

Joint Hearing of the Assembly Committee on Aging and Long-term Care and
Assembly Judiciary Committee

Perspectives on Physician Aid in Dying for the Terminally Ill: Competency Issues.

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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 Chairman of the Department of Radiation Oncology at Oregon Health & Science University for over 15 years. [I speak for myself and not for that university.] I am opposed to the legalization of assisted suicide and euthanasia. Since the passage of Oregon's physician-assisted suicide law, I have learned the significant harm and danger of assisted suicide to the vulnerably ill and to society.

LEGALIZATION OF ASSISTED SUICIDE PROTECTS DOCTORS, NOT PATIENTS

Assisted suicide legalization does not give any new rights to patients; its purpose is to legally protect doctors who write prescriptions for lethal drugs. The assisted suicide focus is not on comfort care, is not on pain management and is not on palliative care. The assisted suicide focus is to make assisted suicide legal. When you legalize assisted suicide, you give every doctor (good or bad) that power.

Physicians have the duty to safeguard human life, especially life of the most vulnerable: the sick, elderly, disabled, poor, ethnic minorities and that society may consider the most unproductive and burdensome. The false message of assisted suicide is that doctors can do a better job of killing patients than they can of caring for their medical needs. The physician's proper role as a "healer, comforter, and consoler" is not compatible with assisted suicide or

euthanasia. When a doctor writes a prescription for lethal drugs for assisted suicide, the message to the patient is: "I don't value you or your life." It destroys the trust between doctor and patient.

ASSISTED SUICIDE DESTROYS THE TRUST BETWEEN PATIENT AND DOCTOR

I have personal experience regarding this matter. My wife had been suffering for three years from advancing malignant lymphoma. In May 1982, we met again with her physician to see what more could be done for her. It was evident that not much more could be done other than comfort care. As we were about to leave his office, her physician said, "Well, I could write a prescription for an 'extra large' amount of pain medication for you." He did not say it was for her to hasten her death, but she and I both felt his intended message. We declined the prescription, since her current pain medication was sufficient. As I helped her to our car, she said, "He wants me to kill myself!" She and I were devastated. How could her physician, her trusted physician, subtly suggest to her that she take her own life? We had felt much discouragement during the prior three years, but not the deep despair that we felt at that time when her physician subtly suggested that her suicide be considered. Six days later she died naturally, with dignity and at ease in her bed, without the suggested medication.

ASSISTED SUICIDE "SAFEGUARDS" ARE BARRIERS TO ACCESS

The assisted suicide movement speaks of the "safeguards" in Oregon's assisted suicide Act. However, these "safeguards" are really boundaries or "fences". They are a barrier for access to assisted suicide for those outside those boundaries.

The assisted suicide movement exploits autonomy and self-determination as their main arguments for assisted suicide. They acknowledge that pain is not the reason to legalize assisted suicide. The patients in Oregon have been described as being extreme in their desire for continuing their coping mechanism of control in dying as they have in their life. The problem is that autonomy and boundaries (safeguards) don't mix. Autonomous people do not want boundaries. That is why the boundaries have not held in Oregon, and they will not hold in California.

Establishing competency for assisted suicide depends on who is asked to make the determination. Physicians favoring assisted suicide are more likely than physicians opposed to

assisted suicide to determine that a person requesting assisted suicide is competent. That is why the establishment of competency is such a fallacy. Regardless of what guidelines are written into an assisted suicide law, they will be ignored, bypassed and not followed. We have seen that occur in Oregon many times.

ASSISTED SUICIDE HAS OCCURRED IN SPITE OF MENTAL ILLNESS AND DEMENTIA.

THE ASSISTED SUICIDE MENTALITY COMPROMISES MEDICAL CARE.

Psychiatric observers have noted that acceptance of assisted suicide or euthanasia as a medical option has resulted in loss of knowledge about how to respond to suicidal ideation in the seriously ill. Legalistic, either-or action decisions, rather than nuanced clinical thinking, can hamper good medical evaluation and treatment. Patients who are discouraged and have suicidal ideas should be given hope and treatment. [\[1\]](#)

The first instance where there has been access to medical and psychiatric records of an Oregon patient who received a lethal prescription under Oregon's assisted suicide law has revealed the problems of determining competency of a patient. It has also illustrated how the medical care of a patient with a serious illness is compromised in the assisted suicide setting.

Michael Freeland was a 62-year old man with newly diagnosed lung cancer who was in contact with advocates opposed to assisted suicide as well as with advocates favoring assisted suicide. In spite of a history of depression requiring hospitalization, and of an attempted suicide attempt at an earlier age, about one year after his cancer diagnosis he received lethal medication from assisted-suicide advocates without a psychiatric evaluation.

He was later admitted to a hospital with the diagnosis of depression. A social worker's home-visit found many firearms and ammunition in his home, which were removed by the police prior to Mr. Freeland's hospital discharge. However, his lethal medication was left. Concerning the need for attendant care at home, 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". A day after hospital discharge, the 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.

Mr. Freeland lived for almost two years after receiving a terminal diagnosis, ultimately dying without using the lethal medication. [2]

Careful examination of the events during the last two years of his life demonstrate that the attempt to mix the traditional clinical approach and the assisted-suicide competency model results in a confusing approach to seriously ill patients, particularly those with a history of pre-existing mental illness. It is evident from his story that he was much better cared for by the traditional clinical care than he was by the assisted suicide competency approach.

Kate Cheney was a well-publicized case of an 85-year old woman with stomach cancer who sought assisted suicide. When a psychiatrist determined that her dementia made her incapable of making a decision, she received a second competency evaluation from a psychologist who said there was no severe impairment that would limit her ability to make a medical decision. Each evaluation drew different conclusions. There was also a question of coercive influence from her daughter. Mrs. Cheney ultimately received a prescription for lethal medication from a Kaiser Permanente Northwest physician, and she died of a barbiturate overdose. [3]

DEPRESSION, NOT PAIN, IS THE MAIN CAUSE OF SEEKING ASSISTED SUICIDE

Experience has shown that pain is not an important factor in determining if a person favors or desires assisted suicide or euthanasia. A scientific study of the attitudes & experiences of cancer patients, cancer specialists and the public in Massachusetts has shown that cancer patients actually experiencing pain were less likely to find assisted suicide or euthanasia acceptable than were those not experiencing pain. Patients with substantial pain or who had cancer were substantially more likely to say they would change cancer doctors if their doctor told them they had provided assisted suicide or euthanasia for other patients. The general public was more likely to favor assisted suicide than were patients with cancer. However, patients with depression and psychological distress were significantly more likely to find assisted suicide or euthanasia acceptable. [4]

A study of the attitudes of elderly patients and their families regarding physician-assisted suicide revealed that family members were more in favor of assisted suicide than were the

patients. The study found that patients who oppose assisted suicide represent a particularly vulnerable element of society (elderly persons, women, black individuals, and poor, uneducated, and demented persons), and such patients may warrant special protection. [5]

A prospective survey of 92 terminally ill patients who passed a cognitive screening test found that 17% were classified as having a high desire for hastened death. Desire of hastened death was significantly associated with a clinical diagnosis of depression and hopelessness. [6]

The central psychiatric issue in desire for death/suicide/assisted suicide is the recognition and treatment of depression. Depression in patients with advanced cancer is best managed using a combination of supportive psychotherapy, cognitive-behavioral techniques, and antidepressant medications. [7]

Yet, even cancer specialists have been found to markedly underestimate the level of depression in moderate or severely depressed patients. [8]

THERE IS MARKED VARIATION IN DESIRE FOR ASSISTED SUICIDE OVER TIME.

A scientific survey in six locations outside the state of Oregon of 988 terminally ill patients and their caregivers, found that 11% of patients seriously considered euthanasia or assisted suicide for themselves. At a follow-up interview a few months later, half of the terminally ill patients who had considered euthanasia or assisted suicide had changed their minds, while an almost equal number began considering these interventions. Terminally ill patients who had newly thought about euthanasia or assisted suicide at the follow-up interview were significantly more likely to have depressive symptoms or shortness of breath. Terminally ill patients whose physical functioning or pain worsened were not more likely to have newly considered euthanasia or assisted suicide. Ultimately, of the 256 patients who had died, one died by euthanasia or assisted suicide. [9]

A terminally ill patient's will to live has been shown to be highly unstable, with marked fluctuation over time. The four main predictor variables are depression, anxiety, shortness of breath and sense of well being, with the prominence of these variables changing over time. [10]

Individuals with prior serious illness have expressed gratitude that assisted suicide was not available at the time of that serious illness, for had it been available they might not now be alive and doing well.

PSYCHIATRISTS HAVE DIFFICULTY EVALUATING PATIENTS WHO DESIRE ASSISTED SUICIDE.

A PSYCHIATRIST'S VIEWS REGARDING ASSISTED SUICIDE CAN BIAS THE DETERMINATION OF THE PATIENT'S COMPETENCY.

Only 6% of Oregon psychiatrists are very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide. That means that over 90% of Oregon psychiatrists do not feel confident that they can adequately assess whether a psychiatric disorder is impairing the judgment of a patient requesting assisted suicide. Yet, the majority of Oregon psychiatrists who would agree to evaluate a patient under these circumstances also favor legalization of assisted suicide. Since psychiatrists and psychologists are in the position of gatekeeper to access to Oregon's assisted suicide law, there is great opportunity for bias in the competency evaluation. [\[11\]](#)

A national survey of forensic psychiatrists found that the majority believed that the presence of major depressive disorder should result in an automatic finding of incompetence. The specific capacity to consent to physician-assisted suicide cannot be scientifically determined. The ethical views of psychiatrists may influence their clinical opinions regarding patient competence to consent to assisted suicide. [\[12\]](#)

The authors of the "Mental Health Consultation" chapter in "The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals" [developed by The Task Force to Improve the Care of Terminally-Ill Oregonians convened by The Center for Ethics in Health Care, Oregon Health & Science University] have acknowledged the importance of the mental health consultation, as well as the opportunity for bias in the competency evaluation. The first two of their recommended guidelines are: [\[13\]](#)

"We strongly recommend mental health consultation for any person desiring a prescription under the Act. Mental health consultation is especially recommended for patients who are not enrolled in hospice. (A psychosocial evaluation by a social worker is standard practice for patients enrolled in hospice.)"

"Mental health professionals with strong personal biases for or against physician-assisted suicide should consider declining the consultation. Biases should be disclosed to the attending physician at the time of the referral."

The Mental Health Consultation chapter's authors' concluding recommended guideline is:

"When a mental health consultant cannot make a determination of capacity with confidence, the consultant can suggest treatments, reevaluate, or recommend a second mental health evaluation."

My personal responses to these Oregon guidelines are that they certainly are not being followed. That only 5% of those dying from assisted suicide in Oregon in 2003 had a mental health evaluation is a far cry from the recommendation of a "mental health evaluation for any person desiring a prescription under the Act". And what evidence do we have that mental health professionals with strong personal biases for or against physician-assisted suicide are declining the consultation? In truth, we have none. In fact, we have evidence that at least some of the psychiatrists who have participated in the few evaluations that have occurred are also publicly publishing papers supporting the case for assisted suicide. [\[14\]](#) The final guideline is a biased guideline in that it favors a second mental evaluation when a determination of capacity cannot be made in confidence. Why is not the reverse of this also being recommended; that is, if a determination of capacity is made by the first mental health consultation, a second mental health consultation should be recommended that may reverse the first determination of capacity?

WHAT IS THE EMOTIONAL EFFECT OF PATIENTS' AND FAMILIES' ANGER DIRECTED TOWARD THE PSYCHIATRIST WHO DISQUALIFYS THE PATIENT FOR ACCESS TO ASSISTED SUICIDE?

Psychiatrists who disqualify a patient's access to assisted suicide have faced anger from the patient and the patient's family. [\[15\]](#) [\[16\]](#) This anger may result in pressure on psychiatrists to act to permit that patient or future patients to have assisted suicide.

THERE IS VERY LIMITED MENTAL HEALTH EVALUATION OF PATIENTS SEEKING ASSISTED SUICIDE IN OREGON.

In 2003, only 5% of the 42 Oregonians dying from assisted suicide received a psychiatric/psychological examination. [\[17\]](#)

WE ARE DEPENDENT ON SELF-REPORTING BY INVOLVED PHYSICIANS AND THERE IS SECRECY REGARDING WHAT IS REALLY HAPPENING IN OREGON

Once an Oregon doctor has prescribed a lethal prescription there is very little oversight from the Oregon Health Department. The Oregon Health Department has no regulatory authority or resources to detect under-reporting or non-compliance. In 2003, doctors were present at the time patients took lethal medication only 29% of the time. How do we know what happened with the other 71% of patients who took the medication? We don't.

There is much information missing from the annual reports from the Oregon Department of Human Services. For the first five years of assisted suicide in Oregon, the reports have not even provided information regarding the number of doctors who had written lethal drugs. They did not report the number of doctors writing prescriptions in the 1998 & 2000 years; nor did they report the number of doctors writing prescriptions in the 1999, 2001 or 2002 years for those who died from lethal drugs.

This erratic reporting of information is exemplified in the following table which is derived from information in the Oregon DWD Act annual reports (1998 to 2003):

Year	# of prescriptions written	# of doctors writing prescriptions for lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior years	# of PAS deaths in year	# of doctors writing prescriptions for those who died from ingesting lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior years
1998	24	?	no prior year	16	14 of 15 deaths in 1st year report	no prior year
1999	33	22	6	27	?	?
2000	39	?	?	27	22	?
2001	44	33	?	21	?	?
2002	58	33	?	38	?	?
2003	67	42	?	42	30	?

The "?" represents absent information in the Oregon Department of Human Services published annual reports. They do not even know such basic information as the number of doctors involved in writing prescriptions for assisted suicide in Oregon!

THE PROPONENT ORGANIZATION OF PHYSICIAN-ASSISTED SUICIDE APPEARS TO KNOW MORE ABOUT WHAT IS HAPPENING IN OREGON THAN DOES THE OREGON DEPARTMENT OF HUMAN SERVICES.

It is noteworthy that the initial information regarding the number of Oregonians dying from physician-assisted suicide in the 2004 year came from the executive director of Compassion in Dying of Oregon (CID). An internet communication dated January 31, 2005, reported that there were 35 assisted suicide deaths in Oregon in 2004, and that 29 of those deaths were CID "clients". How did CID know there were 6 deaths of non-CID clients? The communication clearly includes specific details that would be impossible to know without access to information from the Oregon Health Division. For example, the communication reported that 29 CID clients took the medication, eighteen had a CID client support volunteer present, whereas the person's physician was present for only 8 of the 29 patients. [\[18\]](#)

There has been no public notification from the Oregon Department of Human Services regarding any information pertaining to physician-assisted suicides in the year 2004 in Oregon. One can only conclude that there is active and secret information-sharing between the CID and the Oregon Department of Human Services in the reporting process.

It is therefore, obvious from these numbers that it is the CID people who control the information reported to the majority of patient's physicians, who would then report what happened at the time of death to the Oregon Department of Human Services. The wall of secrecy around assisted suicide in Oregon continues unabated.

WHAT CALIFORNIANS MAY FACE

In 2003, there were 67 prescriptions for lethal drugs written and 42 deaths from assisted suicide in Oregon. California has 10 times the population of Oregon, so comparable annual numbers in California would be 670 prescriptions and 420 deaths.

I urge Californians to not follow the example of Oregon. For the protection of your vulnerably ill, I urge you to not legalize assisted suicide in California.

THERE WILL BE SIGNIFICANT CALIFORNIA STATE GOVERNMENT COSTS IN SETTING UP AND MONITORING PHYSICIAN-ASSISTED SUICIDE

I have been told that the state government of California is evaluating every cost. Those involved need to know that there will be administrative costs of legalized assisted suicide, especially if it is to be monitored as it should be monitored. This will probably be at least in the hundreds of thousands of dollars for a state that has ten times the population of Oregon.

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[16] Lee BC, editor *Compassion in Dying*, Kate Cheney chapter, pp 76-77. NewSage Press, Troutdale, Oregon, 2003.

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[18] Eighmey G. Fewer Oregon assisted suicides, *Self-Deliverance Right-to-Die Euthanasia Weblog*, January 31, 2005. <http://self-deliverance.blogspot.com>.