

Pain and Physician-Assisted Suicide – What is Going On?

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Review by Dr. Kenneth R. Stevens, Jr., M.D.,
Professor Emeritus Radiation Oncology, OHSU,
Vice-President, Physicians for Compassionate Care

1. Pain is a scare tactic

The proponents of physician-assisted suicide (PAS) have always used scare tactics in their promotions. They foster fear and doom and gloom. They tell the public that PAS is needed because of uncontrollable pain; “your doctor will not be able control your pain”. They tend to disparage the significant medical science advances in pain control and palliative care. It is an emotional argument that does not match with the reality. No one wants to suffer needlessly. The reality is that uncontrolled pain in the terminally ill rarely occurs. There has been much experience in properly treating the symptoms of terminally ill patients, including pain control. There are pain and palliative care organizations and publications. Pain is not the issue. There is not one case in Oregon of assisted suicide being used for actual untreatable uncontrollable pain.

The lack of physical suffering among Oregon assisted suicide patients is reported in the medical article “Why Oregon Patients Request Assisted Death: Family Member’s Views” by Linda Ganzini, Elizabeth R. Goy and Steven K Dobscha in the Feb. 2008 issue of *Journal of General Internal Medicine* 23 (2):154-157. The authors report regarding what the patients’ families thought were the reasons for their family member requesting physician-assisted suicide (PAS). Much of the information came from family members who learned about the study through Compassion and Choices, formerly Compassion in Dying. We learn from this paper that that organization reported in 2005 that they had given information to or assisted 180 of the 246 persons who died of PAS in Oregon. This is further evidence regarding how that organization controls physician-assisted suicide in Oregon.

The family members’ views on why patients requested PAS are tabulated. Using a scoring system based on a scale of 1 to 5 (1=not at all important reason for request, 5=very important reason for request) none of the patients’ current physical complaint or suffering reasons had a median score of greater than 2. The scores of 3,4 & 5 were related to future fears and concerns, or of poor quality of life. This underscores what we have said before, these people are not choosing PAS because of uncontrollable pain or suffering, although that was the argument used to pass the Oregon law in 1994 and 1997. They are primarily concerned about future concerns. Rather than a doctor writing a prescription for a lethal overdose of sleeping medication, doctors should properly assess and deal with these patients’ fears and concerns.

The confirmation of the lack of physical suffering among these assisted suicide patients was also noted with the statement in the concluding paragraph that: “Some Oregon clinicians have expressed surprise at the paucity of suffering at the time of the request among these patients”, referencing the paper “Oregon Physicians’ Responses to Requests for Assisted Suicide: a Qualitative Study” by Dobscha, Heintz and Ganzini in *Journal Palliative Medicine* 2004; 7:450-461.

The DHS annual reports of Oregon PAS have included what doctors have reported regarding patients' end-of-life concerns. For the 341 PAS deaths from 1998-2007, the end-of-life concerns were:

Losing autonomy	89% of patients
Less able to engage in activities making life enjoyable	87%
Loss of dignity	82%
Losing control of bodily functions	58%
Burden on family, friends, caregivers	39%
Inadequate pain control or concern about it	27%

As noted on the 2001 year annual report: "Patients discussing concern about inadequate pain control with their physicians were not necessarily experiencing pain." Concern about future pain would be included in this "pain" category.

We need to promote a message of hope, not the message of despair that is promoted by the pro-assisted suicide campaign.

Depression is not being properly evaluated. It is a tragedy that none of the 49 patients dying from PAS in Oregon in 2007 had a psychiatric evaluation; overall in the 10 years, 1998-2007 only 11% of those dying from PAS had such a referral.

"Exit parties" arranged by patients and Compassion in Dying, Compassion and Choices, and attended by the media, show patients dancing with George Eighmey, C & C executive director, immediately prior to taking the barbiturate overdose. They do not appear to be having pain. (New York Times, June 1, 2004; The Oregonian 'Lovelie Svart' series in Sept. 2007)

In spite of the gloom of pro-PAS proponents, there is much hope for patients with serious illness. There have been many advances in recent years in pain and palliative care treatment. Hospice care is more available. It is ethically appropriate and acceptable to treat a patient for pain. The appropriate dose of pain medication is the dose that will relieve the pain. Physicians should properly evaluate and treat patients for pain and other symptoms. When dosages of painkilling drugs are adjusted to relieve patients' pain, there is little if any risk that they will hasten death. Painkilling drugs and sedatives have even been found to be life-sustaining. Morphine and opioids have not been used to cause Oregon PAS deaths; barbiturate (sleeping pill) overdoses have been used. We should focus on killing the pain and not the patient. We need to continue to improve the care of patients, not kill them. We need to kill the pain and not kill the patient. It is bizarrely ironic that PAS proponents on the one hand imply that doctors are not able to properly care for patients' pain and suffering, while on the other hand they promise that doctors will be able to cause their death by writing a prescription for lethal drugs. Those promoting assisted suicide send the false message that doctors can do a better job of assisting in a patient's suicide than they can of caring for their medical needs. Society will reap the consequences of that demeaning message. Assisted suicide may become the only choice.

Ever since the start of the Oregon Health Plan in 1994, they have not covered the cost of "curative" treatment for patients with a cancer diagnoses with a 5% or less 5-year survival,

specifically even when such treatment has the primary intent to prolong life or alter disease progression. The media has reported on two patients in the Eugene, Oregon area who each received a letter from the Oregon Health Plan in May 2008 informing them that because of their cancer diagnosis, they would not be covered under the Oregon Health Plan for surgical, radiation and chemotherapy treatments. However, in the same letter they were informed that comfort care treatment would be covered, which would include the costs of physician-assisted suicide.

Assisted suicide proponents use “tough cases” where “medicine can do nothing more” as a means to promote the need for assisted suicide. Oliver Wendell Holmes said, “Hard cases make bad laws”. In the same manner, “Hard individual situations make bad public policy.” Example of man driving his care unsafely to get his wife to the hospital before the baby is born – we don’t pass laws for those situations.

If intolerable suffering were the reason for assisted suicide, why then is assisted suicide not successfully promoted in areas of the world where there really is such intolerable suffering? Why assisted suicide only is successful promoted in affluent societies?

2. Once a patient has the means to take their own life, incentives to care for the patient's symptoms and needs decrease.

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 from a mental health unit to his home where he already had lethal assisted suicide 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". Interestingly, the doctor who wrote the prescription for his lethal medication was not evaluating or treating his pain or palliative care needs, but he 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]

3. The legalization of assisted suicide in Oregon has not created a health paradise. There are problems with end-of-life care in Oregon.

On the one hand, PAS proponents promote fear of pain; on the other hand they report that because of PAS legalization in Oregon, Oregon has improved the pain control and palliative care of terminally ill patients compared to other states. It is difficult to understand the relationship of the legalization of PAS in Oregon in 1994 with pain control and palliative care policies within the state.

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 was reported to have deteriorated in Oregon after legalization of PAS. After four 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]

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]

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]

The Wisconsin Pain & Policies Studies Group has issued “grades” regarding states’ pain policies from 2000 to 2008. In the year 2000, Oregon was among 13 C+ states, there were 11 B and one B+ state. In 2003, Oregon was among 17 C+ states, there were 13 B, 3 B+ and one A state. In 2006, Oregon was among 6 B+ states, there were 2 A states. In 2007, Oregon was among 7 B+ states, there were 4 A states. In 2008, Oregon was among 5 A states. The state of Washington had grades of B in years 2003-2007, and B+ in 2008. The state of Washington had higher grades than Oregon in 2000 and 2003. (PAS was legal in Oregon, but not in Washington.) It is significant that all states’ grades have improved since 2000. In 2000 there were one B+, 11 B, 13 C+, 17 C, 7 D+ and 2 D grades among the 51 states and D.C. In 2008 there were 5 A, 11 B+, 17 B, 12 C+ and 6 C grades. (Achieving Balance in State Pain Policy, A Progress Report Card; Pain & Policy Studies Group, University of Wisconsin School of Medicine and Public Health, July 2008, www.painpolicy.wisc.edu)

Information from the Wisconsin Pain Policy publication: Achieving Balance in Federal and State Pain Policy – A Guide to Evaluation (5th Edition, July 2008) www.painpolicy.wisc.edu. Oregon Policies - pages 496-513 (excerpts)

- Pain Treatment Act (page 502) “A health care professional shall not be subject to disciplinary action by a health professional regulatory board for prescribing or administering controlled substances in the course of treatment of a person for pain with the goal of controlling the patient’s pain for the duration of the pain.”
- Medical Board Regulations (page 504) “All licensees of the Board of Medical Examiners, except licensees listed in section (2) of this rule, will complete mandatory continuing medical education (CME) in the subjects of pain management and/or the treatment of terminally ill and dying patients as follows: A one-hour pain management

course specific to Oregon provided by the Pain Management Commission of the Department of Human Services; and a minimum of 6 (six) continuing medical education credit hours in the subjects of pain management and/or the treatment of terminally ill and dying patients. “ The Oregon Pharmacy Board (page 505) has similar CME requirements for their licensees.

- Medical Board Policy Statement (page 506) “ The BME [Oregon Board of Medical Examiners] urges the use of effective pain control for all patients, irrespective of the etiology of their pain...Physicians should make every effort to relieve the pain and suffering of their terminally ill and dying patients. The BME believes this effort is the physician’s primary obligation to these patients. Pain control in the terminally ill/dying patients may require doses of opioids well above the usual amounts administered intermittently or continually. The natural dying process may involve declining blood pressure, decreasing respirations and altered levels of consciousness. When these patients continue to experience pain, opioids should not be withheld on the basis of physiologic parameters or from fear of hastening death...Although there is often a significant amount of latitude regarding the amount of medication required for control of pain, the Board considers undertreatment as well as overtreatment to be below the level of standard of care.”
- There is no mention in the Wisconsin Pain Policy publication regarding the legalization of assisted suicide in Oregon.

Washington state Policies – pages 652-665 (excerpts)

- Medical Board Regulations (page 658) “The commission has adopted guidelines for the management of pain in order to acquaint practitioners with recognized national standards in the field of pain treatment. These guidelines specifically address the patient evaluation and treatment plan, informed consent, periodic reviews, use of consultations, and the necessity for maintaining accurate and complete medical records. These guidelines may be revised from time to time to reflect changes in the practice of pain management. Practitioners who cannot or choose not to treat patients who have complex or chronic pain conditions should offer appropriate referrals for those patients.”
“Practitioners treating pain should be: Knowledgeable about the complex nature of pain, Familiar with the pain treatment terms used in the commission’s pain treatment guidelines, and Knowledgeable about acceptable pain treatment modalities.”
- “No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.”
- Department of Health Guideline (page 660) “Under generally accepted standards of medical practice, opioids may be prescribed for the treatment of acute or chronic pain including chronic pain associated with cancer and other non-cancer pain conditions. Prescribing opioids requires special consideration. It is the position of the Department of Health that opioids may be prescribed, dispensed, or administered when there is an indicated medical need without fear of injudicious discipline.”

Claiming or implying that legalization of PAS in Oregon has been the cause of improvement in Oregon pain policies is dubious logic, since Oregon lagged behind many other states in the reports for the 2000 and 2003 years. As reported in *The Oregonian*, August 8, 2008, "Oregon's per capita drug use above 2006 U.S. average" by Maxine Bernstein, the Oregon Drug Threat Assessment reported that Oregonians abuse of prescription drugs has increased and treatment admissions for illicit prescription drugs increased 332 % in the past 10 years in Oregon. It would be dubious logic to imply that legalization of PAS was a factor in the increase in the use of illicit drugs in Oregon since the legalization of PAS; in the same manner it is dubious logic to imply a relationship between PAS legalization and improved pain control in the state.

4. Pain is not the primary reason Oregonians choose physician assisted suicide.

The assisted suicide movement has acknowledged that physical pain and suffering are not the main reasons for assisted suicide, they propose other arguments. The assisted suicide movement exploits extreme autonomy and self-determination as their main argument for assisted suicide legalization. When the first case of legal assisted suicide in Oregon was reported in the press, the physician who helped the ill woman end her life described the woman's tenacity and determination in her decision. "It was like talking to a locomotive. It was like talking to Superman when he's going after a train."

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] These patients were refusing hospice; they look as hospice as getting in the way of their death.

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]

An example of how important exerting control at the time of death (even if suffering is prolonged) is to some patients is described in (Ganzini et al, Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families, *J. Palliative Med.* 6:381-390, 2003. Physician W recounted: "When I saw her she was very, very weak and very dehydrated. And again, I told her, I said, "Gee, you're within a couple days probably of losing consciousness just from dehydration, and we could make sure that you just slept and did not suffer and it would just be a short time." She had the 15-day wait and she had 4 days before the medication could be prescribed. And I told her that I didn't think she would be able to do that unless she could solve the nausea and dehydration that she would last for 4 days consciously and to take the medicine. And she sort of struggled into a sitting position, asked her husband to get her a glass of water, and said, "I'll get the fluids down somehow." And sort of forced...See, this is the paradox, this is where you learn that lesson about the control issue---she actually reversed the natural process to prolong her suffering, in order to be in control, to push the button herself."

Assisted suicide 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 (such as LULAC) are very opposed and fearful of the legalization of assisted suicide because of their minority status and more limited resources. They are aware of the inequalities of healthcare because of economics.

- 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!"

- There are financial and societal dangers;. 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. Assisted suicide may become the only choice for some patients

In 2003, the Oregon Health Plan stopped paying for medicines for 10,000 low-income Oregonians; this included patients with AIDS, bone marrow transplants, mentally ill and seizure disorders. Over 50,000 low-income people were disenrolled from the Oregon Health Plan to keep the state budget balanced. In the spring of 2008, the Oregon Health Plan began accepting a limited number of new enrollees for the first time in nearly four years. It is a lottery-style system with 3,000 new slots each month. However, more than 91,000 uninsured people signed up to compete in the lottery.

Assisted suicide may become the "only choice" for some vulnerable patients. One in six Oregonians lack health insurance.

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.

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.

From KATU.com (Portland, Oregon TV Channel), Wednesday, July 30, 2008.

Letter Noting Assisted Suicide Raises Questions
By Susan Harding and KATU Web Staff

SPRINGFIELD, Ore.

Barbara Wagner has one wish: for more time. "I'm not ready, I'm not ready to die," the Springfield woman said. "I've got things I'd still like to do." Her doctor offered hope in the new chemotherapy drug Tarceva, but the Oregon Health Plan sent her a letter telling her the cancer treatment was not approved. Instead, the letter said, the plan would pay for comfort care, including "physician aid in dying," better known as assisted suicide. "I told them, I said, 'Who do you guys think you are?' You know, to say that you'll pay for my dying, but you won't pay to help me possibly live longer?" Wagner said. An unfortunate interpretation? Dr. Som Saha, chairman of the commission that sets policy for the Oregon Health Plan, said Wagner is making an "unfortunate interpretation" of the letter and that no one is telling her the health plan will only pay for her to die.

But one critic of assisted suicide calls the message disturbing nonetheless. "People deserve relief of their suffering, not giving them an overdose," said Dr. William Toffler. He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost \$4,000 a month while drugs for assisted suicide cost less than \$100.

Saha said state health officials do not consider whether it is cheaper for someone in the health plan to die than live. But he admitted they must consider the state's limited dollars when dealing with a case such as Wagner's. "If we invest thousands and thousands of dollars in one person's days to weeks, we are taking away those dollars from someone," Saha said. But the medical director at the cancer center where Wagner gets her care said some people may have incredible responses to treatment. Health plan hasn't evolved?

"He said the state has a financial incentive to offer death instead of life: Chemotherapy drugs such as Tarceva cost \$4,000 a month while drugs for assisted suicide cost less than \$100."

The Oregon Health Plan simply hasn't kept up with dramatic changes in chemotherapy, said Dr. David Fryefield of the Willamette Valley Cancer Center. Even for those with advanced cancer, new chemotherapy drugs can extend life. Yet the Oregon Health Plan only offers coverage for chemo that cures cancer, not if it can prolong a patient's life. "We are looking at today's ... 2008 treatment, but we're using 1993 standards," Fryefield said. "When the Oregon Health Plan was created, it was 15 years ago, and there were not all the chemotherapy drugs that there are today." Patients like Wagner can appeal a decision if they are denied coverage. Wagner appealed twice but lost both times. However, her doctors contacted the pharmaceutical company, Genentech, which agreed to give her the medication without charging her. But doctors told us, that is unusual for a company to give away such an expensive medication." (end of news story article)

In conclusion, when considering the legalization of assisted suicide, realize that:

- Pain is a scare tactic.
- Once a patient has the means to take their own life, incentives to care for the patient's symptoms and needs decrease.

- The legalization of assisted suicide in Oregon has not created a health paradise. There are problems with end-of-life care in Oregon.
- Pain is not the primary reason Oregonians choose physician-assisted suicide.
- The arguments favoring assisted suicide are demeaning to people with disabilities:
- There are financial and societal dangers with legalization of assisted suicide. 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. Assisted suicide may become the only choice for some patients.