Physicians for Compassionate Care Friend of the Court Brief on Oregon v. Ashcroft et al

November 8, 2001
Physicians for Compassionate Care filed a friend of the court brief supporting the United States Department of Justice ruling that federally controlled substances may not be used for assisted suicide and protecting aggressive pain management. The brief documents problems with assisted suicide in Oregon (depressed, incompetent, and coerced patients being given assisted suicide, HMOs involved in assisted suicide, failure of safe guards, etc.) and DEA figures documenting the protection of aggressive pain management.

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AMICUS MEMORANDUM

Physicians for Compassionate Care Friend of the Court Brief on Oregon v. Ashcroft et al

UNITED STATES DISTRICT COURT

DISTRICT OF OREGON

STATE OF OREGON,

Plaintiff,

vs

JOHN ASHCROFT, in his official capacity as United States Attorney General; ASA HUTCHISON, in his official capacity as Administrator of the United States Drug Enforcement Administration; KENNETH MCGEE, in his official capacity as Administrator of the United States Drug Enforcement Administration, Portland Office; THE UNITED STATES OF AMERICA; THE UNITED STATES DEPARTMENT OF JUSTICE; and THE UNITED STATES DRUG ENFORCEMENT ADMINISTRATION

Defendants.

)

CASE NO. CV011647-JE

AMICUS MEMORANDUM OF PHYSICIANS FOR COMPASSIONATE CARE IN OPPOSITION TO PLAINTIFF*S MOTION FOR TEMPORARY RESTRAINING ORDER INTEREST OF AMICUS

Physicians for Compassionate Care (PCC) is a non-profit medical organization. Founded in Oregon, it currently has members in over 40 states. Its purpose is to provide education about pain relief and palliative care for seriously ill patients. This educational effort assists doctors and nurses to meet the needs of suffering patients who may be nearing the end of their lives. The issue presented to the court in this case concerns whether or not to issue a temporary restraining order forbidding the United States of America to enforce its laws concerning the use of federally regulated and controlled substances in the state of Oregon as it does in the other 49 states.

PCC has witnessed the results of doctor-assisted suicide in Oregon. This organization has developed and presented yearly regional medical conferences on how to treat patients with serious, often life-threatening illnesses without ever needing to resort to assisted suicide or euthanasia. Based on the above, PCC is uniquely positioned to provide information to the court regarding the dangers of physician-assisted suicide and the fallacies of the State*s position.

SUMMARY OF ARGUMENT

Experience with physician-assisted suicide in the state of Oregon, has revealed that it occurs in a complex medical, social, and economic system, making the individual patient vulnerable to adverse influence. There is evidence that family members and others sometimes pressure the patient to commit assisted suicide.1 It has unfairly discriminated against vulnerable individuals and has put seriously ill individuals contemplating suicide at dangerous and unequal risk of death by failing to provide equal protection of their lives.2 One vulnerable class of individuals, those labeled "terminally ill," have been devalued and are no longer afforded the same protection against assisted suicide3 which other Oregonians enjoy.4 This failure to assure equal protection has resulted in some of the depressed and mentally infirm who have been labeled terminally ill receiving assisted suicide instead of medical care. 5

Legalization and institutionalization of assisted suicide in Oregon not only has had an adverse effect on particular individuals who may feel like giving up on life; it also has harmed the general welfare of society as a whole.6 7 As observed in the Code of Medical Ethics, Sec. 2.211, overthrowing laws protecting the public against doctor-assisted suicide is destructive to the doctor-patient relationship, proves impossible to control, and poses serious societal risks.8 It creates an economic environment with institutional incentives favoring suicide over medical care.9 It is impossible to adequately monitor.10

Any illusion that assisted suicide could be confined to self-administered oral overdose quickly dissipated once the practice was allowed. Lethal injection must necessarily also be allowed for those who cannot quickly swallow the contents of the 90 or so

capsules it takes to commit assisted suicide or who have failed in their assisted-suicide attempt. The inevitable introduction of lethal injection or infusion transfers power and control to the doctor and the medical establishment rather than the individual as originally intended.

The United States of America has the right and responsibility to uphold its laws, especially those laws that are intended to address an imminent danger to some of our most vulnerable citizens. The State*s request for a temporary restraining order should not be granted.

ARGUMENT

I. PRESSURE ON VULNERABLE PATIENTS

Because physician-assisted suicide occurs in a complex medical, social, and economic system, discouraged patients are vulnerable to pressure, coercion, and less direct forms of influence to commit suicide. The literature is replete with examples of the subtle and not so subtle pressure that is placed on sick or elderly patients.

Mrs. Kate Cheney was an elderly, Oregon woman with growing dementia and a diagnosis of a potentially terminal cancer.11 When her daughter accompanied her to her doctor's appointment to formally request assisted suicide under the new suicide law, the doctor did not agree with that course of action. The daughter,12 not the patient, then insisted the mother obtain a second opinion from a new doctor within the patients Health Maintenance Organization, Kaiser Permanente. The HMO approved the daughters request on behalf of her mother for a second opinion regarding the assisted suicide request.

The second doctor approved the assisted suicide request and arranged for a psychiatric evaluation, a standard procedure for the HMO. The psychiatrist, who released a written report to the newspaper, found that Mrs. Cheney had short-term memory deficits and dementia, and that the assisted suicide request appeared to be the daughter's "agenda."13 The daughter, who also accompanied Mrs. Cheney to this appointment, "coached her" in her answers, even when the psychiatrist asked her not to do so.14 Concerning the patient, the psychiatrist observed, "she does not seem to be explicitly pushing for this."15 The psychiatrist concluded that the patient lacked sufficient capacity to weigh options about assisted suicide; thus, she was not eligible for doctor-assisted suicide.16

The patient accepted this assessment. Her daughter, however, "became angry."17 The daughter, not the patient, then "decided on a second competency evaluation."18 Kaiser HMO apparently authorized this second off-panel mental health evaluation.

The new psychologist admitted the patient could not even remember when she was diagnosed with terminal cancer, although it had only been within the last three months. She also wrote that the patient's "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive".19 Nevertheless, she approved the assisted suicide.

With two conflicting mental health opinions, the final decision, far from being an "autonomous" decision made in private by the patient, was made by Kaiser HMO doctor-administrator, Dr. Robert Richardson, who approved giving a lethal overdose to the elderly woman, notwithstanding the coercive family pressure.

Kaiser Permanente is a capitated HMO with a financial incentive plan for its doctors. The existence of an economic incentive program put in place purposefully to induce doctors to reduce medical costs creates at least the potential for tragic conflict of interest issues.

This well documented case in Oregon illustrates the myriad of problems, both legal and moral, inherent with physician-assisted suicide. In Ms. Cheney*s case, even those who made the final decision to go ahead with the assisted suicide admitted that she had been diagnosed as mentally infirm. The pressure directed at Ms. Cheney from her family was so assertive, her own motivations could not clearly be distinguished from those of her daughter's. Psychiatric evaluation served no protective function for her, since an opinion protecting her against assisted suicide, merely prompted the daughter, not the patient, to search for another opinion.

Outside pressure or influence is not unusual when assisted suicide becomes legalized. In fact, in the Netherlands, where assisted suicide is legal, the majority of physicians believe that it is appropriate to recommend assisted suicide even without a specific patient request.20 Numerous cases of patients under family pressure to commit assisted suicide have been recorded in the Netherlands.21 As the Cheney case illustrates, Oregon is not immune to such problems. Doctor assisted suicide harms the public interest in protecting the lives of vulnerable individuals.

II. DISCRIMINATION AGAINST THE VULNERABLE

The law that legalized Ms. Cheney's physician-assisted suicide, a law, according to its backers, that would give her a new right to a "dignified death," actually discriminated against her and put her at increased risk of dying prematurely because she had been labeled "terminal." Assigned to this arbitrary, non-verifiable, and non-rational category of "terminally ill," Ms. Cheney*s life was devalued to the point that she no longer was protected by laws against assisted suicide that protect all other Oregon

citizens.22 In contrast, a demented patient who was not labeled "terminal" would have been protected against assisted suicide regardless of pressure from the family.

The "terminal" illness designation is arbitrary, defined in Oregon law as a prediction according to the doctor's judgment that the patient will die within six months.23 This prediction is notoriously difficult to make.24 All physicians have known patients who were thought to have a lethal condition for whom the diagnosis was mistaken or who unexpectedly recovered entirely and went on to live productive lives. The difficulty in determining when a patient might only have six months to live and therefore can be deemed "terminal" and eligible for assisted suicide is illustrated by the fact that at least one Oregon case took the lethal drugs more than six months after they were prescribed,25 and more than six months after the patient had been labeled "terminally ill."

Even if "terminal illness" could be accurately predicted, that is no reason to discriminate against this category of individuals by considering their lives any less worthy of equal protection of the law than anyone else's.26 The physician's belief in the inherent and equal value of each patient is a fundamental, underlying feature of the doctor-patient relationship which protects vulnerable individuals.27 As noted by Washington state and reiterated by the United States Supreme Court "... all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law."28 Failure to give this full protection of the law to perhaps the most vulnerable individuals in our society harms public interest in assuring equal protection of the law.

III. LACK OF PROTECTION FOR THE MENTALLY ILL AND OTHERS

Individuals suffering from depression and other mental illnesses, who have been singled out by the label "terminally ill," acquired an additional burden of vulnerability when protections against doctor-assisted suicide were removed in Oregon. This factor is particularly important, since medical studies have demonstrated that seriously ill individuals who desire an early death are usually afflicted with treatable depressive symptoms.29

The first publicly reported case of doctor-assisted suicide in Oregon was a woman who had been diagnosed as depressed, yet she was given assisted suicide in two-and-a-half weeks from the time she was referred to the Compassion in Dying Federation. This woman, in her early 80's, had a more than twenty year history of breast cancer. When she eventually developed metastases in her lungs, her physician told her these metastases may eventually prove fatal.30 At that time, the state had been saturated by frightening portrayals of the normal dying process as exaggeratedly grotesque, demeaning, and undignified. When she reportedly requested assisted suicide, her

regular physician declined to give her a lethal overdose. As in the Cheney case, an opinion with a second physician with a different opinion was sought.[31] This doctor, however, concluded that the patient was depressed and needed treatment of her depression,[32] not assisted suicide. He even gave her a prescription for antidepressant medication.[33] The potentially lifesaving prescription, however, was never filled.[34]

Instead of insisting that the patient follow through on treatment likely to alleviate feelings of hopelessness associated with a depression,[35] a family member, not the patient herself, sought yet another opinion, this time from the Compassion in Dying Federation, a politically active group promoting legalization of assisted suicide, which had just moved to Oregon a few weeks after the assisted suicide law finally became effective. Dr. Peter Goodwin, medical director of that organization, determined over the telephone that the patient was "rational"[36] without ever having actually examined her himself. He then gave the patient a referral to a doctor who, like him, had been active in the political campaign promoting legalization of assisted suicide, Dr. Peter Reagan.[37]

Oregon law,[38] similar to the Dutch practice,[39] does not require patients to receive psychiatric evaluation before being given assisted suicide. When such an evaluation is obtained, it is at the discretion of the assisted suicide doctor him- or herself. Even then, the presence or absence of depression or other mental disorder itself is not considered the crucial factor. The Oregon law states that the depression must be thought by the physician to cause "impaired judgment"[40] before the assisted suicide decision is called into question or postponed. This qualification that the depression must be impairing judgment is unusual since "impairment of judgment is a basic characteristic of the disorder."[41] Depression typically causes feelings of hopelessness, either-or thinking, and a tendency to overlook possible solutions to problems.[42]

In a prominent guidebook on implementing Oregon's assisted-suicide law,[43] depression does not disqualify one for assisted suicide. The guidebook makes this assertion, despite the fact that thorough epidemiological studies of suicide conclude, "A psychiatric disorder is a necessary condition for suicide to occur."[44] And the psychiatric literature observes that "patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition."[45] The guidebook itself asserted, "Treatment of psychiatric disorder in those who attempt suicide is very effective in abolishing suicidal ideation."[46] It is inexplicable, then, how the same guidebook concluded that even after a depression is diagnosed "refusal of mental health treatment by the patient does not constitute a legal barrier to receiving a prescription for a lethal dose of medication."[47]

The doctors to whom this woman, diagnosed with depression, was referred by Compassion in Dying, however, apparently did not consider the patient to have been

depressed or to have impaired judgment,48 although the previous psychiatrist had diagnosed her as depressed and attempted to treat her depression instead of giving her a lethal overdose of federally controlled substances.

The psychiatrist approved the assisted suicide after only one visit. This quick judgment was made despite the fact that another doctor had already diagnosed the patient as depressed and there is no indication that the physician who attempted to treat her depression was consulted to consider the basis of his diagnosis and treatment. Only 6% of Oregon psychiatrists are very confident they can determine in a single visit when depression may be affecting decisions to commit assisted suicide in the absence of a long-term relationship.49 Nevertheless, this life and death decision was made in a single visit by a psychiatrist chosen by the assisted-suicide doctor himself. None of the doctors who carried out the assisted suicide had a long-term relationship with the patient.

This woman did not receive the kind of effective psychiatric treatment which has been described throughout the medical literature and has been discussed specifically in regard to this particular case.50 She did not receive the kind of treatment that would be appropriate for any other depressed and suicidal individual. Instead, because she was labeled "terminally ill," she was given assisted suicide using federally controlled substances by doctors who barely knew her.

Standard medical practice requires doctors to respond to suicidal wishes with a thorough evaluation of possible causes of the suicidal wishes and an attempt to remove those causes.51 Depression is the most common cause of suicidal ideas and feelings even among the seriously ill; the addition of substance abuse, especially alcoholism,52 adds significantly to the risk, as does membership in certain ethnic groups. For example, American Indians, along with Alaskan natives, "have the highest suicide rates of any ethnic group in the United States,"53 putting individuals from those groups at significantly greater risk for suicide in general and therefore also for doctor-assisted suicide, since there has been no demonstrable difference in the causes of suicide in the elderly or ill than in anyone else.

The idea that being elderly or having a physical illness without a psychiatric disorder might be a significant, independent cause for suicide is unfounded and appears to be based on bias alone. While physical illness is sometimes associated with suicide among the elderly, physical illness is so common among the elderly that the appearance of association is misleading. Statistical analysis demonstrates that there is no evidence that physical illness alone is an independent risk factor for suicide, and there is considerable evidence that "comorbid psychopathologic condition is likely to be the underlying factor in elderly suicide."54 In one study, among non-demented 85-year-olds, "No mentally healthy subject had seriously considered taking his or her life

during the month before examination,"55 regardless of their physical condition, although 6% had at least a fleeting suicidal feeling. A recent medical consensus statement published in the Journal of the American Medical Association56 noted that depression in the elderly frequently accompanies physical illness, which makes this potentially lethal condition especially easy to overlook. It emphasized that while late-onset depression is a common characteristic in elderly suicide, even cancer did not independently add risk to the relationship between depression and suicide.

Thus, lifting protections against doctor-assisted suicide from one class of individuals, those labeled "terminally ill," adds the most burden of risk to members of a group of individuals already found to be vulnerable and stigmatized -- the mentally ill. Instead of being given a thorough clinical evaluation for the purposes of diagnosing and treating the causes of suicidal despair, these patients can now be given a minimal assessment of competence to make medical decisions and can be given assisted suicide instead of treatment. Or, they may be given no evaluation of possible mental illness contributing to their suicidal thoughts. Under Oregon law (ORS 127.825) no mental health evaluation is required. This decision is placed entirely in the hands of the doctor intending to carry out the assisted suicide. In practice, in the Netherlands, only 3% of assisted suicide and euthanasia cases are even referred for psychiatric evaluation.57 In Oregon, only 19% of recently reported assisted-suicide cases had been referred for mental health evaluation.58 We know that in previous years dementia was diagnosed in one and depression in another, yet they were given assisted suicide nevertheless. Any other suicidal patient, not stigmatized by the label terminally ill, would have been given treatment, not a lethal overdose in response to their suicidal impulses.

Therefore, it can be seen that within the category of those labeled "terminally ill," there are those suffering from mental illness, especially depression and alcoholism, who are particularly vulnerable and who were put at additional discriminatory risk once protections against assisted suicide were lifted. As recognized by the U.S. Supreme Court in Glucksberg,

"legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses."59

The failure in Oregon to protect the mentally ill against assisted suicide using federally controlled substances has harmed the public interest in providing equal protection of the law to vulnerable groups.

IV. CONTEXT OF ECONOMIC INCENTIVE

A psychiatrist and a psychologist both agreed that Mrs. Cheney was under direct influence from her family to commit assisted suicide. Yet, the removal of societal prohibition against assisted suicide also creates less direct, but more pervasive, influences promoting assisted suicide.

For example, Kaiser Permanente, the medical system in which Mrs. Cheney was given a lethal overdose, is a capitated HMO. Such organizations receive compensation for the number of patients enrolled in their system regardless of the cost of their medical care. This HMO also has a financial incentive plan for its physicians as a strategy to minimize expenses. While it is unlikely that Dr. Richardson was directly and overtly pressured to bias his decision in favor of Mrs. Cheney*s doctor-assisted suicide, institutional profit sharing plans do affect the decisions of physicians. That is why such plans exist.

In Oregon additional financial incentives have already arisen. For example, Oregon has a rationed health plan for the poor called the Oregon Health Plan (OHP). The OHP denies payment for more than 170 needed services, but fully funds assisted suicide.60 Assisted suicide can cost the state as little as $45, according to its own estimates, and some of the treatments it denies are extraordinarily expensive.61 This denial of funding for needed medical assistance and providing state funding for assisted suicide, while not overtly coercive, creates an incentive for assisted suicide in the economic environment in which doctor-assisted suicide is conducted.

In addition to the forthright denial of funding for treatment, the OHP contains within its arrangements and structures other cost saving features. These bureaucratic arrangements have resulted in over 38% of OHP members reporting barriers to obtaining mental health services.62 Similarly, within weeks of the assisted suicide law being implemented, Oregon state Senator Jeannette Hamby63 complained that the state placed barriers in the way of funding for state-of-the-art psychiatric medicines for the poor. Since depression is the most frequent cause of requests for assisted suicide,64 this funding restriction is particularly troublesome.

In the private sector, many Oregon insurance companies have skirted federal laws forbidding discriminatory dollar limits on mental health benefits by translating those dollar limits directly into number of visits; and Oregon, unlike many states, has failed to provide parity for mental health care.65 Limits on funding for mental health care and poor access to that care, along with the state of Oregon calling suicide a "dignified" death and paying for doctor-assisted suicide, creates an economic environment which can influence the seriously ill who become discouraged to chose suicide. The result of such economic policies may not be intended by health policy planners to encourage assisted suicide, but the result is the same -- the poor and disabled find doctor-assisted suicide easier to "access" than treatment of their anxiety,

discouragement, or fear. The U.S. Supreme Court recognized this danger in Glucksberg, citing the New York Task Force,

"The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group."66

Even within the hospice system, most hospice care in Oregon is either capitated or has a total limit.

In addition to economic pressures created by these limits, there are other, more subtle barriers to good hospice care. To obtain funding for hospice treatment, most individuals must waive any right to active treatment of their disorder, thereby assigning themselves to a "hopeless" category. This economic arrangement can have a highly destructive influence on seriously ill and vulnerable individuals. For example, despite the fact that radiation therapy for primary brain tumors or metastases has a greater than 50% chance of decreasing pain and improving function, most patients must give up the hospice benefit to receive radiation therapy.67 Such a barrier can

place a patient in an agonizing dilemma between being able to receive the kind of treatment for pain that they need and their wish to obtain optimal palliative care in a hospice. When assisted suicide is offered as a way out of that dilemma, the results can be disastrous.

Even more blatantly, one Oregon HMO (Qual Med) has been reported to cap in home palliative care at $1,000 while fully funding assisted suicide.68 The vice-president and legal counsel for this same large, Oregon HMO wrote an opinion piece only a few weeks after implementation of the assisted suicide law titled, "What Price Dying? The Debate over How to Die Now Can Shift to How Much Money We Think It's Worth."69 This HMO executive implied throughout the article that care of the seriously ill, who may be near the end of life, might be an unnecessary extravagance which society can no longer afford.

Most managers of health care dollars may not intend to drive people toward assisted suicide to save money. Once the protections against physician-assisted suicide were lifted, however, the result has been that their decisions do just that. Restrictive economic decisions combined with allowing doctors to write lethal prescriptions to assist patients in committing suicide jeopardizes good palliative care, including pain care and treatment of depression, and thereby creates a public danger and harms the public interest in protecting society against the creation of financial schemes which favor assisted suicide over medical care.

V. DAMAGE TO THE DOCTOR-PATIENT RELATIONSHIP

The U.S. Supreme Court in Glucksberg recognized the legitimate public interest in protecting the doctor-patient relationship. It concluded that, "The State also has an interest in protecting the integrity and ethics of the medical profession."70

The American Medical Association (AMA) along with other medical and physicians' groups have concluded, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."71 The New York Task Force on Life and the Law72 agreed that lifting protections against doctor-assisted suicide would undermine trust essential to the doctor-patient relationship. Since that relationship is based on the assumption that the doctor values the life of each patient equally,73 the erosion of that relationship becomes inevitable, once some patients' lives are no longer considered equally valuable and equally deserving of protection as other people's lives.

This mistrust caused by allowing doctor-assisted suicide expands to the entire medical system, which doctors represent. In the Netherlands, for example, loss of trust has resulted in the finding "that 60 percent of older people were afraid that their lives could be ended against their will."74

This erosion of trust has already become apparent in Oregon. For example, one Oregon Health Plan patient had to leave hospice care because of shifts he noticed in the attitudes of hospice personnel. He went to the hospital to have a procedure to relieve painful pressure from a closed space in his abdomen. He reported that he was shocked and hurt when his hospice nurse saw him and criticized him, "What are you doing here? You are a hospice patient."75 Regardless the motivation for the nurse*s queries, the feeling of trust between this patient and his nurse and the hospice system in general had been undermined by the legalization of doctor-assisted suicide. He no longer trusted the doctor-patient relationship or the nurse-patient relationship.

Unfortunately, this feeling of mistrust may have been warranted. Five seriously ill patients in a Sheridan, Oregon, hospice were given excessive doses of morphine by a nurse, between November, 1997, and January, 1998, just after the Oregon assisted-suicide law was implemented, according to criminal investigators.76 The overdoses resulted in the deaths of four of the five patients. Some patients were determined by investigators to have refused pain medication and were given it nonetheless. Another was given repeated narcotic doses when he was unconscious or unresponsive.77 The one woman who survived had been placed on hospice, which meant that she had been determined to be "terminally ill" and to have less than six months to live by the nurse who eventually gave her a life threatening overdose. In fact, she failed to meet the criteria for "terminal illness" because two years later she was still alive.

Her experience with the attempts to kill her with a lethal overdose of federally controlled substances, however, undermined her trust in the medical care system to the extent that she insists on always sleeping with her door locked.78

The erosion of trust in the doctor-patient relationship, and more broadly in the complex medical system in which people are actually treated, has already begun in the state of Oregon as it has in the Netherlands, thereby harming public interest in protecting the integrity and ethics of the medical profession and of the medical system in which doctors practice.

VI. INABILITY TO REGULATE AND CONTROL

While some might argue that the overdose of five hospice patients was an aberration resulting from a single deranged individual's action, there is considerable statistical information to the contrary. Once assisted suicide is allowed in some circumstances, individual medical personnel increasingly interpret that acceptance as approval of other kinds of killing in the medical setting.

In the Netherlands, where doctor-assisted suicide has been allowed longer than in Oregon, there is evidence that killing in the medical setting moves from doctor-assisted suicide to active euthanasia, from the terminally ill to the chronically-ill, from voluntary to non-voluntary.79 For each voluntary assisted suicide in the Netherlands, there are more than twice as many cases of involuntary euthanasia. As the U.S. Supreme Court stated,

"The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as 'the deliberate termination of another's life at his request'), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patient's explicit consent." 80

It is not surprising, then, that such abuse is already becoming apparent in Oregon.

VII. STATE MONITORING IS INEFFECTIVE

While some initially contended that the Oregon Health Division (OHD) report on the first year experience with doctor-assisted suicide81 indicated that there was no abuse of doctor-assisted suicide in Oregon, that report has been widely criticized.82 The OHD review of 1998 reported cases was particularly criticized because of "its failure to address the limits of the information it has available, overreaching its data to draw unwarranted conclusions."83 The report's declaration of a lack of problems was

unwarranted.[84] The first publicly reported case of assisted suicide was widely known to have been diagnosed with depression, yet the report failed to reveal this fact. Neither did the report note that same woman mentioned that concerns about finances were one motivating factor in her decision for assisted suicide.[85] The OHD apparently overlooked these problems and other problems, because it only interviewed the doctors who prescribed the lethal drugs and who therefore had a vested interest in justifying their behavior.

Since that time, OHD has issued two more reports with similar unwarranted reassurances based upon similar methodological shortcomings. The second year, the OHD also interviewed some family members, but those family members were chosen by the assisted-suicide doctors themselves and were also motivated to justify their recent behavior.

There is solid evidence that not all the cases were reported. At least one assisted suicide attempt resulted in such disturbing symptoms that the family called 911. The patient was taken to the hospital and resuscitated. This case apparently was never reported. This instance when a known failed assisted suicide case was not reported suggests that there is skewed reporting with complications being hidden. Assisted suicide and euthanasia advocate, Dr. Sherwin Nuland,[86] cast doubt on the credibility of the Oregon report when he observed that a Dutch report in the New England Journal of Medicine indicated 18% of assisted suicide attempts needed to be ended with lethal injection, usually due to complications,[87] but the OHD was yet to find a complication, undoubtedly due to biased and faulty data collection.

The OHD also failed to mention documented dementia in the Kate Cheney case, similar to its failure to mention the diagnosis of depression in the first publicly reported case that should have been discussed in the first report. It did not mention known multiple or conflicting mental health opinions. It only mentioned that 10 of 27 cases were referred for such evaluations that year, but said nothing about the results.

Neither did OHD report that there were any instances of family pressure or coercion, despite the fact that two mental health professionals were known to have found such factors present in the Kate Cheney case. It is not known in how many other cases such pressures may have played a part.

Concerning the issue of economic pressures, OHD only asserted that all the assisted-suicide cases were insured. It provided no information about what the financial arrangements of the insurance companies might be. It did not mention the capitated and financial incentive plan of Kaiser HMO where Mrs. Cheney died. It did not mention the rationing of health care and the barriers to mental health care on the OHP upon which four cases had to rely.[88] And, it said nothing about how many patients

belonged to HMOs which put limits on payments for in-home palliative care at very low amounts, yet fully fund assisted suicide, as Qual Med HMO has been reported to do.

In its third and most recent report, instead of gathering useful information, OHD once again reverted to only gathering information from the doctors who performed the assisted suicide themselves, with no independent validation of the adequacy of palliative care. OHD again entirely overlooked complications and troublesome cases, such as the Joan Lucas case.89

Joan Lucas was a 65-year-old woman with amyotrophic lateral sclerosis (ALS), who made a suicide attempt, not through assisted suicide, but by taking an overdose of her own medication, as is so often the case with suicidal individuals. Because she had a serious illness, instead of rushing her to the hospital, her family watched her writhing in agony for an entire day. When she finally awakened, her family did not obtain the psychiatric consultation she needed and deserved. Instead, they asked Compassion in Dying to refer her to an assisted-suicide doctor. This doctor eventually sent her to a psychologist, as the doctor put it, only to cover himself, apparently against liability. When no reputable psychiatrist would perform such a perfunctory assisted-suicide evaluation instead of an evaluation for treatment, a psychologist cooperated. He sent Mrs. Lucas a Minnesota Multiphasic Personality Inventory (MMPI), a multiple choice questionnaire, because she could not go to the clinic. Her adult children read her the questions and filled out the form as a group with considerable levity. Based on the test results, the psychologist declared that the patient was not depressed and could have assisted suicide despite her having made a previous suicide attempt. The OHD reported that only 19% of patients who were given lethal overdoses of federally controlled substances that year were referred for psychiatric evaluation. It did not reveal that at least one of the evaluations was pro forma and intended to cover the assisted-suicide doctor. It did not reveal how many more such problems there might have been. It did not reveal any notable problems at all.

The failure of Oregon to aggressively monitor assisted suicide and to provide meaningful protections for vulnerable individuals is creating a public health crisis and harming the public interest in providing equal protection to the vulnerable.

VIII. ASSISTED SUICIDE EXPANDS TO INCLUDE LETHAL INJECTION

One of the complications the OHD failed to report occurred in Patrick Matheny's case.90 Mr. Matheny was a man with amyotrophic lateral sclerosis (ALS), who received through the mail a huge quantity of barbiturates prescribed by an assisted-suicide doctor.91 When he undertook his assisted suicide with no doctor in attendance, he had difficulty swallowing the contents of the large number of capsules,

because of his medical condition. He could not complete his attempt and tried again the next morning. After he could not complete the second attempt, his brother-in-law said he "helped" him die and complained that Oregon's suicide law discriminates against those who cannot swallow.92

The body was cremated within a day; consequently, no autopsy could ascertain the cause of death. Doctors and other citizens demanded that the prosecutor investigate the death, because illegal suffocation of the patient has been the most frequent method of "helping" patients whose attempts fail.93 The Coos County prosecutor, however, refused to pursue the case because, according to the prosecutor, individuals who are disabled by being unable to swallow should have the "right" to assisted suicide, presumably through lethal injection.94

It is virtually certain that failed assisted suicide cases will lead to the acceptance of lethal injection in Oregon. That is what has happened in the Netherlands. That is what Oregon's Derek Humphry has been demanding as a solution to the problem of inability to swallow and failed attempts.95 And that is what Deputy Attorney General David Schuman in Oregon has advocated. Even in the Oregon Health Law Manual,96 there is already language setting up the acceptance of lethal infusion, as if that were somehow distinct from lethal injection.

The inevitable progression to lethal injection, which occurred in the Netherlands,97 is already occurring in Oregon98 and poses a severe threat to the public interest in protecting the lives of its citizens.

IX. NO EFFECT ON PAIN TREATMENT AND PALLIATIVE CARE

The most recent OHD report on assisted suicide99 reveals that 99.9% of patients who die in the state of Oregon continued to receive medical and palliative care and died of natural causes. The other 0.1% of cases also could have been treated medically, humanely, and comfortably to the natural end of their lives, as is clearly possible,100 instead of being killed by assisted suicide using federally controlled substances. As the AMA succinctly concluded after reviewing the most recent OHD reports,

"...the issues expressed by patients in Oregon can be addressed without physician-assisted suicide."101

At Physicians for Compassionate Care conferences on state-of-the-art pain treatment and palliative care, each year national experts have reassured doctors, nurses, and hospice workers that no patient needs to die in unrelieved pain. In fact, not one patient during the first three years of assisted suicide in Oregon102 listed actual untreatable pain as the main cause of their suicidal wishes. Instead, those individuals who were

given lethal overdoses in Oregon were anxious, depressed, or had other subjective psychological and social concerns. Among these anxieties was fear of being a burden on their families in nearly two-thirds of the cases.103 Many of these anxieties may also have been contributed to by the exaggerated portrayal by assisted suicide advocates of the natural dying process as somehow undignified, demeaning, or grotesque, a portrayal which may literally frighten some vulnerable individuals to death. These subjective concerns, and any anxiety or depression they occasioned, could have been more appropriately addressed through other means than giving the patient a lethal overdose using federally controlled substances.104

Reassurance, the presence of another caring human being, competent treatment of depression and anxiety with medication and psychotherapy, the promise of adequate pain care, and a commitment not to abandon patients and to value them to the natural end of their lives is a more appropriate response to fear or depression than the offer physician-assisted suicide.

In announcing its plans to enforce federal laws protecting the seriously ill against the misuse of federally controlled substances for assisted suicide uniformly, the U.S. Department of Justice officially has clarified for the first time that aggressive pain management will be protected even if it may increase the likelihood of patient death in rare instances. This clarification is consistent with the position of the AMA and should be reassuring to doctors in every state.

Concerning Oregon and assisted suicide, the Department of Justice has commented that the Drug Enforcement Administration (DEA) will only need to look at the assisted-suicide reporting forms themselves--which name the drugs used--and therefore will not increase its scrutiny of physicians using controlled substances for pain management in Oregon. It has wisely reassured doctors in an open letter that the DEA will not be spotlighting physician prescribing practices in Oregon. Physicians for Compassionate Care is distributing that letter and the actual details of the ruling to all physicians in Oregon to counter any attempts by assisted suicide advocates to misconstrue DEA intentions and thereby potentially frighten Oregon doctors.

The Department of Justice announcement of its ruling includes all the reassurances Oregon's U.S. Senator Gordon Smith, an opponent of assisted suicide, requested in his January 25, 2001, letter to President Bush.105 It also includes those elements emphasized by the AMA official stance on pain care and assisted suicide, and it reaffirms the time-honored AMA ethic that doctors must never intentionally harm their patients.

X. CONCLUSION

Doctor-assisted suicide is not a private action, but takes place in a complex medical, social and economic setting. The social and institutional nature of doctor-assisted suicide subjects the discouraged or anxious patient to influence and coercion. It discriminates against a vulnerable class of individuals, those labeled "terminally ill," as well as the mentally ill and/or alcoholic who are put especially at increased risk.

Because assisted suicide is not a "private" and "autonomous" act, it endangers not only the individual contemplating assisted suicide, but also the general welfare of society and the public interests of the state. It is destructive to the doctor-patient relationship and leads to the creation of economic circumstances favoring assisted suicide over more expensive responses to serious illness. Because it cannot be adequately monitored, it is impossible to control and inevitably leads to the introduction of lethal injection for difficult cases.

The United States of America has both the right and the responsibility to uniformly uphold its laws protecting its citizens against the use of federally controlled substances. As set forth above, that enforcement is necessary to prevent egregious wrongs that would otherwise occur in Oregon.

DATED November 8, 2001

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