

"Death With Dignity": A Recipe For Elder Abuse and Homicide (Albeit Not By Name)

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Death with Dignity Acts in Oregon and Washington authorize physicians to write life-ending prescriptions for their patients.¹ Oregon's Act went into effect thirteen years ago.² Washington's Act was passed as a citizen's initiative in 2008 and went into effect in 2009.³ Both Acts are touted as providing "choice" and "control" for end-of-life decisions. During Washington's election, the "For Statement" in the voters' pamphlet declared: "Only the patient – and no one else – may administer the [lethal dose]."⁴ Washington's Act, however, does not say this anywhere. In fact, neither Act even requires the patient's consent when the lethal dose is administered.⁵ These problems and other problems are discussed below.

How the Acts Work

Both Acts have an application process to obtain the lethal dose, which includes a written request form with two required witnesses.⁶ One of these witnesses is allowed to be the patient's

¹ Or. Rev. Stat. § 127.815 § 3.01(1)(k) (2009); Wash. Rev. Code Ann. § 70.245.040(1)(k) (West 2009).

² Or. Rev. Stat. §§ 127.800-995. Oregon's physician-assisted suicide act was passed as Ballot Measure 16 in 1994 and went into effect in 1997. *See* act, available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ors.aspx>

³ Wash. Rev. Code Ann. § 70.245.903. Washington's Death with Dignity Act was passed as Initiative 1000 on November 4, 2008 and went into effect on March 5, 2009. *See* Washington State Dept. of Health, Ctr. for Health Statistics, Death with Dignity Act, available at <http://www.doh.wa.gov/dwda/default.htm>. The full text of the Act is available at <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245>

⁴ The voters' pamphlet for Initiative 1000 can be viewed on the Washington State Secretary of State website, for previous elections. Click on this link: <http://wei.secstate.wa.gov/osos/en/PreviousElections/Pages/default.aspx>. Then go to the 2008 General Election and follow the prompts to view the "For Statement" for Initiative Measure 1000.

⁵ *See* Wash. Rev. Code Ann. § 70.245.010-904, available at <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.245> and Or. Rev. Stat. § 127.800-995, available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/statute.pdf>

⁶ Wash. Rev. Code Ann. § 70.245.030(1); Or. Rev. Stat. § 127.810 § 2.02(1). *See* the Acts' official lethal dose request forms requiring two witnesses, Washington State Dept. of Health, Request for Medication to End My Life in a Humane and Dignified Manner, available at <http://www.doh.wa.gov/dwda/forms/WrittenRequest.pdf>; Oregon State

heir, who will benefit from the death.⁷ Once the lethal dose is issued by the pharmacy, there is no supervision over its administration.⁸ The death is not required to be witnessed by disinterested persons.⁹ No one is required to be present.¹⁰

A Comparison to Probate Law

When signing a will, having an heir act as one of the witnesses can support a finding of undue influence. Washington's probate code, for example, states that when one of two witnesses is a taker under the will, there is a rebuttal presumption that the taker/witness "procured the gift by duress, menace, fraud, or undue influence."¹¹

Other states have similar laws. Consider *Burns v. Kabboul*, which states: "[i]t will weigh heavily against the proponent [of the will] on the issue of undue influence when the proponent was . . . present at [its] dictation"¹² The lethal dose request process, which allows an heir to act as a witness on the request form, does not promote patient choice. It invites coercion.

A Relaxed Standard of Competency

In Washington, patients signing the lethal dose request form are required to be "competent."¹³ In Oregon, patients are required to be "capable."¹⁴ Regardless of the term used, this is a relaxed standard *in which someone other than the patient is allowed to speak for the*

Dept. of Health, Request for Medication to End My Life in a humane and Dignified Manner (Apr. 2006), available at <http://www.public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/pt-req.pdf>

⁷ See Wash. Rev. Code Ann. §§ 70.245.030 and 70.245.220; see also Or. Rev. Stat. §§ 127.810 § 2.02, 127.897 § 6.01 (providing that one of two required witnesses on the lethal dose request form cannot be a patient's heir or other person who will benefit from the patient's death; the other witness may be an heir or other person who will benefit from the death). These provisions can be viewed via the links at note 5, *supra*.

⁸ See generally Wash. Rev. Code Ann. §§ 70.245.010-904 and Or. Rev. Stat. §§ 127.800-995. These provision can be viewed via the links at note 5, *supra*.

⁹ *Id.*

¹⁰ *Id.*

¹¹ Wash. Rev. Code Ann. § 11.12.160(2), available at http://www.margaretdore.com/pdf/D-RCW-11.12.160_001.pdf

¹² *Burns v. Kabboul*, 595 A.2d 1153, 1163 (Pa. Super. Ct. 1991).

¹³ Wash. Rev. Code Ann. § 70.245.010(11) (defining a "qualified patient" as a "competent adult.")

¹⁴ Or. Rev. Stat. § 127.800 § 1.01(11) (defining a "qualified patient" as a "capable adult.")

patient. For example, the Washington Act states: "Competent' means . . . a patient has the ability to make and communicate an informed decision . . . , including communication through persons familiar with the patient's manner of communicating"15

There is no requirement that the person speaking for the patient be a designated agent such as an attorney-in-fact.¹⁶ The person could be an heir or a new "best friend."¹⁷ Regardless, without a requirement of strict competency, both Acts set the stage for undue influence by heirs and others who will benefit from the patient's death.¹⁸

No Mental Standard or Consent Required at the Time of Administration

Neither Act requires that the patient be competent, capable, or even aware when the lethal dose is administered.¹⁹ There is also no language requiring the patient's consent at the time of administration.²⁰ Without these requirements, when the lethal dose is administered, the Acts again set the stage for undue influence and worse.

"Doctor Shopping"

Under both Acts, the initial decision as to whether the patient is "competent" or "capable"

¹⁵ Wash. Rev. Code Ann. § 70.245.010(3) (emphasis added). The Oregon Act has similar language. See Or. Rev. Stat. § 127.800 § 1.01(3)(stating "[c]apable' means . . . a patient has the ability to make and communicate health care decisions . . . , including communication through persons familiar with the patient's manner of communicating" (Emphasis added).

¹⁶ See generally Wash. Rev. Code Ann. §§ 70.245.010-904 and Or. Rev. Stat. §§ 127.800-995. These provisions can be viewed via the links at note 5, *supra*.

¹⁷ *Id.* For a discussion of new "best friends" and other signs of elder financial abuse, see MetLife Mature Market Institutions, Study: Broken Trust: Elders, Family, and Finances: A Study on Elder Financial Abuse Prevention, March 2009, at 22-23, available at <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>

¹⁸ See e.g., Mont. Code Ann. § 28 2-407(2) (defining undue influence as "taking an unfair advantage of another's weakness of mind"); *Burns v. Kabboul*, 595 A.2d at 1162 (describing "weakened intellect" as a factor for undue influence).

¹⁹ Both Acts only address whether the patient is "competent" or "capable" in conjunction with the lethal dose request, and not later at the time of administration. See Wash. Rev. Code Ann. §§ 70.245.010(3)(5)(11), 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220 (regarding "sound mind"); Or. Rev. Stat. §§ 127.800 § 1.01(3)(5)(11), 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(3), 127.897 § 6.01 (regarding "sound mind.")

²⁰ Both Acts contain provisions requiring that a determination of whether a patient is acting "voluntarily" be made in conjunction with the lethal dose request, not later. See Wash. Rev. Code Ann. §§ 70.245.020(1), 70.245.030(1), 70.245.040(1)(a)(d), 70.245.050, 70.245.120(3)(4), 70.245.220; Or. Rev. Stat. §§ 127.805 § 2.01(1), 127.810 § 2.02(1), 127.815 § 3.01(1)(a)(d), 127.820 § 3.02, 127.855 § 3.09(3), 127.855 § 3.09(4), 127.897 § 6.01.

is made by the doctor who will be prescribing the lethal dose (the "attending physician").²¹ As a safeguard, this doctor is required to obtain a second opinion from a "consulting physician."²² In practice, this requirement is circumvented through "doctor shopping." Dr. Charles Bentz describes the following incident:

[My patient's cancer specialist] asked me to be the "second opinion" for his suicide . . . I told her that assisted-suicide was not appropriate for this patient and that I did NOT concur . . . [A]pproximately two weeks later my patient was dead from an overdose prescribed by this doctor²³

In other words, the prescribing doctor asks multiple doctors to give the second opinion until one agrees to do so.

"Self-administer" Does Not Necessarily Mean That a Patient Administers the Lethal Dose to Himself

Both acts imply that patients administer the lethal dose to themselves. There is, however, nothing in either Act that requires this. There is no language that "only" the patient can administer the lethal dose to himself.²⁴

The Washington Act instead states that the patient may "self-administer" the dose.²⁵ In an Orwellian twist, the term "self-administer" does not mean that administration will necessarily be by the patient. "Self-administer" is instead defined as the patient's "act of ingesting." The Washington Act states: "'Self-administer' means a qualified patient's act of ingesting medication

²¹ Wash. Rev. Code Ann. § 70.245.040(1)(a); Or. Rev. Stat. § 127.815 § 3.01(1)(a).

²² Wash. Rev. Code Ann. § 70.245.040(1)(d) (requiring the attending physician to refer the patient to a consulting physician to confirm that the patient is "competent"); Or. Rev. Stat. § 127.815 § 3.01(1)(d) (requiring the attending physician to refer the patient to a consulting physician "for a determination that the patient is capable")

²³ Charles Bentz, Letter to the Editor, "Don't Follow Oregon's Lead: Say No to Assisted Suicide," *The Advocate*, official publication of the Idaho State Bar, December 2010, available at http://www.margaretdore.com/info/Bentz_Letter.pdf. See also Ian Dowbiggin, A CONCISE HISTORY OF EUTHANASIA, Rowman and Littlefield Publishers, Inc., 146 (2005) ("Barbara Coombs Lee of Compassion and Dying [now Compassion and Choices] told the *Washington Post* in 1998: 'if I get rebuffed by one doctor, I can go to another' to get the necessary signatures.") See link to book at <http://www.amazon.com/Concise-History-Euthanasia-Medicine-Critical/dp/0742531104>.

²⁴ See supra at Introduction, note 5 and accompanying text. See also Wash. Rev. Code Ann. §§ 70.245.010-904 and Or. Rev. Stat. §§127.800-995.

²⁵ See Wash. Rev. Code Ann. §§ 70.245.010(7)(11)(12), 70.245.020(1), 70.245.090, 70.245.170, 70.245.220.

to end his or her life . . ." (Emphasis added).²⁶

In other words, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby "ingest" the dose.²⁷ Someone else putting the lethal dose in a feeding tube or IV nutrition bag will also qualify because the patient will thereby "absorb" the dose, i.e., "ingest" it.²⁸

Oregon's Act does not use the term "self-administer."^{29 30} Official forms for both Acts also refer to administration as "ingestion," "ingesting," and other forms of the word "ingest." *See*, for example, Washington's "Attending Physician's After Death Reporting Form."³¹ With administration defined as mere ingestion, someone else is allowed to administer the lethal dose to the patient.

Both Acts Allow Involuntary Killing

In summary, someone other than the patient is allowed to administer the lethal dose.³² The Acts contain no requirement that the patient be competent, capable, or even aware when the lethal dose is administered.³³ There is no requirement that the patient consent when the lethal

²⁶ Wash. Rev. Code Ann. § 70.245.010(12)

²⁷ Neither Act defines "ingest." *See* Wash. Rev. Code Ann. §§ 70.245.010-904 and Or. Rev. Stat. §§127.800-995. Dictionary definitions include "to take(food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing" (emphasis added). Webster's New World College Dictionary, www.yourdictionary.com/ingest.

²⁸ Webster's New World College Dictionary, *supra* note 27.

²⁹ *See* Or. Rev. Stat. §§ 127.800-995.

³⁰ Or. Rev. Stat. § 127.875 § 3.13 (stating "[n]either shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy." (Emphasis added)).

³¹ *See* Washington State Dept. of Health, Attending Physician's After Death Reporting Form, (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest"), *available at* http://www.margaretdore.com/info/WA_doctor_death_report_001.pdf. *See also* Oregon Dept. of Human Servs., Oregon's Death With Dignity Act Attending Physician Interview Form (referring to administration of the lethal dose as "ingestion," "ingesting," and other forms of the word "ingest."), *available at* http://www.margaretdore.com/info/OR_doctor_death_rpt_form_001.pdf

³² *Supra* notes 24-31 and accompanying text.

³³ *Supra* notes 19-20 and accompanying text.

dose is administered.³⁴

Intentionally killing an incompetent or unaware person, or intentionally killing some other person without his consent, is homicide.³⁵ Both Acts, however, allow this result as long as the action taken is "in accordance with" the Act. For example, Washington's Act states: "Actions taken in accordance with this chapter do not, for any purpose, constitute . . . homicide, under the law."³⁶

The Acts' Official Reports and Forms Provide Further Support That the Acts Allow Involuntary Killing

Under both Acts, physicians and pharmacists who participate in the lethal dose request process are required to complete official forms. The data collected is summarized in annual statistical reports, which are displayed on official web sites.³⁷

None of these official forms and reports ask about, or report on, patient competency, consent, or awareness at the time of administration, or whether the patient administered the lethal dose to himself.³⁸ These factors are not relevant to compliance with either Act.

Counter Arguments

Proponents sometimes argue that "only" the patient can administer the lethal dose because both Acts prohibit mercy killing and active euthanasia (another name for mercy killing).³⁹ This argument is word play. The prohibition against mercy killing and euthanasia is defined away in the next sentence. For example, the Washington Act states: "Nothing in this chapter authorizes . . . mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for

³⁴ *Id.*

³⁵ Cf. Wash. Rev. Code Ann. §§ 9A.32.010 (defining "homicide"), 9A.32.020 (regarding "premeditation"), 9A.32.030 (defining "murder in the first degree") and Or. Rev. Stat. § 163.005 (defining "criminal homicide.")

³⁶ Wash. Rev. Code Ann. § 70.245.180(1); Or. Rev. Stat. § 127.880 § 3.14 (stating that "[a]ctions taken in accordance with [this Act] shall not for any purpose, constitute . . . homicide, under the law.").

³⁷ See Oregon Dep't of Human Servs., Death With Dignity Act website, available at <http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ar-index.aspx>. See also Washington State Dep't of Health Ctr. For Health Statistics, Death with Dignity Act, available at <http://www.doh.wa.gov/dwda> (last visited Mar. 22, 2010).

³⁸ *Id.*

³⁹ Webster's New World College Dictionary, <http://www.yourdictionary.com/mercy-killing> (last visited May 28, 2011) (defining "mercy killing" as "euthanasia.")

any purpose, constitute . . . mercy killing [also known as 'euthanasia']"⁴⁰

Proponents may also argue that patient consent is required because patients may rescind the request for the lethal dose "at any time."⁴¹ A provision that a patient "may" rescind is not, however, the same thing as a right to give consent when the lethal dose is administered. Consider, for example, a patient who obtained the dose on a "just-in-case" basis without consenting to taking it. If such patient would later become incompetent, be sedated, or simply be sleeping, he would not have the ability to rescind. Without the right to consent, someone else could, nonetheless, administer the lethal dose to him. Without the right to consent, the patient's promised control over the "time, place, and manner" of his death is an illusion.

Finally, proponents may argue that the Acts protect patients due to provisions that impose civil and criminal liability.⁴² None of these provisions penalize administration of the lethal dose without the patient's consent.⁴³

No Witness at the Death

If, for the purpose of argument, the Acts do not "allow" a patient's death without his consent, patients are, nonetheless, unprotected from this result due to the lack of required witnesses at the death.⁴⁴ Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi.

This scenario would seem especially significant for patients with money. A California case, *People v. Stuart*, states: "[F]inancial considerations [are] an all too common motivation for killing someone"⁴⁵

⁴⁰ Wash. Rev. Code Ann. § 70.245.180(1); Or. Rev. Stat. § 127.880 § 3.14 (stating that "[n]othing in [this chapter] shall be construed to authorize . . . mercy killing or active euthanasia. *Actions taken in accordance with [this chapter] shall not, for any purpose, constitute . . . mercy killing [also known as 'euthanasia']*" (Emphasis added)).

⁴¹ Wash. Rev. Code Ann. § 70.245.100; Or. Rev. Stat. § 127.845 § 3.07.

⁴² Wash. Rev. Code Ann. § 70.245.200; Or. Rev. Stat. § 127.890 § 4.02.

⁴³ *Id.*

⁴⁴ See Washington and Oregon Acts in their entirety. Wash. Rev. Code Ann. §§ 70.245.010-904; Or. Rev. Stat. §§ 127.800-995 (lacking a requirement that administration be witnessed by a disinterested party or anyone at all).

⁴⁵ *People v. Stuart*, 67 Cal. Rptr. 3d 129, 143 (Cal. App. 2007)(daughter had killed her mother with a pillow).

Official Cover

In Washington, a further alibi is provided by a reporting requirement that medical examiners, coroners, and even prosecuting attorneys treat the death as "natural."⁴⁶ Any death certificate not complying with this requirement is to be rejected by the Washington State Registrar.⁴⁷ In Oregon, the Act and official forms do not explicitly require that the death to be treated as natural.⁴⁸ This is, however, the implication of § 127.880 § 314, which states: "Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." Under local practice, the deaths are treated as natural.⁴⁹

Illusory Liability for Undue Influence

Both Acts impose criminal, but not civil liability for undue influence in connection with the lethal dose request.⁵⁰ Undue influence, as described in the Oregon and Washington Acts, does not appear capable of being criminally enforced.

Neither Act defines undue influence or provides elements of proof.⁵¹ Undue influence is also a traditionally equitable concept "not susceptible of precise definition . . ."⁵² For example,

⁴⁶ See Washington State Dep't of Health, "Instructions for Medical Examiners, Coroners, and Prosecuting Attorneys: Compliance with the Death with Dignity Act" (last visited May 28, 2011), *available at* <http://www.doh.wa.gov/dwda/forms/MEsAndCoroners.pdf>.

⁴⁷ *Id.*

⁴⁸ Or. Rev. Stat. §§ 127.800-995.

⁴⁹ See Bentz, *supra* note 23 ("[My patient's] death certificate, filled out by this doctor, listed the cause of death as melanoma [not assisted suicide].")

⁵⁰ Wash. Rev. Code Ann. § 70.245.200(2) (stating that "[a] person who coerces or exerts undue influence on a patient to request medication to end the patient's life . . . is guilty of a Class A felony.") The Oregon statute has nearly identical language. See Or. Rev. Stat. § 127.890 § 4.02(2) (stating that "[a] person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life . . . shall be guilty of a Class A felony.")

⁵¹ See Washington and Oregon Acts in their entirety. Wash. Rev. Code Ann. §§70.245.010-904; Or. Rev. Stat. §§ 127.800-995.

⁵² Mark Reutlinger, *Washington Law of Wills and Intestate Succession*, Washington State Bar Association 88 (2006).

in Washington, the test for undue influence consists of multiple nonexclusive factors.⁵³ With this situation, the "crime" of undue influence appears too undefined and/or vague to be enforced.⁵⁴

Both Acts also allow conduct that would generally provide proof of undue influence (allowing an heir to act as a witness on the lethal dose request form).⁵⁵ How do you prove beyond a reasonable doubt that undue influence occurred when the Act prohibiting undue influence also specifically allows conduct used to prove undue influence? It's hard to say. The purported criminal liability appears to be illusory.

The Annual Reports are Consistent with Elder Abuse

As noted above, both Acts require annual statistical reports.⁵⁶ Washington has generated two reports.⁵⁷ In Oregon, there have been thirteen reports.⁵⁸

In Oregon and Washington, the annual reports do not track income or net worth.⁵⁹ They do, however, show that the majority of people who have died under the Acts have been well-educated.⁶⁰ Typically, people with this attributes would be those with money, i.e., the middle class and above. The statistics also show that the majority of persons dying have been age sixty-

⁵³ *Estate of Lint*, 957 P.2d 755, 764 (Wash. 1998) (stating the test for undue influence: "The most important of such facts are (1) that the beneficiary occupied a fiduciary or confidential relation to the testator; (2) that the beneficiary actively participated in the preparation or procurement of the will; and (3) that the beneficiary received an unusually or unnaturally large part of the estate. Added to these may be other considerations, such as the age or condition of health and mental vigor of the testator, . . .")

⁵⁴ Compare *City of Tacoma v. Luvene*, 827 P.2d 1374, 1384 (Wash. 1992) (stating that prohibited conduct must be defined "with sufficiently specificity to put citizens on notice of what conduct they must avoid . . ."); see also *Mays v. State*, 68 P.3d 1114, 1120-21 (Wash. App. 2003) (holding a statute unconstitutionally vague where "reasonably intelligent persons must guess at its meaning.")

⁵⁵ *Supra* notes 6-12 and accompanying text.

⁵⁶ Wash. Rev. Code Ann. § 70.245.150(3); Or. Rev. Stat. § 127.865 § 3.11(3).

⁵⁷ See <http://www.doh.wa.gov/dwda/default.htm>

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<http://www.public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

⁵⁹ *Id.*; see *supra* note 57.

⁶⁰ See e.g. Oregon's Annual Report for 2010, available at <http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/documents/year13.pdf> ("Of the 65 patients who died under DWDA in 2010, most (70.8%) were over age 65 years; the median age was 72 years. As in previous years, most were white (100%), well-educated (42.2% had a[t] least a baccalaureate degree) . . .")

five or older.⁶¹

These statistics can be explained by older persons with money feeling a "duty to die" so as to pass on funds to their heirs.⁶² The statistics are also consistent with elder abuse. A recent MetLife Mature Market Institute Study states that "[e]lders' vulnerabilities and larger net worth make them a prime target for financial abuse . . . [v]ictims may even be murdered by perpetrators who just want their funds and see them as an easy mark."⁶³

The Barbara Wagner Scenario

The statistics, which also show some poor people dying, are consistent with the "Barbara Wagner" scenario. Wagner was an indigent resident of Oregon who had lung cancer.⁶⁴ The Oregon Health Plan refused to pay for a drug to possibly prolong her life and offered to pay for her suicide instead.⁶⁵ Unable to afford the drug, she was steered to suicide.⁶⁶ Moreover, it was the Oregon Health Plan, an Oregon government agency, doing the steering.

Citizens are "Burdens"

In both Washington and Oregon, the official reporting forms include a check-the-box question with seven possible "concerns" that contributed to the lethal dose request.⁶⁷ These concerns include the patient's feeling that he was a "burden."⁶⁸ The prescribing doctor is instructed: "Please check 'yes,' 'no,' or 'don't know' depending on whether or not you believe

⁶¹ *Id.*

⁶² *See, e.g.,* Licia Corbella, If Doctors Who Won't Kill are 'Wicked,' the World Is Sick, *The Calgary Herald*, Jan. 10, 2009; *see* Dr. Margaret White, Letter in Response to Nurses, Undertakers, and the Duty to Die, *The Times*, July 30, 2009 (stating "I am happy here in the nursing home with no wish to die, but were voluntary euthanasia to be made legal I would feel it my absolute duty to ask for it as I now have 19 descendants who need my legacy.")

⁶³ MetLife Mature Market Institutions, *supra* note 17, at 4, 24.

⁶⁴ *See* Susan Donaldson James, Death Drugs Cause Uproar in Oregon, *ABC News*, Aug. 6, 2008, available at <http://www.abcnews.go.com/Health/Story?id=5517492> ; and *Katu.com*, Letter Noting Assisted Suicide Raises Questions (July 30, 2008), available at <http://www.katu.com/news/26119539.html>.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *See* Attending Physician's After Death Reporting Form, *supra* note 31, at question 7; *see also* Oregon's Attending Physician Interview Form, Question 15.

⁶⁸ *Id.*

that a concern contributed to the request."⁶⁹

In other states, a person being described as a "burden" is a warning sign of abuse. For example, an Idaho Adult Protection Services information document describes the following "warning sign": "Suspect behavior by the caregiver . . . [d]escribes the vulnerable adult as a burden or nuisance."⁷⁰ The recommendation is that when such "warning signs" exist, a report should be made to law enforcement and/or to the local adult protective services provider.⁷¹ Washington and Oregon, by contrast, instruct its doctors to check a "burden" box.

Washington and Oregon promote the idea that its citizens are burdens, which justifies the prescription of lethal drugs to kill them. Washington's and Oregon's Acts do not promote patient "control," but officially sanctioned abuse of vulnerable adults.

Individual "Opt Outs" are Not Allowed

Neither state's Act allows patients to opt out of its provisions. The Washington Act states that any provision that affects whether a person may make or rescind a lethal dose request "is not valid."⁷² Oregon's Act has a similar provision.⁷³ So, if a person knows he gets talked into things, and he doesn't want to get talked into requesting the lethal dose, committing suicide and/or facilitating his own homicide, he is not allowed to make legal arrangements to try and prevent it. So much for personal "choice" and "control."

People Commit Suicide Anyway

Patients have the "choice" to commit suicide without legalization. Vermont resident, Kelly Bartlett, states "[s]uicide advocates talk about the 'right to suicide,' forgetting that patients

⁶⁹ *Id.*

⁷⁰ Sarah Scott, Adult Protection: Safeguarding Every Person's Basic Human Right to a Safe and Decent Life, Regardless of Age, Regardless of Condition, *available at* http://www.margaretdore.com/pdf/Adult_Protection.pdf

⁷¹ *Id.* (stating that these "'warning signs' should . . . serve as indicators that a problem may exist and a report should be made to law enforcement or to the local Adult Protection service provider.").

⁷² Wash. Rev. Code Ann. § 70.245.160(1) (stating that "[a]ny provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid." (Emphasis added)).

⁷³ Or. Rev. Stat. § 127.870 § 3.12(1) (stating "[n]o provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid." (Emphasis added)).

. . . already can and do commit suicide."⁷⁴

The Big Picture

Signing the Form Will Lead to a Loss of Control

By signing the lethal dose request form, the patient takes an official position that if he dies suddenly, no questions should be asked. He will be unprotected against others in the event he obtains the dose on a "just-in-case" basis or changes his mind and decides that he wants to live. This would seem especially important for older people with money. There is, regardless, a loss of control.

Prognoses Can Be Wrong

Both Acts apply to adults determined by an "attending physician" and a "consulting physician" to have a disease expected to produce death within six months.⁷⁵ But, what if the doctors are wrong? This is the point of a 2008 Seattle Weekly article.⁷⁶[76] The article states: "Since the day [the patient] was given two to four months to live, [she] has gone with her children on a series of vacations. . . . '[w]e almost lost her because she was having too much fun, not from cancer' [her son] chuckles."⁷⁷

Conclusion

Death with Dignity Acts in Oregon and Washington State are not about patient "choice" and "control." These laws instead enable heirs, other people and even government agencies to pressure or steer people to an early death, or even cause that death. What was previously "homicide" is now "death with dignity." Elderly persons with money, i.e., the middle class and above, appear to be especially at risk. Don't let physician-assisted suicide come to your state.

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⁷⁴ Kelly Bartlett, Letter to Editor in Response to Legalizing Suicide Draws in Others, Burlington Free Press, Dec. 9, 2008.

⁷⁵ 70.245.050, 70.245.010(13); Or. Rev. Stat. §§ 127.815 § 3.01(a), 127.820 § 3.02, 127.800 § 1.01(12).

⁷⁶ Nina Shapiro, "Terminal Uncertainty: Washington's New "Death with Dignity" Law Allows Doctors to Help People Commit Suicide – Once They've Determined That the Patient Has Only Six Months to Live. But what if they're wrong?," *Seattle Weekly*, January 14, 2009, *available at* <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>

⁷⁷ *Id.*