PHYSICIANS FOR COMPASSIONATE CARE NEWS

Affirming An Ethic That All Human Life is Inherently Valuable

Vol.2, No.1, Spring 1999

The Five Symptoms of Kevorkianism

Despite the fact that Kevorkian has been sentenced to prison in Michigan, his assisted suicide movement roams free in Oregon, according to Wesley Smith, a lawyer for the International Anti-Euthanasia Task Force and author of "Forced Exit: The Slippery Slope From Assisted Suicide to Legalized Murder" (Times Books, 1997). Smith delivered a compelling and comprehensive lecture at PCC's Annual Spring Lecture and Banquet outlining the five symptoms that are present when a state is plagued by Kevorkianism.

"Although, initially, those promoting assisted suicide tell the public that it is only for those with untreatable pain, unbearable pain, when nothing can be done, a last resort, in actuality, those killed by Kevorkian and the assisted suicide and euthanasia movement have not been in unbearable pain. The first symptom of Kevorkianism," Smith said, "is that the malady of those killed isn't relevant." He went on, "In Oregon, the first 15 cases presented to the public in a state report demonstrated that those killed in Oregon, did not die because of unbearable pain, but instead, because of fear of possible future dependence. Their fears about the dying process and the desire to be dead was what lead to their deaths, not untreatable, unbearable pain. That's Kevorkianism."

Smith described the second symptom of Kevorkianism as arising when, "The doctors who participate in suicides don't have a long-term relationship with the patient, keeping in mind that Kevorkian got together with the patient solely to perform assisted suicide or euthanasia." In a report released about Oregon's assisted suicides, at least 6 of the doctors who prescribed drugs that were intended to kill the patient knew the patient about 15 days, the exact length of time Oregonians must wait before committing "legal" suicide. The other cases reported were vague with regard to length of doctor-patient relationship. "It appears many of the patients in Oregon meet the doctor for the sole purpose of a euthanasia," Smith pointed out. The others may have simply had the misfortune of having a doctor who was in favor of assisted suicide.

The third symptom of Kevorkianism is that the killing is based on ideology, not medical necessity or medical urgency. "There is always something that can be done

for these patients medically," Smith said. "When a patient asks for suicide and a doctor says 'OK' that's not a neutral statement; it's a cruel confirmation, by an authority figure, of the patient's worst fears, that of being seen as a valueless life. That's not compassion. That's a cruel and devaluing ideology. These doctors go to killing, because of their ideology, not because they have exhausted all medical options or even because of medical urgency." In fact, those who died by suicide were even more functional than those who continued to live, according to the state report.

The fourth symptom of Kevorkianism is that assisted suicide promotion moves to euthanasia. Recall that even Kevorkian said, at first, that patients must be in control, then he took the life of Thomas Youk, because his case "necessitated" it. Faye Girsh, President of the Hemlock Society has recently said that lethal injections should be available. Dereck Humphrey says the Kevorkian conviction shows the need for laws to change so that euthanasia becomes a justifiable type of homicide. "In Oregon, only one year after the law allowing doctors to dispense lethal overdoses to people who could swallow them on their own, a public official brought up how that law might well be seen as discriminatory against those who can't swallow lethal drugs," Smith said holding up a copy of a letter written by Oregon Deputy Attorney General, David Schuman. The Deputy Attorney General wrote in his letter to a state senator that the law would in effect be discriminatory because it requires self-administration and not everyone is capable of that. "The Act would be treated by the courts as though it explicitly denied the 'benefit' of a 'death with dignity' to disabled people," Schuman wrote in the letter. Euthanasia in Oregon may only be a lawsuit away.

Finally, the fifth symptom of Kevorkianism is that the a majority of the people in the state shrug their shoulders. "What was once unthinkable becomes unremarkable," Smith said of Oregonians apathy. The state of Michigan once plagued by Kevorkianism, now has laws against assisted suicide. A voters initiative that would have allowed the killing of people in the medical setting failed. Kevorkianism was arrested in Michigan, by stopping Kevorkian.

Yet Kevorkianism persists in Oregon. "This symptom pattern of Kevorkian style killing in the medical setting can be recognized and stopped, even in Oregon," Smith says, calling his listeners into action. "The first step is to point out it's existence. To combat Kevorkianism, ethical physicians must inform the public and expose the assisted suicide movement for what it is in Oregon: abandoning and dismissive of the value of patients lives, just as Kevorkian was of the people he killed. Ethical physicians in Oregon must continue to treat suicide requests as they always have, as a cry for help, and engage in suicide prevention rather than suicide facilitation. They must continue to stand against killing in the medical setting," encouraged Smith. "They must proudly proclaim their offices and practices as assisted suicide free zones.

They need to let people know that they will be treated and valued as long as they live and will never be given poison."

State Study Minimizes Suicides
By Robert DuPriest, MD

Oregon's suicide rate is 42% higher than the nation's; and the suicide death rate for those 75 or older is 63% higher than the nation's (Suicide And Suicidal Thoughts by Oregonians. OHD, 1997). Adding 15 more cases by physician-assisted suicide last year is a tragedy for Oregon, not a "great value" as the Eugene, Oregon, Register Guard newspaper article described it (Fifteen Suicides... by David Steves). Far from praising the findings of the Health Division's report, (Legalized Physician-Assisted Suicide in Oregon-The First Year's Experience; Chin et al., NEJM, 2-18-99. p.577), Physicians for Compassionate Care grieves for the lives of these human beings taken by suicide. And our sorrow is all the more that doctors have given the deadly drugs with the intention of the patient's suicide.

In a seeming attempt to reduce suicide to statistics and tables, the Health Division's report does little to lift the shroud of secrecy that covers assisted suicide in Oregon, because there is no penalty for doctors who do not report cases and there are no safeguards protecting the depressed who are suicidal and seriously ill; the Register Guard article accepted the numbers no questions asked (Fifteen Suicides... by David Steves). The crucial problem with the report lies in the questions the Health Department did not ask. For example, there is nothing useful said about the mental state of any of the fifteen patients reported to have died by overdose. While the report states that 6 of 15 of these people went to two or more doctors before finding a doctor who would participate in their suicide, the report doesn't reveal the opinion of the patient's long-term physician, or that of the second or third physician. Nor does it address why these physicians chose not to give lethal drugs. The questionnaire was filled out only by the doctor who participated in the suicide. Thus the Health Division's report, and the actual implementation of the law, ignores the opinions of certain treating Oregon physicians.

A prime example is the first publicly reported case of assisted suicide. This woman was found depressed by her own doctor and, therefore, not eligible for the law. But when the family called the Compassion and Dying Federation, the woman was declared "rational" during a telephone consultation with one of their doctors. She was dead in just over three weeks. The report said nothing about the opinions of her first two doctors, and their opinions were apparently ignored, as were questions raised about the woman's depression and the attempts or the lack thereof to treat her

depression. Thus, as Physicians for Compassionate Care predicted, there are no real or effective safeguards for the depressed who are seriously ill in Oregon. If the patient's doctor thinks depression exists, a pro-suicide doctor can simply ignore that opinion and call the request "rational" without ever referring the patient for evaluation or attempting to alleviate the emotional, physical or spiritual conditions that leads to suicidal ideation in the seriously ill.

The Health Division's report says nothing about the competency of the doctor to assess the patients' fears about end-of-life issues, nor whether the doctor was competent to correctly determine whether fear and anxiety constitute an underlying depressive disorder. It is known that 50 % of all cases of depression are missed by primary care doctors. This is not an indictment of any physician's diagnostic ability. It is a reflection of the difficulty and complexity of making a proper diagnosis in such patients. Social isolation and concerns about loss of autonomy and control of bodily functions were associated with assisted suicide, but the report does not indicate how or whether these issues were addressed. Whether realistic or imagined, these fears are part of the normal reaction to any serious illness, and they can be treated with love, support, education, reassurance, and sometimes medication.

Suicidal ideation in the seriously ill is just like suicidal ideation in any other patient. It is a sign of distress and is a symptom demanding diagnosis and treatment. William P. Wilson, MD, former professor of Psychiatry at Duke University Medical School, states that existential depression is a spiritual disease. It may include a sense of purposelessness; the lack of, or a failure to adhere to a value system; and the fear of dying (The Grace to Grow, Word Books, 1984, p.74). Properly recognized and treated, these patients can experience deeper self-understanding and find meaning in this season of life. The Health Division's report, as superficial as it is, leads us to believe that assisted suicide is going just as badly as we predicted; some depressed, isolated, elderly patients are being given deadly drugs, instead of the medical care they deserve.

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Medical Abstracts from Journal Articles by PCC Members

Physician-Assisted Suicide: Reflections on Oregon's First Case. Hendin, MD; Foley, MD; White, JD. Issues in Law and Medicine, Vol. 14, No. 3 Winter 1998. 3 South 6th Street, Terre Haute, IN 47807 3510.

The authors analyze Oregon's first reported assisted suicide of Mrs. A as a real life application of the Oregon Death with Dignity Act. They critique the effectiveness of the Act's safeguards as illustrated by the case of Mrs. A. They point out that the Act does not require that physicians be adequately trained in palliative care in order to participate in assisted suicide. Most physicians do not have such training. Without it, they are not able to effectively present alternatives to patients requesting assisted suicide. Most physicians also lack the expertise to assess patients' decision-making capacity. Nor does the Act ensure that physicians will be in a position to assess coercion of patients' decisions. The Act requires physicians to report only minimal information about their cases, and there are no enforcement provisions to see that even this is done. Under the Act, a good faith standard rather than the more usual negligence standard immunizes physicians from civil or criminal liability even when they act negligently. The authors demonstrate that the Act protects physicians more than patients, and encourages secrecy. The authors conclude that secrecy will need to be replaced by openness to permit the kind of examination the practice of assisted suicide warrants.

The Case Against Physician Assisted Suicide. James K. Beohnlein, MD., M.Sc. Community Mental Health Journal, Vol. 35, No. 1 February 1999.

Physician assisted suicide (PAS) engenders debate about the meaning of professional identity, what is proper in the doctor/patient relationship, and the physician's appropriate role in society. Polarization on PAS largely arises from different views on what defines compassion in relieving pain and suffering, and the proper balance between individual autonomy and social imperatives. This paper discusses the ethical, social and economic arguments against PAS, including a historical perspective on the other socially-sanctioned inappropriate uses of medical technology and expertise. This paper maintains that a truly dignified death does not come at the hand of a physician-healer, despite compelling arguments that it is a compassionate act.

Therapeutic Response to Assisted Suicide Request. N. Gregory Hamilton, MD and Catherine A. Hamilton, MA; Bulletin of the Menninger Clinic. Vol. 63, No. 2, p.191-201 Spring 1999.

The authors review the first publicly reported case of legal assisted suicide in the United States and discuss possible clinical responses other than assistance in suicide. 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. The authors discuss specific therapeutic interventions that may be appropriate for seriously ill patients requesting suicide.

On Valuing Life
From the Editor

Physicians for Compassionate Care upholds the principle that all human life is inherently and equally valuable regardless of age or health status. Therefore, so-called "poor quality of life" does not enter the value equation, nor does it ever render a patient less deserving of good and standard medical care. Our philosophy deems a persons' life as valuable simply because he or she is alive; the value of human life does not change with variations in health status. While it may be true that certain health conditions decrease activity, mobility and even independence, the worth of the individual does not decline with their worsening illness. One's ability to perform does not equal one's self-worth. This conceptualization of self-worth is based on the assumption that everyone is born with an equal amount of value; so, just as an infant is valuable, an elderly person is valuable. The well are just as valued as those with illness, not because they are able to do something great, but simply because they exist.

If a patient's health is declining and they begin to devalue themselves or to talk about feelings of worthlessness, the physician who values all life equally, while empathizing with the patient's feelings about loss of function or restriction of activity, can counsel the patient regarding self-worth. Replacement activities can be suggested, but the patient's assumption that her or his personal value is based on task performance can be challenged. Infants have restricted activity and are completely dependent, yet we value them. Individuals with post-trauma amputations are valued, so why wouldn't the seriously ill person be valued? By teaching the patient self-acceptance in the process of a health transition and by communicating and acting in ways which say; "You are valuable to me," the doctor provides the patient with hope and models an alternative philosophy that is life valuing.

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