

PRESS RELEASE - March 5, 2010

Physician Assisted Suicide in Washington State, 2009 DOH Release of Information

Washington state's Department of Health (DOH) yesterday released its first ever tabulation of physician-assisted suicides. This was based on information from Washington physicians and pharmacists who, in 2009, issued fatal overdoses sought by 63 patients who were thought to have 6 months or less to live before they were expected to die naturally from illness.

Washington's assisted suicide law, officially known as the "Death with Dignity Act" was passed by initiative (I-1000) in November 2008 and enacted March 5, 2009.

[It is difficult to know how complete this information is, as, under the Act, there is no specific penalty for failure to provide this information to DOH; DOH notes they will contact the involved party should information not be received. It is unclear however how they would know to contact a physician or pharmacist if no information at all is received.]

With the above caveat in mind, following is an overview of information released yesterday and pertaining to the period from enactment, March 5, 2009, through December 31, 2009, along with several of PCCEF WA's concerns.

- **A fatal overdose is known to have been issued to 63 patients, or their agents**, in 2009 as follows:
 - A barbiturate overdose was issued in the name of 47 patients and of these, 36 patients died after ingestion, 7 died without ingesting the drug, and ingestion status was unknown for the remaining 4.
 - Fatal overdoses (drug type not specified) were issued to an additional 16 patients (whose status was unknown at the time of DOH's information compilation)
- **Only 7%, or 3 patients, was referred for psychiatric evaluation—despite the fact that the primary reason people attempt and die from suicide is underlying depression.** There is no substantiated basis on which to presume that depression is not likewise a very significant factor among patients seeking assisted suicide after learning of a poor prognosis and short life expectancy. Yet, inexplicably, there is no requirement that a patient be evaluated by a psychiatrist or psychologist to rule out depression or other psychiatric disorder which might readily respond to treatment which in turn may lead to resolution of the thoughts and plans of suicide. Under the Act, referral for such an evaluation is left entirely up to the "attending physician" and "consulting physician", neither of whom may have any experience whatsoever in identifying and treating depression, anxiety, or other distressing and potentially contributory disorders.
- **The top concerns of those to whom a fatal overdose was issued** (as cited by the 44 for whom information was available to DOH), were:
 1. Concerns about losing autonomy (100%)
 2. Decreased ability to engage in activities making life enjoyable (91%)

3. (Perceived) loss of dignity (82%)

- The fourth most commonly cited concern was losing control of bodily functions (41%) **Thus, acquired or fear of acquiring in the future a disability of one sort or another (loss of control or loss of functional ability) was the most prominent overriding factor driving these patients to assisted suicide.**
- Additionally, about a **quarter of patients had concerns that they were a burden** on family, friends, or caregivers and the same percentage had concerns about inadequate pain control or actual inadequate pain control (unspecified.)
- **The physician who wrote for the fatal overdose was present at the time it was ingested in only 3 of the 36 cases.**
- In 17 other cases, another “provider” of some sort was present at death. In 12 cases, no provider was present and in 4 cases, it was unknown. **Who are these witnesses to death? Are they advocates of assisted suicide, such as associates of Compassion & Choices, the advocacy organization that was involved in 97% of assisted suicide deaths in Oregon in 2009? C & C arose from the original Hemlock Society and was the chief group behind legalizing assisted suicide in Washington.)**
- **In the remaining 45% of cases, we have no information as to whether anyone was present with the patient when they died. Did they die alone?**
- One patient was known to have regurgitated the drug and 2 others to have awakened after taking it. Patients were known to have died between 9 minutes and 28 hours after ingestion.
- The drug **may have been issued months earlier (10 months earlier in one case, highlighting the difficulty in predicting life expectancy). Without an unbiased, disinterested witness at death, there is no way to know if the patient was of sound mind and making an informed choice when the actual ingestion took place, or even if the patient ingested it voluntarily.**
- The median **duration of patient-physician relationship** was not included in the information released by DOH but it **was as little as 3 weeks in one case and no more than 6 months in over half of the cases.** This may be a consequence of the fact that most physicians believe in and honor their Hippocratic Oath which precludes assisting in a patient’s suicide. It is the long-standing position of the Washington State Medical Association, the American Medical Association, the American College of Physicians-American Board of Internal Medicine and other major physicians’ associations to oppose physician-assisted suicide. **Washington physicians may also be offended by the Act’s unusual requirement that the overdose-writing physician falsify the death certificate and list the cause of death as natural, even while simultaneously reporting to DOH that it occurred due to lethal overdose.**

Physicians for Compassionate Care Education Foundation Washington promotes the ethic that all human life has inherent value and that physician-assisted suicide:

- *Undermines trust in the patient-physician relationship*
- *Changes the societal role of the physician from healing to medical killing*
- *Endangers the value that society places on life, specifically for those who are most vulnerable, those who are frail, elderly, and at the end of life.*