Community Conversation Panel: Assisted Suicide v. Death with Dignity

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The Consequences of Physician-Assisted Suicide Legalization

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I have been in the practice of Radiation Oncology, treating cancer patients, for 38 years in Oregon. I have been professor and Chair of the Department of Radiation Oncology at OHSU for the past 16 years. I retired from full-time medical practice on July 31, 2005.

I have extensively studied Oregon's assisted suicide law since its passage in 1994. The chief argument of the proponents of legalizing assisted suicide has been that of "choice and personal determination". In today's society, that is a compelling argument. However, it is important to evaluate the consequences of the legalization of assisted suicide and euthanasia, for euthanasia is related to assisted suicide. We need to educate ourselves regarding the whole picture of physician-assisted suicide. This presentation will discuss many of those consequences:

1. Legalizing assisted suicide devalues human life, and results in a loss of protection for terminally ill patients against doctors writing a prescription for the sole purpose of causing their death. Assisted suicide is a reversal of the proper roles of a physician as a healer, comforter and consoler. Physician-assisted suicide is not compatible with those roles.

2. Those promoting assisted suicide send the false message that doctors can do a better job of assisting in a patient's suicide that they can of caring for their medical needs. I am concerned that society will reap the consequences of that demeaning message.

3. The legalization of assisted suicide and euthanasia can inhibit the progress of medical advances, and tends to result in fewer efforts by the doctor to find a solution to the patient's distress. A euthanasia doctor in The Netherlands described a request for a consultation from a physician whose patient had gastrointestinal obstruction. The requesting doctor told him that "in the past in this situation, I solved it by euthanasia. Now this patient doesn't want it, and I do not know what to do". The consulting doctor stated: "This is my biggest concern in providing euthanasia and setting a norm of euthanasia in medicine: that it will inhibit the development of our learning from patients, because we will solve everything with euthanasia." [Dr. Zylicz, Q1533, in Select Committee on the Assisted Dying for the Terminally Ill Bill. *Assisted Dying for the Terminally Ill Bill HL, Vol. II: Evidence,* .London, The Stationery Office Limited. April 4, 2005]

4. Once a patient has the means to take their own life, there can be decreased incentive to care for the patient's symptoms and needs. Michael Freeland is an example of this. He was a depressed lung cancer patient, who had been admitted to a mental hospital unit. When his doctors were planning for his discharge to his home where he already had lethal drugs, a palliative care consultant wrote that he probably needed attendant care at home, but providing for that additional care may be a "moot point" because he had "life-ending medication". His assisted suicide doctor did nothing to care for his pain and palliative care needs, but did offer to sit with him while he took the overdose. This seriously physically-ill and mentally-ill patient was receiving poor advice and medical care because he had lethal drugs. [Hamilton & Hamilton, Competing paradigms or response to assisted suicide requests in Oregon. *Am J Psychiat 2005;162:1060-1065]*

5. The immunity offered to physicians under the Oregon assisted-suicide law requires only "good-faith compliance" with the law. This is not a medical-legal standard of care, and is not applicable to any legitimate medical treatment.

6. There are problems with end-of-life care in Oregon. The national organization, "Last Acts", issued a "report card" in November 2002 to states regarding their end-of-life care. Oregon was given a "D" grade for hospice (less than 1/3 of dying Oregonians used hospice), and an "E" grade for palliative care programs (only 20% of hospitals had palliative care programs). [Last Acts, Press Release, November 18, 2002]

Pain management has deteriorated in Oregon. After fours years of assisted suicide in Oregon (from June 2000 to March 2002), there were almost twice as many dying patients in moderate or severe pain or distress, as there had been prior to Oregon's assisted suicide law being used. [Fromme, Tilden, Drach, Tolle. Increased family reports of pain or distress in dying Oregonians: 1996 to 2002. *J Palliative Med* 2004;7:431-442]

7. Oregon's increased use of morphine is not going to dying patients. Oregon has been a consistently leading state in per capita use of opioids/morphine. In recent years there has been no difference between the increased use of morphine in Oregon and the increased use in the rest of the United States. Researchers at OHSU reported that while there had been a 2.5 fold increase in opioid use in Oregon in the three years from 1997 to 1999 (the same increase as in the United States); that inpatient morphine use at OHSU did not increase significantly for dying patients during that time. [Tolle, Hickman, Tilden et al. Trends in Opioid Use Over Time: 1997 to 1999. *J Palliative Med* 2004;7:39-45]

8. When other states have enacted recent new laws to ban assisted suicide or strengthen or clarify existing bans, the per capita use of morphine increased in each of those eleven states. [Americans for Integrity in Palliative Care, *Presentation to AMA House of Delegates Meeting,* June 11, 2003]

9. This is not about being on or off life-support. Medical professionals and the courts (including the U.S. Supreme Court) make a distinction between the individual's right to refuse unwanted lifesaving medical treatment and assisted suicide.

10. Pain is not the issue. There is not one case in Oregon of assisted suicide being used for actual untreatable pain. Pain can be treated. Assisted suicide has been used for psychological and social concerns. There is scientific evidence that there is an inverse relationship between a patient having pain and their desire for assisted suicide or euthanasia. It is ethically appropriate and acceptable to treat a patient for pain, even if the treatment may shorten life; the treatment is being given to treat the pain and not specifically to cause death.

11. Oregon assisted suicide patients have been described by their doctors as being fiercely independent and controlling people. They fear dependency. [Ganzini, Dobscha, Hientz, Press. Oregon physicians' perceptions of patients who request assisted suicide and their families. *J Palliative Med*.2003;6:381-390]

12. Ann Jackson, executive director of the Oregon Hospice Association told a newspaper reporter, in describing these patients: "In effect, they've said no to hospice. Either they don't believe we in hospice can meet their needs, or we're not meeting their needs " [Colburn. Suicide: Study is the first based on interviews. *The Oregonian newspaper*, June 12, 2003]

13. Assistedsuicide has been described [www.wesleyjsmith.com/blog] as "a policy of privilege". Proponents tend to be upper middle class or higher; white, well-off, well, and worried. History has taught us that when laws are established by and for controlling people, that the poor and vulnerable are discriminated against. African-

American and Hispanic organizations are very opposed and fearful of the legalization of assisted suicide because of their minority status and more limited resources.

14. The arguments favoring assisted suicide are demeaning to people with disabilities: Proponents of legalizing assisted suicide say, "there are situations that are worse than death." This has mobilized the disability community against the legalization of assisted suicide. They have formed organizations such as "Not Dead Yet!".

15. There are financial and societal dangers; assisted suicide may become the only choice for some patients. There is concern nationally and within Oregon regarding the rising costs of health care. Financial conditions may lead to assisted suicide as an answer to those rising costs. Oregon Medicaid, the Oregon Health Plan, covers the costs of assisted suicide with state dollars, but it does not cover the costs for curative or local medical treatment for patients with cancer with a less than 5% chance of living 5 years, even when that treatment can prolong valuable life.

16. In 2003, the Oregon Health Plan stopped paying for medicines for 10,000 poor Oregonians; this included patients with AIDS, bone marrow transplants, mentally ill and seizure disorders. In 2004 and the first half of this year, an additional 75,000 Oregonians were cut from the Oregon Health Plan, to keep the state budget balanced. Assisted suicide may become the "only choice" for some vulnerable patients.

17. Even if a patient has Medicare or Medicaid health coverage, there is limited access to health care in Oregon. Sixty percent of Oregon physicians limit or do not see Medicaid patients, forty percent of Oregon physicians limit or do not see Medicare patients. Seventeen percent of Oregonians are without health insurance, and the share of Oregonians without health insurance has grown faster than in any other state over the past four years.

18. Oregon's assisted suicide "safeguards" are not being followed. There is no protection for the depressed or mentally ill. In 2003 and 2004 only 5% of those dying from assisted suicide had a mental health consultation. We have published reports of a patient diagnosed by a psychiatrist as having dementia, and still receiving a prescription for lethal drugs. The drug is supposed to be self-administered and we have newspaper reports of patients being assisted in taking the drugs, because they were not able to be self-administered.

19. The prospect of euthanasia was raised by Mr. David Schuman, then an Oregon Deputy Attorney General in 1999, in a letter to a state senator. He wrote that Oregon's assisted suicide law would in effect be discriminatory because of the Americans with Disabilities Act, because the Oregon law requires self-administration and not

everyone is capable of that. "The assisted suicide law would be treated by the courts as though it explicitly denied the 'benefit of a 'death with dignity' to disabled people," Mr. Schuman wrote.

20. Many doctors are writing prescriptions for lethal drugs to patients for whom they have not previously cared. Dr. Rasmussen had reported that "75% of the patients who come to him regarding assisted suicide are patients he has never seen before." Regarding the "slippery slope" of assisted suicide, Dr. Rasmussen said, "I think all involved in the Oregon law must recognize that we are on a slippery slope, and we have to be careful with every step. But just because it's a slippery slope doesn't mean we shouldn't go there. [Robeznieks. Oregon sees fewer numbers of physician-assisted suicides. *American Medical News.* April 4, 2005]

21. Oregon continues to have a high rate of suicides, especially among the elderly. Between 1999 and 2002, Oregon had a rate of suicide (not deaths from assisted suicide) among those $\geq$65 years of age, that was 6th highest in the nation and 156% that of the national average. [Elder Suicide in Oregon. CD Summary. Oregon Dept. of Human Services. Feb. 22, 2005]

22. There is no real monitoring of Oregon's assisted suicides. In 2004, the prescribing doctor was present at the time the patient took the lethal doses of sleeping drugs in only 6 of the 37 deaths. Following Mr. David Prueitt's failed assisted suicide attempt in January 2005, the state Department of Human Services (DHS) publicly stated that they had "not authority to investigate individual Death with Dignity cases - the law neither requires or authorizes investigations from DHS,"

23. There is no evidence that legalization of assisted suicide in Oregon has decreased the rate of physician-assisted suicide. We do not know what the assisted suicide rate is in other states. [Stevens & Toffler. Comment on Ganzini and Dobscha regarding comparing rates of physician-assisted suicide in Oregon with that of other states. *J Clinical Ethics* 2004; 15:363-364]

24. Oregon's "assisted suicide social experiment" is being poorly conducted and managed. The basic Oregon assisted suicide data for the early years has been destroyed, as noted in the following personal communication from Darcy Niemeyer of the Oregon Department of Human Services to me: "Unfortunately, we are unable to provide any additional information than is currently available in our Annual Reports. Prior to 2001, we did collect the names of physicians who were participating. However, because of concerns about maintaining the confidentiality of participating physicians, we began using a numeric coding system in 2001. When we implemented this coding system, we destroyed the identifying data from the earlier years." [D.

Niemeyer letter to K. Stevens, Feb 17, 2004]. How can we learn from the "Oregon Experiment" when critical data has been destroyed?

As I have noted in the above examples, there are serious and dangerous consequences to the legalization of physician-assisted suicide. It is important for this issue to be studied in depth. I appreciate the opportunity to participate in this discussion, and to provide some additional information that may not be known by many Oregonians.

Additional information may be obtained from the following websites:

- www.pccef.org - Physicians for Compassionate Care Educat. Foundation
- www.internationaltaskforce.org - International Anti-euthanasia Task Force
- www.euthanasia.com
- www.vaeh.org - Vermont Alliance for Ethical Healthcare
- www.notdeadyet.org - Not Dead Yet! Organization

Recommended Publication:

- Foley & Hendin, *The Case Against Assisted Suicide, For the Right to End-of-Life Care.* Johns Hopkins University Press, 2002.