COMPETING PARADIGMS OF RESPONDING TO ASSISTED-SUICIDE REQUESTS IN OREGON: CASE REPORT

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INTRODUCTION

Legalization of assisted suicide in Oregon ushered in a new approach to evaluating suicidal patients with serious medical illnesses. Two competing paradigms-the traditional clinical (1-3) and the assisted-suicide competency (4) models-now exist. No more dramatic illustration of the inconsistencies in these differing approaches can be found than the case of Michael P. Freeland.

This sixty-three-year-old lung cancer patient was admitted to Providence Hospital in Portland, Oregon, after he developed depression and was thought to have both suicidal and homicidal ideation. Before discharge from the hospital the attending psychiatrist noted in the medical record, "The guns are now out of the house, which resolves the major safety issue." The same summary also stated that the patient still had in his

possession a legally prescribed, lethal dose of barbiturates, which he "keeps safely at home." When he returned home, he retained this means of suicide. While removal of guns may have resolved at least one safety issue, it did nothing to address another important safety concern; a lethal prescription intended for the purpose of suicide remained in the home of this depressed patient. This inconsistency very likely did not arise from any oversight on the psychiatrist's part, but from the competing paradigms informing his decisions.

This paper compares the traditional clinical approach to evaluating and treating suicidal symptoms with the assisted-suicide competency model delineated in an assisted-suicide guidebook (4) used in Oregon, the only state where such a practice is legal. The case of Michael Freeland illustrates these competing paradigms. This is the first reported case of a patient legally prescribed assisted-suicide drugs for which medical records have been made available. The patient, Michael Freeland, out of a wish to help others, agreed to numerous prospective interviews and generously provided his written consent for release to the authors of all medical records from Providence Portland Medical Center. And he granted permission for publication of his case without disguise.

CLINICAL MODEL

"No group of suicidal patients has been more ignored than those who become suicidal in response to serious or terminal illness" (1, p558), concludes the "Suicide, Assisted Suicide, and Euthanasia" section of *The Harvard Medical School Guide to Suicide Assessment and Intervention*. Herbert Hendin, author of this chapter,

[and our discussant in this Symposium]

points out that these individuals are no different from other suicidal individuals. While physical illness may be a precipitating cause of despair, these patients usually suffer from a treatable depression, he reminds us. Patients considering assisted suicide are deeply ambivalent about their desire for death, just as are other suicidal patients. This conclusion is consistent with evidence that poor health is not an independent risk factor for death by suicide but is correlated with depression or other mental illness as a key intervening variable (3,5). A noted, large scale study

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demonstrates that seriously ill individuals expressing an interest in assisted suicide all suffered from symptoms of depression or irrational hopelessness (6). Kissane (7)

[who gave us such a lucid discussion earlier this afternoon]

termed this later factor demoralization syndrome and found that hopeless feelings and depression were major contributing factors in the Australian assisted-suicide deaths during his country's brief experiment with the practice.

The clinical approach to dealing with assisted-suicide requests, as with other suicidal symptoms, begins with assessment. After a more open-ended portion of the interview aimed at empathically understanding the patient, the doctor typically inquires about the onset and recurrence of psychiatric symptoms, previous similar episodes and treatments, recent stresses, social and economic difficulties, and religious or spiritual concerns (3). Symptoms of depression and substance abuse are noted. In this population, the clinician must pay particular attention to medications that can cause or exacerbate psychiatric disturbance, cancers or other illnesses known to cause depression or anxiety, the adequacy of pain control, and whether or not the patient has been reassured about the effectiveness of aggressive pain management and other palliative care interventions.

Thoughtful clinicians consider it equally important to explore sources of hope, self-esteem, and strength. At some point, the clinician directly asks about the seriousness and urgency of suicidal intent and the availability of means, including access to firearms and potentially lethal medications. The doctor must also explore the patient's ambivalence about dying, which is virtually always present (1).

When it comes to treatment, the approach in this population emphasizes an effort to "understand and relieve the desperation that underlies the request for assisted suicide" (1, p 553). To do so the clinician must resist assuming the role of "gatekeeper," who would focus on issues of competence alone (1,7,8). Such patients often suffer from feelings of worthlessness, demoralization, or guilt and may be making a plea for reassurance (1,7). Depressed patients may indulge in rigid, black-and-white thinking and overlook possible solutions to problems. They often have complex fantasies about their doctors; for instance, they might see the doctor from whom they are requesting suicide as a savior with whom they will unite in death or as an executioner or in any number of other roles (1). Exploring such feelings and fantasies and whatever other concerns arise can be reassuring and validating for the patient and can go a long way toward dispelling feelings of demoralization and worthlessness.

As our co-presenter, Brian Kelly, so clearly demonstrated in the chapter he wrote with Varghese, "Countertransference and Assisted Suicide," physicians typically must deal with their own feelings of helplessness in the face of death (1,2,7,9). Various authors (2,10-12) have discussed the process of containing the feelings of troubling patients requesting assisted suicide through empathic listening, accepting whatever feelings of helplessness or other feelings that may arise, reflecting upon those feelings, and

offering back to the patient understanding and meaning in the form of a comment or gesture.

Underlying physical illness may contribute to depression and must be treated if possible. While depression and fear, not pain, are the most frequent motivating factors for assisted suicide requests (2,3,6,13), pain care often can be improved. Antidepressant, antianxiety, or psychostimulant medication can play a crucial role in alleviating underlying depression or fear leading to desperation. Most psychiatrists have heard a patient convincingly describe a seemingly hopeless circumstance only to find the patient's perception of the very same circumstances entirely changed after a successful course of antidepressant medication.

While many patients with suicidal symptoms can be treated as outpatients, sometimes psychiatric hospitalization is required to protect the patient while treatment is initiated. Hospitalization may also be needed in those requesting assisted suicide.

A thorough assessment of patients nearing the end of life is often organized around a palliative care model that explores physical, psychological, social, and spiritual (14) contributions to symptoms. Palliative care specialists routinely perform this evaluation, but most experts agree that when requests for assisted suicide arise a psychiatric consultation is required (14, p2901).

The traditional clinical approach described here assumes that suicidal symptoms in the seriously ill should be evaluated and treated as they are in all other patients (15) and that such evaluation and treatment can be extremely helpful, often lifesaving.

ASSISTED-SUICIDE COMPETENCY MODEL

In contrast to the traditional clinical approach just described, the guidebook for Oregon assisted suicide emphasizes that mental health consultation, when required at all, should be "a form of a competency evaluation, specifically focused on capacity" (4, p 30) to make a decision. Ganzini and Farrenkopf, who authored the mental health section state, "The evaluation should focus on assessing the patient's competency and factors that limit competency such as mental disorders, knowledge deficits, and coercion" (4, p 30). When it comes to diagnosing a psychiatric disorder, however, these authors insist that the presence of a mental disorder does not disqualify a patient from assisted suicide. While acknowledging that depression may affect a patient's judgment about assisted suicide they emphasize, "The presence of depression does not necessarily mean that the patient is incompetent" (p31). This opinion is at variance with the majority of forensic psychiatrists, who believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" (16, p595) to make decisions about assisted suicide. A more nuanced approach proposed by

Kissane (17), which includes assessment of demoralization in determining competency for assisted suicide, is not in use among Oregon assisted-suicide practitioners.

In the assisted-suicide competency model, as used in Oregon, there is no obligation to treat depression or any other mental illness even when one is found. The guidebook concludes, "If the mental health professional finds the patient competent, refusal of mental health treatment by the patient does not constitute a legal barrier to receiving a prescription for a lethal dose of medication" (4, p31).

The guidebook mentions the importance of determining the presence or absence of coercion as a part of competence determination. As these guidelines are applied, however, coercion is narrowly defined. Such was the case in the widely discussed assisted suicide of Kate Cheney (18-20), an eighty-five-year old cancer patient with growing dementia, whose psychiatrist believed she was being pressured by her family; nevertheless, she was given assisted suicide in Oregon.

The Oregon law requires that the patient who makes an initial assisted-suicide request be judged to have less than six months to live. A second physician must confirm the prognosis. The assisted-suicide doctor typically chooses this consultant. There must be a second assisted-suicide request after a fifteen day waiting period, and one of the requests must be in writing. There is no requirement for a psychiatric evaluation. Only if the doctor intending to write the prescription for overdose 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 patient's requesting assisted suicide are ever referred for such an evaluation. The percentage sent for mental health consultation prior to assisted suicide in Oregon has steadily dropped over five years to only 5% (21).

REQUEST FOR ASSISTED SUICIDE BY A PSYCHIATRIC PATIENT

These two distinct paradigms for dealing with suicidal ideation in the seriously ill can become competing approaches as illustrated by the care of a single individual, Michael Freeland.

Just after receiving a cancer diagnosis, this 62-year-old man made a telephone call to Physicians for Compassionate Care (PCC), a medical group dedicated to improving the care of the seriously ill without ever resorting to or condoning assisted suicide or euthanasia. He seemed to be asking about how to get the process of assisted suicide started. Although he did not say so, he may have intended to call the Compassion in Dying Federation (CDF), a politically active group that shepherds over three quarters of assisted suicides in Oregon. Or, this well informed man may have known about

PCC and called this organization as a cry for help. At any rate, the call was answered by a volunteer, my co-author, Cathy Hamilton, who was trained in counseling and helping the seriously ill and who is opposed to the practice of assisted suicide.

Mr. Freeland sounded distraught. He explained that he saw no purpose in undergoing chemotherapy. Although he had just received his prognosis, he was already making funeral arrangement, he said, and added, "I might as well just end it." When Cathy empathized with how upset he must be, just having received such a dire prognosis, he became tearful. He said he did not want to tell his daughter about his cancer because she was moving to another state to attend graduate school and he did not want to interfere with her education. He lived alone.

Cathy explained her views on assisted suicide and assured him that with good palliative care his symptoms could be addressed. As she would have with any other suicidal individual, she told him she did not want him to kill himself and offered to help him find treatment for his depression. She promised to advocate for him and find a doctor who could treat any pain he might have or address other symptoms.

In subsequent conversations, he mentioned that he had felt haunted by suicidal feelings ever since his mother died from a self-inflicted gunshot wound when he was twenty-one. Shortly after her death, he attempted suicide himself and was treated for depression in a psychiatric hospital. He made at least two other suicide attempts and remained preoccupied with the possibility of suicide, he explained. Later, he developed alcoholism but joined alcoholics anonymous and remained sober for over twenty years. Despite intermittent depression, he was able to work as an electronics technician for a local television station. He was divorced and had a daughter and a few friends. For unknown reasons, he did not allow his daughter or friends into his home, and he kept elaborate surveillance cameras trained on the perimeter of his property.

Cathy kept frequent contact with Mr. Freeland during the next year. With encouragement, he did undergo chemotherapy and radiation treatment for his cancer, which alleviated his symptoms significantly.

Near the anniversary of his receiving a terminal prognosis, however, he announced, "I have the pills." He received the prescription from Doctor Peter Reagan, an assisted-suicide advocate who was associated with CDF. Doctor Reagan had already described in *Lancet* (22) giving an overdose to another patient diagnosed with depression (2,23). He referred that woman for a competency evaluation (2,20,23), which cleared her for assisted suicide approximately two weeks after he met her. In contrast to that case, Reagan commented that he did not think a psychiatric consultation would be "necessary" for Mr. Freeland, according to his daughter who accompanied him to an appointment.

Mr. Freeland mentioned that another member of Compassion in Dying had been calling him regularly to talk with him about the assisted-suicide option. He had seen her on a television show, which he said "convinced me it [assisted suicide] was the way to go." When asked if that doctor knew about his depressions and suicide attempts, Freeland said, "She didn't get into that. Our conversations have been superficial."

With urging, the patient finally let his daughter know about his cancer. She gladly postponed her graduate studies and returned to care for him. Cathy urged him to take the 50 mg. of sertraline his primary care doctor prescribed for his depression. While he continued to be suspicious, kept a variety of loaded assault weapons in his home, and used his surveillance cameras as always, he did begin to allow a few people, including his daughter and Cathy, into the house for the first time. Cathy received permission to communicate with his primary care doctor and initiated home visits in an effort to help him overcome his depression and his fears of the dying process.

Six months later, Mr. Freeland could not be reached for several days. The doctor's office mentioned that their patient had begun having more "mental problems" and had been admitted to the hospital psychiatry ward. After his ex-sister-in-law began pursuing guardianship, according to a psychiatric report, he grew upset. He had saved a substantial amount of money, and it was important to him to retain control of his resources. His doctor became worried that the patient was increasingly suicidal, or even homicidal, and he arranged for the patient to be placed on an involuntary hold.

The emergency room physician's report showed that she evaluated him for "possible suicidal or homicidal ideation." A psychiatric social worker and a mental health technician both described possible suicidal and homicidal ideation. The social worker report mentioned that threats may have been made toward a hospice nurse and toward his daughter. Both reports documented the history of a previous overdose, following his mother's suicide. When he was admitted to the hospital and evaluated by the inpatient psychiatrist, however, possible homicidal comments were featured prominently in the chief complaint and suicidal intentions were all subsumed under discussion of an interest in assisted suicide. The psychiatrist's report denied a history of suicide attempts, without any attempt to reconcile this comment with documentation from emergency room personnel that there was a history of suicide attempts. Other than these two omissions and the failure to account for the paranoia mentioned by the emergency room doctor, the psychiatric record was fairly consistent with the known history.

The inpatient psychiatrist noted that the patient had diminished appetite and had lost 70 pounds, but his sleep was adequate with the numerous sedative medications he was taking. He reported confusion and some memory problems. In addition to sertraline,

medications listed, without the dose, included diazepam, temazepam, hydromorphone, morphine oral solution, rofecoxib, salmeterol inhaler, pirbuterol inhaler, choline, and laxalose.

The mental status report described him as thin and tearful. His speech was clear. His affect was discouraged. His thought processes were well organized, and he denied thoughts of harming himself or others. Paranoia was not mentioned in the psychiatric examination. He was alert and oriented and judged to have above-average intelligence. Laboratory studies showed hemoglobin was mildly low (12.4 g/dL), but his blood count and chemistry screen were otherwise normal.

The psychiatrist diagnosed him with depression not otherwise specified as the primary diagnosis, chronic adjustment disorder with depressed mood, probable intermittent delirium, narcissistic personality traits, and metastatic lung cancer with guarded prognosis.

During the patient's inpatient stay, a social work home visit revealed that his home was uninhabitable-with heaps of clutter, rodent feces, ashes extending two feet from the fireplace into the living room, lack of food and heat, etc. Thirty-two firearms and thousands of rounds of ammunition were removed by the police. The lethal medications, however, were left. Although the psychiatrist noted in the discharge summary that the patient would continue to be subject to intermittent delirium, he did not seem to consider the presence of a lethal overdose in the house potentially problematic. Concerning the need for attendant care, a palliative care consultation obtained by the psychiatrist said the fact that the patient had "life-ending medications" may make that problem "a moot point."

The day after discharge, the same psychiatrist wrote a letter to the court supporting guardianship by saying he "is susceptible to periods of confusion and impaired judgment." He concluded that Mr. Freeland was unable to handle his own finances and that his cognitive impairments were unlikely to improve.

At a subsequent home visit, Mr. Freeland reminded Cathy that he had already far outlived the original six months to live prognosis; and he added that the assisted-suicide doctors gave him a new six months to live prognosis so his assisted suicide would be "legal." That was at least ten months prior to his eventual death, which took place nearly two years after he was first given a prognosis of less than six months to live.

Cathy redoubled her efforts to stay in contact with him and encourage him. Fortunately, so did some old friends from AA and others, who began to visit him daily. His house was cleaned up and refurbished; and his mood brightened. Cathy

encouraged him to relinquish his lethal barbiturate prescription, but he refused to do so.

Two months later he entered the hospital briefly to be treated for dyspnea. The medical record described him as tearful and as having labile affect. He was thought to have "steroid psychosis" and was tapered off of steroid medication. This confused man was sent home, once again, with the lethal drugs in his possession.

Over the coming months, he received antidepressants, social and spiritual support, and encouragement. A friend spent most days with him. His few friends were clear that they valued him and did not want him to kill himself. Hospice, however, remained "neutral" on this issue, and he grew suspicious of that organization. As he put it, "I'm going to get rid of hospice. I don't trust them. Then there's the morphine. I'm not in any pain. I don't know why they want me to take all this morphine." He dismissed hospice, decreased the pain medication, and both his mood and cognitive clarity improved for several months.

Three weeks prior to his death, however, pain became a significant factor again. As his pain increased, he used more controlled-release oxycodone, which contributed to constipation, which in turn became excruciating in itself. Because of abdominal discomfort, he stopped drinking fluids, as well as eating, and became confused and more suspicious again. He now wondered what might be in the liquids people gave him and in the pain medications, so he didn't take them. At a home visit by Cathy and me, his medication tray showed that he was taking minimal, if any pain medication. He said that he was desperate because of the pain and was on the verge of killing himself with the overdose and that Doctor Reagan had recently offered to sit with him while he took it.

We explained that he was frightened because of his confusion, but that pain medication and fluids, along with 24-hour care, would help him. Fluids might also help alleviate his constipation, which had become so painful. We handed him the controlled-release oxycodone tablets from his bedside stand, and he took them as prescribed for the first time in days. Cathy then insisted that his doctor should prescribe a morphine pump to be delivered the next day so his confusion would not interfere with his receiving needed pain relief. She also arranged for a 24-hour attendant care, which he could readily afford. With these interventions his confusion cleared, his pain abated, and he felt much relieved during the remaining two weeks of his life, even while his physical condition deteriorated.

During this time, which he had been on the verge of cutting short, he was able to express his gratitude to and say goodbye to the many people who had helped him. Most important, he was able to reconcile with his daughter, from whom he had been

alientated since the psychiatric hospitalization. She enthusiastically renewed her relationship with him. This opportunity was very meaningful to her as well as to him.

DISCUSSION

Removing lethal means is central to the clinical treatment of suicidal symptoms; but providing lethal means is central to the assisted-suicide model. These and other differing approaches of the competing paradigms revealed themselves in different ways among the many individuals involved in Michael Freeland's care.

Cathy, who was a volunteer for Physicians for Compassionate Care, and members of Compassion in Dying Federation (CDF) took openly competing approaches. Cathy considered the patient's current depression central to his motivation to kill himself. She took his suicide threats seriously, especially in light of his having made previous attempts prior to developing a life threatening illness. She recommended psychiatric evaluation and treatment; and, when he refused referral to such treatment, she spent long hours talking with him about his fears of death, his spiritual concerns, the trauma of his mother's suicide, his identification with his deceased parent, his depression and paranoid fears, and his past accomplishments and hopes for the future. She called the primary care doctor and encouraged him through communication with his nurse to provide antidepressant medication. She interacted with those who could visit with him. When he became desperate because of apparent delirium and poorly treated pain in the last few weeks, she made certain he received the pain care he needed and arranged for intensified palliative care, including 24-hour attendant care. She consistently reminded him that she did not want him to kill himself.

In contrast, according to the patient, neither CDF doctor seemed "very interested" in his psychiatric history and previous suicide attempts. Doctor Reagan, who prescribed the assisted-suicide drugs, told the patient and his daughter that even a psychiatric evaluation would not be "necessary." Perhaps the issue of whether or not Mr. Freeland was depressed or had made previous suicide attempts seemed irrelevant to CDF doctors, because, as the guidelines recommend, it is only competency to make decisions that is required legally. Doctor Reagan did offer to make a home visit and sit with the patient while he took the overdose, but he apparently was not aware of the patient's plight when he was delirious and desperate and not receiving enough pain medication. Neither did he seem aware that the inpatient psychiatrist did not consider Mr. Freeland competent to handle his own affairs and had written a letter to that effect prior to the patient's six-months-to-live prognosis being renewed.

Other clinicians, however, took different approaches. The emergency room doctor, along with the social workers and court investigators at his psychiatric admission, considered his depression and previous suicide attempts most seriously. They

discussed his physical illness as a complicating diagnosis. Even these notes, however, skirted the issue of his possessing a lethal overdose and focused more directly on homicidal than suicidal ideation, although the danger of suicide was clear. The health care professionals seemed placed in a clinical bind when presented with a suicidal mentally ill patient, who had been given an overdose by another doctor.

The inpatient psychiatrist seemed to mix both the traditional clinical approach and the assisted-suicide competency model with predictably mixed results. He did an evaluation, diagnosed the depression and intermittent delirium, and attempted to treat the depression. He protected the patient from danger to himself or others through inpatient treatment for over a week and recommended antidepressant medication and social support. He took care to make sure guns were removed from the home prior to discharging the patient. All of this is consistent with the traditional clinical model. In deference to the assisted-suicide competency model, however, he noted that the patient had been given a lethal prescription and left that prescription in his possession, despite having kept the patient hospitalized to protect him from harm to self or others. Perhaps his attempt to mix both approaches is what led him to list only homicidal danger in his notes without mentioning the history of suicide attempts or threats, except in the context of mentioning that he was interested in assisted suicide and had received a lethal prescription.

It is even more perplexing to consider how the psychiatrist could leave the lethal drugs with his depressed patient, apparently believing he had a right to the overdose, and then could write a letter to the court only a day later, claiming the patient was not competent to make his own decisions. Perhaps he concluded he could not make decisions about finances but could make them about assisted suicide. Perhaps he felt it was within Doctor Reagan's purview to address that issue because he was the assisted-suicide doctor. He did not clarify his thinking about this issue in the medical record.

Not only did the mixing of models affect the psychiatric response, it also affected planning for adequate palliative care after discharge from the hospital. Following a detailed discussion of Mr. Freeland's medical history and condition, a hospital consultant asked to make recommendations for further medical and palliative care predicted that the patient most likely would be further incapacitated in a "matter of weeks" but that, because he has "life-ending medications," providing for additional care may be "a moot point." Those were the final words of the report and the consultant made no specific recommendations for further care. As a result, no attendant care was provided.

A most interesting clinical dilemma appears present for the primary care doctor. He initially used a mixed model but eventually switched to a clear, traditional clinical approach. He diagnosed depression early on and treated it with medication. While he

did not provide assisted suicide himself, he willingly collaborated with the assisted-suicide doctors, thereby giving the patient a mixed message. The patient said it was this primary care doctor who gave the six-months-to-live prognosis, which is needed to proceed with the assisted-suicide protocol-he did so twice. This approach is entirely consistent with the assisted-suicide competency model, which admits that depression can contribute to suicidal ideation but insists that the doctor can help him commit suicide anyway. When the patient became more desperate and confused, however, this doctor changed models and had him hospitalized against his wishes. This doctor's attempt to straddle both approaches, to create a kind of neutral zone, broke down in the end; and he was released from the case because of the patient's heightened distrust.

This case illustrates how difficult it is to combine the two paradigms of responding to suicidal ideation. Attempts to mix the clinical and the assisted-suicide competency models in this case resulted in perplexing clinical interventions, inconsistent approaches, and attempts to switch models during times of crisis.

We believe that the two approaches are incompatible, because they are based on differing underlying assumptions. The traditional clinical approach assumes that suicidal seriously ill individuals are no different from any other suicidal patient, and the wish for death is considered symptomatic of underlying psychiatric illness to be evaluated and treated. This treatment usually should be provided voluntarily, but when the danger is great, it can be provided involuntarily. The patient's life is always considered worth protecting and talk of suicide is considered a plea for help. The assisted-suicide competency approach agrees with the above underlying assumptions for all patients who are judged to have more than six months to live. Once patients are judged to have less than six months to live, however, they are treated differently. At this point, according to the competency model, not only does the clinician no longer have an obligation to treat the suicidal symptom as a cry for help and to protect the patient, the doctor actually has the right to help the patient in killing themselves. It is interesting in this case that the legality of using the assisted-suicide competency model turned on the crucial issue of how much time the patient might live, when that fact could not be accurately determined-he was given multiple prognoses of only six months to live and out lived all of them, the most recent one by nearly half a year. In total he lived more than two years beyond the initial predictions of rapid death.

This case demonstrates that the attempt to use competing or mixed paradigms can result in mentally ill patients being given lethal prescriptions in Oregon as they have in the Netherlands (1); but that fact would not have been revealed in the official statistics. Had Mr. Freeland taken his overdose, he would have only been listed in the state report as another patient who did not need to be referred for psychiatric evaluation. The fact that he had a pre-existing psychiatric disorder and previous suicide attempts would not have been revealed, because the Oregon Health Division

(OHD), which is responsible for protecting the public by overseeing assisted suicide, does not ask such questions. OHD would have only gathered information from Doctor Reagan, the assisted-suicide doctor, who did not consider psychiatric consultation necessary. As it was, he was only listed in the statistics published March 6, 2003 (23) as a patient who obtained an overdose but did not take it.

This case where assisted-suicide drugs were actually prescribed is the only one for which medical and psychiatric records have been made available. Even with this information, many unanswered questions remain. Would the patient have killed himself with the lethal overdose had friends and volunteers not attempted to dissuade him? Did the involuntary hospitalization and mental health treatment prevent assisted suicide or even a homicide? Was this man, who may have had a character disorder along with depression, engaging in splitting and projective identification (10-12) to further polarize views of him? Were the doctors involved swept up in acting out a countertransference reaction to a character disordered patient's lethal projections? Or was this case simply one of poor medical care?

These and other questions concerning similar cases can only be answered more fully through systematic and careful, independent review of cases prospectively or, at least, by retrospective review of medical and psychiatric records. Such studies, including review by multiple clinicians with differing viewpoints of all psychiatric records with identifying data of assisted-suicide patients masked, have been proposed to OHD. OHD, however, has refused access even to masked records for any independent review. So the information available will remain based on OHD reports, which rely on the assisted-suicide doctors themselves, and on the records of individual patients who are willing to release their medical records independently. To date, Michael Freeland is to only person in over 250 cases prescribed overdoses to do so.

CONCLUSIONS

The legalization of doctor-assisted suicide in Oregon has resulted in the introduction of competing paradigms-the traditional clinical approach and the assisted-suicide competency model-for responding to suicidal thoughts and behaviors in seriously ill individuals. Careful examination of events leading up to the death of the only case in which assisted-suicide drugs were legally prescribed for which medical records are available demonstrates that different models were used by some clinicians and others attempted to mix models, resulting in a confused and confusing approach to a life threatening symptom. These competing models appear to be based on incompatible underlying assumptions about the value of protecting human life depending on predictions of how long a patient might live, a prediction which cannot be made accurately. We conclude that the attempt to mix models is confusing to both clinicians

and patients and endangers seriously ill patients, particularly those with a history of pre-existing mental illness.

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