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## PHYSICIANS FOR COMPASSIONATE CARE NEWS

Affirming An Ethic That All Human Life is Inherently Valuable

Vol.1, No.2, Spring 1998

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### CLINICAL GUIDELINES: Non-Participation in Doctor Assisted Suicide

These recommendations are intended to protect our patients, preserve our own moral integrity, and maintain our right not to participate in assisted suicides.

Post a copy of your professional ethics so that patients are informed in advance of your principles. \*

Avoid initiating discussion of assisted suicide in the context of discussing patient treatment options, because initiating such discussion suggests the doctors approval of the patients suicide.

Continue to treat suicidal ideation as a symptom requiring diagnosis and treatment. Just as with any other patient who brings up suicide, if the seriously ill patient expresses suicidal thoughts, this symptom should be taken seriously. The suicidal thoughts should be discussed with the patient and included in the overall treatment plan. Case consultation, family meetings, referral for counseling, psychiatry referral for medication evaluation, pastoral care, pain management consults, and palliative care may all be appropriate treatment interventions for the suicidal, seriously ill patient.

If the patient insist upon discussing suicidal ideation in terms of political “rights” rather than as a clinical problem, remind the patient that you value all human life including theirs and that you want to continue to work with them. Reassure the patient that treatment of pain, discomfort, or depression is very likely to help them feel their live is still worth living.

Continue to offer good care. The patient is free to transfer to another doctor at their own initiative without your suggesting such a move. The law does not require the physician to refer the patient to a doctor who will participate in the suicide.

Decline to refer for assisted suicide, because to refer for suicide will contribute to the patient's discouragement, compromise the physician's moral integrity, and be considered by an act of participation. The law states specifically, “No health care provider shall be under any duty, whether by contract, by state or by any other legal requirement to participate...”(127.885 4.01.Immunities. no. (4)).

\* (The PCC ethics statement is printed inside this issue. A copy of professionally printed ethics is available from PCC, a \$10.00 donations is appreciated.)

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Assisted Suicide and Medical Illness:  
Herbert Hendin at PCC spring lecture

by Catherine Hamilton

Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention and Professor of Psychiatry at New York Medical College, delivered a compelling and learned presentation to PCC members and friends titled “Assisted Suicide and Medical Illness: with Reference to the New Oregon Law.

In his opening remarks, Dr. Hendin said: “People assume that seriously or terminally ill people who wish to end their lives are different from those who are otherwise suicidal...such people are not significantly different from people who meet other crises with the desire to end the crisis by ending their lives.” Hendin went on to say that “frightened patient are likely to listen to doctors who suggest assisted suicide.”

Doctor Hendin further demonstrated that when the seriously ill patients’ fear and untreated physical symptoms are effectively addressed in treatment, the desire for assisted suicide disappears. On the other hand, “Ignorance of how to care for the complex issues of severely ill patients is the most likely rationalization for a doctor to comply to assisted suicides,” Hendin contended.

In a series of case presentations, Dr. Hendin found that, “Doctors felt free to ignore patient autonomy when they knew how to help the patient.” However, “Patient autonomy was in essence a rationale for assisted suicide when doctors felt helpless and did not know what to do.” According to Hendin, the danger in Oregon is in the fact that: “Under the Oregon law...They (the doctors) are not required to inquire into the source of the desperation that underlies such a request or to be knowledgeable about the alternatives that may relieve it.”

When Dr. Hendin was asked by a member of the audience what doctors in Oregon should do with a patient who is requesting assisted suicide, he said: “I don’t think it would be difficult to help a suicidal, severely ill patient get over suicidal desires, even if it is the law. It wouldn’t be any different than helping any other patient who was suicidal.”

The cultural effects of assisted suicide leading to complacency and stigmatization of a particular group within a population is addressed in Dr. Hendin’s new book, *Seduced by Death*, but he added that the dangerous results of accepting assisted suicide is a medical profession and a general population that has no conceptualization of any other response to elderly or terminally ill, except assistance in suicide.

In conclusion, Hendin said that Oregon doctors should improve the quality of care at the end of life. “Knowledge of how to minister to the physical and psychological needs of terminally ill people is the most promising development in medicine. Our challenge is to bring that knowledge and that care to all patients who are terminally ill.”

Doctor Hendin is one of the worlds leading experts in the study of suicide. He helped start the American Society of Suicide Prevention at a time when he had little interest in the subject of assisted suicide. As the Dutch experience unfolded, however, Hendin visited Holland with no particular position on what public policy in the area of assisted suicide and euthanasia should be. After four trips to the Netherlands and extensive interviews and research, each trip lasting up to six weeks, he became increasingly convinced of the dangers of assisted suicide.

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Oregon Health Plan to Fund Suicides?

Public hearing held

Testimony falls on deaf ears

“They called it a hearing, but they didn’t listen,” claims Sandy Willows, director of Friends of Seasonal and Service Workers, one of nearly a dozen Oregon groups who testified against the Oregon Health Plan funding suicides of the poor. Here’s what some of them said:

“Having a rationed state health care plan for the poor and disabled that offers suicide as an alternative to good care is a recipe for disaster.” N. Gregory Hamilton, M.D., Physicians for Compassionate Care.

“Under this plan(Oregon Health Plan) life-saving surgeries have been denied and children with leukemia allowed to die...It is outright unethical for the state to fund physician-assisted suicide, death, when it is eliminating life-giving services. ” Victoria Jerome, M.D., Coalition of Concerned Medical Professionals.

“Instead of offering life saving treatments and medical care to alleviate suffering, the state will offer assisted suicide. Why? The answer is economics.” Christopher Day, Ph.D. Northwest Seasonal Workers Association.

“We believe that since the Oregon Health Plan continues to cut funding for many treatments that help the poor get well and stay well, it should certainly not offer itself the cheaper way out: encouraging people to save the state money by killing themselves.” Alan Hakimoglu, Friends of Seasonal and Service Workers.

“It is not appropriate for the Commission to consider including doctor-assisted suicide as part of a “condition\treatment” on the Priority List, when the guidelines for prioritization of condition\treatment by the Commission include: ‘Ability of the treatment to prevent death’ and ‘avoidance of death.’” Dr. Kenneth Stevens, M.D., Chairman, of Radiation Oncology Dept. at OHSU and PCC Board Member.

“Funding suicides for the poor and disabled is a direct threat to the lives of disabled citizens which are stigmatized by the Oregon law.” Ellie Jenny, Not Dead Yet, an advocacy group for the protection of disabled citizens.

Not one poor person who receives the Oregon Health Plan came to the hearings pleading for suicide as an option on their state HMO. All the groups represented the poor and disabled and protested against such ranking. But the Oregon Health Commission voted 10 to 1 to rank assisted suicide as a “health service,” number 260 out of 745 services. No one on the Commission seemed to pay much attention to the fact that the Assisted Suicide Funding Restriction Act blocks federal funds from being used for suicides. The state health plan is funded largely by federal Medicaid dollars.

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From the President

The reaction of Physicians for Compassionate Care to the reported death of an Oregon woman by assisted suicide was one of profound grief for the patient, the profession of medicine and each and every American. To treat one person’s life as if it were not equally meaningful and valuable, diminishes and devalues all seriously ill individuals. All of the rest of us enjoy the protection of society and the profession of medicine against despondency and suicidal ideation; but this one group, those with serious, perhaps terminal illnesses do not enjoy that same protection. For the rest of us, hope and treatment would be offered. The meaningfulness of our lives would be recognized, we would not be handed a lethal potion. This death diminishes all of us. One suicide that takes place within the doctor-patient relationship is too many. It is a betrayal of trust.

No suicide occurs in a vacuum. It takes place in a powerful social and emotional context. There is no autonomy within the doctor-patient relationship. The doctor-patient relationship is highly charged emotionally, and there is a power differential heavily weighted toward the doctor’s side. When a doctor agrees with a patient’s suicidal ideation and hands them a lethal

potion, he or she is giving that patient the message that there is no hope, that their life is no longer as valuable and as meaningful as the lives of others.

To give even one patient this message, to participate in the suicide of even one patient, stigmatizes and devalues each and every person with a serious, perhaps terminal illness. By allowing one class of citizens to be treated as if their lives were not as valuable as the lives of the rest of us, we endanger each and every American.

N.Gregory Hamilton, M.D.

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#### Friends of Seasonal Workers Solicits Physicians Volunteers

Friends of Seasonal Workers (FSW) asked us to help them find physicians to volunteer time for health care clinics. FSW helps citizens of Oregon who often are not eligible for health care coverage, to obtain the medical care and other professional services needed. After discussion by the PCC Board of Directors, it was decided that since we uphold a principle that values all human life equally, and because we are not a one issue organization, it is entirely appropriate for PCC to help FSW find physician volunteers. PCC is very grateful to Friends of Seasonal Workers for their clear opposition to assisted suicide and their protest against the state funding suicides of the poor through the Oregon Health Plan. To volunteer a few hours a week, once a month, or even a one time only donation of time, call: (503) 228-1826.

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#### PCC proposes changes

Dr. Kenneth Stevens, professor and Chairman of Radiation Oncology at OHSU and PCC Board Member, testified at the Oregon Health Division hearing on assisted suicide reporting requirements. He emphasized that it is the standard of the practice of medicine to properly document and evaluate the outcomes of new treatments and medical services. The Oregon Health Division should follow the same scientific standards to collect and evaluate information regarding doctor-assisted suicides in Oregon that are used to evaluate all new treatments in medicine.

The Oregon Health Division administrative rules should obtain information to answer the following questions:

1. How many patients start the Process?
2. How many of the patients who start the process receive a prescription?
3. How many of the patients who receive a prescription have it filled?
4. What drugs and quantity of drugs are prescribed?
5. How many of the patients who have a prescription filled actually take the drugs?
6. What happens to those who start consuming the drugs?
  - a. How many consume all of the drugs?
    - 1) How many die?
    - 2) What are other outcomes, complications, etc.?
  - b. How many do not consume all of the drugs?
    - 1) How many die?
    - 2) What are other outcomes, complications, etc.?
7. What other devices (suffocation bags, etc.) are used in addition to drugs to assist in suicide?
8. How long after consuming the drugs does death occur?
9. Who witnesses and documents what happens to the patient when the drugs are taken?
10. What are the demographics of these patients: age, race, gender, economic status, etc.?

Instead of accepting such recommendations, the Health Division seems bent on defining reporting requirements so vaguely that no useful information can be gathered, and there is no provision for enforcement's of the so-called requirements to be reported. The Health Division appears to be assuring secrecy and anonymity for doctors and care providers over and above the need to protect Oregon patients.

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Other recommended newsletters:

Life at Risk: a chronicle of Euthanasia  
Trends in America  
3211 4th Street  
Washington DC 20017-1194  
Ph: (202) 541-3020 Fax: (202) 541-3054

International Anti-Euthanasia Task Force Update  
PO Box 760  
Steubenville, OH 43952  
Ph: (740) 282-3810

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PCC ADDRESS:

P.O. Box 6042  
Portland, Oregon 97228  
503-533-8154 Phone  
503-533-0429 Fax  
[www.pccef.org](http://www.pccef.org)  
PCC News Editor: Catherine Hamilton

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