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Affirming An Ethic That All Human Life is Inherently Valuable

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OHD's Reporting Mechanism Fundamentally Flawed

Leads to Faulty Data

Twenty-seven assisted suicides in the year 2000 brought the state's number of overdose deaths caused by Oregon doctors to a tragic 70 cases. The most telling piece of information from the Oregon Health Division's (OHD) third annual report on assisted suicide, however, was found in the comments section, "...our numbers are based on a reporting system for terminally ill patients who legally receive prescriptions for lethal medications, and do not include patients and physicians who may act outside the law" (Hedberg, et al 2001). If a doctor didn't fill out the form, the case wasn't reported. There is no penalty for not reporting. A doctor may simply

choose not to do the paperwork, as is so common in Holland. Hedberg also referred to last year's report on the subject of underreporting; it said, "Underreporting cannot be assessed and noncompliance is difficult to assess." We are left with the impression that OHD's figures are not the actual figures of those who have died by assisted suicide in the Oregon.

Inherent in OHD's guidelines on reporting are the potentials for underreporting and biased sampling. OHD's own guidelines don't require it to report all cases. The standard OHD guideline states, "After the death of a patient for whom a prescription for medication to end life has been written pursuant to the Act, the Division may send the attending physician a confidential form to verify information concerning the circumstances surrounding the patient's death" [(Reporting 333-009-0010 (b)]. So, they also may not inquire, for example, in the case of a botched suicide when the patient does not die from the overdose or there are other complications.

Furthermore, OHD indicates in this year's report, "Vital Records files are searched periodically for death certificates that correspond to physician reports. The death certificates allow us to confirm patient's deaths and provide patient demographic data." However, the local assisted suicide advocacy group which claimed 21 of the 27 assisted suicide cases in 2000 (US Newswire, February 20, 2001), insisted in a Portland Community College class (December, 1999) that the doctors not write 'assisted suicide' on the death certificate of these patients, but instead indicate the patient's underlying disease on the death certificate. So, how is OHD going to identify and match the cases? Yet even those cases which were mentioned by OHD in this year's report were disturbing. Doctor's listed fear of being a "burden on family, friends or caregivers," in a startling 63% of the patients who committed assisted suicide. Apparently, the "duty to die" is becoming a reality in Oregon. And, despite the vast literature that shows a high incidence of depression in the seriously ill, only 19% of assisted suicide victims received even cursory referrals for psychiatric evaluations.

For the third year in a row, concerns about pain trailed the list of reasons for seeking assisted suicide, to the point of being negligible. The threat of a patient's intractable pain was frequently used by activists to promote legalization of assisted suicide to the citizens of Oregon. What has been considered the most compelling argument among pro-assisted suicide strategists has been rendered myth by the assisted-suicide doctors themselves. Yet, even here, serious doubts remain, because OHD obtained no outside information about the quality of pain treatment and palliative care provided by assisted-suicide doctors. With such faulty reporting procedures, no wonder the conclusions are flawed. Oregon citizens are left with no safeguards at all.

The AMA News responded to this year's OHD report by saying, "...the issues expressed by patients in Oregon can be addressed without physician-assisted suicide...In the realm of setting public policy, what we witness from this data raises serious doubts about the urgency of legalizing and performing physician-assisted suicide."

Assisted-Suicide -- a Response to Depression and Suicidal Ideation?

According to information reported by the "...Dying Federation" of Oregon, an advocacy group which promotes legalized assisted suicide, "...only 4 of 12..." individuals who presented to them with so-called "violent" suicidal ideation completed their suicides in 2000 by using an overdose of drugs provided by an Oregon doctor. If 1/3 of the suicidal patients in any medical practice ended up killing themselves with a drug overdose, something would be seriously wrong. No physician would praise himself for those numbers. And what about other depressed patients who were given assisted suicide? What about people with a history of depression? What about those people with a history of a previous "non-violent" suicide attempt, by an overdose of drugs, who then ended their lives by completing an assisted suicide with the help of the Dying Federation?

Joan Lucas was a 65-year-old Oregon woman with amyotrophic lateral sclerosis, who made a suicide attempt using pills she had hoarded. Instead of taking her to the emergency room for diagnosis and treatment, her adult children watched her "...lay on her bed, moaning and writhing, obviously in pain..." for an entire day, because they couldn't make up their minds what to do, according to the Medford Mail Tribune (June 25, 2000), until "...it became real apparent she wasn't dying. She was in agony." When Mrs. Lucas awakened, did the family get her the evaluation and treatment she needed for her suicidal despair? Far from it. They called George Eighmey, executive director of the Oregon chapter of the Dying Federation. And Eighmey arranged her assisted suicide.

The suicide doctor wouldn't reveal his name, but he told a local newspaper he decided to get a psychiatric opinion (not required by Oregon) to "...cover my ass." Not to treat or even to protect the vulnerable patient, but to protect himself!

The anonymous Oregon doctor's major apparent concern was making sure the suicide was carried out to specifications and protecting himself. When no reputable psychiatrist could be found to perform a perfunctory assisted-suicide evaluation instead of an evaluation for treatment, a psychologist cooperated. This individual sent Joan Lucas a Minnesota Multiphasic Personality Inventory (MMPI), a paper and pencil questionnaire, because she could not travel to the clinic. There is no indication the psychologist ever personally examined the patient. Instead, the adult children read

her the questionnaire and filled out the form for her, apparently with some levity. "We were just cracking up," they said. With such unreliable information, the psychologist declared Joan Lucas was not depressed (Mail Tribune, June 26, 2000). The psychologist made this determination despite the fact that studies published in the American Journal of Psychiatry show 94% of Oregon psychiatrists don't feel confident they can determine when depression is affecting decisions about assisted suicide in a single visit, no less, no visit at all.

There were no safeguards for Joan Lucas after her suicide attempt, anymore than there were for Oregon's first reported case, a woman given assisted suicide drugs despite having been diagnosed as depressed by her own doctor. People with depression and suicidal ideation are committing assisted suicide in Oregon. This is a tragic failure to provide appropriate treatment and prevention for the suicidal seriously ill.

FAILED ASSISTED-SUICIDE EXPERIMENT
N. Gregory Hamilton, M.D.

The Oregon Health Division (OHD) reported 27 assisted suicides in 2000, the same as in 1999. Again, the report gathered information only from those needing to justify recent collusion in a suicide -- the assisted-suicide doctors themselves.

The report claimed an assisted suicide rate of 9/10,000 Oregon deaths. So, most people died without taking an overdose, while psychological fears and social concerns led the rest to assisted suicide. The psychosocial fears of all patients should be treated. And the victims of assisted suicide should have been cared for, like all other dying individuals. But they were not.

In fact, only 19% of the Oregon assisted-suicide victims reported were even referred for a psychiatric opinion. We know at least one of those referrals this year, as reported in the Medford Mail Tribune (6/25&26/00), was made only to "cover" the suicide doctor. After extensive doctor shopping, a psychologist sent home a Minnesota Multiphasic Personality Inventory (MMPI) -- a multiple choice questionnaire -- which the family helped the patient fill out, reportedly while they were "cracking up" laughing. There is no evidence the psychologist ever saw the woman in person or attempted to treat her psychological fears and concerns.

This year, as in previous years, the OHD reported no failures or complications. Sherwin Nuland from Yale medical school said he found the Dutch data showing a complication rate of at least 15% more "credible" than the rosy picture coming out of

Oregon. The rate of unacceptable complications reported by the Dutch ranges between 15 and 25%.

This year, too, the report was overly reassuring about lack of financial pressures, but provided no information about known caps and rationing of health care while assisted suicide is fully funded by many Oregon HMO's.

The experiment in death by assisted suicide has failed. What little information one can glean from this biased data gathering points to one conclusion: It's time to start improving treatment of the psychological and social needs of seriously ill patients. It's time to stop giving this small, but significant minority lethal overdoses instead of the care they need and deserve.

CLINICAL GUIDELINES:
Non-Participation in Doctor-Assisted Suicide

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

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

Refrain from suggesting assisted suicide by naming it as a treatment option, since assisted suicide is not a treatment. Initiating the discussion of assisted suicide may suggest suicide and may also imply the doctor's approval of patient suicides.

Continue to treat all 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, even if the suicidal plan involves thoughts of an assisted suicide. Suicidal thoughts should be explored thoroughly. (A mental health history, history of suicidal ideation and /or suicide attempts and family history of suicides should be taken. Always use a mental status examination to assess the patient for possible suicidal ideation. A treatment plan for dealing with the suicidal patient is always necessary. The psychological as well as the physical distress must both be addressed. Medication evaluation, case consultation, family meetings, psychiatry referral, referral for counseling, pastoral care, pain management consults, and palliative care evaluation may all be appropriate treatment interventions for the suicidal, seriously ill patient.)

Let the seriously ill suicidal patient know you value his or her life. As with other suicidal patients it may be appropriate to say such things as: “I don’t want you to kill yourself. And I assure you that your treatment team and I will care for you in such a way that you won’t have to take your life through suicide,” or “I don’t want you to kill yourself. If you get to feeling suicidal again, you call me and we’ll take care of your pain or fear or whatever, so you don’t feel like you have to take your own life.”

If the patient insists that his/her suicidal ideation is a political “right” rather than a clinical problem, remind the patient that you value all human life including theirs, that you wouldn’t condone any type of suicide and that you want to continue to work with them with that understanding in mind.

Reassure the patient. Recent health division reports show fear of the future, not pain, leads to assisted suicide. Tell them they will be able to handle their illness and the changes that come with it. Address their fears of disabling symptoms. Dispel any bias they might have against people with decreased functioning or people who need help. Impart confidence by telling them that you and the treatment team will be able to manage their pain, discomfort, or anxiety, if they ever become a problem.

Continue to offer good care. The patient is free to transfer to another doctor at their own initiative without your suggesting such a move.

Decline to refer for assisted suicide. Remember that the law does not require the physician to refer the patient to a doctor who will participate in the suicide. Such a requirement would violate your right to non-participation, since referral to facilitate assisted suicide would constitute a form of material participation in assisted suicide. Referral for suicide may contribute to the patient's discouragement and may lead them to suicide. It would compromise the physician's moral integrity. 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 the professionally printed ethics statement is available from PCC (a donation for costs and mailing is appreciated.)

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