

“Oregon Plus One” Equals Fifty?

Rita L. Marker

In May 2008, 64-year-old retired school bus driver Barbara Wagner received bad news from her doctor. She found out that her cancer, which had been in remission for two years, had returned. Then, she got some good news. Her doctor gave her a prescription that would likely slow the cancer’s growth and extend her life. She was relieved by the news and also by the fact that she had health care coverage through the Oregon Health Plan.

It didn’t take long for her hopes to be dashed.

Barbara Wagner was notified by letter that the Oregon Health Plan wouldn’t cover her prescription. But the letter didn’t leave it at that. It also notified her that, although it wouldn’t cover her prescription, it would cover assisted suicide.¹

Welcome to Oregon-style health care. Welcome to Oregon, the only state to have transformed the crime of assisted suicide into a “medical treatment.” Welcome to the state where assisted-suicide advocates say that the “Death with Dignity Act” has worked flawlessly for more than ten years. And be aware that an attempt is now underway to expand Oregon-style assisted-suicide laws into every state in the nation, using a strategy called “Oregon plus One.”

That strategy is now playing out in Washington State. But no matter how the Washington campaign ends, every state will face the same challenges in upcoming months and years.

Background

Oregon wasn’t the first state where an assisted-suicide law had been proposed. In 1991, Washington State voters rejected Initiative 119, which would have legalized both euthanasia (permitting doctors to end patients’ lives with a lethal injection) and assisted suicide (permitting doctors to prescribe an intentional deadly overdose of drugs for a patient to commit suicide). The following year, an identical proposal, called Proposition 161, was on California’s ballot. Both measures failed by a vote of 54 to 46 percent.

Recognizing that the specter of a syringe-wielding physician had played a significant role in causing voters to repulse the measures, the Hemlock Society and its spin-off group, Compassion in Dying, revised their proposal and, two years later, Measure 16, the “Oregon Death with Dignity Act” (which permits physician-assisted suicide, but not physician-administered lethal injections) appeared on Oregon’s ballot. It passed in 1994 by a vote of 51 to

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49 percent and went into effect in 1997.

The assisted-suicide groups that were behind the Oregon law thought they had found the magic solution. They fully expected that other states would soon follow. But they were wrong: Since Oregon's law passed in 1994, there have been 89 proposals in 22 states,² all modeled on Oregon's law. Each and every one met with failure.

Rather than giving up, supporters sought to determine the reason behind the stall. They turned to focus groups and polling. The result? They found that the word "suicide" (like the image of the syringe-wielding physician associated with euthanasia) was causing voter revulsion.

So they embarked on a mission to sanitize the language associated with their efforts. No longer do its advocates refer to "assisted suicide." Instead, they call it "aid in dying," "physician-assisted dying," "death with dignity," or other soft-sounding names that could apply to any number of things, including wiping a dying patient's brow. In addition, groups behind the efforts changed their names. Hemlock and Compassion in Dying merged under the new name Compassion & Choices. Working hand in hand with the Portland-based organizations, Oregon Right to Die and the Death with Dignity National Center, they developed a strategy to break the logjam.

The Plan

In 2005, a plan that would establish a new starting point—but not a new goal—was developed by the Death with Dignity National Center in conjunction with Compassion & Choices. They called it "Oregon plus One."³ They theorized that Oregon is not a trend-setting state, so at least one more state would be required to mount successful efforts in other states. That one additional state would serve as the tipping point for victory.

Before any public discussion, the Death with Dignity National Center spent almost a quarter of a million dollars setting the groundwork,⁴ described as seed money, for the campaign.⁵ Along with Compassion & Choices, it selected the state of Washington for a 2008 ballot initiative.⁶

Seattle Post-Intelligencer columnist Joel Connelly described this selection in early July 2008, just after the Washington measure qualified for the ballot: "When Initiative 1000 certified for the ballot last Thursday, few would have thought a measure legalizing physician-assisted suicide would transform Washington voters into a 'Chosen People.'"⁷ His point was clear. Washingtonians had not chosen assisted suicide. It had chosen them.

Manipulation on Parade

Assisted-suicide advocacy groups have been the driving force behind each

and every assisted-suicide proposal. Nowhere have such proposals come from the grassroots. Rarely does an activist group make an unabashed admission of its role. An exception to this, however, are the brash admissions in statements from the Death with Dignity National Center's 2007 annual report acknowledging its role in virtually every aspect of the Washington campaign:

- "We have spent the last year actively researching and collecting data to determine the state which is most likely to adopt a Death with Dignity law. Through these efforts we have identified Washington as the state."⁸

- "Campaigns, such as the one in Washington, take a great deal of time, effort, and money. In 2006-2007, we invested each of these resources in planning for a 2008 ballot initiative. We raised nearly \$250,000 to provide seed money to the campaign, and we participated in extensive early research efforts."⁹

- The Death with Dignity National Center also had a role in selecting the campaign's spokesperson, whom it described as "the popular former governor of Washington, Booth Gardner, who has taken a political and personal interest in the issue."¹⁰

- "[W]e have never had such great odds of success as we have in Washington in 2008. That is why we will be directing \$1.5 million over the next year and a half to the efforts in Washington."¹¹

- "We believe that Washington's proximity to Oregon and the state's history of enacting policies through the initiative process make Washington the most likely place for a Death with Dignity law. Our organization is providing leadership, political strategy, and financial resources to this monumental effort."¹²

The formal campaign began at the end of August 2007 with the registration of the political-action committee called the "It's My Decision Committee" (later changed to the "Yes on I-1000 Committee"). True to the decision of avoiding any mention of suicide, the committee's registration stated that it would be providing support for an "Initiative to People of Washington Regarding Care and Compassion in Dying."¹³ The drive to obtain the number of registered voters' signatures needed to put the measure on the fall ballot began in early 2008. On signature petitions as well as on the ballot, the phrase "assisted suicide" is absent. Instead, the reference is "allowing certain terminally ill competent adults to obtain lethal prescriptions."¹⁴

Newspapers, however, have continued to call Initiative 1000 an assisted-suicide measure, causing outrage among its supporters. For example, when the *Olympian*, the daily newspaper of the state capital, published an article discussing the initiative's petition drive, Louise Benoit, an assisted-suicide

supporter, wrote to the paper demanding that the wording be changed:

Section B of the Sunday edition contains a gross error in the item concerning petitions. It refers to the Booth Gardner petition I-1000 as “the assisted suicide measure.” It is officially and properly named “Death with Dignity.” This needs to have a correction printed. You are propagating an outright lie and misinformation meant to frighten people. I sincerely hope your staff will be informed that it is NEVER to be referred to as “assisted suicide.” I will be looking for an apology and a correction in the *Olympian* within a day or two.¹⁵

Benoit’s demand drew an immediate response from Vicki Kilgore, the paper’s executive editor, who stated:

The *Olympian* has chosen to use the phrase “assisted suicide” to describe the initiative because

a) This is the choice the Associated Press has made. Much of our state-wide content comes from that news service so it’s a matter of consistency; and

b) Even more important, the phrase is a simple, accurate description of the proposal. We recognize there are negative connotations attached to the word suicide, but its definition is clear—the act of taking one’s own life voluntarily and intentionally.

Our intent is to keep the explanation of the initiative as plain as possible while maintaining accuracy. Assisted suicide does that.

Nonetheless, during any and all promotion of their agenda, assisted-suicide activists will continue to demand that euphemisms replace plain language.

Spokespersons for Assisted Suicide

As noted earlier, the Death with Dignity National Center and Compassion & Choices had tapped Booth Gardner as the prime spokesperson long before the campaign became public. Gardner was a politically savvy selection. He was an incredibly popular two-term governor and remains well known and well liked in the state, even though he has been out of office for 15 years. After leaving office, he was diagnosed with Parkinson’s Disease, which makes him a sympathetic figure. On top of that, he has great personal wealth as an heir to the vast Weyerhauser¹⁶ fortune. His stepfather was Norton Clapp, one of the original owners of Seattle’s Space Needle. Gardner has pledged to back the initiative with speaking and financial support.

From the public announcement of the initiative campaign through the duration of the signature-gathering campaign, Gardner and assisted-suicide advocacy groups contributed more than \$600,000 in cash and a similar amount of in-kind donations of goods and services for the effort.¹⁷ This is only a fraction of the amount expected to be provided from July through October.¹⁸

In addition to Gardner and groups like the Death with Dignity National Center and Compassion & Choices, the campaign employed more than one

thousand on-the-ground spokespersons during the signature-gathering process. More than \$1 million was spent before the initiative even qualified for the ballot—most of it used to hire paid signature gatherers, many of whom were hired by out-of-state firms.¹⁹ Signature gatherers were paid for each person who signed petitions.

Signature gatherers were ubiquitous. They circulated petitions in venues like fairs, senior centers, farmer's markets, stores, etc. They were instructed to be friendly and quick and were told to explain that signing the petition would "simply help put this initiative on the ballot."²⁰ Two signature gatherers I encountered in mid-June at the Farmer's Market in Seattle's Wallingford district definitely adhered to the talking points.²¹

The first was a sixty-something woman, dressed in upscale Washington casual, who was stationed at an entrance to the market. She approached me and asked me to sign the "death with dignity" petition. When I inquired if it was the assisted-suicide measure she assured me that it wasn't about assisted suicide, but about people being able to make decisions regarding their own medical treatment. She followed that description by telling me that the Washington State Medical Association supported the measure. I expressed surprise, telling her that I'd heard that the WSMA was against assisted suicide. (The WSMA has publicly opposed both euthanasia and assisted suicide since 1991.) She disagreed and, for several minutes, attempted to persuade me that I was mistaken. Remaining pleasant, she again asked me to sign the petition, prefacing her request by saying my signature would only be giving others an opportunity to vote on it.

After that brief encounter, I walked through the market and, at the other entrance, was approached again—this time by a polite gentleman who also asked me to sign the "death with dignity" petition. I told him I had been asked to do so when I had first entered the market, but that I hadn't signed it. He then described the measure as an opportunity for people to make their own medical decisions. I explained to him that I was dismayed to find that the measure was being misrepresented as having support from the state medical association. He quickly moved away from any discussion of the medical association and brought out what was obviously the stock response to any reluctance to sign the petition, using a slight variation of the appeal the woman had made earlier. He told me that signing the petition did not mean that I favored it but that, by signing it, I would be giving voters the opportunity to decide a very important measure. When I declined, he moved quickly to approach another person who was walking by.

The signature gathering in Washington was successful. At the beginning of July, the "Yes on I-1000 Committee" turned in more than 300,000

signatures to the Secretary of State's office, qualifying the measure for the 2008 general-election ballot.

Implementing the Plan

The campaign strategy in Washington—which will also be used in other states—includes five elements:

1. Promote the “death with dignity” proposal as a measure that allows patients to discuss their concerns with their doctors and, after such discussions, request and receive a prescription to use only as a last resort.
2. Highlight Oregon's official annual reports to show that the state provides a model for flawless implementation of such a law.
3. Publicize studies that prove that no abuses occur when assisted suicide is legal.
4. Show that legalized assisted suicide actually improves patient care and pain control.
5. Emphasize protective safeguards.

The Fantasy of Lengthy Doctor-Patient Discussions

Proponents of legalizing assisted suicide portray it as something that would be rare. They soothingly explain that it would take place only after a patient has had lengthy discussions with a caring personal doctor. It would be only after that extensive heart-to-heart communication and only after the patient has explored all other options that the caring physician, if asked by the patient, would write a prescription for “medication” that could be taken as a last resort.

Such a scenario sounds good—but it belongs in the realm of fantasy. Today, only a minuscule number of patients have the opportunity to discuss anything at length with a physician and even fewer have a personal physician. This applies not only to the millions of people who do not have health-insurance coverage, but also to those who do. The average time a person spends at any given medical appointment is about 15 minutes—not because doctors don't want to take the time to talk to patients, but because, in the current managed-care and HMO context, doctors are under tremendous pressure to see as many patients as possible. Time, after all, is money. Furthermore, the actual treatment that is authorized often depends on cost effectiveness. The least expensive treatment for a particular condition is, more often than not, the one that is authorized by insurance companies.

Considering the fact that a prescription for assisted suicide costs less than \$100, one needs to be aware of the economic force of gravity when assisted suicide becomes a medical treatment. What could be more cost effective

than a lethal overdose of drugs?

However, assisted-suicide leaders have consistently dismissed any notion that money would drive end-of-life decisions. And they point to Oregon and, specifically, to Oregon's official reports to bolster their claim that everything is working well in that state. But Oregon's official annual reports are deeply flawed.

Oregon's Official Annual Reports

It is true that Oregon does issue annual official reports. The Oregon law, as well as the Washington proposal, mandates such reporting.²² However, information contained in those reports is questionable at best since information in them is based on self-reporting by the same doctors who are carrying out assisted suicide. Ever since the Oregon law was implemented, the problematic nature of that self-reporting has been apparent. In the official summary for the first annual report, the state noted (using rather surprising language for an official report): "For that matter the entire account [received from a prescribing doctor] could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves."²³ Furthermore, Oregon officials in charge of formulating annual reports have conceded that "there's no way to know if additional deaths went unreported" because Oregon's Department of Human Services "has no regulatory authority or resources to ensure compliance with the law."²⁴

Basing official reports on self-reporting is naive and dangerous. Consider using self-reports in other situations. For example, now that gasoline prices are so high, suppose that a state decided to save money by pulling patrol cars from freeways and replacing them with self-reporting by drivers. Suppose this self-reporting required that, after reaching their destinations, drivers were to phone an 800 number and respond to the following questions: Did you drive within the speed limit? Did you drive carefully, or recklessly? Did you use a hands-free device for your cell phone? Did you drive under the influence of alcohol or drugs?

How many drivers would report that they drove 80 in a 60 miles-per-hour zone? How many would acknowledge that they drove recklessly? Would the person who had three or four drinks before driving admit to driving under the influence?

Then, suppose there were no penalty for incomplete or inaccurate reporting and no way for the state to investigate the reports. Such a scheme would be both foolish and dangerous. Yet, that is the situation in existence pertaining to assisted suicide in Oregon. Self-reporting produces statistics. But the statistics only provide information that is unverified and unverifiable. All

that can be stated with certainty regarding the number of deaths, complications, etc. is that they reflect “reported” deaths, “reported” complications and other “reported” information. No one can say with certainty whether the reported figures are or are not accurate.

Even the reported information raises concerns. For example, the annual reports list the number of reported complications. However, physicians who submitted the data about complications indicate that they were present at only 21.7 percent of reported assisted-suicide deaths.²⁵ Thus, any information about the remaining deaths might have come from secondhand accounts of those present at the deaths²⁶ or may be based on guesswork.

Asked if there is any systematic way of determining and recording complications, Dr. Katrina Hedberg, a lead author of most of Oregon’s official reports, replied, “Not other than asking physicians.”²⁷ She acknowledged that, “after they write the prescription, the physician may not keep track of the patient.”²⁸ In addition, she said, “After we issue the annual report, we destroy the records,”²⁹ so even if any investigations were provided for under the law, there would be no way to check on information that had been submitted after one year had elapsed.

Nonetheless, Oregon’s official reports continue to be used as the basis for demonstrating that all is well under Oregon’s assisted-suicide law. A widely publicized study released in late 2007 is but one example of this.

Study Far from Neutral

In October 2007, just as the campaign for Initiative 1000 was getting underway, a study published in the *Journal of Medical Ethics*³⁰ was receiving coverage in newspapers across the country. Most of the articles about it quoted Compassion & Choices legal director Kathryn Tucker, who called the study “the most pre-eminent examination” to date showing that assisted suicide is abuse-and problem-free, even for vulnerable people.³¹ The data on which the study’s conclusions were based, however, came from Oregon’s 2007 official report. This highlights the circular nature of such data and studies. First, data are obtained from flawed official reports—and then they are used in a “neutral” study to prove the absence of problems or abuses. Subsequently, the academic study, rather than the official report, becomes the prime source cited as definitive proof that Oregon’s assisted-suicide practice is working flawlessly.

In addition to the dubious nature of the statistics used in the study, readers of the journal article and initial news coverage about it were led to believe that it had been written by dispassionate, neutral academics. Crucial affiliations of its lead author, University of Utah professor Margaret Pabst

Battin, were not disclosed. Battin has long advocated assisted suicide. She is a member of the advisory board of the Death with Dignity National Center.³² She is also a donor to the I-1000 campaign.³³ In her recent book, *Giving Death a Helping Hand*, she wrote favorably about assisted suicide becoming a normal, accepted way of dying in which people schedule death, just as they plan for other family events. In it, Battin opined that, although current assisted-suicide promotion is based on assurances that it is intended to be “safe, legal, and rare,” that stance will be subject to cultural change in which planned death becomes the norm, rather than the exception. Her view of that outcome? “I think it would be good,” she wrote. “I think it is possible to discern motion beyond the current view that physician-assisted suicide should be rare” to a time when there would be the “psychological and social freedom” within which individuals would make this manner of death an eventual part of their plans. This would, she wrote, provide the “practical and legal freedom to plan whatever family gathering, ceremonies, and religious observances they might wish—not as a desperate last resort or reactive escape from bad circumstances, but as a preemptively prudent, significant, culminative experience. How long this process of cultural change might take, and what might interrupt it or hasten it, only time will tell.”³⁴

Few readers of the *Journal of Medical Ethics* and few people who see the journal cited as a definitive study about the benign nature of Oregon’s law will be aware of its lead author’s bias.

Pain Report Deception

As it did in referring to the Battin article, Compassion & Choices used a deceptive interpretation of a report about pain policies to advance their contention that Oregon’s assisted-suicide law has been beneficial.

A headline on the assisted-suicide group’s website states, “Oregon ranks high in pain care.”³⁵ The article claims that Oregon’s “A” grade (up from “B+”) in a major national study on pain policies is proof that Oregon’s assisted-suicide law has enhanced pain control for Oregonians: “Oregon’s high standing is additional evidence of the state’s excellent pain management, thanks in large part to the Death with Dignity Act.” It continues that Washington “could learn from Oregon’s example by passing Initiative I-1000 this November.”³⁶

There is just one problem with that claim. It implies that pain *care* has improved in Oregon. However, Oregon’s “A” grade did not deal with the provision of pain control or with patients’ having better pain management. According to the actual study, issued by the University of Wisconsin School of Medicine and Public Health, Oregon’s grade was “changed from a ‘B+’

to an ‘A’ by repealing the term ‘intractable pain’ from a statute.” Furthermore, the study noted that now the policies must be implemented.³⁷

Therefore, the pain report card, although described by Compassion & Choices as evidence of Oregon’s high rank in pain *care*, has nothing to do with care. It is a study of policies, not care. No patient has ever been made more comfortable merely because a policy exists on paper.

Illusory Safeguards

The “safeguards” in Oregon’s law and in the Washington proposal are, at best, illusory. The cavalier manner in which they can be disregarded and the lack of true protections become apparent upon examination, making their true purpose transparent. They are based on political calculation, not patient protection. For example:

- **Fifteen-day waiting period:** At least 15 days must elapse between the first request and the time the prescription is written.³⁸ However, Kathryn Tucker of Compassion & Choices has acknowledged that, if challenged in court, the “fifteen-day waiting period would be struck down immediately as unduly burdensome.” She also admitted that the waiting period was included in the law solely to sway voters: “To pass, you need to have measures that *convince people* that it’s suitably protective so you see a fifteen day waiting period.”³⁹

- **Oral and written requests:** The requirement of three requests—two oral and one written⁴⁰—appears to add protection and enhance doctor-patient communication. Washington’s “Yes on I-1000 Committee” erroneously states that the proposal’s safeguards “include independently witnessed oral and written requests.”⁴¹ That claim is false. There is no requirement that oral requests be witnessed, nor do they need to be made in person. (They could actually be phoned in and left on a physician’s answering device.) The written request must be witnessed (but could be mailed or faxed to the prescribing physician). Dr. Peter Rasmussen (an advisory-board member of Compassion & Choices of Oregon who has acknowledged writing assisted-suicide prescriptions in the double digits⁴²) said that 75 percent of patients who come to him for assisted suicide are people he has never seen before. He said he spends a minimum of three hours with each patient—either in multiple visits *or by telephone conversation*—before writing the prescription.⁴³

- **Six months life expectancy:** The requirement that a patient must be “terminally ill,” defined as a prognosis of six months or less, to be “qualified” for the lethal prescription⁴⁴ is disregarded or impossible to determine. Dr. Rasmussen states, “Admittedly, we are inaccurate in prognosticating” the time of death. “We can easily be 100 percent off, but I do not think that is a problem. If we say a patient has six months to live and we are off by 100

percent and it is really three months or even twelve months, I do not think the patient is harmed in any way.”⁴⁵ Furthermore, according to a letter from Dr. Hedberg, patients who live much longer have received the deadly overdoses. Of the reported 341 patients in Oregon who died after taking a prescription for assisted suicide, 5 percent took the assisted-suicide drugs *more than 6 months* after the prescription was written. In addition, 6 patients died *more than one year* after receiving their lethal prescriptions.⁴⁶ No physician who prescribed the drugs was found to be in violation of good-faith compliance with Oregon’s law.⁴⁷

- **Mental illness and depression:** Doctors can prescribe assisted suicide for mentally ill or depressed patients. Even if a patient is mentally ill or depressed, under Oregon’s law and the Washington proposal, a referral for counseling or psychological evaluation is only required if the doctor believes that the mental illness or depression is *causing impaired judgment*.⁴⁸ According to Oregon’s tenth annual official report, *not one patient was referred for psychological evaluation or counseling before receiving a prescription for assisted suicide in 2007*.⁴⁹ Yet depressed or mentally ill patients are receiving assisted-suicide prescriptions. And information about deeply depressed patients like Michael Freeland are not found in official reports. Freeland, 64, had a 43-year history of acute depression, suicide attempts, and impaired judgment when he received a prescription for assisted suicide. Freeland’s case became public only when his family authorized release of his medical records for presentation at a meeting of the American Psychiatric Association.⁵⁰

- **Doctor shopping:** If one doctor refuses to prescribe assisted suicide for a patient, that patient can go from doctor to doctor until one is found who will write the prescription. Such was the case of Kate Cheney. After one doctor refused to write a prescription because he felt Ms. Cheney was no longer competent, her daughter took her to another physician. The second physician also refused, after determining that Ms. Cheney was competent but that her daughter was pressuring her.⁵¹ This practice of doctor shopping is not prohibited and refusal to prescribe is not included in official reports.

- **No family notification:** Because of privacy laws, physicians cannot notify family members that a loved one has requested a prescription for suicide. While Oregon’s law and the Washington proposal state that the physician “shall recommend” that a patient notify next of kin⁵² of the death request, family members may be unaware that any such decision has been made until after the death of their loved one.

- **No “safeguards” after prescription is written:** According to Oregon’s law and Washington’s initiative, a patient is to knowingly and voluntarily

request the assisted-suicide prescription.⁵³ However, *neither Oregon's law nor Washington's proposal contains any requirement that the patient knowingly and voluntarily take the deadly overdose*. Dr. Hedberg acknowledged that there is no assessment of patients after the prescribing is completed.⁵⁴ “Our job is to make sure that all the steps happened *up to the point the prescription was written*,” she said. “[T]he law itself only provides for writing the prescription, not what happens afterwards.”⁵⁵

Assisted Suicide as Cost Containment

Assisted-suicide advocates claim that it would never be used to contain health-care costs. However, facts have now shown the falsity of those claims. Proof of this came in June 2008 when Barbara Wagner's case (described at the beginning of this article) was reported. Shortly after those revelations, it became apparent that Wagner was not the only person to receive such a letter when news broke about 52-year-old Randy Stroup—who had been denied treatment, and told that the Oregon Health Plan would cover the cost of his assisted suicide. Oregonians soon learned that Wagner's and Stroup's cases were not isolated.⁵⁶ Many Oregon patients have received similar letters under Oregon's “five-year, five percent rule.”⁵⁷

Compassion & Choices and other groups supporting assisted-suicide laws have claimed that no patients chose assisted suicide because they lacked insurance coverage for treatment. To back up their claims they have pointed to official reports that indicate that 99.1 percent of patients who have died under the Oregon law had insurance (either private, Medicare, or Medicaid coverage).⁵⁸ However, both Barbara Wagner and Randy Stroup had insurance. If—instead of taking their cases to the media—they had opted for the only “treatment” that their insurance plan would cover, they would have been statistics in an official Oregon report and it would have been assumed that they had chosen assisted suicide rather than treatment.⁵⁹

There should be little doubt that there have been and will continue to be attempts to contain health-care costs, often at the expense of vulnerable patients. Legalized assisted suicide may be a “choice” for the comfortably well off, but it could eventually become the only “medical treatment” that most people with life-threatening conditions can afford.

Washington Would Require Doctors to Falsify Death Certificates

Washington's Initiative 1000 mirrors Oregon's Death with Dignity Act in virtually every way. However, one provision is unique to Washington and has shocked physicians and members of the public who have heard about it. Under the Washington proposal, doctors would be forced to lie about the

cause of death. The initiative requires that, when a patient dies after taking the prescription for assisted suicide, the physician “shall list the underlying terminal disease as the cause of death.”⁶⁰

The Washington State Medical Association’s president, Brian Wicks, M.D., described the requirement in a WSMA press release opposing the initiative:

Under I-1000, if a physician prescribes a lethal overdose, when that physician completes the death certificate, he or she is required—actually required—to list the underlying disease (say lung cancer) as the cause of death, even when the doctor knows full well that the patient died due to the suicidal overdose he or she prescribed. To my knowledge *there’s no other situation in medicine in which the death certificate is deliberately falsified*—and in which this falsification is mandated by law.⁶¹

Expansion Inevitable

During campaigns like that now taking place in Washington, assisted-suicide leaders and organizations publicly frame their agenda as an opportunity for a relatively small number of people to choose self-administered “aid in dying” in limited circumstances. However, their own statements sometimes belie this stance. In a lengthy *New York Times Magazine* cover story, Initiative 1000 spokesperson Booth Gardner provided a glimpse into expansion plans. According to the article: “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.”⁶²

Logically, expansion will take place if other states follow Oregon’s lead. Yet, some ask why expansion hasn’t taken place in Oregon, now that an assisted-suicide law has been in effect there for more than ten years. The answer is simple: Expansion plans have had to be put on hold until one or more states join Oregon in legitimizing physician-assisted suicide. After all, if other states have refused to pass laws patterned on Oregon’s current, seemingly restrictive law, it is a sure bet they would be even less likely to follow Oregon’s lead if it were to be expanded.

Conclusion

Once something is legal, it is inevitable that people begin to view it as good and moral. Once it is legalized, those who previously recoiled from an illegal practice move—ever so slowly, but ever so surely—to question whether that now-legal practice might be okay, at least in certain circumstances.

Today, in Oregon, someone waiting in line at a pharmacy to pick up

medication may overhear the pharmacist giving a prescription to the person ahead of her, instructing that person to take “all of this with a light snack and alcohol to cause death.” That is the provision of a legally permitted prescription in Oregon.

The outcome of “Oregon plus One”—in Washington and in other states—will determine whether Oregon’s experience will become common. And whether, after becoming common, it is eventually embraced as normal.

Will our children and grandchildren grow up in a society where their playmates will discuss going to grandma’s over the weekend to attend her death? Will our children and grandchildren grow up in a society where they will ask their parents why a sick relative hasn’t chosen assisted suicide yet? Will our children and grandchildren grow up in a society where vulnerable people will feel guilty for not “choosing” death?

NOTES

1. “The Gift of Treatment,” *Eugene Register-Guard*, June 6, 2008.
2. For information on failed attempts to pass Oregon-style laws, see: “Failed Attempts to Legalize Euthanasia/Assisted Suicide in the United States” (<http://www.internationaltaskforce.org/usa.htm>) and “Euthanasia & Assisted-Suicide Measures Proposed (2007)” (http://www.internationaltaskforce.org/us_bills.htm).
3. Oregon plus One proposal, received November 2005 (on file with author).
4. Death with Dignity National Center, IRS Form 990 for 2006, filed Mar. 31, 2007, indicates that the organization spent \$243,237 on the Oregon Plus One program the previous year. Available at: http://www.dwd.org/documents/06X_7065CLNT_V1.PDF (last accessed July 22, 2008).
5. Death with Dignity National Center, 2007 Report, p. 3. Available at: <http://www.deathwithdignity.org/documents/DDNC2007annualreport.pdf> (last accessed July 22, 2008).
6. Supra note 3.
7. Joel Connelly, “Assisted suicide gets push from out of state,” *Seattle Post-Intelligencer*, July 27, 2008.
8. Supra note 5.
9. *Ibid.*
10. *Ibid.*, p. 5.
11. *Ibid.*
12. *Ibid.*
13. “It’s My Decision Committee” C-1 report form, filed with Washington State Public Disclosure Commission, Aug. 23, 2007.
14. Initiative 1000: Ballot Title, Statement of Subject.
15. “‘Assisted suicide’ describes initiative correctly,” *The Olympian*, July 15, 2008. Available at: <http://www.theolympian.com/210/story/507284.html> (last accessed Aug. 11, 2008).
16. Weyerhaeuser is one of the world’s largest pulp and paper companies. It is the world’s largest private owner of softwood timberland. The company has more than 40,000 employees in 18 countries.
17. See: “Funding for WA Assisted-Suicide Initiative (I-1000)” at <http://www.internationaltaskforce.org/funding.htm>. Information at that site compiled from information obtained from the Washington State Public Disclosure Commission website: <http://www.pdc.wa.gov/>.
18. Because all voting is done by mail in 37 of Washington’s 39 counties, most television and radio advertising is expected to take place before mid-October when voters will begin to cast their ballots.

19. An advertisement on Craig's List from National Ballot Access, a national firm that recruits paid signature gatherers, stated that petition circulators "make over \$1000 a week at an average of about \$20 to \$30 an hour" (March 24, 2008 posting on Craig's List). A similar firm, the California-based Progressive Campaigns, Inc. was also a signature vendor for I-1000.
20. "Tried and True Signature Gathering Tips," prepared by Active Roots Consulting, Inc. Distributed at a Kick-Off Meeting for prospective signature gatherers; Spokane, WA; Feb. 23, 2008.
21. Wallingford Farmer's Market, June 25, 2008. (I had been traveling in Washington for meetings, interviews, and presentations in June. When I arrived early for a meeting in the Wallingford area in June, I saw the Farmer's Market and decided to walk through it for a few minutes.)
22. Documented information about flaws in Oregon's reporting system is available at "Ten Years of Assisted Suicide in Oregon" (<http://www.internationaltaskforce.org/orrpt10.htm>). Official reports that are mandated in the Washington proposal would contain the same problems with verification and enforcement.
23. Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999), p. 2 (<http://egov.oregon.gov/DHS/ph/cdsummary/1999/ohd4806.pdf>).
24. Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News*, Sept. 7, 1998.
25. DHS, "Tenth Annual Report on Oregon's Death with Dignity Act," March 18, 2008, Table I (<http://www.oregon.gov/DHS/ph/pas/docs/yr10-tbl-1.pdf>) (last accessed Aug. 1, 2008). The annual report states that the presence of the attending physician in 74 out of 341 reported deaths is 27.9 percent, but the calculation is mathematically inaccurate. The correct calculation is 21.7 percent.
26. DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods" (<http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf>).
27. Testimony of Dr. Katrina Hedberg before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*, Apr. 4, 2005, p. 263, question 597. Note: The hearings were held in Portland, Oregon, during December 2004, but they were published in April 2005. Available at: <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf> (last accessed March 19, 2008).
28. *Ibid.*, p. 259, question 567.
29. *Ibid.*, p. 262, question 592.
30. Margaret Pabst Battin *et al.*, "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable groups,'" *Journal of Medical Ethics*, Vol. 33, pp. 591-597 (Oct. 2007).
31. See, for example: Kristen Stewart, "U. study shows no abuse of legal doctor-assisted suicide," *Salt Lake Tribune*, Sept. 26, 2007.
32. DDNC website (<http://www.dwd.org/whatwedo/staff.asp>) (last accessed July 29, 2008).
33. "Yes on I-1000" C-3 report form, filed with Washington State Public Disclosure Commission, Record No. 100263159, July 22, 2008.
34. Margaret Pabst Battin, "Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future," 46, 37-47, in *Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy. An International Perspective*, Dieter Birnbacher & Edgar Dahl eds., Springer, 2008.
35. "Oregon Ranks High in Pain Care Study," July 15, 2008, Compassion & Choices web site, Top Stories (<http://www.compassionandchoices.org>) (last accessed July 21, 2008).
36. *Ibid.*
37. University of Wisconsin School of Medicine and Public Health, *Achieving Balance: 2008 Pain and Policy Report Card and Evaluation Guide: Grade Changes between 2007 and 2008* (http://www.painpolicy.wisc.edu/Achieving_Balance/index.htm) (last accessed, July 19, 2008).
38. ORS 127.840 §3.06 and WA I-1000, Sec. 9.
39. Transcript of presentation by Kathryn Tucker, legal counsel for Compassion & Choices, Seattle Pacific University address, "What's at Stake with Assisted Suicide," July 12, 1997.
40. Requirements for requesting assisted suicide: Oregon - ORS 127.306, §6.01 & ORS 127.897, §6.01; WA I-1000, Sec. 9 & Sec. 22.
41. "No on Assisted Suicide Lies," *Yes! on I-1000* website (<http://www.itsmydecision.org/default.aspx?ID=44>) (last accessed July 30, 2008).
42. "Challenge to Oregon's Assisted Suicide Law" transcript, *To the Point*, Public Radio International, Santa Monica, CA, Feb. 23, 2005, p. 5.

43. Andis Robeznieks, "Oregon sees few numbers of physician-assisted suicides," *American Medical News*, Apr. 4, 2005.
44. ORS 127.800 (12) & ORS 127.805 §2.01(1) and WA I-1000, Sec.1(13) & Sec. 2 (1).
45. Testimony of Peter Rasmussen before the 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*, Apr. 4, 2005, p. 312, question 842.
46. Letter from Dr. Katrina Hedberg to Duane French, June 13, 2008 (on file with author).
47. *Ibid.*
48. ORS 127.825 §3.03 & WA I-1000, Sec. 6.
49. Supra note 25.
50. N. Gregory Hamilton, M.D., and Catherine Hamilton, M.A., "Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report," presented at the American Psychiatric Association Annual Meeting, New York, NY, May 6, 2004.
51. Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
52. ORS 127.835 §3.05 and WA I-1000, Sec. 8.
53. See the patient and witness statements contained in the form for the written request in ORS 127.897 §6.01 and WA I-1000, Sec. 22.
54. Supra note 27, p. 259, question 566.
55. *Ibid.*, p. 259, question 567. (Emphasis added.)
56. Dan Springer, "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," *FOX News*, July 28, 2008 (<http://www.foxnews.com/story/0,2933,392962,00.html>) (last accessed July 29, 2008); and Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," *ABC News*, Aug. 6, 2008 (<http://abcnews.go.com/Health/story?id=5517492&page=1>) (last accessed Aug. 8, 2008).
57. Under the "five year, five percent rule," the Oregon Health Plan won't approve payment for treatment that doesn't provide at least a five percent chance of survival after five years. However, the basis for the five-year survival rate is based on cancer and other life-threatening-disease prognoses that are more than 15 years old. ("State Denies Cancer Treatment," *KATU Channel 2 TV News*, Portland, Oregon, July 30, 2008.) Oregon includes the payment for assisted suicide in its prioritized listing of services under "comfort/palliative care." "Health Service Commission Current Prioritized List," Apr. 1, 2008 (http://www.oregon.gov/OHPPR/HSC/current_prior.shtml) (last accessed July 29, 2008). The prioritized list describes the five year, five percent rule in its "Statement of Intent for the April 1, 2008 Prioritized List of Health Services. The section regarding "Comfort/Palliative Care" lists "Services under ORS 127.800-127.887 (Oregon Death with Dignity Act), to include but not be limited to the attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications" among the services available to those who are denied treatment under the five year, five percent rule (<http://www.oregon.gov/OHPPR/HSC/docs/Apr08list.pdf>, p. 93) (last accessed Aug. 1, 2008).
58. Supra note 25.
59. Barbara Wagner's and Randy Stroup's stories have happy endings. The manufacturer of the cancer drug that Wagner's doctor had prescribed is now providing it to her without charge. Stroup successfully appealed his case and is currently receiving the medication prescribed by his doctor.
60. WA I-1000, Sec. 4, (1)(ii)(B)(2).
61. "As I-1000 Signatures are Counted, Washington State Medical Association Opposition to Physician-Assisted Suicide Reiterated," *Reuters*, July 2, 2008. (Emphasis added.)
62. Daniel Bergner, "Death in the Family," *The New York Times Magazine*, Dec. 2, 2007 (<http://www.nytimes.com/2007/12/02/magazine/02suicide-t.html>) (last accessed Aug. 1, 2008). Also see, for example, Rita L. Marker, "Euthanasia, Assisted Suicide & Health Care Decisions: Protecting Yourself and Your Family" (http://www.internationaltaskforce.org/rpt2006_1.htm); "Revealing Quotes from Those in the Know" (http://www.internationaltaskforce.org/Revealing_Quotes_03_20_08.pdf); "Assisted Suicide: Not for Adults Only?" (<http://www.internationaltaskforce.org/noa.htm>).