns about health care inequalities and assisted suicide are belied by the fact that the reported assisted suicide deaths in Oregon have largely occurred to white educated individuals who are not poor. However, these concerns are not strictly about the handful of official reported assisted suicides, but the wider indirect impact of legalization on medical and legal practice.

The death of Wendy Melcher in August 2005 illustrates this impact. Two nurses, Rebecca Cain and Diana Corson, gave Melcher large overdoses of morphine and phenobarbital. They claimed that she had requested assisted suicide, but they administered the drugs without her doctor’s knowledge, in clear violation of the law. Yet no criminal charges have been filed against the two nurses. Proponents of assisted suicide argue that this case has no connection to it. But it is a strong indication of the legal erosion of public protections associated with assisted suicide. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon’s] Death with Dignity Act are for naught."

Supporters of assisted suicide frequently make the claim that where it is legal, there is no longer any underground practice of assisted suicide. No documentation is ever offered to support this claim. But Melcher’s death suggests the exact opposite. It appears that underground assisted suicide is thriving in Oregon, due to the breakdown in legal rules and codes of conduct that elsewhere protect health care patients, a breakdown that may be an inevitable by-product of assisted suicide’s legalization.

Other indirect harms of assisted suicide are discussed below, especially in the section, One Visit, Rarely: The Impact on the Individual.

II. THE FAILURE OF SAFEGUARDS AND THE CASE OF OREGON

Oregon’s Death with Dignity Act initiative, known as Measure 16, narrowly passed in November 1994, but court proceedings delayed its implementation. After the court dismissed the challenge, the Oregon legislature, concerned that Measure 16 might soon be enacted, and knowing it to be dangerously flawed, referred it back to the voters for reconsideration in a November 1997 special election. After a campaign in which
assisted suicide’s proponents succeeded in keeping the public’s attention away from the proposal’s actual problems, Oregon voters legalized assisted suicide.\textsuperscript{27}

Washington State’s Initiative 1000, nearly identical to the Oregon law, passed in November 2008, and went into effect as the Death with Dignity Act in March 2009. And the Montana Supreme Court ruled assisted suicide to be legal in December 2009.

One of the myths about assisted suicide in Oregon is that it is highly regulated and has strong safeguards. Those alleged safeguards include limiting assisted suicide to people who are terminally ill, requiring doctors to present patients with the option for palliative care, ensuring that each request is voluntary, requiring that a second opinion be obtained, ensuring that patients are competent to make the decision to end their lives, requiring a fifteen-day waiting period, and requiring doctors to inform the state of any lethal prescriptions they write.\textsuperscript{28} However, each and every one of these reportedly strong rules is either fundamentally flawed or has been rendered an empty ritual.

The discussion that follows focuses largely on Oregon because assisted suicide has been legal in that state for over a decade. Exploring Oregon and Washington is a means to examine many significant problems with the legalization of assisted suicide. These problems include the myth of free choice and self-determination; the fundamental loophole of terminal illness prognosis; the safeguards in name only; the danger to people with depression and psychiatric disabilities; Oregon’s minimal data and fatally flawed oversight; and the questionable circumstances of Oregon deaths.

The Myth of Free Choice and Self-Determination


Margaret Dore, a specialist in elder law, has extensively documented how the Oregon and Washington State assisted suicide laws, contrary to the rhetoric, dramatically undermine patient control. In a May 2009 article on the website of the King County (Seattle) Bar Association, she pointed out:

During the election, proponents touted [assisted suicide] as providing “choice” for end-of-life decisions. A glossy brochure declared, “Only the patient—and no one else—may administer the [lethal dose].” The Act, however, does not say this—anywhere. The Act also contains coercive provisions. For example, it allows an heir who will benefit from the patient’s death to help the patient sign up for the lethal dose. … The Act also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient’s heir. This does not promote patient choice; it invites coercion.

By comparison, when a will is signed, having an heir as one of the witnesses creates a presumption of undue influence. The probate statute provides that when
one of the two required witnesses is a taker under the will, there is a rebuttable presumption that the taker/witness “procured the gift by duress, menace, fraud, or undue influence.”

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that “only” the patient may administer the lethal dose; it provides that the patient “self-administer” the dose. … Someone else putting the lethal dose in the patient’s mouth qualifies as “self-administration.” Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. “Self-administer” means that someone else can administer the lethal dose to the patient. … Indeed, someone could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi.

This situation is especially significant for patients with money. A California case states, “Financial reasons [are] an all too common motivation for killing someone.” Without disinterested witnesses, the patient’s control over the “time, place and manner” of his death, is not guaranteed.

If one of your clients is considering a “Death with Dignity” decision, it is prudent to be sure that they are aware of the Act’s gaps. By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected against others in the event he changes his mind after the lethal prescription is filled and decides that he wants to live.

As Dore also stated, “Involuntary killing is not an ‘abuse.’ It is allowed by the statute.” And Dore pointed out that assisted would actually restrict choice and self-determination by giving insurers a supposedly humane and dignified alternative to covering a patient’s health care and by making people with disabilities and chronic illness vulnerable to predators by removing the protection of illegality for assisted suicide.

These concerns are developed further below in The Questionable Circumstances of Oregon Deaths.

Moreover, there is a significant danger that many people would choose assisted suicide due to external pressure. Elderly individuals who don’t want to be a financial or caretaking burden on their families might take this escape. In fact, the percentage of reported Oregon cases attributed to patients’ reluctance to burden their families has risen alarmingly. It totaled 12 percent in 1998, but increased to 26 percent in 1999, then 42 percent in 2005, and 45 percent in 2007. Nothing in the Oregon law will protect patients when there are family pressures, whether financial or emotional, which distort patient choice.

The impact of pressures to choose assisted suicide was illustrated when Rob Miller, Director of the pro-assisted suicide group Compassion & Choices of Washington,
commented on the death of Linda Fleming, the first reported death under Washington State’s assisted suicide law. When asked if he knew that Fleming, who was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy in 2007, Miller said he was unaware of all that, but that her case presented "none of the red flags" that would cause his organization to reconsider supporting her suicide request.\textsuperscript{33}

Also troubling is that research has documented widespread elder abuse in the United States. The perpetrators are often family members.\textsuperscript{34} Such abuse could easily lead to pressures on elders to "choose" assisted suicide.

Still others may undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. A case in point, Oregon resident Kate Cheney (discussed below) appears to have been strongly motivated to take her life by fear of the nursing home where she had just spent an unhappy week. As Diane Coleman noted regarding Oregon's law, "Nor is there any requirement that sufficient home and community-based long-term care services be provided to relieve the demands on family members and ease the individual's feelings of being a ‘burden’ … The inadequacy of the in-home long-term care system is central to the assisted suicide and euthanasia debate."\textsuperscript{35}

While the proponents of legalization argue that it would guarantee choice, assisted suicide would actually result in deaths due to a lack of choice. Real choice would require adequate home and community-based long-term care; universal health insurance; housing that is available, accessible, and affordable—a full range of social supports currently unavailable to many, if not most people. In a perverse twist, widespread acceptance of assisted suicide is likely to reduce pressure on society to provide these very kinds of support services, thus reducing genuine options even further.\textsuperscript{36}

**The Fundamental Loophole of Terminal Illness Prognosis**

The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear distinction between those who are terminally ill with six months to live, and everyone else. Everyone else is supposedly protected and not eligible for assisted suicide.

But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it's only in the last few weeks of life. With every disease other than cancer, prediction is unreliable.\textsuperscript{37} Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad, far beyond the supposedly narrow group its proponents claim. The affected group could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead of them.
This poses considerable danger to people with new or progressive disabilities or diseases, who may often be misdiagnosed as terminally ill but who in many cases outlive these prognoses by years or even decades. Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in our lives. However, the adaptation usually takes considerably longer than the mere fifteen-day waiting period required by assisted suicide proposals and the Oregon and Washington laws. People with new diagnoses of terminal illness appear to go through similar stages. In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make the final choice, one that is irrevocable.

Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, doctors often classified him as terminally ill. He experienced severe depression for two years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life. How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide?

Safeguards in Name Only

**Doctor Shopping: All Roads Lead to Rome**

There are many other significant weaknesses in Oregon’s safeguards. For example, physicians are not permitted to write a lethal prescription under a set of inappropriate conditions defined in the law, such as when a patient is incompetent or when a request is involuntary. But in many instances, patients have engaged in "doctor shopping," which can circumvent any of these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient didn't meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and a fourth, until someone eventually agreed to write the prescription.

As the International Task Force on Euthanasia and Assisted Suicide stated to the Montana Supreme Court in April 2009,

Many other patients seeking assisted suicide have … had to ask more than one physician for the lethal prescription. There is no way to know if physicians declined due to personal convictions, because they believed the patients were not terminally ill or because they determined that the patients had impaired judgment. During the first three years of legal assisted suicide in Oregon, reports indicated that, in 59 percent of cases, patients had to ask two or more physicians before receiving the lethal drugs. After the third year, official reports stopped including this category.
Patients or their families can doctor shop until a willing physician is found. And, since non-prescribing physicians are not interviewed for official state reports, there is no way to know why they refused to lethally prescribe.\textsuperscript{41}

To understand how easily the approval-by-two-doctors “safeguard” can be circumvented as well, it is important to know that the lead organization advocating for assisted suicide, Compassion & Choices, also facilitates most of Oregon’s reported assisted suicides, often by referring individuals to assisted-suicide-friendly doctors. (In addition, the organization’s officers “are the authors [of the law] … and [are its] self-proclaim[ed] … stewards … .”\textsuperscript{42}) Dr. Peter Goodwin, the group’s former Medical Director, said that about 75 percent of those who died using Oregon’s assisted suicide law through the end of 2002 did so with the organization’s assistance.\textsuperscript{43} In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.\textsuperscript{44} According to Dr. Elizabeth Goy of Oregon Health and Science University, Compass in Dying (since renamed Compassion & Choices) sees “almost 90 percent of requesting Oregonians….”\textsuperscript{45} And “in 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all [OPHD] reported deaths.”\textsuperscript{46} (More information about the role of Compassion & Choices in the Oregon law is discussed in the section below on Minimal Data and Fatally Flawed Oversight.)

H. Rex Greene, M.D., also noted that:

This law [referring to a California bill patterned on the Oregon law] would allow marginal physicians, say two Botox dermatologists, to diversify into end-of-life prescribing. This is a real concern as a study done a few years ago indicated that the more experience physicians have in end-of-life care the more they disapprove of PAS. Conversely, it is those that rarely care for the dying that tend to support it. Thus, this law will necessarily put vulnerable patients in the hands of physicians who either lack experience or hold philosophical beliefs that an approach to end-of-life care includes lethal overdoses to relieve "suffering."\textsuperscript{47}

The first person reported to die under Oregon law, whose name was not revealed, represents an example of doctor shopping. Her doctor and a second physician refused her a lethal prescription. The latter diagnosed her as “depressed.” Nonetheless, a doctor affiliated with Compass in Dying wrote the prescription after knowing her for only a short time.\textsuperscript{48}

Another example is Kate Cheney, an 85-year-old woman.\textsuperscript{49} Cheney saw two physicians. Her daughter thought the first doctor was “dismissive” and requested another opinion. The second physician ordered a psychiatric evaluation, which found that Cheney lacked “the very high level of capacity required to weigh options about assisted suicide.” Cheney’s request was then denied, and her daughter “became angry.” Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her “choices may be influenced by her family’s wishes and her daughter, Erika, may be
somewhat coercive.” Cheney soon took the drugs and died, but only after spending a week in a nursing home.

**Alternatives: Presented But Not Provided**

In the Oregon law, physicians are required to discuss alternatives to assisted suicide as another safeguard. However, there is no requirement that these alternatives actually be made available to patients, or even that the professional who discusses them fully understands them. Kate Cheney's case exemplifies this. Further, her case demonstrates the shocking laxness with which safeguards in Oregon are being followed. Cheney decided to take the lethal medication immediately after spending a week in a nursing home in order to give her family a break from caregiving. The chronology shows that Cheney felt she had only three choices: burdening her family, the hell of a nursing home, or death.

As Herbert Hendin, M.D., and Kathleen Foley, M.D., suicide prevention and end-of-life care experts, wrote about Kate Cheney, “one can readily see how in the best of circumstances frail, elderly patients can feel coerced to die. … How can any physician be sure there is no coercion unless the physician has met the family and seen the interaction among them and with the patient? … This particular case raises the question of what real meaning or value Oregon’s prohibition of coercion has if it can be circumvented so easily."

After reading about Kate Cheney, Diane Coleman of Not Dead Yet sent a letter via the Internet to Dr. Robert Richardson, who authorized Cheney’s request for lethal drugs. It stated, in part:

In my role as a long-term care advocate, I have heard for years of Oregon's claim to operate the most progressive long-term care programs in the country, model programs that emphasize in-home and community-based services, even for the most frail elderly. What in-home services was Ms. Cheney receiving? How is it that Ms. Cheney had to spend a week in a nursing home to give her family respite from caregiving? Did Ms. Cheney and her family know of other respite options? If not, who failed to tell them? How can their actions have been based on the informed consent promised in Oregon's law? Or did the family choose the nursing home respite option with the knowledge of other alternatives (an even more disturbing possibility)? …

There are many ways to resolve the feeling of being a burden on family, and the family's feelings of being burdened. In what depth were these issues explored? In this context, family relationships are complex, and the emotional dynamics could not realistically be uncovered in a brief consultation.

It appears from the newspaper account, as well as your response to Dr. Hamilton, that these issues were not meaningfully addressed. Ms. Cheney appears to have been given the message that she had three choices—to be a burden on family, to
go to a nursing home, or to die. After a week in a nursing home, an experience I wouldn't wish on my opponents except perhaps to educate them, it appears that Ms. Cheney felt she had only one option. How is this a voluntary and uncoerced decision based on informed consent?\footnote{51}

Dr. Richardson did not reply.

**Good Faith: A Safeguard for Doctors, Not Patients**

There is one foolproof safeguard in the Oregon and Washington laws. Unfortunately, it is for physicians and other health care providers rather than for patients—the good faith standard. This provision holds that no person will be subject to any form of legal liability, whether civil or criminal, if they act in good faith.\footnote{52} However, a claim of a good faith effort to meet the requirements of the law is virtually impossible to disprove. Moreover, this particular provision renders all other alleged safeguards effectively unenforceable.

Even more alarming, for all other medical procedures, doctors are liable under a much stronger legal standard, that of negligence. Yet even if negligent, practitioners of assisted suicide will not be found to have violated the law as long as they practice in good faith. In an ironic twist, assisted suicide doctors and other practitioners are safer from liability if they cause a patient’s death than if they provide his or her medical treatment.

As Diane Coleman asked, "...is society really ready to ignore the risks, tolerate the abuse, marginalize or cover up the mistakes, and implicitly agree that some lives—many lives—are expendable, in order to enact a law that immunizes health care providers and other participants in assisted suicide?"\footnote{53}

Hendin and Foley offered this analysis:

A concern with physician protection, rather than patient protection, pervades the Oregon experience. ... Oregon physicians assisting in a suicide are exempt from the ordinary standards of care, skill, and diligence required of Oregon physicians in other circumstances (e.g., a physician’s conduct when withdrawing life support).

Instead, the physician is immunized from civil and criminal liability for actions taken in “good faith” in assisting a suicide irrespective of community standards in other matters and even when the physician acts negligently.

Good faith is a troublesome, subjective standard. ... In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute’s provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate.\footnote{54}
The Danger to People with Depression and Psychiatric Disabilities

Depression and the Wish to Die

The drive to legalize assisted suicide comes from anecdotes of painful, uncomfortable deaths. Yet available data shows that when assisted suicide is legal, those who use it are not typically acting based on current pain or other discomfort. As H. Rex Greene, M.D., stated in 2006:

… the psychosomatic literature [describes] … Demoralization Syndrome, which is very common in chronic, … life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon’s law, who are consistently reported NOT to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of what might come in the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates.

Greene also stated:

The wish for death is a "cry for help," a reliable sign of depression. How absurd that it would be met with a lethal prescription. Such an act violates professional standards of palliative care as much as if I were presented with a suicidal patient and handed her a gun or drove her to the Golden Gate Bridge. …

What this legislation neglects is the fact that advances in palliative medicine have made it possible to relieve … symptoms in virtually all dying patients. The argument that five to ten percent of dying patients experience intractable symptoms relies on outdated data. (Of course, the victims of the Oregon law were not imminently dying or suffering intractable pain; they were suffering from depression and despair.) Those patients who are truly at the end-of-life need access to excellent palliative and hospice care, not a lethal overdose.\(^5^5\)

Other research supports Greene’s conclusion that most patients requesting death do so not based on physical symptoms such as pain or nausea, but rather based on depression and other forms of psychological distress.\(^5^6\)

Ignoring What Lies Beneath: The Abandonment of the Patient

Addressing the situation of the individual patient, Hendin stated in Congressional testimony:

a request for assisted suicide is … usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognize that ambivalence as well
as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.\textsuperscript{57}

As Hendin and Foley wrote in 2008, when patients requesting a doctor’s assistance to die “are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.”\textsuperscript{58} Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legal, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

The danger assisted suicide raises for people with depression and psychiatric disabilities has been very real in Oregon, and this is a key way that assisted suicide harms people with disabilities. N. Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric Association and co-founder of Physicians for Compassionate Care, has demonstrated how Oregon’s flimsy safeguards do not protect people with psychiatric and other mental health disabilities. In his 2004 testimony to a British delegation considering a law similar to Oregon’s, Hamilton documented the case of Michael Freeland, a man with “a long history of serious depression and previous suicide attempts” who nonetheless received lethal drugs under the Oregon law.\textsuperscript{59} A recent study in the \textit{British Medical Journal} confirmed that that some of the reported Oregon cases were patients who were, in fact, depressed.\textsuperscript{60}

People with depression can receive lethal drugs in Oregon and Washington legally, because they are still technically eligible as long as they are deemed legally competent, that is, “competent and not suffering from a psychiatric or psychological disorder or depression \textit{causing impaired judgment}.”\textsuperscript{61} Yet the notion that patients with depression may be considered legally competent to decide to end their lives merely because the depression doesn’t impair their legal competency—Orwellian at best—is also at variance with the majority of clinical and forensic psychiatrists who believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide.\textsuperscript{62} And as Hendin and Foley pointed out, “Reducing the psychiatric consultation to the issue of competency ignores all the other psychological factors that go into the request for assisted suicide.”\textsuperscript{63}

\textbf{One Visit, Rarely: The Impact on the Individual}

Over time, serious abuses of the Oregon law exemplified by the cases of Michael Freeland and Kate Cheney, discussed above, have come to light. But this has occurred only sporadically, in the media and by word of mouth, because neither the Oregon nor the Washington law requires any investigation of abuse (the laws’ weak enforcement is examined below in Minimal Data and Fatally Flawed Oversight). The example of Michael Freeland, as well as those that follow, offer an indication of the serious problems that have beset people with depression and psychiatric disabilities since the Oregon law went into effect.
In discussing Joan Lucas, an Oregon woman whose evaluating psychologist did not “take the trouble to see,” and “on the basis of a single questionnaire administered by her family, … was willing to give an opinion that would facilitate ending [her] life,” Hendin and Foley pointed out that when a psychiatric evaluation is employed in Oregon, it has a tendency to be used to protect clinicians rather than patients:

[The Oregon Public Health Division’s] monitoring procedures do not make it possible for OPHD to evaluate the care Joan Lucas received. To do so OPHD would have to interview Joan’s primary care physician who had refused to assist in her suicide and to assess the quality of her psychological evaluation. Using psychologists or psychiatrists as gatekeepers only to establish a patient’s capacity to make a decision for assisted suicide contributes to pro forma, meaningless consultations.

In the Lucas case, we have no way of knowing if Joan Lucas was seriously depressed or if the doctor or psychologist was disposed to proceed even if she were. Even more troubling is that OPHD does not seem to want to know about the psychiatric status of patients requesting assisted suicide. Under the current monitoring system, OPHD collects no information from psychiatrists who did not find patients to be competent and has no direct communication with psychiatrists or psychologists who did. Its monitoring reflects a lack of concern with the welfare of depressed patients.  

And as N. Gregory Hamilton, M.D., pointed out,

The Oregon law does not require … a psychiatric evaluation. Only if the doctor intending to write the prescription, or the consultant, believes that the patient has seriously impaired judgment due to a mental disorder is there any requirement for referral to a psychiatrist. In actual practice, few patients requesting assisted suicide are ever referred for such an evaluation—it has dropped to only 5%. When made, it’s to a psychiatrist or psychologist chosen by the assisted suicide doctor and the evaluations tend to be pro forma, so they provide no protective function … even if an opinion disallows assisted suicide … seeking alternative opinions until one that favors assisted suicide can be found, is permitted. Thus, the law provides no effective protection for the mentally ill.

Only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit, yet the Oregon and Washington State definitions of a psychiatric consultation permit one visit only.

Psychiatric evaluation of individuals who die from assisted suicide dropped from 31 percent in 1998 to a mere five percent in 2003 – 2004. In the 2007 Oregon report, no Oregon patients underwent a psychiatric evaluation. And “over the [following] two years in Oregon, less than 2% of patients committing assisted suicide were referred for psychiatric evaluation.”
Yet Hendin and Foley described an Oregon example of what can happen when psychiatric consultation is not provided:

[A] woman in her mid-fifties with severe heart disease … requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. Therefore, she was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered … his responsibility ended. … [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed herself the next day.71

Proponents of assisted suicide may argue that this event does not constitute an assisted suicide abuse, because the woman did not die from lethal drugs provided under the Oregon law. But her depression may well have been treatable by a medical provider seeking to help her. That her practitioners narrowed their consideration to her eligibility for assisted suicide surely demonstrates another of assisted suicide’s significant indirect harms.

As the two associations of California oncologists stated, considering all the Oregon assisted suicides to date, “What percentage of these cases might have been helped by aggressive psychiatric intervention or spiritual counseling?”72

Minimal Data and Fatally Flawed Oversight

The State of Oregon’s minimal data collection and gross lack of strong oversight of assisted suicide undermines any pretense of rigorous monitoring or strict regulation. A series of problems renders any conclusions based on the data to be critically flawed. Washington State’s law, which is much newer, contains similarly limited, deeply flawed oversight provisions.

Oregon’s annual reports tell us very little. In reality, we don’t know what is happening under the Oregon law due to the following oversight problems:

1. The reporting requirement lacks teeth. On paper, the law requires doctors to report all lethal drug prescriptions, but sets no penalties for physicians who fail to report. As a result, there is no enforcement of this requirement.73

2. Non-compliance is not monitored. The law requires annual statistical reports from the Oregon Public Health Division (OPHD), but OPHD does not monitor underreporting, noncompliance, or violations. Many of Oregon’s reports acknowledge that the State cannot confirm compliance with the Oregon law. OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside the law’s framework, stating “[W]e cannot detect or
collect data on issues of noncompliance with any accuracy.”

And every annual report through Oregon’s seventh year came with disclaimer similar to this one from the fifth year: “[O]ur numbers are based on a reporting system for terminally-ill patients who legally receive prescriptions for lethal medications, and do not include patients and physicians who may act outside the law.”

3. **Important questions go unasked.** Most information in OPHD reports comes from doctors who wrote lethal prescriptions. For its first annual report, OPHD gathered most information in 20-minute telephone interviews. OPHD continues to gather data through questionnaires and telephone interviews. However, OPHD does not gather information from important parties other than the prescribing physicians—for example, asking why doctors refused to assist patients in suicide. Doctors who said “no” may have concluded that a patient did not meet legal requirements—essential information if one truly intends to evaluate the law’s outcomes. Nor does OPHD regularly interview family members or friends to learn about the physical and emotional status of those who died, nor does it interview or collect any information from patients prior to their deaths. Such information is necessary for many reasons, including because the law does not require autopsies to determine if deceased patients were actually terminally ill.

As Hendin and Foley observe, OPHD could correct this glaring limitation by gathering information from doctors who, for whatever reason, said no; from any psychiatrists who may have evaluated these patients, regardless of the results; and from nurses, social workers, or family members who cared for the deceased. Without this data, no one can know how many annual requests for assisted suicide are made, why some doctors declined while others agreed, and what transpired in individual cases.

4. **There is no investigation of abuse.** OPHD reports fail to investigate cases of expansion and complications reported in the media or documented by others. There is no method through which the public can report abuse. The State has no resources or even authority to investigate violations. In fact, in 2005, the Oregon Department of Human Services (DHS, of which OPHD is a part) issued a news release stating:

> The Oregon Department of Human Services has no authority to investigate individual Death with Dignity cases . . . . The state law authorizing physician-assisted suicide neither requires nor authorizes investigations by DHS, said Barry S. Kast, DHS Assistant Director for Health Services.

According to Dr. Kenneth Stevens, Oregon DHS has limited funding and they do not have the time, financial resources, authorization, or desire to investigate what is happening with assisted suicide in Oregon. He pointed out that, as the years have progressed, there is less and less information in the OPHD annual reports, adding:
But in contrast, Compassion & Choices of Oregon has much more information. … C&C wrote the law; they control the data; and when they say that everything is under control with “death with dignity” (assisted suicide) in Oregon, they are correct in that they control it.82

5. **Secrecy pervades the operation of assisted suicide.** There is an unnecessarily high level of secrecy about assisted suicide that undermines the public’s right to know, as well as any independent, in-depth research. As Hendin and Foley wrote regarding Oregon:

> OPHD has focused more on patient-doctor confidentiality than on monitoring compliance or abuse. The agency has developed confidentiality measures unique to physician-assisted suicide which appear to be unnecessarily secretive and limit the potential for thorough research … .

The Oregon law specifically states that although OPHD will issue a report each year based on a selected sample of cases, “the information collected shall not be a public record and may not be made available for inspection by the public.” There is no provision for an independent researcher or evaluator to study whatever data are available.

Medical standards require openness about facts, research data, and records to assess the appropriateness of treatment. The anonymity and secrecy about physician practice of assisted suicide makes such an assessment impossible. If physician-assisted suicide is to be part of the medical treatment for terminal illness, why are existing patient-doctor confidentiality rules not sufficient to protect physicians in this setting? Restricting access to information about the indications for assisted suicide, patient data, radiologic documentation, and specific drug therapy limits the opportunity to establish an objective standard of care, provides excessive protection to the physician and, in the name of confidentiality, leaves the patient vulnerable.83

And regarding Washington, an article by John Ruhl and William Watts, M.D., on the King County (Seattle) Bar Association website discussed the Washington law’s extraordinary requirement that on the death certificate, a patient’s underlying disease must be listed as the cause of death—even if he or she died from lethal drugs at a time when that disease manifested no symptoms.84

Ferreting out victims of abuse would be even more difficult because the patient’s death certificate would be required to “list the underlying terminal disease as the cause of death” rather than suicide. Nor would the press or public be able to verify the accuracy of the State’s summary statistical reports, because I-1000 provides specifically that “[e]xcept as
otherwise required by law, the information collected [regarding compliance with I-1000] is not a public record … .” 85

6. The underlying data is destroyed annually. Alarmingly, officials have acknowledged that OPHD destroys each year’s underlying data records after it issues each annual report. 86

Assisted suicide is practiced in Oregon in secret and without oversight. In this lax context, without any systematic investigation of abuse, or even a way to report it, the examples that come to light in the media and through other means are likely to be only the tip of the iceberg. An editorial in The Oregonian pointed out that the law established “a system that seems rigged to avoid finding” the answers. 87 These problems, in aggregate, belie the allegation by assisted suicide’s proponents and backers that it is safely regulated.

In discussion of Kate Cheney, Hendin and Foley wrote, “This case makes a compelling argument for the need for openness and transparency—and perhaps even judicial review of competency determinations … .” 88 Certainly, judicial review is required on other matters no less significant than what is at stake here.

As Daniel Callahan, Senior Research Scholar and President Emeritus of the Hastings Center, wrote:

[The Oregon law] is a laboratory lacking all transparency and accountability, with no information other than of a statistical kind made available to the public. The proposed Washington law is no less blunt in its denial of public information: “the department of health shall adopt rules to facilitate the collection of information. … Except as otherwise required by law, the information … may not be made available for inspection by the public.”

In the case of Oregon, we have been assured that all is well, that no abuses are occurring. In their confidence and firmness, those assurances are the equal of those expressed in the Netherlands prior to its confidential surveys. But Oregon has never sponsored a confidential survey, and probably never will. If you know, just know, there are no abuses, why bother? The flavor of the proposed law in Washington does not suggest a survey will ever be carried out there either. Regulations of that kind, protected from public scrutiny, but with the ring of authority and oversight, are a Potemkin village form of regulatory obfuscation. They look good, sound good, feel good, but have nothing behind them.” 89

In a final blow to transparency and regulation, rather than correcting any of these fundamental limitations, OPHD responded to pressure from pro-assisted suicide advocates not to use the term “assisted suicide.” OPHD had used this term each year on its website and in its annual reports. But Compassion & Choices, responding to polling data that public support for assisted suicide decreases if the word “suicide” appears,
successfully pressured OPHD in 2006 to switch to more nebulous terms such as “persons who use the Oregon Death with Dignity Act.”

The Questionable Circumstances of Oregon Deaths

There are additional troubling aspects of how assisted suicide is practiced in Oregon. One is that there are no monitoring mechanisms or, indeed, controls of any kind once the prescription for lethal drugs has been written. No one knows what may happen to the lethal agents that are not taken by the patients who originally request them, and the Oregon reports have made it clear that some patients have died of other causes.\(^90\) The drugs could be stored over time in private homes or workplaces, with no oversight to protect public safety.

As if to underscore this point, Dr. Katrina Hedberg, a lead author of most of Oregon's official reports, testified in 2004:

Our job is to make sure that all the steps happened up to the point the prescription was written. … In fact, after they write the prescription the physician may not keep track of that patient. … The law itself only provides for writing the prescription, not what happens afterwards. … We do not have a way to track if there was a big bottle [of lethal drugs] sitting in somebody's medicine cabinet and they died whether or not somebody else chose to use it.\(^91\)

Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement … [Then, they could] express the medication through a large bore syringe that would go into their G tube."\(^92\) Dr. David Jeffrey wrote, “The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS.”\(^93\)

Moreover, Oregon’s 2008 *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* states, “The Oregon [law] does not provide guidance on the degree of assistance with self-administration that may be given by another person.” The Guidebook also notes, "Under the Oregon Act, physicians are not legally permitted to provide a lethal injection if the patient’s self-administered medication does not result in death."\(^94\) But it does *not* state that a patient cannot end his or her own life by lethal injection. And according to Sue Davidson of the Oregon Nurses Association, a 2002 survey found that nurses are very actively involved in the process and that "some indicated that they had assisted [patients] in the taking of [the lethal dose]."\(^95\)

There is at least one documented example in Oregon in which assistance by others in the dying process has been acknowledged. Discussing a case in which a man said he helped his brother-in-law take the prescribed drugs, Dr. Katrina Hedberg said, "[W]e do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted. …"\(^96\) Supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone
must actually ingest the lethal agents, and do so very quickly, before the drugs’ effects stall the process. But if a patient or someone assisting uses a feeding tube or an injection, intravenous or intramuscular, abuse is far more difficult to detect and prove.

The ambiguity about what happens after the prescription is written—the actual manner of death—is highly problematic. Again contrary to the impressions created by assisted suicide supporters, the lethal drugs are not at all simple to take quickly. According to Kenneth R. Stevens, Jr., M.D., former Chairman of Radiation Oncology at Oregon Health & Science University and Vice-president of the Physicians for Compassionate Care Education Foundation, assisted suicides in Oregon have generally used one of two agents, secobarbital or pentobarbital (Nembutal). Use of secobarbital, a powder, requires a person to take the contents of 90 to 100 large capsules. These capsules cannot feasibly be swallowed, because the individual would fall asleep before ingesting enough to achieve the intended purpose. So the capsules must be emptied into applesauce or pudding, which cannot disguise the very strong and exceptionally bitter, distasteful flavor. Taking a substance to numb the mouth is not necessarily a good way to make the drug more palatable, because it could interfere with swallowing. The other agent, pentobarbital, is only available as an injectable liquid. Four bottles, or approximately seven ounces of liquid, must be taken to reach the needed dose of ten grams, and this potion is also exceptionally distasteful.

Dr. Stevens commented on how bitter a death oral ingestion provides, and he pointed out that in at least one known Oregon case, a feeding tube was used. He observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once the injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.

This slide away from self-administration is a cause of considerable concern to the disability community, which has known a long history of involuntary euthanasia at the hands of others, whether governments, medical establishments, or families that did not necessarily value their presence. With no controls on the drug after the prescription is filled, and with the possibility of administration through a nasogastric tube or gastrostomy feeding tube, or even through injection by third parties—how does this scheme protect vulnerable people from abuse, particularly at home?

The two professional associations of California oncologists wrote:

Despite the reporting requirements, death by physician-assisted suicide in Oregon largely occurs in the dark. There is little accurate information about what actually happens at the time of death, as physicians are not required to be present at the time …. In 2005, physicians were in attendance in only 23% of cases….
Between 1998 and 2005, the time between ingestion and death ranged from four minutes to 48 hours. It is hard not to imagine that those patients who required 48 hours to die might have experienced suffering over and above that brought on by the terminal illness. Indeed, this has been the experience in the Netherlands, with a report from 2000 showing that so-called “problems with completion” (a longer-than-expected time to death, failure to induce coma, or induction of coma followed by awakening of the patient) occurred in 16% of cases, prompting physician intervention 18% of the time, which of course blurs the line considerably between suicide and euthanasia.100

Other physicians specializing in end-of-life care have also questioned the circumstances of Oregon deaths. Doctors at Physicians for Compassionate Care wrote, “The range of time between ingestion and death ranged from 2 minutes to 25 hours. Both of those times are problematic. It is very unlikely that someone would die within 2 minutes of taking an overdose of sleeping medication. Likewise, the major effect of the short-acting sleeping medication would have worn off by 25 hours. So what was the cause of death in these circumstances?”101

H. Rex Greene, M.D. responded to these observations by pointing out that prior reports from Oregon consistently reported five-minute deaths—and only one victim has survived. He agreed that nobody dies five minutes—or even twenty minutes—following oral ingestion of a lethal dose of barbiturates. “About 15 percent of the Dutch overdoses survive and need to be euthanized,” Greene concluded. “If true, the Oregon numbers suggest they are asphyxiating the patients … in violation of the Oregon law.”102

III. SO-CALLED “NARROW” PROPOSALS CAN EASILY EXPAND

Most assisted suicide supporters claim that assisted suicide will be narrowly limited to people who are terminally ill, but these so-called "narrow" proposals, if enacted, can easily expand. As the New York State Task Force on Life and the Law wrote,

Once society authorizes assisted suicide for ... terminally ill patients experiencing unrelievable suffering, it will be difficult if not impossible to contain the option to such a limited group. Individuals who are not [able to make the choice for themselves], who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of assisted suicide, and no principled basis will exist to deny [it].103

The Netherlands: Pandora’s Box

The example of the Netherlands demonstrates clearly that assisted suicide cannot be limited to a small, targeted group once Pandora's box is opened. The Dutch example provides the longest experience with assisted suicide in any country. Although it remained technically illegal until 2002, the Netherlands first began to legally tolerate
assisted suicide in the early 70s. Today, active euthanasia—doctors giving lethal injections—has almost completely replaced assisted suicide.

The Netherlands has become a frightening laboratory experiment because of how far assisted suicide and lethal injections have spread. Herbert Hendin documented how assisted suicide and lethal injections have become not the rare exception, but the rule for people with terminal illness in the Netherlands. Hendin was one of only three foreign observers given the opportunity to study these medical practices in the Netherlands in depth, to discuss specific cases with leading practitioners, and to interview Dutch government-sponsored euthanasia researchers.

Hendin stated in Congressional testimony, "Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical [assistance to die], i.e. euthanasia, to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves."

Hendin has also described how the government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands: 50 percent of Dutch cases of assisted suicide and euthanasia are not reported, more than 50 percent of Dutch doctors feel free to suggest euthanasia to their patients, and 25 percent of these doctors admit to ending patients' lives without their consent. Further, he reported that, for a thousand people each year in the Netherlands, physicians have ended their patients' lives without consulting the patients.

U.S. assisted suicide advocates, attempting to distinguish the Oregon experience from that of the Netherlands, argue that the numbers of reported users of assisted suicide in Oregon are low. But in fact, the number of people requesting lethal drugs has steadily increased. In the beginning, the numbers were low in the Netherlands as well, but usage grew along with social acceptance of the practice. There is no reason to believe that legalization in the U.S. would not be followed, in 20 years or more, with the kind of extraordinary growth that has taken place in the Netherlands.

Other Factors Driving Toward Expansion

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates
range from 15 percent to 25 percent.110 The way to prevent these "problems," in the view of euthanasia advocates, is by legalizing lethal injections by physicians—that is, legalizing active euthanasia. This is the likely next step if society first accepts assisted suicide as a legitimate legal option.

Assisted suicide proponents tell us that none of these things will happen in the United States. But once assisted suicide is legalized, no significant barriers remain to prevent them. The very existence of assisted suicide as a legal option is likely to gradually erode social resistance, as it has in the Netherlands. In fact, the leading public champion for assisted suicide in Washington State, former Governor Booth Gardner, openly articulated a vision of its expansion as his dream. According to the New York Times Magazine in December 2007:

Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide. …

Gardner’s campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation’s resistance will subside, the culture will shift and laws with more latitude will be passed …111

Thus, the danger of expansion is another reason why it is important to maintain the legal barriers prohibiting assisted suicide.

CONCLUSION

The movement to legalize assisted suicide would do far better to advocate for high quality end-of-life care. Within the context of prevailing negative attitudes about disability and a profit-driven health care system, people with disabilities pay a high price for legalizing assisted suicide. But we are not alone in doing so, because the negative consequences of legalization affect many dimensions of society, extending well beyond the disability community and the health care system.

Leading disability rights organizations and advocates in the U.S. and in many countries, as well as most health care providers and many others, will continue to oppose the legalization of assisted suicide and euthanasia. In place of legalization, we will call for adequate home and community-based long-term care, universal health coverage, and a range of social supports that provide true self-determination for everyone. As Paul Longmore wrote, "Given the absence of any real choice, death by assisted suicide becomes not an act of personal autonomy, but an act of desperation. It is fictional freedom; it is phony autonomy."112
ENDNOTES


2 Currently, these twelve nationally prominent disability organizations have stated their opposition to the legalization of assisted suicide: American Disabled for Attendant Programs Today (ADAPT); American Association of People with Disabilities (AAPD); Association of Programs for Rural Independent Living (APRIL); Disability Rights Education and Defense Fund (DREDF); Justice For All (JFA); National Council on Disability (NCD); National Council on Independent Living (NCIL); National Spinal Cord Injury Association; Not Dead Yet (NDY); TASH; the World Association of Persons with Disabilities (WAPD); and the World Institute on Disability (WID). See Not Dead Yet, National Disability Groups Opposed To Legalization of Assisted Suicide, available at http://www.notdeadyet.org/docs/supporters.html (accessed July 11, 2009); updates from NDY staff in personal interview, March 26, 2003. Many state and local disability community leaders and organizations have declared their opposition in states where assisted suicide proposals have been introduced, and the Disability Section of the American Public Health Association has also declare opposition.


12 See, e.g., the story of Dr. Linda Peeno. In 1996, before the U.S. House of Representatives Commerce Committee, she testified, "In the spring of 1987, as a physician [and managed-care executive for the HMO Humana], I caused the death of a man [by denying coverage of a heart transplant] … I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just


17 Ibid.

18 Kenneth R. Stevens, Jr., M.D., Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients—Paying to Die But Not to Live, Physicians for Compassionate Care Educational Foundation, June 6, 2008, available at http://www.pccef.org/articles/art67.htm (accessed July 9, 2009). Stevens is Professor Emeritus and former Chairman of Radiation Oncology at Oregon Health & Science University and Vice-president, Physicians for Compassionate Care Education Foundation.


21 Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., noted in 2008 in The Oregonian that many states do better than Oregon. For example, the latest data ranks Oregon ninth (not first) in Medicare-age use of hospice; four out of the top five are states that have criminalized assisted suicide. See Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., “Assisted suicide: Conspiracy and Control,” The Oregonian, September 24, 2008. See Steven’s qualifications above. Toffler is Professor of Family Medicine at Oregon Health and Science University (OHSU) and the National Director of Physicians for Compassionate Care Educational Foundation.


31 Margaret Dore, personal communication, June 16, 2009.


34 The National Elder Abuse Incidence Study (NEAIS) was conducted by the National Center on Elder Abuse at the American Public Human Services Association. It showed that, in 1996, 450,000 elders age 60 and over were abused, according to a study of observed cases. In almost 90 percent of the elder abuse and neglect incidents with a known perpetrator, the perpetrator was a family member, and two-thirds of the perpetrators were adult children or spouses. See National Center on Elder Abuse, *National Elder Abuse Incidence Study (NEAIS)*, American Public Human Services Association, 1998, p. 4–28.

35 Coleman, "Not Dead Yet," *The Case Against Assisted Suicide*, p. 224.
Laura Remson Mitchell, a public policy analyst, consultant, and writer who specializes in disability and health-care issues, has explored this concept in articles and other writings. Personal correspondence, March 13, 2003.


44 Compassion in Dying of Oregon, Summary of Hastened Deaths, data attached to Compassion in Dying (now called Compassion and Choices) of Oregon's IRS Form 990 for 2003.

45 Dr. Elizabeth Goy of Oregon Health and Science University (OHSU) is an Assistant Professor in the Department of Psychiatry, School of Medicine, OHSU and has worked with Dr. Linda Ganzini in surveys dealing with Oregon's law. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon's assisted-suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament. They held closed-door hearings on December 9 and 10, 2004 and published the proceedings on April 4, 2005. House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL] Vol. II: Evidence (London: The Stationery Office Limited, 2005), p. 291, Question 768, available at: http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf (accessed July 13, 2009).

46 Stevens, The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization.

47 H. Rex Greene, M.D., Letter to the Council on Ethical Affairs, California Medical Association, February 22, 2006, available at http://dredf.org/assisted_suicide/greene.shtml. H. Rex Greene, M.D., is the former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, California, currently a member of the AMA Ethics Council, and a leader in bioethics, health policy and oncology.


51 Coleman, "Not Dead Yet," The Case Against Assisted Suicide, p. 226.

52 Or. Rev. Stat. § 127.885(1)–(3).

53 Coleman, "Not Dead Yet," The Case Against Assisted Suicide, p. 227.


55 Greene, Letter to the Council on Ethical Affairs.

56 The two professional associations representing oncologists in California wrote:

   “In this debate, it is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do not do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues.

   This has been borne out in numerous studies and reports. For example, … a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada … showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient’s expressed desire or support for euthanasia/PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to be suffering from depression or anxiety, but not somatic symptoms such as pain.

   An important study from the Netherlands of a cohort of 138 cancer patients with a life expectancy of three months or less demonstrated similar findings. In this study, the authors had hypothesized that patients requesting euthanasia would be unlikely to have depressed mood or affect, since it would be expected that such a request would be a well-thought out decision, particularly since euthanasia has been legal in the Netherlands since 2002. The authors expected that these patients would be more accepting of their terminal diagnosis and therefore better adjusted. What they found surprised them—depressed patients were more than four times as likely to request euthanasia as patients who were not depressed. Over 40% of depressed patients requested euthanasia. Of those who requested euthanasia, about half were depressed.”


61 Revised Code of Washington 70.245.010; Oregon Legislative Statue 127.800 §1.01.


64 Ibid., p. 1623.


67 Revised Code of Washington 70.245.010; Oregon Legislative Statue 127.800 §1.01.


72 Association of Northern California Oncologists and Medical Oncology Association of Southern California, Position Statement on Physician-Assisted Suicide and Opposition to AB 374.


78 Ibid.


80 Though OPHD has no investigative authority, assisted suicide’s defenders have occasionally responded to this critique by pointing out that the annual reports detail 20 referrals made to the Oregon Board of Medicine and one referral to the Board of Pharmacy. But no reports suggest that any disciplinary action was ever taken. Such referrals are made when physician-completed questionnaires or interviews involve minor paperwork irregularities such as “incorrectly completed report forms” or “an incomplete written consent.” Yet these referrals do not constitute a meaningful investigation or a true safeguard, as they depend entirely on self-reporting; they address very minor irregularities, and there has not been disciplinary action. Oregon’s second report acknowledges this problem, noting, “Under reporting and non-compliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division.” Oregon Public Health Division, *Oregon’s Death with Dignity Act: The Second Year’s Experiences*.


84 Revised Code of Washington 70.245.020 (2).

85 John Ruhl and William Watts, MD, “I-1000: Prescription for Coercion, Not Freedom,” King County (Seattle, Washington) Bar Association website, available at http://www.kcba.org/newsevents/barbulletin/archive/2008/08-10/article27.aspx. John Ruhl was the president of the King County Bar Association in 2006 – 2007. William Watts, M.D., was the president of the King County Medical Society in 2007.


95 Witnesses' testimony was published in House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]* Vol. II, pp. 352-353, Question 1058.


97 On March 11, 2007, a Los Angeles Times story described David Bradley, a man with esophageal cancer, who moved to Oregon from New Mexico, and reportedly underwent

98 Kenneth R. Stevens, Jr., M.D., personal communication, July 8, 2009; information on lethal drugs based on data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports.


104 Both euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973, although they were against the law until 2002. The Dutch situation between 1973 and 2002 was an outgrowth of a series of court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a Dutch physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother. See Nederlandse Jurisprudentie 1973, no. 183, District Court of Leeuwarden, 21, February 21, 1973; translation in Walter Lagerway, *Issues in Law and Medicine*, Vol. 3, pp. 429, 439 – 42, 1988. Her admission that she had given her mother a lethal injection seemed calculated to force public and legal reconsideration of the laws against assisted suicide (Penal Code of the Netherlands, §294) and euthanasia (Penal Code of the Netherlands, §293). While finding Dr. Postma guilty of the crime of mercy killing that was punishable by imprisonment for a maximum of 12 years, the court imposed a one-week suspended sentence and a week’s probation. The Dutch court relied heavily on expert testimony by the District’s medical inspector who set forth certain
conditions “under which the average physician thought euthanasia should be considered acceptable.” Inclusion of those conditions formed the basis for subsequent acceptance of euthanasia and assisted suicide in the Netherlands. The guidelines required that the patient must be considered incurable and experiencing subjectively unbearable suffering; the request for termination of life should be in writing; and there should be adequate consultation with other physicians before death could be induced. See Carlos Gomez, Regulating Death: Euthanasia and the Case of the Netherlands (Old Tappan, NJ: Free Press, 1991), p. 30. Other cases followed, each widening the boundaries and further liberalizing the conditions under which euthanasia and assisted suicide, although remaining illegal, would not be punished. Among the cases was the Alkmaar case (Nederlandse Jurisprudentie 1985, no. 106) in which a woman died after requesting death because “her advancing age and physical condition caused her to be dependent on others, thus leading to psychological suffering.” The case gave rise to the 1986 decision by the Hague Court of Appeals that recognized "psychic suffering" and "potential disfigurement of personality" as grounds for induced death. The courts have also exonerated physicians who assisted in the suicides of a young woman with anorexia nervosa (Amelo, Tijdschrift voor Gezondheidsrecht, 1992, No. 19) and a woman who was depressed over the death of her two children and the failure of her marriage (Assen, Nederlandse Jurisprudentie 1994, No. 656). This discussion is drawn from the International Task Force on Euthanasia and Assisted Suicide, Assisted Suicide & Death with Dignity: Past, Present & Future—Part III, International Perspective, available at http://www.internationaltaskforce.org/rpt2005_3.htm (accessed July 13, 2009). For additional discussion of these and other cases, see Gomez, Regulating Death; I.J. Keown, "The Law and Practice of Euthanasia in the Netherlands," Law Quarterly Review, Vol. 108, 1992, pp. 51 – 52; Herbert Hendin, Seduced by Death: Doctors, Patients, and Assisted Suicide (New York: W.W. Norton & Co., 1997); and Jonathan T. Smies, "The Legalization of Euthanasia in the Netherlands," Across Borders International Law Journal, Vol. 7, 2004.


106 Hendin, Suicide, Assisted Suicide and Euthanasia: Lessons From the Dutch Experience, Testimony Summary.


108 "The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they "terminated the lives of patients
without an explicit request’ from the patient. Another third of the physicians could conceive of doing so.” Ibid.

109 The following table demonstrates the steadily increasing numbers of reported lethal prescriptions and deaths under Oregon’s assisted suicide law.

**Eleven-year Breakdown of Reported Oregon Requests for Lethal Prescriptions and Reported Assisted Suicide Deaths from Oregon’s Annual Reports**

<table>
<thead>
<tr>
<th>Year (Year)</th>
<th>Reported Lethal Prescription Recipients</th>
<th>Reported Deaths After Lethal Drug Administration*</th>
<th>Reported Deaths from Underlying Terminal Illness</th>
<th>Reported Alive at Year’s End</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1998)</td>
<td>24</td>
<td>16</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>2 (1999)</td>
<td>33</td>
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<td>5</td>
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<td>3 (2000)</td>
<td>39</td>
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<td>8</td>
<td>5</td>
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<td>4 (2001)</td>
<td>44</td>
<td>21</td>
<td>14</td>
<td>11</td>
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<tr>
<td>5 (2002)</td>
<td>58</td>
<td>38</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>6 (2003)</td>
<td>67</td>
<td>42</td>
<td>18</td>
<td>10</td>
</tr>
<tr>
<td>7 (2004)</td>
<td>60</td>
<td>37</td>
<td>13</td>
<td>12</td>
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<td>8 (2005)</td>
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<td>9 (2006)</td>
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<td>19</td>
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<td>10 (2007)</td>
<td>85</td>
<td>49</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>11 (2008)</td>
<td>88</td>
<td>60</td>
<td>22</td>
<td>12</td>
</tr>
</tbody>
</table>

Total Reported Lethal Prescription Recipients: 627
Total Reported Deaths After Lethal Drug Administration: 401
Total Reported Deaths from Terminal Illness Within One Year of Receiving Prescription: 162
Total Reported Alive Within Year of Receiving Prescription: 101

* Annual reports note that death total includes patients who received prescriptions in previous years.
