

Montana State Legislature

2013 Session

ADDITIONAL DOCUMENTS MAY INCLUDE THE FOLLOWING:

- **Business Report**
- **Roll Call - Attendance**
- **Standing Committee Reports**
- **Tabled Bills**
- **Fiscal Reports etc.**
- **Roll Call Votes**
- **Informational Items**
- **Witness Statements**
- **Any Documents; such as;**
 - * **Petitions if any.**
 - * **Any and all material handed end after the meeting ends.**

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Montana Historical Society
and may be viewed there.**

**Montana Historical Society
Archives
225 N. Roberts
Helena MT 59620-1201
2013 Legislative Scanner Susie Hamilton**

BUSINESS REPORT
MONTANA SENATE
63rd LEGISLATURE - REGULAR SESSION
SENATE JUDICIARY COMMITTEE

Date: Tuesday, March 26, 2013
Place: Capitol

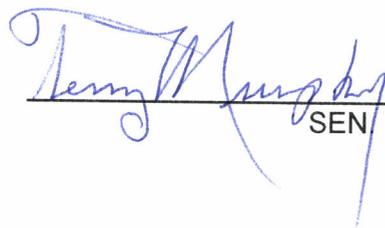
Time: 8:00 A.M.
Room: 303

BILLS and RESOLUTIONS HEARD:

HB 505 - Clarify offense of aiding or soliciting suicide - Rep. Krayton Kerns
SB 377 - Generally revise medical marijuana laws and regulate industry - Sen. David
Wanzenried

EXECUTIVE ACTION TAKEN:

Comments:



SEN. Terry Murphy, Chair

MONTANA STATE SENATE

2013 JUDICIARY COMMITTEE

ROLL CALL

DATE: 3/26/13

<u>NAME</u>	<u>PRESENT</u>	<u>ABSENT/ EXCUSED</u>
CHAIRMAN, SENATOR TERRY MURPHY	—	
VICE CHAIRMAN, SENATOR SCOTT SALES	—	
SENATOR SHANNON AUGARE	—	
SENATOR ANDERS BLEWETT	—	
SENATOR SCOTT BOULANGER	—	
SENATOR JOHN BRENDEN		—
SENATOR ROBYN DRISCOLL	—	
SENATOR JENNIFER FIELDER	—	
SENATOR LARRY JENT	—	
SENATOR CLIFF LARSEN	—	
SENATOR CHAS VINCENT	—	
SENATOR ART WITTICH	—	

MONTANA STATE SENATE
Visitors Register
SENATE JUDICIARY COMMITTEE

Tuesday, March 26, 2013

SB 377 - Generally revise medical marijuana laws and regulate industry

Sponsor: Sen. David Wanzenried

PLEASE PRINT

Name	Representing	Support	Oppose	Info
CANDACE Payne	Rimrock Foundation		X	
Susan Smith	Safe Community Safe Kids		X	
Cherrie Brady	Safe Comm Safe Kids		X	
DR PAT PARLIS	SELF	X		
Nathan Pierce	MT CFR	X		
SHAWN B. PALMER	Mt. C.F.R.	X		
Berniece Stule	Self	X		
DAVE PANTE	self		X	
Emily Bentley	Self	X		
Katy Heitstuman	ACell of Montana	X		
Tom HEYES	SELF	X		
MAREN KEENER	SELF	X		
Kentor Hickethier	Dept of Justice / MNOR		X	
Robert Self	self	X	X	
PAT Keim	ALTERNATIVE		X	
Jeff Caszloppy	MT Family Foundation		X	
Garnett Rope	self		X	
Mark E. Rope	self		X	
Luk E Rope	Self		X	
Jammy Wigg	self		X	
Chala Benedict	Self		X	
Chandee Benedict	self		X	

Please leave prepared testimony with Secretary. Witness Statement forms are available if you care to submit written testimony.

MONTANA STATE SENATE
Visitors Register
SENATE JUDICIARY COMMITTEE

Tuesday, March 26, 2013

HB 505 - Clarify offense of aiding or soliciting suicide

Sponsor: Rep. Krayton Kerns

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Name	Representing	Support	Oppose	Info
Katy Heitsman	ACHA of Montana		X	
Doris Fischer	Self		X	
Moe Wosopka	Montana Catholic Conference	X		
Janet Hess-Iderburt	self		X	
Jane Lu HAMMAN	self		X	
Janet Knopf			X	
Jack Jundrow	self		X	
MAREN KEENER	SELF		X	
Barbara H. Kuykendall	self		X	
PAT Keim	ALTERNATIVES			
P. Tummaisono		X		
Thomas Roberts MD	Montana Medical Association		X	
Bill Callashee	SELF	X		
Mark E. Rope	self	X		
Luke E. Rope	self	X		
Jammy Wipf	self	X		
Chala Benedict	self	X		
Chandee Benedict	self	X		
Annita Benedict	self	X		
STEVE ZABALA	Montana Amulch Assuam		X	
B.G. Stumberg IV	Montana Southern Baptist	X	X	
Phyllis Lamping	1806 Townsend Self	X		

Please leave prepared testimony with Secretary. Witness Statement forms are available if you care to submit written testimony.

MONTANA STATE SENATE
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SENATE JUDICIARY COMMITTEE

Tuesday, March 26, 2013

HB 505 - Clarify offense of aiding or soliciting suicide

Sponsor: Rep. Krayton Kerns

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Name	Representing	Support	Oppose	Info
Bradley Williams	Montanans Against Assault	X		
Tom Hayes	Self		X	
Emily Bentley	CIC		X	
Jane Jelinski	self		X	
Tom Scanlin	self		X	
BOB Errichello	"		X	
JANE MULLER	SELF		X	
Robert King	self		X	
Eric Knies	self		X	
Tony Shellnutt	CWA			
Bea Knight	self		X	
Nancy Israel	self		X	
Garnett Rope	self	X		
Danika Hahn	self	X		
Rick Blewins (Occupy)	by proxy B. Hahn	X		
Jeff Leszloff	MT Family Fedn	X		
Mignon Waterman	self		X	
Linda Gryczan	self		X	
Phil Gryczan	self		X	
Judy Fay	self		X	
Greg Treptow MD	self	X		
Robin Lynn Treptow, PhD	self	X		

Please leave prepared testimony with Secretary. Witness Statement forms are available if you care to submit written testimony.

Gregg TRUDE

Reply to Le. dnt

X

MONTANA STATE SENATE
Visitors Register
SENATE JUDICIARY COMMITTEE

Tuesday, March 26, 2013

HB 505 - Clarify offense of aiding or soliciting suicide

Sponsor: Rep. Krayton Kerns

PLEASE PRINT

Name	Representing	Support	Oppose	Info
Christina Hayden	self	X		
Don Hahn	self	X		
Rich Blevins	proxy	X		
Annie Bukack	self	X		
Margaret Dove	Self of choice is at 1/2013	X		
Carrie Walker	self	X		
MIKE MOE	self	X		
CORT FREEMAN	Self	X		
MELDA FREEMAN	"	X		
Jeremiah Daniel Laurin	" "	X		
Elizabeth Poiana	" "	X		
Paul Gorsuch MP	self	✓		
Mary Heidlebaugh	self	X		
Hugh Meyer	self	X		
Debra Mills	"	X		
Holly Olszewski	self	X		
Sarah Zook	self	X		
TOM PRITCHETT	self	X		
John Copeland	self	X		
Shirley HERRIN	SELF	X		
Mary McClachan	self	X		
Self	SELF	X		

Please leave prepared testimony with Secretary. Witness Statement forms are available if you care to submit written testimony.

LEONARD STUK

self

X

John Meyer

self

X

Montana State Legislature

**2013 SESSION
ADDITIONAL DOCUMENT**

This is an

ADDITIONAL DOCUMENT

which was submitted
after the committee hearing
was ended and/or was
submitted late, but regarding
information in the committee
hearing.

**Montana Historical Society
Archives**

225 N. Roberts

Helena MT 59620-1201

2013 Legislative Scanner Susie Hamilton

SEDUCED

Dear Committee Member, ³⁻²⁶⁻¹³

My name is Johann Copeland. I am a resident of Lewis + Clark County. I am a registered voter. I am a wife, a mother, and a grandmother and I am greatly concerned with some of the issues that are being brought before you.

Today I humbly, and respectfully ask that you vote a do pass for HB 505, on behalf of the sick, the elderly, the children, the mentally + physically disabled, on behalf of these who cannot speak for themselves, and for all of the people of Montana -

Please close the door on assisted suicide.

Do pass HB 505

Thank you - Respectfully,
Johann Copeland

ADDITIONAL
DOCUMENTS

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n, M. D.

Hendin's objections
Post Book World

ADDITIONAL
DOCUMENTS

Seduced by Death

Doctors, Patients, and Assisted Suicide
Herbert Hendin, M.D.

ADDITIONAL
DOCUMENTS

"A POWERFUL CONTRIBUTION TO THIS DEBATE. . . ."

—Charles E. Rosenberg, *New York Times Book Review*

Few issues set off such impassioned debate as euthanasia and assisted suicide, but until now no one has shown what their practice means in the experience of patients, doctors, and families.

Herbert Hendin has studied such experience in the United States and also in the Netherlands, where assisted suicide and euthanasia are accepted. Using interviews with leading medical and legal architects of Dutch practices, and evaluating actual cases, Dr. Hendin addresses difficult questions such as: Who actually makes the decision that a patient will die? How do the needs and character of family, friends, and doctor affect the choice?

In an "important and alarming report" (*Publishers Weekly*), Dr. Hendin—cited twice in the Supreme Court's 1997 decision on physician-assisted suicide—outlines what we can do to find more and better options in the final phase of life. In this fully revised paperback edition, he also considers the impact in the United States of the Court's decision and reviews troubling new evidence from the Netherlands.

Herbert Hendin, M.D., medical director of the American Foundation for Suicide Prevention and professor of psychiatry at New York Medical College, is an internationally recognized authority on suicide. His previous books include *Suicide and Scandinavia*, *Black Suicide*, and *Suicide in America*.

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**ADDITIONAL
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APR 11 1954
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The main distinction between terminal sedation and euthanasia is time.

*As argued by Dr. J. Andrew Billings in
the Journal of Palliative Care, 1996*

Is It Euthanasia?

Terminal sedation with the purpose of killing the patient is euthanasia. Doctors and medical ethicists may hide behind convoluted arguments, but the reality is that they are killing their patients. Statistics are hard to come by, because doctors are unwilling to talk openly about something that is so closely linked with euthanasia.

What Is Wrong with Euthanasia?

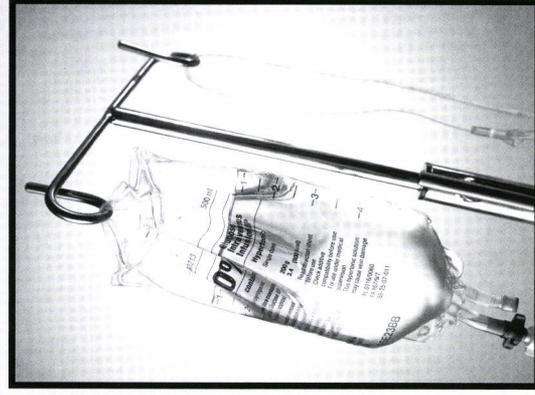
The legalization of euthanasia creates a starting point that is used to expand who can be killed and for what reason. This creates a legitimate concern for the lives of the weakest and most vulnerable in our society.

This "slippery slope" argument is always painted by supporters of euthanasia as a fear tactic but reality shows it to be true. In countries where euthanasia has been practiced there has been a documented slide into allowing deaths earlier, for less significant reasons, and without the consent of the one being killed.⁴

Death with Dignity

The end of life has many complications and is not always simple or easy. It may include the need for pain medication that reduces comprehension, and it may require family care for the elderly. While it isn't easy to care for those who are older, it is the right thing to do. To offer them concern, care, and help instead of death will give them comfort even in their troubles. To cherish those we love until the day they pass on and to show them respect in their old age will give them the death with dignity they deserve.

1. Johnston, Brian, *Deathly Quiet*, WorldNet Daily, April 13, 2002. Accessed at <http://www.wnd.com/index.php/index.php?pageid=13513> on 2/27/2010
2. George R, Regnard C. *Lethal opioids or dangerous prescribers?* *Palliative Medicine*, 2007; 21: 77-80.
3. Hartocollis, Anemona, *Hard Choice for a Comfortable Death: Sedation* New York Times, December 26, 2009. Accessed online at <http://www.nytimes.com/2009/12/27/health/27sedation.html> on 2/27/2010.
4. P. Van der Maas, J. Van Delden and L. Pijnenborg, 'Euthanasia and Other Medical Decisions Concerning the End of Life - Volume 2' (1992) 22(2) *Health Policy* (Special Issue), p 672.

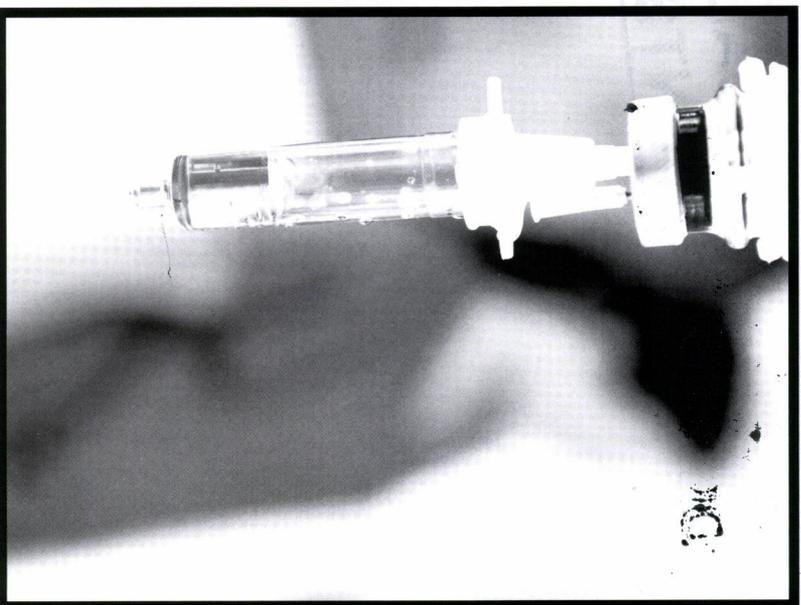


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Terminal (Palliative) Sedation

**What You
NEED
to Know**



facilities is really the sedation of a patient with the intention of causing their death.

Does It Cause Death?

Terminal sedation as now practiced is often used to either cause death through the side effects of the drug or to mask the pain of death by starvation and dehydration.

Terminal Dehydration

It is now commonplace in the United States to use the removal of hydration along with terminal sedation to cause the death of a patient. Many doctors insist that the removal of hydration is necessary for the continual state of unconsciousness. Dr. Rex Greene, a California oncologist, believes they are just trying to hide their true intentions:

“The insistence that hydration be removed is not valid. It is very rare that its provision is burdensome. In fact, I have routinely found that adequate hydration is necessary to alleviate terminal delirium. Insisting that hydration be withdrawn as a form of treatment belies their real intention, which is to kill.”

The Double Effect Principle

Doctors providing palliative care often justify killing a person with drugs before they naturally die with the “double effect principle,” a term first coined by Thomas Aquinas. This principle states that if a service is provided for the good of the patient but ends up doing harm as a side-effect, the service was still moral. In other words,

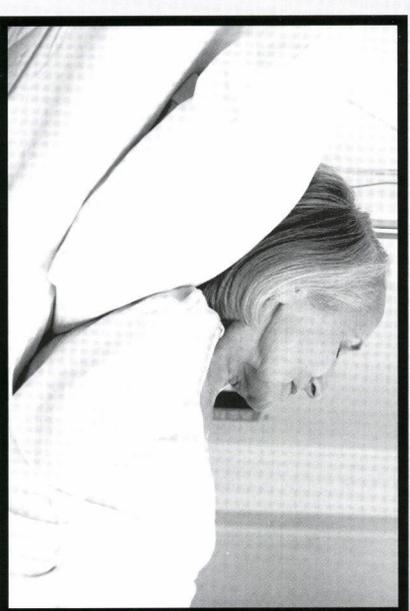
“Terminal sedation seems consistent with accepted practices ... however terminal sedation is tantamount to euthanasia, or a kind of slow euthanasia.”

—Dr. David Orentlicher
New England Journal of Medicine

if the reason you are doing something is moral, the end effect is justified.

In terminal sedation, this argument is used to justify giving a patient drugs that will kill them by saying that the intention was to ease their pain. The truth is, unfortunately, more sinister. Palliative care experience and research has shown that it is possible to manage pain or distress without hastening death.² The pain and suffering can be avoided without bringing an early death.

In case after case, the reality is that the drugs are given to kill the patient faster than their disease would, in what can only be described as slow euthanasia.³



What Is Palliative Sedation?

Palliative sedation is the use of pain relieving drugs to provide comfort care to a patient with a serious illness or disease. This type of care is normally provided during the last stages of a terminal disease. Palliative care focuses on relieving symptoms such as pain, anxiety, nausea, and difficulty breathing by putting the patient into a semi-conscious or unconscious state.

What is Terminal Sedation?

The terms “terminal sedation” and “palliative sedation” are often used to describe the same process. However, terminal sedation as now practiced in many hospice

In 1966, Julia Tavalaro suffered two strokes and a brain hemorrhage and was believed to be in a vegetative state. Six years later a family member saw Julia trying to smile after she told her a joke. She alerted doctors, and a speech therapist was able to see that her eye movements had meaning. Convincing the doctors was difficult, but after a time she was recognized as being in a locked-in state. She learned to communicate with eye blinks and became a poet and author. Eventually, she gained the ability to move her head enough to touch a switch with her cheek which operated a motorized wheelchair and a computer.

A person such as Nick has been tragically struck down and needs all the help he or she can get to rediscover something worth living for.

— Grant Gillett
Professor of medical ethics

Nick Chisholm, the young man hurt on the rugby field, is working hard to show the doubting doctors that he can improve. Through extraordinary hard work and persistence, he is now able to say many words and string them together in simple sentences. Nick says, "I'm just glad to still be alive; I just have to make the most of each day in my journey toward recovery."⁵

The Truth

It has become too common for doctors to recommend removing food and water and other life support for those they believe are in a persistent vegetative state. While statistics are unknown, it is believed there are thousands of cases each year of patients who are "locked-in." The people with this syndrome need to be recognized as human beings with dignity and value. Moreover, doctors and nurses need to be trained to look for this syndrome and encourage family members to look for the same. By working together and truly valuing human life, families and medical professionals can create an environment where people are valued not because of their output, but because they are people, too.

1. Bauer, G. and Gerstenbrand, F. and Rumpel, E. (1979). "Varieties of the locked-in syndrome". *Journal of Neurology* 221 (2): 77--91.
2. Maiese, Kenneth, MD. "Locked-in Syndrome". *The Merck Manual of Patient Symptoms*. Revised January 2008. Found at <http://www.merck.com/mmpe/sec16/ch212/ch212c.html> accessed on 3/8/2010.
3. Gillett, Grant. Clinical review, "The patient's journey: Living with locked-in syndrome". *BMJ* 2005;331:94-97 (9 July), doi:10.1136/bmj.331.7508.94. Found at <http://www.bmj.com/cgi/content/full/331/7508/94> accessed on 3/8/2010.
4. Robinson, Tasha, "The Diving Bell And The Butterfly". *The A.V. Club*. November 29, 2007. Found at http://www.avclub.com/content/cinema/the_diving_bell_and_the_accessed_on_3/8/2010.
5. Foer, Joshua, "The Unspeakable Odyssey of the Motionless Boy", *Esquire Magazine*, October 2, 2008.

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Locked-in Syndrome (Coma Vigilante)



What Is Locked-In Syndrome?

Coma Vigilante, commonly referred to as locked-in syndrome, is a condition where a patient is conscious and aware but unable to communicate due to paralysis of nearly all voluntary muscle movement. Most patients are still able to move their eyes. In rarer instances patients may have total locked-in syndrome where their eye movement is paralyzed as well.¹

The Misdiagnoses

When dealing with a “locked-in” patient many doctors will misdiagnose the condition as a “persistent vegetative state.”² It is normally the families who fight this diagnosis when they realize their loved ones are trying to communicate but are just unable to. Grant Gillet, professor of medical ethics, has studied many locked-in cases and found that “It is more often relatives than medical staff who realize the patient’s predicament (usually by noticing intuitively that the patient is awake and registering what is going on).”³

The Danger

Those doctors who misdiagnose locked-in syndrome as a coma or persistent vegetative state may also make a larger mistake in recommending the removal of food, water, and/or life support systems. Many times, because the doctor believes the patient to be unable to hear and understand, the request to let them starve to death is made within hearing range of the patient.

“It felt like I was in a really bad nightmare constantly for about the first three months. I could only just hear (I couldn’t even open my eyes or breathe by myself); without them even knowing that I still could hear, the doctors and specialists in front of me said to my mum that I would die. They even asked my mum if she wanted them to turn the life support machine off after a few days.”

*Nick Chisholm
Locked In Syndrome Patient*

The Reality

On July 29, 2000, a young man named Nick Chisholm was hurt on the rugby field in England. He was taken to the hospital and was found to be unresponsive after a number of strokes in his brain stem. He recalls that he could hear many of the conversations had at his bedside even though others thought he could not. He heard the doctors say he was going to die. He heard the doctors ask his mother if she wanted to pull him off life-support. He also heard his mother and girlfriend begging with the doctors to see what they saw — that he was trying to respond but was unable to... Finally, when the doctors did further diagnosis based on the insistence of this mother, he even heard the doctors say he would never improve. But the story was not over...

The Challenges

Locked-in syndrome is a serious condition that is difficult for both the patient and family. The issues it brings with it are immense and the struggles are difficult. There are also larger implications to consider as people are daily starved to death because they are thought to be in a persistent vegetative state.

The medical community and families across the world need to take up the challenge of protecting those who are weaker and unable to speak for themselves. As the knowledge of locked-in syndrome grows, there needs to be a stronger effort to end the practice of death by starvation and look more to therapy and new technology for communication. We can’t deny the life changes brought on by this condition, but neither can we deny the humanity of a person who is simply unable to talk or communicate.

The Hope

When a person is diagnosed with locked-in syndrome, their life goes on. Journalist Jean-Dominique Bauby suffered a stroke in December 1995. He awoke 20 days later to find his body was almost completely paralyzed. He could control only his left eyelid. Some may have thought him useless, but he decided he would continue working. By blinking his eye, he dictated one alphabet character at a time. He was able, over a great deal of time, to write his memoir *The Diving Bell and the Butterfly* which became a number-one best-seller across Europe.⁴

The Reflection

Taking care of the elderly not only helps to sustain our society, it is also a reflection of the true character of our generation. When a culture fails and becomes completely self-centered, it is the most vulnerable who are harmed first. When looking at the challenge presented by caring for those in need, it is worth remembering others are watching. If we are to be an example, if we are to be a beacon on a hill, then we first must start with loving and compassionate care for the elderly.

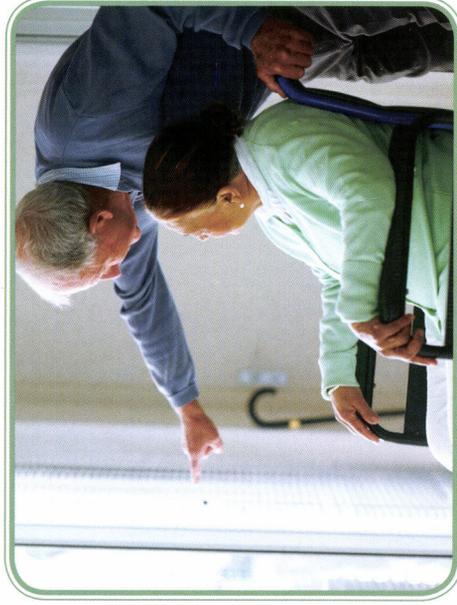
“A test of a people is how it behaves toward the old. It is easy to love children. Even tyrants and dictators make a point of being fond of children. But the affection and care for the old, the incurable, the helpless, are the true gold mines of a culture.”

— Abraham J. Heschel
Jewish Theologian and Philosopher

Is It Worth It?

It takes countless hours of hard work to be a caregiver. So is it really worth the effort?

If you ask those being cared for, the answer would be a resounding “YES!” To have a peaceful end-of-life journey, surrounded by love and care, is an incredible gift.



It is simply the best way to leave this world: in the care of loved ones.

If you were to ask those giving care, they would also say, “Yes!” Their work is tough, but their reward is the knowledge that they did what was right for those they love when called upon. They work not for selfish reasons, but to provide an environment of concern and affection around their family.

So, is it worth the effort? The answer can be nothing less than “absolutely.” Providing hope, care, and love to those in need is nothing short of the work of God on earth. While the full reward may not be known in this lifetime, it is still and always will be work worth doing.

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*Where Our
Heart Lives*



A Great Call

Caring for the elderly and the frail has been a responsibility for all people since the beginning of mankind. The requirements and stress of the work have caused many to wonder if it is worth the effort. In recent times these doubts have grown into a societal shift that devalues the elderly. This has led to the point of legalizing and recommending euthanasia as a “solution” for end-of-life issues.

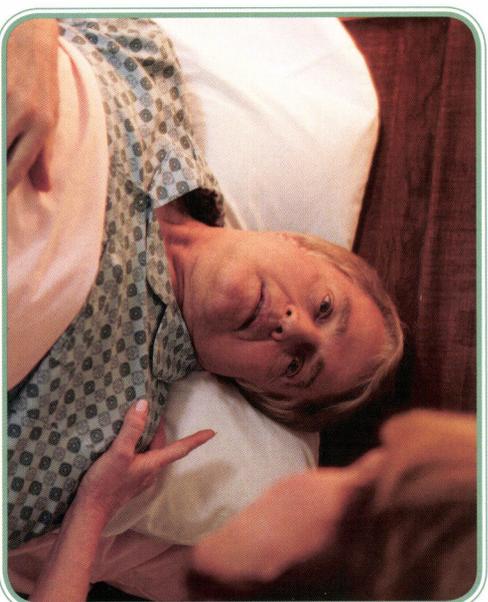
With such a somber background, it is now more important than ever to understand the value of our older generations. Their wisdom and guidance reach out from their years and give us advice born of experience. But their value reaches beyond their usefulness. They are valuable human beings, and caring for them is an education in life. While it often requires a dedicated person to care for the elderly, it is a work of love that shapes the character of the caregiver, the family, and the society as a whole.

As our parents and grandparents age, we now face a looming question. Are we willing to take up this great call to love in action? Are we willing to grow through serving others? Are we willing to care for those who cared for us first?

Giving Love

The purpose of giving care is to provide a loving environment for the elderly in their time of need. This is easy to forget as the caregiver works through the many mundane tasks of care. Giving love as a primary goal creates a layer of genuine concern on top of these everyday jobs.

With this perspective and purpose, the real virtue and honor of end-of-life care can be seen. The result is a life that ends with dignity and love. When the day is finished, the caregiver can rest knowing that their work is worthwhile and that they are making a true difference in the life of a loved one.



*If I can stop one heart from breaking,
I shall not live in vain;
If I can ease one life the aching,
Or cool one pain,
Or help one fainting robin
Unto his nest again,
I shall not live in vain.*

—Emily Dickinson (1830–1886)

What We Learn

Caring for the elderly and the sick not only helps those receiving care. The process of learning to love through the giving of ourselves builds character, maturity, and understanding. These lessons are learned in the crucible of real life and can make a caregiver into a person of great wisdom and insight.

It is this life-knowledge gained in unselfish giving that has helped to make our society great. The influence of caregivers who do what is right even when it is not convenient cannot be understated. After their primary care work is done, they continue to interact, teach, and advise those around them. They may not even know the depth of the wisdom they have gained, but its impact is real.

The grace and love shown by these caregivers become the cords of strength that run through the tapestry of our society. By giving care we are not only helping those in need, we are building and strengthening ourselves.

**ADDITIONAL
DOCUMENTS**

Gallagher and Associates, PLLC
COUNSELOR AND ATTORNEY AT LAW

March 26, 2013

Chairman Murphy, and members of the
Senate Judiciary committee
P O Box 200500
Helena MT 59620-0500

RE: Prevent Elder Abuse, Vote "Yes" on HB 505

Senate Judiciary Committee:

I am writing you in my individual capacity and as a practicing elder law and estate planning attorney.

As an interesting aspect my practice, I have observed two consistent attributes, one of the "greatest generation" that in the coming years will transfer an estimated **forty-one (41) trillion dollars of wealth** and the other in the next generation, waiting expectantly for that wealth.

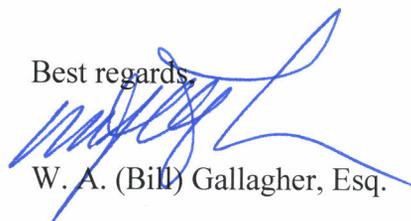
- 1) The older generation generally feels an **overwhelming sense of guilt** about using their wealth for their own comfort and care. Indeed, their wealth was built upon the principal of self-sacrifice.
- 2) The adult children and descendants of the older generation, who typically have not embraced the principal of self-sacrifice and saving, often **have a strong proprietary attachment, or sense of entitlement to the assets** their parents sacrificed to save.

I must often remind my elderly clients not to feel guilty. I remind them: "**fly 1st class, your children certainly will**". As an example, a woman called me about contesting her mother's Will. When I asked when her mother had died, the response was her mother was still alive, but had recently changed her Will decreasing the daughter's inheritance share. The daughter sought to sue her own mother for a larger share of her still living mother's estate. I thought of her when I read HB 505.

The two generational contexts described above are key reasons for the rapidly increasing problem of elderly abuse for financial gain. **These older Montanans, our "greatest generation," by virtue of their culture of sacrifice are ever so susceptible to the abuse** that legal assisted suicide would afford.

Give our greatest generation the respect and protection they deserve. **Vote "yes" on HB 505** to clearly state that assisted suicide is not legal in Montana.

Best regards,



W. A. (Bill) Gallagher, Esq.

ADDITIONAL
DOCUMENTS

ADDITIONAL DOCUMENTS

Testimony Against HB 505

Mr. Chairman and members of the Senate Judiciary Committee:

I have been a Registered Nurse for over 50 years. During my years of practice I have helped people at all stages of life, including the final stage of dying. I believe that every person should have all options available to them to live and to die with dignity and in comfort. Unfortunately the choice of death with dignity and comfort is not always available.

The Montana Supreme Court ruled in the Baxter decision that aid in dying is legal and is a decision between the individual and their physician when they are terminally ill. There is much confusion and misinformation being circulated regarding the Baxter decision, and what aid in dying means. This is not euthanasia, and it is not physician assisted suicide. End of life assistance very specifically is for the terminally ill adult who is mentally competent. It is the patient, not the physician who makes the decision to choose aid in dying. The physician should have the ability to support their patients' end-of-life choices.

I am here today representing myself, as a senior citizen who will soon be facing end-of-life decisions. If I have a terminal illness I wish to have all options available to me as my life comes to an end. I do not believe that the Baxter decision or any other law that allows us autonomy in our end-of-life decisions leads to elder abuse. Although elder abuse occurs in Montana, I do not believe it is related to our right to end-of-life choices. Do we have so little faith in our physicians and our loved ones? HB 505 will not only take away my option to request aid-in-dying, but will not even allow me to discuss this with my physician without endangering his or her medical practice. Please do not support HB 505.

Mary M. Douglass, RN, MS
1920 E. Broadway St.
Helena, MT 59601
406-422-4529

End the confusion over the legality of assisted suicide in Montana

ADDITIONAL DOCUMENTS



We Physicians Support HB 505 - this will end the confusion over whether physician assisted suicide is legal by clearly providing that physician-assisted suicide is not legal.

Physician assisted suicide means a physician prescribes a lethal medication to another person to commit suicide. This practice is open to abuse and error.

"Physician-assisted suicide is fundamentally incompatible with the physicians' role as healer, would be difficult or impossible to control, and would pose serious societal risks."

AMA ethics opinion 2.211

"If my doctor had believed in assisted suicide, I would be dead."

In 1997, I voted for the initiative that legalized assisted suicide in Oregon.

In 2000, I was diagnosed with cancer and told that I had six months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I did not want to suffer, and I did not want to do radiation. I wanted Dr. Stevens to help me, but he didn't really answer me.

Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

It is now 12 years later. If Dr. Stevens had believed in assisted suicide, I would be dead. I thank him and all my doctors for helping me choose "life with dignity." Assisted suicide should not be legal.

Thank you so much.

Jeanette Hall
King City, Oregon



SCAN TO LEARN MORE

TELL YOUR SENATOR *Vote yes* on HB 505

WE MONTANA PHYSICIANS SUPPORT A YES VOTE ON HB 505

Tim Adams MD Internal Medicine Bozeman	Dave Enbrecht MD Family Practice Great Falls	Tanya Jagodzinski MD Pediatrics Billings	Daniel O'Neill DDS Dentistry Butte	Geoffrey Taylor DO Anesthesiology Kalispell
Marybeth Adams FNP Family Practice Belgrade	Andy Engdahl MD Radiology Kalispell	Paul Johnson MD Sports Medicine Great Falls	Peter O'Reilly MD Anesthesiology Bozeman	James Threatt MD Ophthalmology Billings
Brice Addison MD Internal Medicine Great Falls	Mary Ann Evans MD Psychiatry Great Falls	John Kalbfleisch MD Family Practice Whitefish	Albert Olstzewski MD Orthopaedic Surgery Kalispell	Jason Tinney MD Anesthesiology Great Falls
Dave Anderson MD Pulmonary & Critical Care Great Falls	Dannel Gannon MD Orthopaedic Surgery Bozeman	Jeff Kessler MD Radiology Great Falls	Lyle Onstad MD Family Practice Great Falls	Craig Treptow MD Family Practice Great Falls
Jim Asthalter DO Family Practice Great Falls	Michael Garver MD Pediatrics Great Falls	Libby Lake MD Family Practice Great Falls	Michael Oncutt MD Vascular Surgery Great Falls	Robin Lynn Treptow PhD Psychology Great Falls
Andrew Barber MD Emergency Medicine Great Falls	Shaun J Gillis MD OB/GYN Bozeman	James Legan MD Internal Medicine Great Falls	Varghese Parambi MD Nephrology Great Falls	Thomas Triehy DO Family Practice Great Falls
Gabor Benda MD Family Practice Bozeman	Dan Gordon MD Family Practice Great Falls	John Madany MD Family Practice Dillon	John VanArendonk MD Emergency Medicine Bozeman	Phillip Verdo MD Anesthesiology Great Falls
Don Berdeaux MD Oncology Great Falls	Paul Gorsuch MD Neurological Surgery Great Falls	John Mahan MD Internal Medicine Great Falls	Mark Peterson MD Anesthesiology Great Falls	Dan Walker MD Cardiology Great Falls
Brad Bergman MD Internal Medicine Great Falls	Lea Gorsuch MD Orthopaedic Surgery Great Falls	James Mallander MD Radiology Great Falls	Gordon Phillips MD OB/GYN Great Falls	Roger I. Wallace DO Maternal-Fetal Medicine Billings
Richard Best MD General/Thoracic Surgery Butte	Rob Grasseschi MD Pulmonary & Critical Care Great Falls	Mel Margaris MD Family Practice Great Falls	Leonard Ramsey MD Family Practice Bozeman	Mike Walters MD Radiology Great Falls
Kathleen Blair DO Internal Medicine Great Falls	Walter Graves MD Cardiovascular Surgery Billings	Thomas Matzko MD Ophthalmology Great Falls	Dan Rausch MD Family Practice Kalispell	K. Allan Ward MD Physical Medicine Great Falls
Richard Blevins MD Pulmonary & Critical Care Great Falls	John L. Greene MD Neurological Surgery Kalispell	Bob Maynard MD Internal Medicine Great Falls	David B. Roberts MD OB/GYN Red Lodge	Tom Weiner MD Oncology Helena
David Bees MD Ophthalmology Great Falls	Karl Guter MD Medical Oncology Great Falls	Nancy Maynard MD Pediatrics Great Falls	Pamela Roberts MD Family Practice Kalispell	Carey Welsh MD Family Practice Great Falls
Michael Boharski MD Gastroenterology Kalispell	Alimee Hachigian-Gould MD Orthopaedic Surgery Great Falls	Kevin McCafferty MD Emergency Medicine Kalispell	Carley Robertson MD Emergency Have	Heather J Wheeler MD Family Practice Bozeman
Don Bossard MD Family Practice Whitefish	John Hacketthorn MD Radiology Polson	Kevin McCrea MD Family Practice Laurel	Perrin Roten MD General Surgery Laurel	Kenneth Whipple DO Anesthesiology Great Falls
Keener Boyce MD Anesthesiology Great Falls	David W. Hafer DDS MS Maxillofacial Surgery Kalispell	David McLaughlin MD Family Practice Bozeman	William Rowe MD Cardiology Great Falls Clinic Great Falls	Glenn Winslow MD General Surgery Great Falls
Annie Bukacak MD Internal Medicine Kalispell	Jim Harkness DO Family Practice Great Falls	Wayne A Miller MD Ear/Nose & Throat Kalispell	Antonio Santini MD Plastic Surgery Great Falls	Richard Wise MD Addiction Medicine Kalispell
Todd Cameron MD Orthopaedic Surgery Great Falls	Todd Harper MD Emergency Great Falls	Fred Miller MD Internal Medicine Great Falls	Dale Schaefer MD Neurological Surgery Great Falls	Robert Wynia MD Internal Medicine Helena
Ralph Campbell MD Pediatrics Kalispell	John Heine MD OB/GYN Kalispell	Christine L. Mitchell MD Family Practice Bozeman	John Schwaneveldt MD Ear/Nose & Throat Kalispell	Jim Yurri MD Internal Medicine Great Falls
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Dennis Dietrich MD Neurology Great Falls	Larry Iversen MD Orthopaedic Surgery Kalispell	George Mulcair-Jones MD Family Practice Butte	Larry Sonnenberg MD Family Practice Bozeman	
William Doyle MD Emergency Medicine Hamilton	Ben Jagodzinski MD Anesthesiology Billings	Jeanette Noble FNP Family Practice Hamilton	Doug Swift MD Internal Medicine Billings	

Find out more at EndTheConfusion.org

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Montana State Legislature

**2013 SESSION
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Question 2 insults Kennedy's memory

By ColumnCredit
VICTORIA REGGIE KENNEDY
October 27, 2012 2:00 AM

There is nothing more personal or private than the end of a family member's life, and I totally respect the view that everyone else should just get out of the way. I wish we could leave it that way. Unfortunately, Question 2, the so-called "Death with Dignity" initiative, forces that issue into the public square and places the government squarely in the middle of a private family matter. I do not judge nor intend to preach to others about decisions they make at the end of life, but I believe we're all entitled to know the facts about the law we're being asked to enact.

Here's the truth. The language of the proposed law is not about bringing family together to make end of life decisions; it's intended to exclude family members from the actual decision-making process to guard against patients' being pressured to end their lives prematurely. It's not about doctors administering drugs such as morphine to ease patients' suffering; it's about the oral ingestion of up to 100 capsules without requirement or expectation that a doctor be present. It's not about giving choice and self-determination to patients with degenerative diseases like ALS or Alzheimer's; those patients are unlikely to qualify under the statute. It's not, in my judgment, about death with dignity at all.

My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. Question 2 turns his vision of health care for all on its head by asking us to endorse patient suicide — not patient care — as our public policy for dealing with pain and the financial burdens of care at the end of life. We're better than that. We should expand palliative care, pain management, nursing care and hospice, not trade the dignity and life of a human being for the bottom line.

Most of us wish for a good and happy death, with as little pain as possible, surrounded by loved ones, perhaps with a doctor and/or clergyman at our bedside. But under Question 2, what you get instead is a prescription for up to 100 capsules, dispensed by a pharmacist, taken without medical supervision, followed by death, perhaps alone. That seems harsh and extreme to me.

Question 2 is supposed to apply to those with a life expectancy of six months or less. But even doctors admit that's unknowable. When my husband was first diagnosed with cancer, he was told that he had only two to four months to live, that he'd never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die.

But that prognosis was wrong. Teddy lived 15 more productive months. During that time, he cast a key vote in the Senate that protected payments to doctors under Medicare; made a speech at the Democratic Convention; saw the candidate he supported elected president of the United States and even attended his inauguration; received an honorary degree; chaired confirmation hearings in the Senate; worked on the reform of health care; threw out the first pitch on opening day for the Red Sox; introduced the president when he signed the bipartisan Edward M. Kennedy Serve America Act; sailed his boat; and finished his memoir "True Compass," while also getting his affairs in order, kissing his wife, loving his family and preparing for the end of life.

Because that first dire prediction of life expectancy was wrong, I have 15 months of cherished memories — memories of family dinners and songfests with our children and grandchildren; memories of laughter and, yes, tears; memories of life that neither I nor my husband would have traded for anything in the world.

When the end finally did come — natural death with dignity — my husband was home, attended by his doctor, surrounded by family and our priest.

I know we were blessed. I am fully aware that not everyone will have the same experience we did. But if

Question 2 passes I can't help but feel we're sending the message that they're not even entitled to a chance. A chance to have more time with their loved ones. A chance to have more dinners and sing more songs. A chance for more kisses and more love. A chance to be surrounded by family or clergy or a doctor when the end does come. That seems cruel to me. And lonely. And sad.

My husband used to paraphrase H.L. Mencken: for every complex problem, there's a simple easy answer. And it's wrong.

That's how I feel in this case. And that's why I'm going to vote no on Question 2.

Victoria Reggie Kennedy is an attorney, health care advocate and widow of Sen. Edward M. Kennedy.

PHYSICIAN-ASSISTED SUICIDE IN OREGON: A MEDICAL PERSPECTIVE

Herbert Hendin*
Kathleen Foley**

This Article examines the Oregon Death with Dignity Act from a medical perspective. Drawing on case studies and information provided by doctors, families, and other care givers, it finds that seemingly reasonable safeguards for the care and protection of terminally ill patients written into the Oregon law are being circumvented. The problem lies primarily with the Oregon Public Health Division ("OPHD"), which is charged with monitoring the law. OPHD does not collect the information it would need to effectively monitor the law and in its actions and publications acts as the defender of the law rather than as the protector of the welfare of terminally ill patients. We make explicit suggestions for what OPHD would need to do to change that.

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INTRODUCTION

In 1997, five months after the U.S. Supreme Court ruled that there was no right to assisted suicide in the Constitution but implied that states have the right to decide for themselves whether to permit or prohibit physician-assisted suicide, the Oregon Death with Dignity Act, having survived its own legal challenges, took effect.¹ It was thought that Oregon would serve

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1. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-.897 (1997).

as a “laboratory of the states,” showing us how physician-assisted suicide (“PAS”) would work. This has not occurred, in large part because the Oregon Public Health Division (“OPHD”), charged with monitoring the law, has interpreted its mandate in an extremely restrictive manner.

OPHD limits its yearly reports to general epidemiological data and collects limited information from physicians who have prescribed lethal medication. Physicians who declined to prescribe the lethal medication, as well as nurses and social workers who cared for the patients, pharmacists who filled the prescriptions, and family members, are not interviewed. Not all the information collected is made public,² and after a year “all source documentation is destroyed.”³

Since the passage of Oregon’s Death with Dignity Act, however, various sources—patients, families, healthcare professionals, physicians, nurses, social workers, chaplains, and advocacy groups—have supplied more detailed information that suggests that the implementation of the law has had unintended, harmful consequences for patients.

The Oregon law seems to require reasonable safeguards regarding the care of patients near the end of life, which include presenting patients with the option for palliative care; ensuring that patients are competent to make end-of-life decisions for themselves; limiting the procedure to patients who are terminally ill; ensuring the voluntariness of the request; obtaining a second opinion on the case; requiring the request to be persistent, i.e., made a second time after a two week interval; encouraging the involvement of the next of kin; and requiring physicians to inform OPHD of all cases in which they have written a prescription for the purpose of assisted suicide.

The evidence strongly suggests that these safeguards are circumvented in ways that are harmful to patients. Addressing and correcting the situation would require more information than OPHD has been willing to obtain. Instead, based on the inadequate information it collects, OPHD has been issuing annual reports declaring that terminally ill Oregon patients are receiving adequate care. The available evidence, which we will present in this Article, suggests otherwise.

Nothing in the Oregon law prevents OPHD from collecting needed information. During the second year of the law, OPHD did undertake a survey of the family members of patients who had been assisted in suicide.⁴ Apart from not permitting independent investigators to examine the data, the Oregon law gives OPHD great flexibility. OPHD has not taken advantage of this opportunity.

2. Kathleen Foley & Herbert Hendin, *The Oregon Experiment*, in *THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE* 144, 144–45 (Kathleen Foley & Herbert Hendin eds., 2004).

3. FAQs about the Death With Dignity Act, <http://www.oregon.gov/DHS/ph/pas/faqs.shtml> (last visited Apr. 3, 2008).

4. Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, *NEW ENG. J. MED.* 598 (2000).

This Article draws on six cases previously published, three of them by us. In four of them there was independent information from more than one source. In two of the cases the information is provided by one source only—in one case by a proponent, and in the other by an opponent, of assisted suicide. This Article differs, however, from our earlier treatments of the subject since it focuses on the implementation of the Oregon law and not on the law itself.⁵

Part I of this Article examines OPHD's failure to ensure that palliative care alternatives to PAS are made available to patients. Parts II and III discuss the adequacy of safeguards to ensure a patient's psychiatric health and the voluntariness of the decision. Part IV discusses the emphasis on protecting physicians, rather than patients. Part V examines the role of advocacy groups for assisted suicide. Part VI describes how Oregon's current approach to patient requests for PAS differs from the accepted medical approach both to suicide and to requests for assisted suicide. Part VII concludes with an analysis of the main concerns raised by OPHD's monitoring of the Oregon law and suggests how these concerns could be addressed.

I. PROVIDING ALTERNATIVES

In Oregon, intolerable suffering that cannot be relieved is not a basic requirement of assisted suicide as it is in the Netherlands, the only country to give legal sanction to assisted suicide and euthanasia.⁶ A diagnosis of terminal illness with a prognosis of less than six months to live is considered a sufficient criterion.

The unintended consequence of this provision is that it enables physicians to assist in suicide without inquiring into the source of the medical, psychological, social, and existential concerns that usually underlie requests for assisted suicide, even though this type of inquiry produces the kind of discussion that often leads to relief for patients and makes assisted suicide seem unnecessary.⁷ When a terminally ill Oregon patient makes a request for assisted suicide, physicians are required to indicate that palliative care and hospice care are feasible alternatives. They are not required, however, to be knowledgeable about how to relieve physical or emotional suffering in

5. Two of the cases were first published in our 2002 book, *THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE*, *supra* note 2, copyright © 2002 by The Johns Hopkins University Press. They are reprinted in modified form with permission of The Johns Hopkins University Press. We have reprinted with permission modified portions of Kathleen Foley & Herbert Hendin, *The Oregon Report: Don't Ask, Don't Tell*, *HASTINGS CENTER REP.*, May–Jun. 1999, at 37, copyright © 1999 by The Hastings Center. Excerpts from the original article Herbert Hendin, Kathleen Foley & Margot White, *Physician-Assisted Suicide: Reflections on Oregon's First Case*, 14 *ISSUES IN L. & MED.* 243 (1998) are reprinted with permission. Copyright © 1998 by the National Legal Center for the Medically Dependent & Disabled, Inc.

6. Herbert Hendin et al., *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons From the Dutch*, 277 *J. AM. MED. ASS'N* 1720, 1720–22 (1997).

7. Paul B. Bascom & Susan W. Tolle, *Responding to Requests for Physician Assisted-Suicide: "These Are Uncharted Waters for Both of Us. . ."*, 288 *J. AM. MED. ASS'N* 91, 91–97 (2002); Diane E. Meier, Op-Ed., *A Change of Heart on Assisted Suicide*, *N.Y. TIMES*, Apr. 24, 1998, at A27.

terminally ill patients. Without such knowledge, which most physicians do not have, they cannot present or make feasible alternatives available. Nor in the absence of such knowledge are they required to refer the patient to a physician with expertise in palliative care.

In the absence of adequate monitoring, the focus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements for assisted suicide. Physicians can merely go through the motions of presenting the possibility of palliative care for their patients. How this happens is suggested by a case which was publicized by Compassion in Dying (now Compassion and Choices), an advocacy group which promotes legalized PAS, as the first case of assisted suicide under the Oregon law.⁸

A. *The First Case: Helen*

In earlier works, we gave an account of this case based on a news conference given by Compassion in Dying, our own correspondence with the doctor who assisted in the suicide, and other sources of information to which we will refer. The conference described how a patient in her mid-eighties, who had been diagnosed with metastatic breast cancer and who was then living in a hospice, came to choose assisted suicide.

Helen's own physician had refused to assist in her suicide for unspecified reasons. A second physician refused on the grounds that Helen was depressed. Helen's husband then called Compassion in Dying and was referred to a physician who would assist her.

The medical director of Compassion in Dying said that he had spoken by phone with Helen at the time of the referral and also spoke by phone to her son and daughter. He described Helen as "'rational, determined and steadfast'"⁹ and questioned the opinion of the physician (with whom the medical director also spoke by phone) who described her as having a depression that was affecting her desire to die. He said Helen was "'frustrated and crying because she was feeling powerless.'"¹⁰ He said she had been doing aerobic exercises up until two weeks before she contacted him but told him she could not do them anymore. She was also unable to continue to garden, which had been one of her favorite activities. The medical director said she was not bedridden, was not in great pain, and was still able to look after her own house. He said the "'quality of her life was just disappearing,'"¹¹ and he thought it prudent to act quickly before Helen lost the

8. Part I reprints modified versions of our previous work. Foley & Hendin, *supra* note 2, at 146-50; Foley & Hendin, *supra* note 5, at 38, 40-41; Hendin et al., *supra* note 5, at 244-48. See *supra* note 5 for copyright information.

9. Diane M. Gianelli, *Praise, criticism follow Oregon's first reported assisted suicides*, AM. MED. NEWS, Apr. 13, 1998, at 1.

10. Erin Hoover & Gail K. Hill, *Two Die Using Suicide Law*, OREGONIAN, Mar. 26, 1998, at AO1.

11. Gianelli, *supra* note 9.

capacity to make decisions for herself.¹² He said she was “‘going downhill rapidly. . . . She could have had a stroke tomorrow and lost her opportunity to die in the way that she wanted.’”¹³

The physician who agreed to prescribe the medication had met Helen two and a half weeks before she died and described her as having more physical discomfort than Compassion in Dying had indicated. He said that after twenty years the cancer had spread to her lungs, causing some pain and shortness of breath. He followed a protocol that included an anti-nausea medication that Helen had taken before he arrived to be with her and her family when she died. She then took a mixture of barbiturates (nine grams) and syrup followed by a glass of brandy. She is said to have died within thirty minutes.

B. *The Medical Decision*

Helen's case was presented by Compassion in Dying as an example of how well the Oregon law is being implemented.¹⁴ The organization did not seem aware that, contrary to their expectations, their presentation would raise troubling questions.

The physicians who evaluated Helen offered two contradictory sets of opinions about the appropriateness of her decision. As the decision-making process progressed, there was no mechanism in place for resolving the disagreement based on medical expertise. An ethics committee that would hear the facts of the case before going forward could have resolved this dispute. Instead, the opinions of the two doctors who did not support the patient's decision—one who had known her for some time and another who considered that she was depressed—were essentially ignored. As Barbara Coombs Lee, then the executive director of Compassion in Dying, expressed it, “‘If I get rebuffed by one doctor, I can go to another’”¹⁵

Patients, of course, have the right to obtain other opinions and to seek out physicians who will provide the therapy that the patients choose. We wondered at the time if the prescribing physician consulted either Helen's physician or the physician who diagnosed her as depressed. In reply to a journal article we wrote that asked this question,¹⁶ we received a response from Dr. Peter Reagan, who had been anonymous but who now identified himself as the prescribing physician. He wrote:

12. *Id.*

13. *Id.*

14. After the announcement of what was thought to be the first case of assisted suicide in Oregon, the Hemlock Society in Oregon announced that since the Oregon law had gone into effect it had helped arrange an even earlier assisted suicide at some unspecified date for another patient with cancer. Erin Hoover, *Two Deaths Add New Angle to Debate*, OREGONIAN, Mar. 27, 1998, at A01.

15. William Claiborne, *In Oregon, Suicide Option Brings a Kinder Care*, WASH. POST, Apr. 29, 1998, at A01.

16. Hendin et al., *supra* note 5, at 247.

Before my patient died I didn't personally discuss the case with her regular physician and had only a very cursory contact with her second. I regret this. I don't think either of the previous MDs disagreed with her qualification, but at the time I would have clarified it. Had I felt there was a disagreement among the physicians about my patient's eligibility, I would not have written the prescription.¹⁷

It is noteworthy that Reagan used words like "qualification" and "eligibility" to justify his actions rather than discussing the appropriateness of the decision.

C. Making Options Available

No information indicates Reagan was trying to find any feasible alternatives to suicide. In the taped interview with Helen, he told her that it is important she understand that there are other choices she could make that he will list for her, and in three sentences covering hospice support, chemotherapy, and hormonal therapy, he did:

[Reagan]: There is, of course all sorts of hospice support that is available to you. There is, of course, chemotherapy that is available that may or may not have any effect, not in curing your cancer, but perhaps in lengthening your life to some extent. And there's also available a hormone which you were offered before by the oncologist—tamoxifen—which is not really chemotherapy, but would also have some possibility of slowing or stopping the course of the disease for some period of time.

[Helen]: Yes, I didn't want to take that.

[Reagan]: All right, OK, that's pretty much what you need to understand.¹⁸

During the taped remarks, Helen expressed concern about being artificially fed, a concern that may have contributed to her request for assisted suicide, and suggests greater anxiety and uncertainty about her course of action than the physician perceived. One would expect him to have assured her that this need not happen in any case. Instead he ignored the remark and changed the subject by asking a question about her desire to die.¹⁹

Reagan was impressed by Helen's determination to die. In an interview with Oregon Public Broadcasting, he described talking to her as "like talking to a locomotive,"²⁰ in her desire for death even though she was not in great immediate distress. Although Reagan was troubled by her haste, and with good reason—such stubborn urgency is often a sign of irrational motives—he was unable to resist it. As striking as Helen's determination is,

17. Letter from Peter Reagan to Kathleen Foley (Mar. 23, 1999) (on file with author).

18. *Doctor & Patient: A Conversation on Suicide*, OREGONIAN, Mar. 27, 1998, at A18.

19. *See id.*

20. Hoover, *supra* note 14.

Reagan's haste in presenting and moving past the alternatives to assisted suicide is even more striking.

Reagan subsequently wrote an article for the British journal *Lancet*, in which he stated that he liked Helen immediately. He continued:

The thought of Helen dying so soon was almost too much to bear. . . . On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had about their previous doctor, that I had strung them along, and in a way, insulted them.²¹

Neither reluctance to disappoint her family nor embarrassment at backing out should have been such a significant factor in the decision to end her life.

D. The Palliative Care Alternative

The difference it makes if a cancer patient is seen by someone who has experience in providing palliative care is suggested by the following excerpt from a letter written by a practicing oncologist in response to the law:

As a practicing gynecologic oncologist in Portland, Oregon, where physician-assisted suicide is legal, I informed patients of my views by having a clear statement, based on the Hippocratic Oath posted in my waiting room. This reassured most patients, however, I had two patients who objected. The first was afraid that I would prolong her life beyond her wishes. This conversation helped me to meet her needs and she had a peaceful, comfortable death at home with her family. The second patient wanted me to prescribe lethal medications in case her cancer pain became unbearable. Prior to this conversation, she had been minimizing her pain. This conversation allowed us to work together to better control her pain, after which her desire for assisted suicide disappeared. She died comfortably and naturally two months later.²²

The OPHD's yearly progress reports contend that patients who requested assisted suicide were receiving adequate end-of-life care, citing the frequency with which patients were in hospice care as evidence. However, a referral to hospice care cannot be regarded as a substantive palliative care intervention without knowing what care the hospice provided.

Moreover, available data contradict the OPHD's contention of adequate care. A study at the Oregon Health & Science University indicated that there has been a greater percentage of cases of inadequately treated pain in terminally ill patients since the Oregon law went into effect.²³ However, among patients who requested PAS but availed themselves of a substantive

21. Peter Reagan, *Helen*, 353 LANCET 1265, 1266 (1999).

22. Letter from William Petty to the New England Journal of Medicine (Apr. 30, 2007) (on file with Physicians for Compassionate Care), available at <http://www.pccef.org/articles/art52.htm>.

23. Erik K. Fromme et al., *Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002*, 7 J. PALLIATIVE MED. 431 (2004).

intervention by a physician, forty-six percent changed their minds about having PAS.²⁴

Surviving family members surveyed by the Oregon Board of Medical Examiners ("BME") found a trend of increasing rates of moderate to severe pain reported among patients dying in acute-care hospitals throughout Oregon. This trend led the BME to conclude that inadequate palliative care was a problem in the state.²⁵

A study, *Means to a Better End*, by the Last Acts Program of the Robert Wood Johnson Foundation, evaluated end-of-life care in all fifty states and gave Oregon a mediocre grade. The Foundation and the Last Acts Program have no position on assisted suicide, but they have a strong commitment to improving end-of-life care. Oregon received good marks for its use of advance directives, for not overusing intensive care units in ways that only prolong the dying process, and in training registered nurses in palliative care. Oregon did poorly on five other measures utilized in the evaluations, including the large number of its nursing home residents in persistent pain, the small number of its hospitals providing hospice or palliative care, and the lack of state policies encouraging pain control and palliative care.²⁶

Supporting these findings regarding the quality of palliative care in Oregon is an anonymous survey of Oregon physicians regarding their experience in dealing with patients' requests for assisted suicide. Physicians recommended a palliative care consultation in only thirteen percent of the first 142 requests for assisted suicide after the Oregon law went into effect;²⁷ we do not know how many of these recommendations were actually implemented.

II. PSYCHIATRIC CONCERNS

Because Oregon was the first state to legalize suicide as a treatment for medical illness, it would seem to have a special responsibility to protect the significant number of patients who become suicidally depressed in response to serious or terminal illness. Although pain and other factors, such as lack of family support, contribute to the wish for death, researchers have found hopelessness, which is strongly correlated with depression, to be the factor that most significantly predicts the wish for death.²⁸

24. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000).

25. Susan Tolle & Kathleen Haley, *Pain Management in the Dying . . . Successes and Concerns*, BME REP. (Or. Bd. of Med. Exam'rs, Portland, Or.), Fall 1998, at 1, 4; see also Susan W. Tolle & Susan E. Hickman, *Don't prescribe less—chart better*, BME REP. (Or. Bd. of Med. Exam'rs, Portland, Or.), Winter-Spring 2002, at 1, 4.

26. LAST ACTS, MEANS TO A BETTER END: A REPORT ON DYING IN AMERICAN TODAY 10–42 (2002), available at <http://www.rwjf.org/files/publications/other/meansbetterend.pdf>.

27. Ganzini et al., *supra* note 24, at 559–60.

28. Harvey M. Chochinov et al., *Depression, Hopelessness, and Suicidal Ideation in the Terminally Ill*, 39 PSYCHOSOMATICS 366 (1998). Part II reprints modified versions of our previous

Patients requesting suicide need psychiatric evaluation to determine whether they are seriously depressed, mentally incompetent, or for whatever reason do not meet the criteria for assisted suicide. Oregon law, however, does not require it for patients requesting assisted suicide.

A. *The Second Case: Anonymous*

The next case is an example of what can happen when psychiatric consultation is not provided:

[A] woman in her mid-fifties with severe heart disease . . . requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. Therefore, she was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered . . . his responsibility ended. . . . [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed herself the next day.²⁹

Under the Oregon law, only if the physician believes a patient requesting assisted suicide is suffering from a psychiatric or psychological disorder or from a depression causing *impaired judgment* must the physician refer the patient to a licensed psychiatrist or psychologist. The caveat about impaired judgment is strange, since impaired cognitive function is one of the characteristics of a depressive disorder; a rigid tendency to see only one possible solution (such as suicide) to their problems is also characteristic.³⁰ In any case, a number of studies have shown that physicians are not reliably able to diagnose depression,³¹ let alone to determine whether depression is impairing judgment.

More than pain, depression, or current distress is often involved in patients' requests for assisted suicide. Many patients who request assisted suicide are doing so out of fear of what will happen to them. Such fears often derive from the patient's past experience with the death of someone close to him or her, so a history of these experiences should be part of any physician's evaluation of a request for assisted suicide. That evaluation must reflect an awareness of risk factors for suicide, such as alcoholism, a past history of depression, and, of course, any prior suicide attempts.

work. Foley & Hendin, *supra* note 2, at 150–52, 170–71; Foley & Hendin, *supra* note 5, at 39–40; Hendin et al., *supra* note 5, at 251–52. See *supra* note 5 for copyright information.

29. N. Gregory Hamilton, *Oregon's Culture of Silence*, in *THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE*, *supra* note 2, at 175, 188.

30. Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143, 144 (1993).

31. George E. Murphy, *The Physician's Responsibility for Suicide. II. Errors of Omission*, 82 ANNALS INTERNAL MED. 305 (1975).

Patients attempting assisted suicide are usually ambivalent about dying; so too are patients requesting assisted suicide. Physicians inexperienced in dealing with suicidal patients tend not to hear this ambivalence. Therefore, they are likely to take such requests to die literally and concretely and to act on them.

A guidebook for health care professionals written by the Oregon University Center for Ethics advises physicians to refer all cases requesting assisted suicide for psychiatric evaluation, even though physicians are not legally required to do so.³² Oregon physicians are not following that advice. The percentage of cases referred for psychiatric evaluation dropped from thirteen percent in the eight years between 1998 and 2005 to four percent in 2006.³³

B. *The Third Case: Joan Lucas*

The psychiatric evaluation when employed in Oregon, however, like the palliative care recommendations, has the tendency to be utilized to protect clinicians rather than patients, as the following case illustrates.

Joan Lucas, a patient with amyotrophic lateral sclerosis, attempted suicide. Paramedics were called to Joan's house, but her children sent them away, explaining, "We couldn't let her go to the ambulance. They would have resuscitated her."³⁴ Joan survived her attempt and was assisted in suicide eighteen days later by a physician who gave interviews about the case to an Oregon newspaper on condition of anonymity. He stated that after talking with attorneys from the Oregon Medical Association and agreeing to help aid Joan in death, he asked Joan to undergo a psychological examination. The doctor reported that "[i]t was an option for us to get a psychological or psychiatric evaluation. I elected to get a psychological evaluation because I wanted to cover my ass. I didn't want there to be any problems."³⁵

The doctor and the family found a cooperative psychologist who asked Joan to take the Minnesota Multiphasic Inventory, a standard psychological test. Because it was difficult for Joan to travel to the psychologist's office, her children read the true-false questions to her at home. The family found the questions funny, and Joan's daughter described the family as "cracking

32. TASK FORCE TO IMPROVE THE CARE OF TERMINALLY-ILL OREGONIANS, *THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROVIDERS* 31 (Kathleen Haley & Melinda Lee eds., 1st ed. 1998) [hereinafter OREGON GUIDEBOOK].

33. OR. DEP'T OF HUMAN SERVS., NINTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT tbl. 1 (2007), <http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf> [hereinafter NINTH ANNUAL REPORT]; OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, DEP'T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT tbl. 4 (2006), available at <http://www.oregon.gov/DHS/ph/pas/docs/year8.pdf> [hereinafter EIGHTH ANNUAL REPORT].

34. Bill Kettler, *We knew she would do it: Stricken by ALS, Joan Lucas decides to die—then acts*, MEDFORD MAIL TRIB., June 25, 2000, at 8A.

35. *Id.*

up' " over them.³⁶ Based on these test results, the psychologist concluded that whatever depression Joan had was directly related to her terminal illness, which he considered a completely normal response.

When Oregon psychiatrists were surveyed, only six percent felt very confident that, absent a long-term relationship with a patient, they could satisfactorily determine whether a patient was competent to commit suicide.³⁷ The psychologist's report in Joan's case is particularly disturbing because without taking the trouble to see her, and on the basis of a single questionnaire administered by her family, he was willing to give an opinion that would facilitate ending Joan's life. The physician's attitude toward the consultation surely played a part in his receiving a report that did not meet professional standards.

OPHD's monitoring procedures do not make it possible for OPHD to evaluate the care Joan Lucas received. To do so OPHD would have to interview Joan's primary care physician who had refused to assist in her suicide and to assess the quality of her psychological evaluation. Using psychologists or psychiatrists as gatekeepers only to establish a patient's capacity to make a decision for assisted suicide contributes to *pro forma*, meaningless consultations.

In the Lucas case, we have no way of knowing if Joan Lucas was seriously depressed or if the doctor or psychologist was disposed to proceed even if she were. Even more troubling is that OPHD does not seem to want to know about the psychiatric status of patients requesting assisted suicide. Under the current monitoring system, OPHD collects no information from psychiatrists who did not find patients to be competent and has no direct communication with psychiatrists or psychologists who did. Its monitoring reflects a lack of concern with the welfare of depressed patients.

C. Context of Mental Health Evaluation

Although a competent professional psychiatric evaluation is necessary to determine if a patient has impaired judgment that would make him or her not "capable" of an "informed decision," as required by Oregon law,³⁸ it is needed for other reasons as well. We know that patients requesting a physician's assistance in suicide are usually telling us that they desperately need relief from their mental and physical distress and that without such relief they would rather die. When they are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.

If the patient has seen no one knowledgeable enough to undertake to understand and relieve the desperation, anxiety, and depression that underlie

36. *Id.*

37. Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1473 (1996).

38. See Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.815, .820, .830 (1997).

most requests for assisted suicide, then even if the patient is capable, an informed decision is not possible.

III. VOLUNTARINESS AND THE RISK OF COERCION

The Oregon law requires both that patients requesting assisted suicide voluntarily give informed consent to the procedure and that they have the mental capacity to do so, but it lacks safeguards to ensure that this takes place. OPHD's monitoring does nothing to correct the problem.³⁹

A. *The Fourth Case: Kate Cheney*

The case of Kate Cheney, as described by both Cheney and those members of her family who told their story to *The Oregonian*,⁴⁰ highlights the deficiencies in the informed consent procedures. An eighty-five-year-old widow, Kate was diagnosed with terminal stomach cancer. Kate wanted the option of assisted suicide in case she was in pain or if the indignities of losing control of her bodily functions became unbearable. Her daughter Erika, a retired nurse who had come from Arizona to care for her mother, went with Kate when Kate made the request to her physician at Kaiser Permanente. Erika described the physician as "dismissive"⁴¹ and requested and received a referral to a second physician. He arranged for a psychiatric consultation, a standard procedure at Kaiser. The psychiatrist, who visited Kate at her home, found that Kate did not "seem to be explicitly pushing for [assisted suicide]"⁴² and lacked the "level of capacity . . . to weigh options about [it]."⁴³ Although Kate seemed to accept the assessment, Erika became very angry.

Kaiser then suggested that the family obtain a second assessment from an outside consultant. The psychologist consulted noted that Kate had memory defects and that her "choices [might have been] influenced by her family's wishes and [that] her daughter, Erika, [might have been] somewhat coercive,"⁴⁴ but felt Kate had the ability to make her own decision. A Kaiser administrator saw Kate and decided that she was competent and was making the decision on her own. Kate received the lethal drugs, which were put under Erika's care.

As time passed, Erika and her husband needed a respite, and they sent Kate to a nursing home for a week. When Erika visited, Kate always asked when she would be going home. On the day she returned from the nursing

39. Part III reprints modified versions of our previous work. Foley & Hendin, *supra* note 2, at 156-59; Hendin et al., *supra* note 5, at 255-56. See *supra* note 5 for copyright information.

40. Erin Hoover Barnett, *A Family Struggle: Is Mom Capable of Choosing to Die*, OREGONIAN, Oct. 17, 1999, at G01.

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

home, she told Erika and her husband that she had considered going permanently into a nursing home but had decided to use the pills instead and asked for their help. Her son-in-law asked, "When would you like to do this?"⁴⁵ Kate replied, "Now."⁴⁶ Within a short time, with her family beside her, Kate took the pills and died.

The eagerness of her daughter and son-in-law are likely to have influenced Kate's decision. One wonders if the decision would have been different if her family had responded to her request by saying, "We love you and want to keep you at home and care for you as long as possible." Sending Kate to the nursing home conveyed that she was a burden to her family. Her poignant and repeated requests to go home expressed her distress, as did her request to end her life on the day she did so.

One can readily see how in the best of circumstances frail, elderly patients can feel coerced to die. Caregiver burden has been identified as a serious issue, particularly for women like Erika who are asked to shoulder the work and responsibility of providing twenty-four-hour care to a parent. This particular case raises the question of what real meaning or value Oregon's prohibition of coercion has if it can be circumvented so easily.

B. Financial Considerations

Since ongoing care for terminally ill patients is far more expensive than assisted suicide, the role of a single health maintenance organization ("HMO") administrator in making the final decision in a matter in which the HMO might have a financial conflict of interest, as in Kate's case, was questionable.⁴⁷ Would the HMO have asked for a second opinion if the psychiatrist had deemed the patient competent to request assisted suicide? The Kaiser administrator was indignant at a journalist's implication that financial considerations might have influenced both his recommendation to Kate's family to seek an outside consultant and his own final decision. Yet this case makes a compelling argument for the need for openness and transparency—and perhaps even judicial review of competency determinations—because of the competing interests in deciding what was appropriate for a vulnerable elderly patient whose competency was in question and whose family may have been seriously burdened by her care.

C. Consulting with Family

Under the Oregon law, physicians are required to suggest that patients inform their families of their request for assisted suicide, but the patients are not required to do so. The law instructs physicians not to deny the request

45. *Id.*

46. *Id.*

47. David Reinhard, Editorial, *In the Dark Shadows of Measure 16*, OREGONIAN, Oct. 31, 1999, at D05.

on the basis of such a refusal. Even if the patient complies, the physician is not required by law to ask to see the patient's family.

How can any physician be sure there is no coercion unless the physician has met the family and seen the interaction among them and with the patient? On the other hand, not informing the family can prevent a caring family from expressing their affection in ways that might alter the patient's decision. It also opens the family up to the devastating grief and guilt that we see in survivors of suicide. Much of that guilt comes from feeling there were things they could or should have done to encourage the person who committed suicide to want to live. Feeling cut off from what a loved one was going through before the act is a major contribution to such anguish. Advocates of assisted suicide argue that legalization, by permitting the family to be part of the process, should ameliorate such suffering. Not informing the family makes this impossible.

This problem, to which OPHD seems oblivious, is cited by social workers in Oregon hospices as providing a serious challenge to hospice care professionals who feel that in protecting patients' confidentiality they have failed to help the patients' families, and they feel split in their allegiance between the patients and their families.⁴⁸ The provision of the Oregon law stating that a patient who declines to inform his or her family "shall not have his or her request denied for that reason"⁴⁹ is too sweeping in scope, and monitoring is necessary to learn its consequences.

IV. PROTECTION FOR PHYSICIANS INSTEAD OF PATIENTS

A concern with physician protection, rather than patient protection, pervades the Oregon experience. The statute's liability shield, its incomplete reporting system, and the excessive secrecy with which the law is implemented protect doctors who assist patients with suicide but leave patients vulnerable.⁵⁰

A. Lower Standard of Liability

Oregon physicians assisting in a suicide are exempt from the ordinary standards of care, skill, and diligence required of Oregon physicians in other circumstances (e.g., a physician's conduct when withdrawing life support). Instead, the physician is immunized from civil and criminal liability for actions taken in "good faith" in assisting a suicide irrespective of community standards in other matters and even when the physician acts negligently.⁵¹

48. See Pamela J. Miller et al., *Conversations at the End of Life: The Challenge to Support Patients Who Consider Death with Dignity in Oregon*, J. SOC. WORK END-OF-LIFE & PALLIATIVE CARE, Nov. 2006, at 37-38.

49. Oregon Death with Dignity Act, OR. REV. STAT. § 127.835 (1997).

50. Part IV reprints modified versions of our previous work. Foley & Hendin, *supra* note 2, at 159-61; Hendin et al., *supra* note 5, at 264-66. See *supra* note 5 for copyright information.

51. Or. Rev. Stat. § 127.885(1)-(3).

Good faith is a troublesome, subjective standard. Homicide law provides an example of an area where a good faith test might be appropriate. In some jurisdictions, when a person actually—but *unreasonably*—believes he must kill in self-defense, the person may nonetheless avail himself of the right of self-defense (which means he is guilty of manslaughter rather than murder).⁵² Applying a similar good faith standard to physicians seems curious. As Professor Dan Dobbs has noted:

An instruction [in a medical malpractice case] that tells the jury that the physician is not liable for honest error or good faith mistake injects subjective . . . issues into [what is usually an] objective negligence test and may lead the jury to think that bad faith, not a departure from professional standards, is the test of liability. This kind of instruction is now widely condemned by appellate courts.⁵³

In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute's provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate.

B. Reporting System Lacks Teeth

The fact that it may not be possible to punish physicians even if they have behaved irresponsibly is not a reason for not monitoring their behavior. Ensuring adequate care for patients is the aim of monitoring, and without knowledge of the quality of care being given, that is not possible.

However, there is no enforcement mechanism in the Oregon law should physicians not comply with guidelines set up by OPHD for reporting all cases in which medication for the purpose of assisted suicide has been prescribed. The Dutch experience suggests that even if the Oregon law had noncompliance penalties, nonreporting would still be a serious problem. By continually focusing on this problem, the Dutch have slowly been able to improve reporting. But since OPHD has not addressed the question of non-reporting, it is in the position of drawing conclusions from limited data.

C. Excessive Secrecy

OPHD has focused more on patient-doctor confidentiality than on monitoring compliance or abuse. The agency has developed confidentiality measures unique to physician-assisted suicide which appear to be unnecessarily secretive and limit the potential for thorough research into the dimensions and context of this practice as it unfolds. For example, internal memoranda from OPHD to its county vital records offices instructed all

52. WAYNE R. LAFAVE, 2 SUBSTANTIVE CRIMINAL LAW § 15.3(a), at 514–15 (2d ed. 2003).

53. DAN B. DOBBS, THE LAW OF TORTS § 243, at 635 (2000).

employees that they should "neither confirm nor deny if a [physician-assisted] death has occurred in your county."⁵⁴ To underscore "how seriously this matter is being taken" by OPHD, the memo warned that "[a]ny staff within the Center for Health Statistics that reveals any information they are not authorized to release, will immediately be terminated."⁵⁵

The Oregon law specifically states that although OPHD will issue a report each year based on a selected sample of cases, "the information collected shall not be a public record and may not be made available for inspection by the public."⁵⁶ There is no provision for an independent researcher or evaluator to study whatever data are available.

Medical standards require openness about facts, research data, and records to assess the appropriateness of treatment. The anonymity and secrecy about physician practice of assisted suicide makes such an assessment impossible. If physician-assisted suicide is to be part of the medical treatment for terminal illness, why are existing patient-doctor confidentiality rules not sufficient to protect physicians in this setting? Restricting access to information about the indications for assisted suicide, patient data, radiologic documentation, and specific drug therapy limits the opportunity to establish an objective standard of care, provides excessive protection to the physician and, in the name of confidentiality, leaves the patient vulnerable.

The law sets a low legal standard for physicians' conduct, and OPHD does not provide a mechanism for ascertaining whether physicians are meeting even this reduced standard, thereby precluding accountability.

V. THE ROLE OF COMPASSION IN DYING

Compassion in Dying executives have indicated that the organization has been involved in seventy-five percent of all cases of PAS since the implementation of the Oregon law.⁵⁷ In a study of the role of non-governmental organizations in physician-assisted suicide, however, Stephen J. Ziegler and Georg Bosshard observed that advocacy organizations have unresolved problems in their relationship with doctors,⁵⁸ as the following case illustrates.

54. Memorandum from Sharon Rice, Manager, Registration Unit Center for Health Statistics, to County Vital Records Registrars and Deputies (Dec. 12, 1997), reprinted in *Confidentiality of Death Certificates*, 14 ISSUES L. & MED. 333, 333 (1998).

55. *Id.* at 334.

56. OR. REV. STAT. § 127.865(2).

57. DAVID JEFFREY, *PHYSICIAN-ASSISTED SUICIDE V PALLIATIVE CARE: A TALE OF TWO CITIES* (2007), available at http://www.pccf.org/articles/PCCEF_June07_posting.pdf.

58. Steven J. Ziegler & Georg Bosshard, *Role of non-governmental organisations in physician assisted suicide*, 334 BRIT. MED. J. 295, 297 (2007) (citing SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL, Report, Vol. II: Evidence, 2005, H.L. 86-II).

A. The Fifth Case: A Desperate Wife

Information about this case comes from a talk given by George Eighmey, the executive director of Compassion in Dying of Oregon, to state regulators about Oregon's experience with physician-assisted suicide. Eighmey described a case in which "a woman who was desperate" called Eighmey and said, "I can't take it any more. My husband is begging me to kill him, I cannot stand his continued suffering any more. I love him too much."⁵⁹ Eighmey describes the call and its aftermath as follows:

I begged her to wait and she said, "Unless you're at the door with the pills, don't come." I said, "I cannot be there with the pills, I don't do that." But wait—I arrived at her door, she opened the door, and as with a lot of people who are in emotional states, she saw me and started laughing and crying simultaneously and I hugged her and I walked in and we sat for three hours, talking to her husband and to her at length about the process. Fortunately, her . . . ah . . . his physician had already noted in the file that [the patient] had asked [another physician] for Oregon's Death With Dignity fifteen days prior, so the time had elapsed. So we said, you have to ask for it a second time and you have to put it in writing. And then forty-eight hours after the writing you may obtain the prescription.⁶⁰

The initial physician was unwilling to provide the patient with a prescription, but the advocates helped the patient to make a second request to another physician. After the patient obtained the prescription, Eighmey and two other members of Compassion in Dying went to the patient's house. He describes what happened:

[W]e three Compassion in Dying members were present, the wife, the two friends across the street, and we were preparing everything. [The patient] came up and asked, "What do I wear, and where do I go?" We said, "You might do it in bed, or do it wherever you wish, but we recommend that you do it in bed." [He] crawled into bed, and we left [him] and his wife together for a while. We came in with the medication and we said, "Now you have the choice to change your mind at any time. Please, please do not feel compelled to do this." And he said, "I want to do it. I have had a beautiful life, I have had a loving wife, and it is my time. I said goodbye to this earth." We handed it to him; he took it and he turned to his wife and said to his wife, "I love you very much. We had a good life." In five minutes he was in a deep coma, and died in seventeen minutes. And that is what being open and honest and above-board and regulated by a state statute means in the state of Oregon. We have compassion for people who wish to die with dignity.⁶¹

59. George Eighmey, Oregon's Death with Dignity Act: Health Care Professionals Speak Out on Its Impact, Remarks at the Nineteenth Annual Meeting of the Council on Licensure, Enforcement, and Regulation (Sept. 3, 1999), *quoted in* Hamilton, *supra* note 29, at 184.

60. *Id.* (ellipses in original).

61. *Id.* at 184–85 (fourth alteration in original).

The role of an advocacy group and a lay advocate in facilitating assisted suicide with this patient is troublesome. The advocates formed a relationship with the desperate wife and then coached the patient and his wife in how to access PAS by taking advantage of a loophole in the law that does not stipulate that the two requests for assisted suicide must be made to the same physician. The role of the advocates was to help the patient and family get what they wanted, not to assess whether this was an appropriate option for the patient.

Compassion in Dying identifies their role as helping patients find physicians who will provide them with assistance in death. But advocacy can run amok when passionate volunteers interfacing with demanding families see no options but a prescription for lethal medication. We do not think such volunteers are likely to be able to assess competency or complex psychological issues or family dynamics that may influence the patient's request. Eighmey seems to have an exaggerated idea of his own ability to do so, stating that patients "tell me more in [a] half-an-hour phone call than they sometimes will tell their physician or their spouse. I know more about their life history in that half an hour than a lot of other people close to them."⁶²

The union of Compassion in Dying with the Hemlock Society and the name of the merged organizations, Compassion and Choices, permits them to avoid the word "dying," and the association of the word "hemlock" with lethality. We need to have a clearer picture of the role of such advocacy groups in coaching patients who seek their help and in helping patients to have real choices.

VI. A COMPARISON OF TWO DIFFERENT APPROACHES

The implementation of the Oregon law on assisted suicide encouraged physicians to adopt a different approach to patients with serious medical illness.⁶³ In the medical model, modified by advances in palliative care and practiced in states other than Oregon, patients requesting assistance in suicide are assessed in the same way as other patients intent on suicide. The medical model recognizes that "[a]lthough physical illness may be a precipitating cause of despair, these patients usually suffer from treatable depression and are [almost] always ambivalent about their desire for death."⁶⁴ Study of terminally ill cancer patients has demonstrated that those preoccupied with assisted suicide had symptoms of depression or hopelessness.⁶⁵

62. *Id.* at 185 (alteration in original).

63. N. Gregory Hamilton & Catherine A. Hamilton, *Competing Paradigms of Responses to Assisted Suicide Requests in Oregon*, 162 AM. J. PSYCHIATRY 1060 (2005).

64. *Id.* at 1060.

65. *E.g.*, William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients With Cancer*, 284 J. AM. MED. ASS'N 2907, 2910 (2000).

To help these patients, we need to understand and relieve the desperation that underlies the request for assisted suicide.⁶⁶ Supportive psychotherapy, antidepressant medication, and good palliative care are instrumental in providing relief from distress and making it possible for patients to appreciate and even enjoy whatever time they have left to live.

Oregon's assisted suicide guidebook takes a totally different approach. It stresses that any mental health consultation should be an evaluation of competency focused on the patient's capacity to make a decision,⁶⁷ emphasizing that "[t]he presence of depression does not necessarily mean that the patient is incompetent."⁶⁸ Whether or not one agrees with the majority of clinical psychiatrists and forensic psychiatrists, who believe "that the presence of *major depressive disorder* should result in an automatic finding of incompetence" to make decisions about assisted suicide,⁶⁹ reducing the psychiatric consultation to the issue of competency ignores all the other psychological factors that go into the request for assisted suicide.

A. *The Sixth Case: Mr. A*

A dramatic illustration of the contrast between these two distinct approaches for dealing with suicidal preoccupation in the seriously ill can be found in the case that follows, in which the patient had substantial contact with Physicians for Compassionate Care, an organization that follows the medical model, and with Compassion in Dying, which follows the assisted suicide competency model.⁷⁰

Right after receiving a diagnosis that he had inoperable lung cancer, Mr. A, a sixty-three-year-old computer technician, called Physicians for Compassionate Care requesting information on how he could get drugs for assisted suicide. He said, "I might as well just end it."⁷¹ The volunteer responded by saying Mr. A was understandably upset at this news. In response, Mr. A became tearful.⁷²

The volunteer began a series of phone conversations with the patient about his cancer, his treatment options, family support network, and his own personal history. The patient described his state of mind:

66. Herbert Hendin, *Suicide, Assisted Suicide, and Euthanasia*, in THE HARVARD MEDICAL SCHOOL GUIDE TO SUICIDE ASSESSMENT AND INTERVENTION 540, 553 (Douglas G. Jacobs ed., 1999); see Herbert Hendin et al., *The Role of Intense Affective States in Signaling a Suicide Crisis*, 195 J. NERVOUS & MENTAL DISEASE 363 (2007).

67. OREGON GUIDEBOOK, *supra* note 32, at 30.

68. *Id.* at 31.

69. Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595, 598 (2000) (emphasis added); see also Ganzini et al., *supra* note 37.

70. Hamilton & Hamilton, *supra* note 63, at 1061-65.

71. *Id.* at 1061.

72. *Id.*

[He was] haunted by suicidal feelings ever since his mother died from a self-inflicted gunshot wound when he was 21. Shortly after her death he had attempted suicide himself and was treated for depression in a psychiatric hospital. He made at least two other suicide attempts and remained preoccupied with suicide.⁷³

He had a history of alcoholism but had joined Alcoholics Anonymous and had been sober for more than twenty years. In addition, the volunteer learned Mr. A was not currently in pain.⁷⁴

The volunteer assured him that good palliative care was available for any symptoms he might develop. With her support, he began treatment for his cancer, including chemotherapy and radiation, and received medication for his depression.⁷⁵

Prior to contacting Physicians for Compassionate Care, Mr. A. had been a suspicious person. He did not allow others into his home, which he protected through extensive surveillance and ownership of assault weapons. After a few months of treatment, however, Mr. A was able to allow people into his home. The volunteer began monthly home visits and regular phone calls; Mr. A's daughter eventually moved in with him to help in his care.⁷⁶

While he had been talking to the volunteer, Mr. A had also sought help from two physicians whom he knew were activists for assisted suicide. The first physician who evaluated him gave him a lethal prescription; the second, who was affiliated with Compassion in Dying, regularly communicated with Mr. A about the assisted suicide option. Neither doctor had thought he needed a psychiatric consultation, but neither had known or asked about Mr. A's history of depression and past suicide attempts.⁷⁷

Eighteen months after initially receiving his diagnosis, Mr. A became increasingly agitated and was admitted to a psychiatric hospital after expressing thoughts that were both suicidal and homicidal. His daughter had to move out because of his combative behavior. Mr. A was given a DSM-IV diagnosis of a depressive disorder; when he responded to treatment in the hospital, he was discharged. The volunteer from Physicians for Compassionate Care increased the frequency of her visits. This was a good period for Mr. A. because he was able to enjoy regular visits from old friends and reconciled with his daughter.⁷⁸

After a while Mr. A developed excruciating constipation from his pain medication which led him to discontinue the medication, dismiss hospice, and consider using the medication he had been given for assisted suicide. When he was given fluids to relieve his constipation and prescribed a morphine pump and twenty-four-hour attendant care, however, his pain abated

73. *Id.*

74. *Id.*

75. *Id.* at 1063.

76. *Id.*

77. *Id.* at 1062.

78. *Id.*

and his mood improved.⁷⁹ During the weeks he had left, he said goodbye to his friends and expressed his appreciation to the volunteer and others who had helped him.⁸⁰

There are striking differences in the two approaches. The volunteer for Physicians for Compassionate Care understood that the patient's depression and anxiety were an integral part of his wanting to end his life. By phone and in visits to his home, she maintained a relationship with him and was instrumental in seeing that he received the care he needed. Through communication with his nurse, she encouraged his primary doctor to prescribe antidepressant medication for him. When toward the end of his life he became desperate because of poorly treated pain, she saw to it that he received the care he needed.⁸¹

The contrast with the two doctors associated with Compassion in Dying is significant. Without inquiring about a past history of depression or suicide attempts, "the doctor who prescribed the assisted suicide drugs . . . told the patient and his daughter that a psychiatric evaluation would not be 'necessary.'"⁸² He later admitted that he would have obtained such an evaluation had he known of the prior suicide attempts. He did think, however, that "giving Mr. A the assisted suicide drugs may have added to his sense of control and security and may even have prolonged his life."⁸³ Yet it seems likely that Mr. A would have used the pills at least a year before his death if it had not been for the caring and knowledgeable intervention of the volunteer from Physicians for Compassionate Care.

B. Predicting When a Patient Will Die

An additional problem in the implementation of the Oregon law is its stipulation that eligibility for assisted suicide depends upon patients having six months or less to live. Predictions regarding terminal illness vary in accuracy depending on the disease involved—somewhat higher accuracy for cancer (although not in Mr. A's case) and lower for cardiovascular disease.⁸⁴ The majority of Oregon physicians, when surveyed, were not confident they could make such a prediction.⁸⁵ The nine-year data suggest that a significant number of patients live beyond their six-month prognosis.⁸⁶ OPHD does not indicate the time interval that elapsed until their death, thus preventing

79. *Id.* at 1063.

80. *Id.*

81. *Id.*

82. *Id.*

83. *Id.*

84. See Joanne Lynn et al., *Prognoses of Seriously Ill Hospitalized Patients on the Days before Death: Implications for Patient Care and Public Policy*, 5 *NEW HORIZONS* 56 (1997).

85. Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *NEW ENG. J. MED.* 310, 312 (1996).

86. NINTH ANNUAL REPORT, *supra* note 33, <http://oregon.gov/DHS/ph/pas/docs/year9.pdf>.

evaluation of the reliability of this crucial legal criterion and hiding from the public the uncertainty of these predictions.⁸⁷

VII. TEN-YEAR PERSPECTIVE

A number of medical, psychological, social, and cultural factors have been influencing attitudes toward physician-assisted suicide in the past decade.

A. Palliative Care

The advance in palliative care in the past ten years that has most diminished the need for assisted suicide and euthanasia is the increasing understanding and acceptance that to relieve suffering, it is often necessary to administer pain medication even in doses that might shorten the patient's life. The medical profession, the U.S. Supreme Court, and most religious groups have come to this realization. Lack of knowledge by physicians of established guidelines on withholding care and the use of palliative care approaches has led to confusion between foregoing life-sustaining therapy (the legal right of every competent patient) and active euthanasia. Such uncertainty results in inadequate control of distressing symptoms in terminally ill patients. Some clinicians have argued that morphine drips in such cases are a form of "slow euthanasia."⁸⁸ There is a distinction, however, between the intent of palliative care physicians whose goal is to prevent and treat suffering, and those who intend to hasten death.⁸⁹ Specialists in palliative care have developed guidelines for the aggressive pharmacological management of intractable symptoms in dying patients, including sedation for those near death.⁹⁰

We now know that that proper use of pain medications in patients with chronic pain, as well as patients at the end of life, does not hasten death.⁹¹

87. *Id.* Section VI.B reprints modified versions of our previous work. Foley & Hendin, *supra* note 2, at 154. *See supra* note 5 for copyright information.

88. J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, J. PALLIATIVE CARE, Winter 1996, at 21, 21.

89. *See* Balfour M. Mount, *Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Facts, Not Anecdotes*, J. PALLIATIVE CARE, Winter 1996, at 31; Russell K. Portenoy, *Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Anecdote*, J. PALLIATIVE CARE, Winter 1996, at 44.

90. Nat'l Ethics Comm., Veterans Health Admin., *The Ethics of Palliative Sedation as a Therapy of Last Resort*, AM. J. HOSPICE & PALLIATIVE CARE, Dec.-Jan. 2007, at 483, 488. Section VII.A reprints modified versions of our previous work. Kathleen Foley, *Compassionate Care, Not Assisted Suicide*, in THE CASE AGAINST ASSISTED SUICIDE: FOR THE RIGHT TO END-OF-LIFE CARE, *supra* note 2, at 293, 304-306, 311. *See supra* note 5 for copyright information.

91. *See* Frank J. Brescia et al., *Pain, Opioid Use, and Survival in Hospitalized Patients With Advanced Cancer*, 10 J. CLINICAL ONCOLOGY 149 (1992) (reporting that increased use of pain medication for cancer patients does not affect the relative risk of survival significantly more than other variables do).

Studies have demonstrated that dying patients who received morphine lived longer than those who did not receive morphine.⁹²

Efforts at educating physicians appear to be making a difference in both the United States and the Netherlands. The more physicians know about palliative care, the less they favor assisted suicide; the less they know, the more they favor it.⁹³ The more critical question is whether it changes the way they practice medicine. In the Netherlands, where there was evidence that interesting doctors in palliative care was made more difficult because of the easier alternatives of assisted suicide and euthanasia, the Dutch undertook a national program to bring palliative care and hospice care to the population.⁹⁴

In 2005, for the first time since the Netherlands legalized assisted suicide and euthanasia, a survey showed a slight drop in assisted suicide and a significant drop in euthanasia.⁹⁵ There are now reports by some Dutch doctors who have performed euthanasia that, had they known then what they know now, they would have treated their patients differently.⁹⁶ Such a development was hardly conceivable ten years ago.

B. *Autonomy and Control*

On the other hand, what is most likely to increase the demand for assisted suicide is the impetus to treat the question as one of autonomy and control. Oregon has been in the forefront of this trend. The original impetus for passage of the Oregon law was to help relieve intractable symptoms such as pain, but as the law was written and monitored it has evolved into providing an option for control. Oregon physicians report that the most common reason patients request PAS is not pain or depression but a need for control. This need is usually related to patients' fears of the future and presents the physician with an opportunity to address their specific concerns and to develop interventions that will relieve the anxiety of most patients. Oregon researchers have described these patients, noting that they were inflexible and "dreaded the thought of being dependent on others."⁹⁷

92. William C. Wilson et al., *Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support From Critically Ill Patients*, 267 J. AM. MED. ASS'N 949, 952-53 (1992).

93. Russell K. Portenoy et al., *Determinants of the Willingness to Endorse Assisted Suicide: A Survey of Physicians, Nurses, and Social Workers*, 38 PSYCHOSOMATICS 277, 284-85 (1997).

94. See Zbigniew Zylicz, Letter, *Euthanasia*, 338 LANCET 1150, 1150 (1991); Zbigniew Zylicz, *Hospice in Holland: The story behind the blank spot*, AM. J. HOSPICE & PALLIATIVE CARE, July-Aug. 1993, at 30, 34 (1993).

95. Agnes van der Heide et al., *End-of-Life Practices in the Netherlands under the Euthanasia Act*, 356 NEW ENG. J. MED. 1957 (2007).

96. Margriet Oostveen, *Spijt: Voorvechters van de euthanasiepraktijk bezinnen zich [Regrets: Proponents of euthanasia reorient themselves]*, NRC HANDELSBLAD (Neth.), Nov. 10, 2001, at Z1.

97. Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MEDICINE 381, 382 (2003).

The need for control, however, is characteristic of most suicidal patients. They make absolute conditions on life: "I won't live . . . without my husband," "if I lose my looks, power, prestige, or health" or "if I am going to die soon."⁹⁸ Depression, often precipitated by discovering a serious illness, exaggerates their tendency to see life in black and white terms, but for most such people the need for control has been a dominant feature of their lives. They are unable to tolerate dependency on other people. In any case, the good practice of medicine obliges doctors to relieve distress rather than to assume that hastening death is the best or only way of doing so.

C. Oregon: What We Know and Need to Know

What has the Oregon experience with PAS taught us? Given the expectations that Oregon could serve as a laboratory for understanding and assessing physician-assisted suicide, not very much. Sadly, OPHD is wasting the opportunity to study a natural experiment and to provide understanding of the needs of patients and families at the end of their lives.

To date, OPHD figures indicate that since the Oregon assisted suicide law was enacted, 292 Oregonians have used PAS to die between 1998 and 2006;⁹⁹ 456 received prescriptions to do so.¹⁰⁰ Those who did not use them either died of natural causes or are still alive.¹⁰¹ Sixteen Oregonians used PAS in 1998, and that number has almost tripled, rising to forty-six in 2006.¹⁰² The ratio of PAS deaths to total deaths in Oregon has increased from 5 in 10,000 in 1998¹⁰³ to 14.7 in 10,000 in 2006.¹⁰⁴

From the time the Oregon law went into effect, OPHD officials have admitted that they have no way of knowing how many PAS cases are not reported.¹⁰⁵ If OPHD wished to know what is going on, it would need to follow the Dutch example by granting physicians full immunity and then surveying them with questionnaires and interviews.

The OPHD annual reports are marked by overreaching in the conclusions they draw from the limited information they have. As we have previously discussed,¹⁰⁶ most striking and least justified has been OPHD's contention, without substantiating data, that patients who have requested

98. Hendin, *supra* note 66, at 542.

99. NINTH ANNUAL REPORT, *supra* note 33, <http://oregon.gov/DHS/ph/pas/docs/year9.pdf>.

100. Prescription History—Oregon Death With Dignity Act, <http://oregon.gov/DHS/ph/pas/docs/prescriptionhistory.pdf>.

101. NINTH ANNUAL REPORT, *supra* note 33, <http://oregon.gov/DHS/ph/pas/docs/year9.pdf>.

102. Prescription History—Oregon Death With Dignity Act, *supra* note 100.

103. Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577, 579 (1999).

104. NINTH ANNUAL REPORT, *supra* note 33, <http://oregon.gov/DHS/ph/pas/docs/year9.pdf>.

105. Linda O. Prager, *Details emerge on Oregon's first assisted suicides*, AM. MED. NEWS, Sept. 7, 1998, at 10.

106. Foley & Hendin, *supra* note 2, at 162.

assisted suicide were receiving adequate end-of-life care.¹⁰⁷ Data from Oregon investigators, surveys of and interviews with families who observed the pain or distress of their relatives who received end-of-life care, new surveys of nurses who cared for hospice patients, and new surveys of physicians' experiences do not support this contention.¹⁰⁸

It has been possible to learn enough to know the defects that are there, but much more will need to be known if they are to be addressed and corrected. Any effective change in the way physician-assisted suicide is practiced in Oregon will require OPHD to become a more effective monitor.

What should OPHD be doing? As we have noted, apart from the restriction in the Oregon law that prohibits independent researchers from having access to the data, OPHD has been given great flexibility to do its own research.

OPHD could correct its most glaring limitation by expanding its collection of information beyond physicians who have written lethal prescriptions. OPHD should interview doctors who, for whatever reason, declined to prescribe lethal medication; psychiatrists who evaluated these patients (whether or not they found them to be competent); and nurses, social workers, or family members who cared for the patients. Without such information, we have no idea of how many requests for assisted suicide there are each year, why some physicians declined while others agreed to proceed, or what transpired in any particular case.

OPHD justifies obtaining information only from physicians who prescribed medication that patients actually used to end their lives as necessary "[t]o maintain consistency in data collection and to protect the privacy of the patient and the prescribing physician."¹⁰⁹ Limiting the information collected to one physician when other physicians who saw the patient in connection with an end-of-life decision might have information that would be contradictory runs counter to the basic expectations of research design and undermines the validity of the results. As for privacy, if OPHD collected information from all physicians who received a request for assisted suicide, OPHD would have valuable information about the patients, but the physicians who provided the information and had not written the prescription would not by this process know the outcome, and the privacy of the prescribing physicians and their patients would be protected.

That information could also serve to evaluate the use of a six-month prognosis to define terminal illness; recall that some of the patients receiving prescriptions lived for a year or longer. OPHD should calculate the

107. Chin et al., *supra* note 103, at 582.

108. Fromme et al., *supra* note 23; Linda Ganzini et al., *Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death*, 349 *NEW ENG. J. MED.* 359 (2003); Helene Starks et al., *Family Member Involvement in Hastened Death*, 31 *DEATH STUD.* 105 (2007); JEFFREY, *supra* note 57.

109. ARTHUR E. CHIN ET AL., *OR. DEPT. OF HUMAN RES., OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 3* (1999), available at <http://oregon.gov/DHS/ph/pas/docs/year1.pdf>.

survival time of patients receiving a prescription and provide summary data on the validity of this criterion.

As the years go by, OPHD is providing less information when it should be providing more. For example, only in OPHD's reports for 2004 and 2005 were the number of prescriptions written per physician cited. We were told that the maximum number written by any one doctor was seven in 2004¹¹⁰ and eight in 2005.¹¹¹ We know from other sources, however, that in one hospice that has had twenty-eight PAS cases since 1997, a single doctor was involved in twenty-three of them.¹¹² Whether the doctor was the prescribing physician or the consultant is not clear, but OPHD could ascertain that information. Another piece of data that was only reported for the first two years but that OPHD continues to collect is the number of physicians a patient must see to obtain a prescription. In 1999, ten of the twenty-seven cases went to a second physician and eight went to a third or fourth physician.¹¹³ This information would clarify whether a small cohort of physicians is involved in a majority of the cases and might suggest study of how physicians' biases may be influencing patients' requests.

D. Need for Change

So far OPHD has been collecting limited data and has not tried to address any of the controversial issues the cases we have discussed present. They have rather responded to pressure from advocacy groups not to use the term "assisted suicide." Since the inception of the Oregon law, OPHD had used the internationally accepted term "physician-assisted suicide" in its annual reports and on its website.¹¹⁴ In 2006, however, Compassion and Choices, heeding polling data that indicated that the public responds unfavorably to the practice when the term "assisted suicide" is used, lobbied OPHD not to use it.¹¹⁵ OPHD briefly considered using "physician-assisted death," but gave that up in response to strong objections from PAS opponents and settled on "death with dignity."¹¹⁶

Patients who take a legally prescribed drug overdose to end their lives are to be referred to as "persons who use the Oregon Death with Dignity

110. OFFICE OF DISEASE PREVENTION & EPIDEMIOLOGY, OR. DEP'T OF HUMAN SERVS., SEVENTH ANNUAL REPORT ON OREGON'S DEATH WITH DIGNITY ACT 14 (2005), available at <http://www.oregon.gov/DHS/ph/pas/docs/year7.pdf>.

111. EIGHTH ANNUAL REPORT, *supra* note 33, at 13.

112. JEFFREY, *supra* note 57.

113. AMY D. SULLIVAN ET AL., OR. DEP'T OF HUMAN SERVS., OREGON'S DEATH WITH DIGNITY ACT: THE SECOND YEAR'S EXPERIENCE 10 (2000), available at <http://oregon.gov/DHS/ph/pas/docs/year2.pdf>.

114. Int'l Task Force on Euthanasia & Assisted Suicide, *Oregon Plays Word Games with Assisted Suicide*, UPDATE, Vol. 20, No. 5 (2006), available at <http://www.internationaltaskforce.org/iaa39.htm>.

115. *Id.*

116. *Id.*

Act.”¹¹⁷ Derek Humphry, the founder of the Hemlock Society, objected strongly to the change, calling the term “death with dignity” “wildly ambiguous.”¹¹⁸

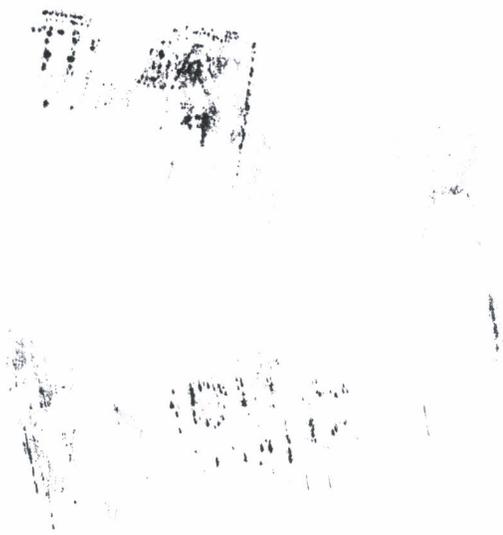
As the Oregon assisted suicide law is currently implemented, “Death with Dignity Act” is something of a misnomer. When patients like Kate Cheney die because their relatives no longer want to care for them, they die feeling rejected, not dignified. Mr. A was terrified when he learned he had an illness that would be fatal. He assumed its course would be painful and a hastened death the only solution. He was supported in that notion by Compassion in Dying. He would likely have died feeling distraught, not dignified, had it not been for the fortunate intervention of a truly compassionate volunteer.

As we have previously noted,¹¹⁹ under the current monitoring system, Oregon physicians appear to have been given great power without being in a position to exercise it responsibly. They are expected to inform patients that alternatives are possible without being required to be knowledgeable about such alternatives or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment without a requirement for psychiatric expertise or consultation. They are expected to make decisions about voluntariness without having to see those close to the patient who may exert a variety of pressures, from subtle to coercive. They are expected to do all of this without necessarily knowing the patient for more than fifteen days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is permitted, physicians are protected from the consequences, and patients are left unprotected while believing they have acquired a new right.

117. *Id.*

118. Derek Humphry, Letter to the Editor, *Stick to Plain English*, REG.-GUARD (Eugene, Or.), Nov. 7, 2006, at A8.

119. Foley & Hendin, *supra* note 2, at 174.



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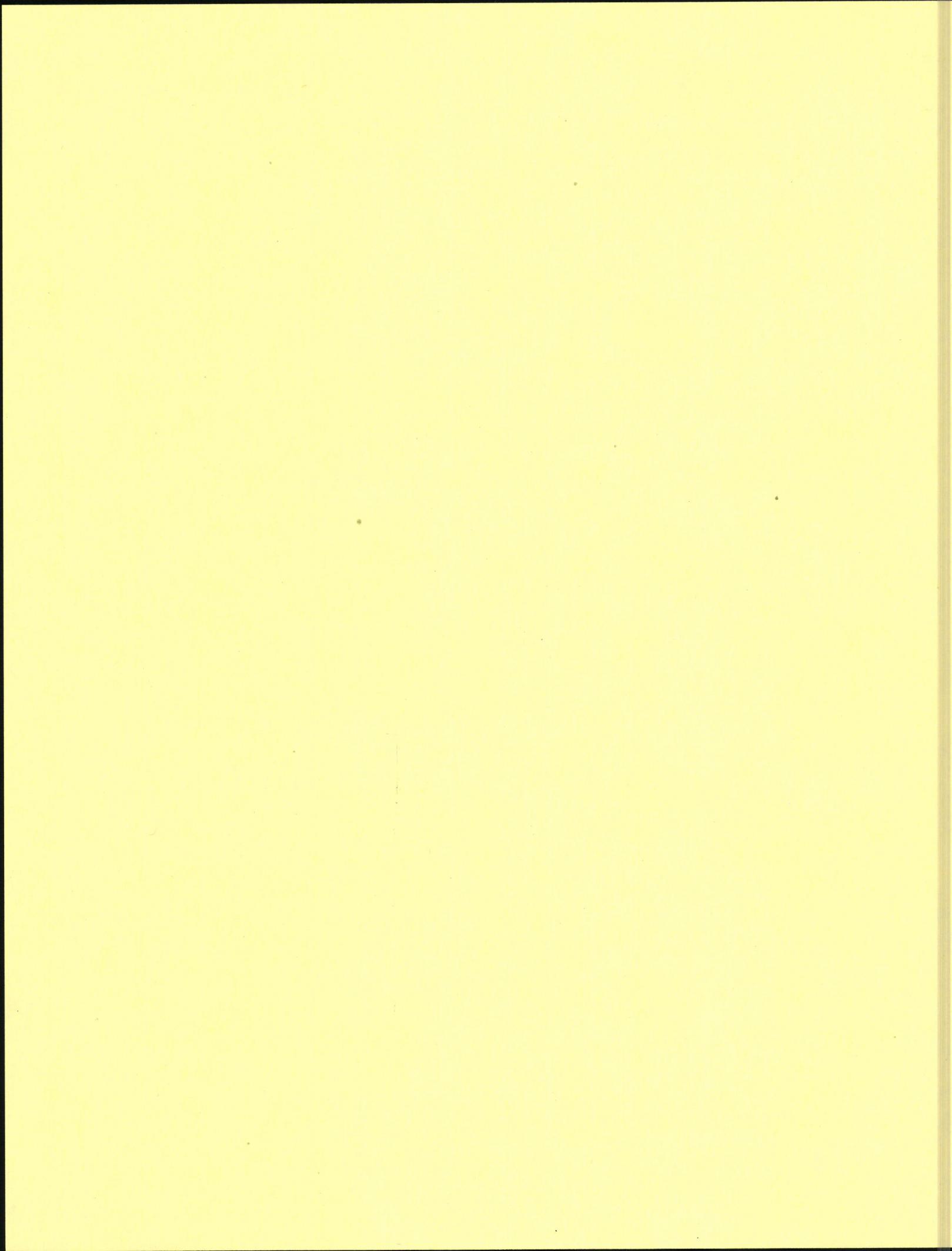
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**The Future of
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and Euthanasia**

Neil M. Gorsuch

s Editor

irs

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THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA



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Neil M. Gorsuch is a judge on the U.S. Court of Appeals for the Tenth Circuit. A former clerk to U.S. Supreme Court justices Byron White and Anthony Kennedy, he has published widely on assisted suicide and many other contemporary legal problems.

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Dutch ultimately may find themselves—namely, routinizing “euthanasia and termination of life *without an explicit request* [such that they are] handled in the same way [as voluntary requests for assisted suicide and euthanasia]: deemed ‘normal medical practice’ and subjected to the controls applicable to other behavior of doctors.”⁹⁴

Absent here, once again, is any linkage between assisted suicide and patient autonomy. A physician would be free to kill his patients *without their consent* and have no reason to fear criminal prosecution. Though Griffiths believes that the decriminalization of nonvoluntary euthanasia would lead to better compliance with self-reporting requirements, he (curiously) does not pause to give any significant consideration to the question whether allowing doctors to kill without consent might also lead to additional cases of abusive, coercive, and mistaken killings. In fact, Griffiths’ proposal seemingly would preclude the criminal prosecution not just of those acting out of motives of mercy, but even those (like Dr. Harold Shipman) who act out of very different and even cruel motives.⁹⁵ In Griffiths’ preferred regime, only professional and civil sanctions would be available as remedies when doctors kill without consent—and even these remedies would be available only if and when doctors kill in the absence of what he calls “normal medical practice”—although Griffiths fails to specify when he thinks killing a patient without consent should be considered “normal.”⁹⁶

Nor does Griffiths fairly make out the case that his proposal would even guarantee better self-reporting: doctors who fail to meet the guidelines for “normal” nonvoluntary killings (whatever those might be) may very well still choose to avoid reporting their activities for fear of professional and civil penalties which, for doctors, can mean the end of their careers and financial security. Indeed, Griffiths himself acknowledges that *any* regime relying on physician self-reporting is “intrinsic[ally] ineffective[.]”⁹⁷ Simply put, the absence of *criminal* penalties may not suffice to ensure that physicians report all cases of killing without consent; the continued presence of financial and professional consequences may still serve as strong deterrents to full and accurate reporting. Meanwhile, Griffiths’ proposal would abjure patient autonomy as the touchstone for when assisted suicide is appropriate, in favor of physicians’ quality of life judgments, and rewrite the boundary of acceptable medical practice from voluntary to nonvoluntary euthanasia. It does not seem at all far-fetched to imagine, however, that Griffiths, once again, has accurately predicted the future of Dutch practice.

7.2 THE OREGON EXPERIENCE:

AN “ALL-TOO-CONSCIENTIOUS” STATUTORY REGIME?

Among American jurisdictions, to date only Oregon has experimented with assisted suicide. Epstein has hailed Oregon’s assisted suicide law as “tightly

drafted legislation" and an "all-too-conscientious attempt" to avoid cases of abuse, mistake, and pressure.⁹⁸ Otlowski concludes that "many fears associated with the legalization of physician-assisted suicide [in Oregon] have simply proven unfounded."⁹⁹ And Oregon's statute is certainly more refined than the medical guidelines long in force in the Netherlands or the recent Dutch statute. But Epstein's and Otlowski's enthusiastic endorsements are themselves subject to question in light of certain deficiencies in both the structure of the Oregon law and its practice in the field.

An Outline of Oregon's Procedures

To qualify for assistance in dying under the Oregon Death with Dignity Act, a patient must be "[a]n adult who is capable . . . and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die"; meeting these qualifications allows a patient to make "a written request for medication for the purpose of ending his or her life."¹⁰⁰

The term "capable" is defined by statute to mean "that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers."¹⁰¹ A "terminal disease" is defined as "an incurable and irreversible disease that . . . will, within reasonable medical judgment, produce death within six months."¹⁰² Written requests for assisted suicide must be "witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request."¹⁰³

An attending physician is required, among other things, to "[m]ake the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily," and to refer the patient to a consulting physician for confirmation of all three of these findings.¹⁰⁴ If the attending or consulting physician believes that "a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling," and no medication to end the patient's life may "be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."¹⁰⁵

Once the medical review process is complete, the attending physician may prescribe life-ending medications.¹⁰⁶ "No less than fifteen . . . days [must] elapse between the patient's initial oral request and the writing of a prescription"; in addition, forty-eight hours must elapse between the patient's written request and the writing of a prescription.¹⁰⁷ Doctors who write death-inducing

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prescriptions in good-faith compliance with the Act's requirements are thereafter shielded from criminal, civil, and professional sanctions.¹⁰⁸

Physicians are responsible for maintaining records regarding each act of assisted suicide, including documents reflecting all of the patient's oral and written requests for assistance in dying; the attending and consulting physician's diagnosis, prognosis, and finding that the patient was capable, acting voluntarily, and with full information; and all reports reflecting any counseling that occurred.¹⁰⁹ Oregon's Department of Human Services is charged with reviewing a sample of these records annually.¹¹⁰

While perhaps representing a drafting improvement over the Dutch statute in some areas, a great many questions might still be asked about how the Oregon law is written and practiced. It is, for example, unclear from the language of the statute whether "terminal" means that the patient is expected to die within six months assuming she is given medical care or assuming she is not.¹¹¹ And, approximately 50 percent of Oregon physicians have acknowledged that they simply are not confident in their own ability to predict whether patients have more or less than six months to live.¹¹² In point of fact, putatively terminal patients have received lethal prescriptions in Oregon and waited to use them for as long as 466 days—over fifteen months.¹¹³ Although proponents have argued that Oregon's regime helps dying patients avoid unnecessary pain and suffering, Oregon's law (unlike even the Dutch guidelines) nowhere conditions access to assisted suicide on the existence of pain of any kind, let alone pain that cannot be fully treated by readily available medicines.

Because the attending physician under Oregon law is allowed to choose a consulting physician who may be related to the attending doctor or the patient professionally or personally, the consultant is not guaranteed to be free to render a dispassionate judgment (something even Dutch guidelines purport to mandate). Nor does the Oregon statute require that either physician have any special expertise; trainees are free to render judgments on whether an illness is "terminal."¹¹⁴ Thus, while approximately 86 percent of patients seeking assisted suicide in 2001 suffered from cancer, prescribing physicians were predominately internal medicine and family practitioners (collectively representing 69 percent of prescribers); oncologists prescribed death-inducing medication in just 25 percent of assisted suicide cases.¹¹⁵ Significantly, there is also no requirement that any of the physicians involved review with the patient potential alternatives (for example, hospice or pain killers), or that those with expertise in such areas (for example, pain management specialists) be brought in to review care options that may alleviate the patient's perceived need for assisted suicide.

While Oregon's statute requires that the attending and consulting physicians make a finding that the patient is mentally capable, it does not require any mental health qualifications or expertise of either doctor, again leaving potentially specialized questions regarding the diagnosis of potential psychological disorders (for example, depression) to individuals without any relevant

expertise—this despite a wealth of evidence suggesting that a significant number of suicides are caused in whole, or part, by clinical depression or mental illness.¹¹⁶ In fact, 28 percent of Oregon physicians polled have admitted that they do not even feel competent to recognize depression.¹¹⁷ Nor has Oregon examined the prevalence of depression among the terminally ill, though a recent study of depression in cancer patients (one notably not dependant on physicians' self-assessed ability to detect depression) found that oncologists detected the condition in only approximately 13 percent of patients who described themselves as suffering from moderate to severe levels of depression.¹¹⁸

Oregon's statute (again, in contrast to Dutch medical guidelines) also does not require the presence of a doctor when the patient commits suicide, and between 1998 and 2002 prescribing physicians were absent 66 percent of the time.¹¹⁹ Given this fact, there is no guarantee that a doctor will assess the patient's mental condition at the time of death; indeed, "capability" is assessed only once under Oregon's regime, when the prescription is written, on a day that may be weeks, months, or perhaps even years removed from the patient's decision to die. The physician's absence also means that reviewing state authorities do "not all have information about what happened when the patient ingested the medication,"¹²⁰ including information about what, if any, complications may arise.¹²¹ It also means that the complications themselves may also go unaddressed. A nationwide survey of U.S. oncologists found that as many as 15 percent of all attempts at physician-assisted suicide are unsuccessful,¹²² and data from the Netherlands, noted above, are similar.¹²³ In Oregon in 2002, thirty-eight patients ingested lethal medications,¹²⁴ and the time to death after ingestion varied widely: one patient lived for fourteen hours, another lived for nine hours, and a third lived for twelve hours;¹²⁵ in at least four cases since 1998, a patient has vomited or expectorated immediately after taking the prescribed medication,¹²⁶ and patients have lived as long as thirty-seven hours after ingestion.¹²⁷

All of the data that Oregon has collected on completed suicides, moreover, come entirely from the very physicians who participate in the assisted suicide process rather than a more disinterested source—and the physicians must report their activities only after the patient is dead.¹²⁸ Consequently, Oregon has no way to review individual cases for compliance with its law until after it is too late to prevent any error or abuse. The Oregon Health Division, which is charged with administering the law, has acknowledged that this statutory arrangement raises "the possibility of physician bias" and means that it "cannot detect or collect data on issues of noncompliance with any accuracy."¹²⁹ Additionally, quite unlike the Dutch regime, Oregon does not have any mechanism for surveying doctors confidentially; all reporting is done "on the record."

Without a means of privately asking doctors about their practices, one might question whether we will ever obtain a true and complete picture of the events on the ground in Oregon. And even if a doctor were actually to take the extraordinary step of reporting himself or herself as having violated the law,

Oregon's statute impose such cases, let alone. Thus, while Oregon is whether assisted suicide. States, Oregon's regulations and case descriptions and to what extent Oregon ever be able to provide dictions considering v

Separately, it are held to a standard treatments they provide different regime when and uniquely immun even professional discipline long as they act in "good mere negligence in a family members when negligence by misdiagnosis as competent.¹³¹

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Oregon's statute imposes no duty on the health division to investigate or pursue such cases, let alone root them out in the absence of any such self-reports. Thus, while Oregon is often touted as a "laboratory" or an "experiment" for whether assisted suicide can be successfully legalized elsewhere in the United States, Oregon's regulations are crafted in ways that make reliable and relevant data and case descriptions difficult to obtain. Given this, it is unclear whether and to what extent Oregon's experiment, at least as currently structured, will ever be able to provide the sort of guidance needed and wanted by other jurisdictions considering whether to follow Oregon's lead.

Separately, it is also rather remarkable that, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, the Oregon assisted suicide statute creates an entirely different regime when it comes to administering this "treatment," specifically and uniquely immunizing doctors from criminal prosecution, civil liability, or even professional discipline for any actions they take in assisting a suicide, as long as they act in "good faith."¹³⁰ Thus, while a doctor may be found liable for mere negligence in any other operation or procedure, there is no recourse for family members when a doctor kills a patient even on the basis of gross negligence by misdiagnosing the patient as terminal or by misassessing the patient as competent.¹³¹

Oregon's Practice of Assisted Suicide

According to the limited, nonconfidential, and self-reported data available from Oregon physicians, in the first five years of implementation (1998 to 2002), a total of 198 lethal prescriptions were written, and the number of prescriptions increased significantly each year: from 1999 to 2002, the overall number of lethal dosages prescribed rose 76 percent.¹³² Many of these prescriptions appear to have been written, moreover, by a very small handful of politically active physicians. In its first-year questionnaire, the Oregon Health Division specifically asked physicians whether the patients they helped kill were referred to them by advocacy organizations, such as Compassion in Dying or the Hemlock Society, but the state inexplicably declined to publish the answer.¹³³ However, it was later revealed by the media that:

[T]he first fifteen assisted suicide cases reported involved fourteen different doctors. Compassion in Dying, an out-of-state assisted suicide group that moved to Oregon just weeks after the law was implemented, claimed eleven of the fourteen doctors were theirs. . . . [A]t least one additional case came through the Hemlock Society. So at least twelve of fourteen, or 86 percent, of the assisted suicide cases were handled by groups politically active in promoting legalization of assisted suicide. This unsettling fact was the one held back, suggesting to many that OHD had become selective in its silence. . . .¹³⁴

TABLE 7.4
Oregon Assisted Suicide Demographics: 1998–2002

Year	1998	1999	2000	2001	2002
Total deaths	16	27	27	21	38
% change from prior year	—	0.7	0	–22	0.8
Median age	69	71	69	68	69
Age range	25–94	31–87	51–93	51–87	38–92
% male	53	59	44	38	71
% female	47	41	56	62	29
% married	13	44	67	38	53
% divorced	27	30	11	33	24
% widowed	33	22	22	24	18

Source: Oregon, First Year's Experience at 13 tbl. 1, at 15 tbl. 3; Ctr. for Disease Prevention and Epidemiology, Or. Dep't of Human Servs., Oregon's Death with Dignity Act: The Second Year's Experience tbl. 1 (2000), available at <http://www.ohd.hr.state.or.us/pas/year2/99pasrpt.pdf> (site visited Oct. 5, 2005) (hereinafter Second Year's Experience); Ctr. for Disease Prevention and Epidemiology, Or. Dep't of Human Servs., Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide at 16 tbl. 1 (2001), available at <http://www.ohd.hr.state.or.us/pas/year3/00pasrpt.pdf> (hereinafter Three Years of Legalized Physician-Assisted Suicide); Fourth Annual Report at 14 tbl. 1; Fifth Annual Report at 18 tbl. 1.

Just as it is inexplicable that Oregon would suppress results from its first-year questionnaire, it is equally troubling that the state has chosen to drop this question from each of its subsequent annual surveys, and to do so without public mention (let alone defense) of its decision—an incident reminiscent of the Dutch Surveys authors' decision to stop reporting on the incidence of euthanasia by omission after 1990.¹³⁵

Of the 198 patients who have received prescriptions for lethal medication, 129 (or 65 percent) have used them to date.¹³⁶ Though these figures provide a small sample, the data do reveal certain correlations, reflected in table 7.4.

As shown in the Table, the number of deaths in 1999 appeared to increase greatly over 1998, although a firm comparison cannot be drawn because the law was not in effect for all of 1998. While the number of deaths in 2001 declined 22 percent compared to 2000, this represented a difference of just six persons. Also, the total number of lethal prescriptions increased in 2001,¹³⁷ and two of these prescriptions were apparently filled in 2002,¹³⁸ when total deaths increased 81 percent over 2001, to 38 persons, by far the largest number of deaths in any year since the Oregon law went into effect, and representing 41 percent more deaths than occurred in 1999, the first full year of legalization.

The median age for assisted suicide seems to be hovering around sev-

enty, although patients including as young and thirty-eight years made into these categories. Information about the committing suicide. Assisted suicide among divorced persons Oregon, well in excess similar underlying

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enty, although patients have sought assisted suicide at much younger ages—including as young as twenty-five years old in 1998, thirty-one years old in 1999, and thirty-eight years old in 2002. Surprisingly, no special examination has been made into these cases, although it would clearly be useful to have more information about the physical and mental condition of such young persons committing suicide. There also appears to be a persistent correlation between assisted suicide and divorce. As shown in table 7.5, in each year except 2000, divorced persons have represented over 24 percent of all assisted suicides in Oregon, well in excess of their representation in the population of all deaths due to similar underlying illnesses.

As reflected in table 7.5, divorced persons constituted 25 percent of all assisted suicides in 1998 through 2002, but 18 percent of all deaths in Oregon due to similar underlying maladies as those afflicting the assisted suicide patients. Meanwhile, married persons constituted 47 percent of all assisted suicides, but 49 percent of all deaths due to similar illnesses. These data suggest that divorced persons are nearly twice as likely to commit assisted suicide than similarly situated married patients. And this correlation between divorce and assisted suicide serves to underscore the question whether other things besides terminal illness (for example, social isolation or depression) may drive the decision to seek death.

Of potential concern as well is that the data show that Oregon physicians are increasingly unlikely to refer their patients for psychiatric or psychological consultation before declaring them competent to make the decision to die, despite the evidence consistently linking suicidal impulses to depression and psychological illness.¹³⁹ Physicians referred patients in just 13 percent of cases in 2002 (5 of 38), compared with 14 percent of cases in 2001 (3 of 21), 19 percent of cases in 2000 (5 of 27), 37 percent of cases in 1999 (10 of 27), and 31 percent of cases in 1998 (5 of 16).¹⁴⁰ Even when evaluations are done, given the fact that many patients are apparently being shepherded to doctors affiliated

TABLE 7.5
Relative Incidence of Assisted Suicide:
Married vs. Divorced Patients: 1998–2002 (percent)

	Married	Divorced
Assisted suicides	47	25
Oregon deaths due to same diseases	49	18
Estimated proportion of assisted suicide deaths per 10,000 Oregon deaths	29.2	54.5
Relative risk	Reference	1.9

Source: Fifth Annual Report at 4.

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TABLE 7.6
Duration of Patient-Physician Relationship (weeks)

Year	1998	1999	2000	2001	2002	Total
Median	11	22	8	14	11	13
Range	2-540	2-817	1-851	0-500	0-379	0-851

Source: Second Year's Experience at tbl. 2; Three Years of Legalized Physician-Assisted Suicide at 20 tbl. 3; Fourth Annual Report at 17 tbl. 3; Fifth Annual Report at 21 tbl. 3.

with advocacy groups that favor assisted suicide, the possibility exists that "a bias may be introduced into the competency evaluation. On balance, the psychiatrists' conclusions may reflect personal values and beliefs more than psychiatric expertise."¹⁴¹

Further, physicians in the Netherlands often have long-standing relationships with patients; as a result, they arguably have some basis for assessing the "patient's concerns, values, and pressures that may be prompting the . . . request [for assistance in dying]."¹⁴² By contrast, the AMA has opposed the legalization of assisted suicide in part because American physicians, increasingly employees or agents of large corporate health maintenance organizations, lack such long-term relationships with their patients: in the AMA's view, American "physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's [assisted suicide] request."¹⁴³ And there is data from Oregon that speaks to this concern. In 2002, the median length of the relationship between patients seeking assisted suicide and the physicians who agreed to help them was just eleven weeks, and in some cases was not even a matter of weeks, but of days or hours.¹⁴⁴

While Oregon reports the duration of the patient-physician relationship, it fails to collect any similar data regarding the length, if any, of the relationship between the patient and the psychiatrist or psychologist who may be called in to assess competency. Given that such a consultation is entirely optional under Oregon's law, it seems likely that these relationships are extremely short, often just a single visit—this despite the fact that a survey of Oregon psychiatrists found that only 6 percent of the psychiatrists surveyed said they were very confident that they could determine whether a patient is competent to commit suicide without a long-term doctor-patient relationship.¹⁴⁵

Finally, while loss of autonomy topped the list of reasons proffered by patients seeking assisted suicide (a concern in 85 percent of cases between 1998 and 2002), many other reasons were also given, as shown in table 7.7.

Again, these data come from after the fact self-reporting performed by the attending physicians, not a more objective source. Even so, the data reveal that 22 percent of cases between 1998 and 2002 were motivated in part by in-

TABLE 7.7
Reasons

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Losing autonomy

Source: First Year's
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TABLE 7.7
Reasons Given by Oregon Patients Seeking Assisted Suicide (percent)

Year	1998	1999	2000	2001	2002	Total
Financial implications of treatment	0	5	4	6	3	2
Inadequate pain control	7	53	30	6	26	22
Burden on family, friends, and caregivers	13	47	63	24	37	35
Losing control of bodily functions	53	68	78	53	47	58
Decreasing ability to participate in activities that make life enjoyable	67	47	78	76	84	79
Losing autonomy	80	63	93	94	84	85

Source: First Year's Experience at 16 tbl. 3; Second Year's Experience at tbl. 4; Three Years of Legalized Physician-Assisted Suicide at 18 tbl. 3; Fourth Annual Report at 16 tbl. 3; Fifth Annual Report at 20 tbl. 3.

adequate pain control, which, taken together with the evidence that many Oregon doctors lack sufficient training in palliative care,¹⁴⁶ raise the possibility that suicide may have been substituted for adequate care in some cases. In contrast to the official state numbers, moreover, a 1999 survey of Oregon doctors who received requests for assisted suicide revealed that 43 percent of patients requesting assisted suicide cited pain as an important reason motivating their request; the same survey shows that physicians recommended a palliative care consultation in just 13 percent of cases.¹⁴⁷ Also of concern is the role the cost of care may play in the decision to die and the possibility that requesting continued expensive end-of-life care may be seen as selfish or extravagant when assisted suicide is available: 35 percent of cases involved patients who sought to kill themselves because they were worried about becoming a "burden" on their family and friends; even more pointedly, 2 percent of cases were expressly motivated by concerns over the financial implications of continued treatment (this in one of the nation's most affluent states where one would expect financial concerns to be less pressing than in other jurisdictions where assisted suicide might be legalized).

"Helen" and "Ms. Cheney"

Kathleen Foley and Herbert Hendin have investigated in detail the case of "Helen" (last name unknown), the first person to obtain assisted suicide

under Oregon's regime,¹⁴⁸ and of Ms. Kate Cheney, a more recent applicant.¹⁴⁹ Foley's and Hendin's findings offer vivid case studies illustrating some of the questions and concerns I have raised regarding Oregon procedures and practices. Helen was a breast cancer patient in her mid-eighties when the Oregon law went into effect.¹⁵⁰ Helen's regular physician refused to assist in her suicide; a second doctor was consulted but also refused, on the stated ground that Helen was depressed.¹⁵¹ At that point, Helen's husband called Compassion in Dying.¹⁵² The medical director of the group spoke with Helen and later explained that Helen was "frustrated and crying because she felt powerless."¹⁵³ Helen was not, however, bedridden or in great pain but enjoyed aerobic exercises until two weeks before contacting Compassion in Dying and, apparently, she was still performing housework.¹⁵⁴ The Compassion in Dying employee recommended a physician to Helen.¹⁵⁵ That physician, in turn, referred Helen to a specialist (whose specialty is unknown), as well as to a psychiatrist who met Helen only once.¹⁵⁶ A lethal prescription was then supplied.¹⁵⁷

After Helen died, the prescribing physician was quoted as saying that he regrets that he did not contact Helen's regular physician, as well as that he had only a "very cursory" discussion with the second doctor Helen approached: "[h]ad I felt there was a disagreement among the physicians about my patient's eligibility"—and no doubt there was—"I would not have written the prescription."¹⁵⁸ The prescribing physician further explained that the thought of Helen dying by lethal medication was "almost too much to bear," but that he felt compelled to proceed because he feared how Helen's family might view him otherwise: "I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they had [felt] about their previous doctor, that I had strung them along, and in a way, insulted them."¹⁵⁹ An *Oregonian* newspaper reporter who interviewed the family was told that Helen was worried that further care would threaten her financial assets.¹⁶⁰

When Cheney, an eighty-five-year-old widow, more recently sought a lethal prescription from a physician, her daughter Erika, a retired nurse, accompanied her.¹⁶¹ Erika described the doctor as "dismissive," so she and her mother requested and received a referral to another physician in the same health maintenance organization (HMO) (in this case, Kaiser Permanente).¹⁶² The second doctor arranged for a psychiatric evaluation; the psychiatrist found that Cheney "did not seem to be explicitly pushing for assisted suicide, and lacked 'the very high level of capacity to weigh options about it.'"¹⁶³ The psychiatrist noted that Cheney accepted his assessment when he presented it, but that the daughter became angry.¹⁶⁴

The HMO then, apparently at Erika's (not Cheney's) request, suggested that the family obtain a second psychiatric evaluation and agreed to pay for it.¹⁶⁵ The second psychologist found that Erika might have been "somewhat coercive" but concluded nonetheless that Cheney was competent to make the decision to die.¹⁶⁶ Cheney thereafter received a lethal prescription, and the

drugs were placed under poorly, became weaker, a nursing home on a temporary returned home, Cheney "in good health," that she did not want to use the lethal injection. When she was presented, Cheney took the

Some Questions

Helen's and Cheney's difficult questions about Oregon law viewed above: what role is the physician playing in patient decision-making and treatment for depression? Do doctors that prescribe lethal medication exist? To what extent do HMOs and physician evaluations exist? In each case had argued against the patient be allowed to "shop" for a doctor? Are they competent? Do HMOs do more than a cursory evaluation of care providers and other providers? Do requests for lethal medication get referred to pay for a second opinion? Do HMOs do this uncompetent? Do HMOs do this unquestionably cheap? Do HMOs do this for them to encourage

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drugs were placed under her daughter's care.¹⁶⁷ As time went by, Cheney ate poorly, became weaker, and, to afford Erika and her husband a respite, went to a nursing home on a temporary basis to regain her strength.¹⁶⁸ On the day she returned home, Cheney said "that something had to be done given her declining health," that she did not want to go into a nursing home again, and that she would like to use the lethal pills in Erika's custody.¹⁶⁹ After the daughter consented, Cheney took the pills and died.¹⁷⁰

Some Questions about Oregon's Experience

Helen's and Cheney's cases encapsulate and illustrate some of the difficult questions about Oregon's assisted suicide regime alluded to by the data reviewed above: what role is depression, as opposed to terminal illness, actually playing in patient decisions to die in Oregon? Are alternative options, including treatment for depression, being fully presented (or presented at all)? Are the doctors that prescribe death even knowledgeable about the alternatives that exist? To what extent are family members unduly influencing patient choices and physician evaluations? What would have happened if family members in each case had argued *against* the request to die and offered care? Should patients be allowed to "shop" around for physicians and psychologists who will find them competent? Do psychologists and physicians have an obligation to do more than a cursory examination? Should they consult the patient's primary care providers and other doctors or psychologists who may have refused prior requests for lethal medication by the patient? Would Cheney's HMO have offered to pay for a second opinion if the first psychologist had found Cheney competent? Do HMOs have a conflict of interest—given that assisted suicide is unquestionably cheaper than continuing care—that may provide an incentive for them to encourage patients to seek death?

7.3 LEGALIZATION AND OTHER UNINTENDED CONSEQUENCES

While the data above raise many questions about the unintended costs that might attend legalization, still others remain to be considered.

The Weak and Vulnerable

What might legalization mean, for example, to the confidence and trust patients have in medicine and medical professionals? Concerned about what might happen to them, many elderly Dutch patients have actually taken to

derstood as racism in the traditional human-animal distinction, Singer's alternative—granting the “right” to life only to those beings, human and animal, who manage to run the gauntlet of infancy and achieve the status of “rational and self-conscious beings” in adulthood, all as a result simply of being lucky enough to be the offspring of parents who chose not to kill them—is a prime example of what some would label “agism,”⁷¹ and what I might suggest is further evidence of the arbitrariness of instrumentalist accounts of human value.⁷² In fact, under Singer's logic, it would seem to be perfectly acceptable for humans to kill not only their own young, but also young animals—to eat spring lamb but not grown sheep, veal but not steak. Though Singer does not discuss this apparent consequence of his analysis, the reader is left to wonder whether Singer, a well-known animal-rights activist and author, would really want to so limit his defense of animal lives, even if he sees little basis for protecting infant human beings.

Notably, too, like his fellow utilitarian Posner, Singer ultimately seems to endorse, in part, something akin to the inviolability-of-life principle, suggesting that *certain* lives must be protected, regardless of their instrumental worth. But, where Posner appears to find the lives of *young* human beings inviolable, Singer would limit his argument for the inviolability-of-life to *adult* humans and animals (i.e., “rational” and “self-conscious” beings). Yet, Singer—like Posner—never supplies a complete account of why the lives of only *some* arbitrary subset of persons, rather than all, should be held inviolable and fully equal, or why his understanding of “personhood”—embracing only adult persons, but also adult animals—is superior to traditional understandings defined by reference to a “species boundary.”⁷³

Further, Singer seems to mistake the inviolability-of-life's affirmative assertion that all human life has intrinsic and equal dignity for the negative claim that no other forms of life have intrinsic moral significance worthy of protection. A secular inviolability-of-life principle may not *mandate* the notion that animals have a right to life, but neither does it rule out such a position; and it certainly is consistent with the traditional view that certain ways of treating animals are morally *wrong* (even if the animal has no *right* not to be so treated). To make the argument that human lives are entitled to special and differential protection and respect is not to say that animals may be treated poorly or cruelly, but simply to say that it is not always and categorically wrong to take an animal's life intentionally.

9.4 THE FUTURE OF THE OREGON EXPERIMENT?

I began this chapter by suggesting that there are certain irreducible human goods, and that human life itself is among these. From that premise, I then argued that, while we cannot help but choose between (and incidentally

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harm) competing goods in a world rich with possibilities, intentional acts by private persons against basic goods, including life, are categorically wrong. After offering this thesis, I proceeded to address certain prominent objections. Having now proceeded this far, we might take a step further and ask how the inviolability-of-life principle might inform future legal debate over Oregon's assisted suicide regime. The Supreme Court has recently heard a narrow administrative dispute over whether Oregon doctors may prescribe lethal medications to their patients, consistent with the federal Controlled Substances Act. The Court's decision, to be rendered after this book goes to print, will be discussed in an epilogue. But beyond the currently pending statutory dispute, a larger constitutional question, one intimately connected to the issues and themes we have discussed in this chapter, remains lurking in the background, unresolved.

When Oregon's law was first enacted, a group of disabled persons, physicians, and other concerned citizens brought a legal challenge seeking a declaration that it violated federal equal protection guarantees. A federal trial court in *Lee v. Oregon*⁷⁴ sustained their challenge, holding that Oregon's law did not rationally advance, or, in equal protection parlance, "fit," its stated objectives.⁷⁵ The trial court's decision was later reversed by the Ninth Circuit, but only on technical standing and ripeness grounds; the appellate panel expressly declined to reach the merits of the trial court's equal protection holding and did nothing to foreclose the possibility that properly situated plaintiffs may have standing in a future case to challenge Oregon's law on equal protection grounds or that the trial court's analysis might correctly apply in such a case.⁷⁶

In any equal protection analysis, courts typically proceed in a two-step fashion, asking first whether the state's proffered distinction or classification is justified (as either rational or under strict scrutiny, depending on the nature of the distinction or classification), and thereafter asking whether the state's classification "fits," or appropriately advances, its stated policy objectives. The trial court in *Lee* focused intently on the second step of this analysis. But the themes and concepts we have discussed in this chapter suggest that a substantial equal protection argument may exist on both steps.

As we have seen, the inviolability-of-life principle is strongly associated with the concept of human equality; the two are mutually reinforcing ideals. Oregon's law, however, candidly treats the lives of different persons quite differently. For the healthy, life is legally inviolable; no private person may take it. For the terminally ill, life is violable, and those physicians who help take it "in good faith" are exempted from any form of criminal or civil liability. Oregon defends this distinction as rational and appropriate and does so on the stated ground that any other legal rule "may simply mean prolonging suffering for a person who has no hope of a significant natural life ahead [and thus the state has] a valid public policy to allow choice based on principles of autonomy and self-determination."⁷⁷ But is Oregon's defense convincing?

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In the first place, it is far from clear that Oregon's scheme should be analyzed merely on the basis whether its distinction between persons is "rational." While the so-called rational basis test controls most equal protection disputes, laws that either embody certain suspect classifications (such as those based on race or national origin) or impinge on fundamental rights receive "strict scrutiny" in equal protection challenges.⁷⁸ Classifications based on yet other grounds, such as gender, are sometimes reviewed under an intermediate level of scrutiny.⁷⁹ Oregon's decision to make a legal discrimination based on physical health (the terminally ill versus everyone else) seems a candidate for heightened review.⁸⁰ This is especially so given that Oregon's law expressly implicates a fundamental right—that is, the scope of the right to life.

Even when courts do apply a so-called rational basis review, moreover, if the state law at issue discriminates against a particular group of persons in a manner suggesting that they possess a less valuable form of living (past cases have involved the mentally disabled, unconventional families, homosexuals, individuals having sexual relations out of wedlock), such laws are typically subjected to a particularly searching form of rational basis review. Once again, Oregon's law may qualify, treating as it does the lives of the terminally ill as meriting fewer protections and safeguards against intentional destruction through mistake, abuse, or coercion than the lives of all other persons.⁸¹

Whatever the doctrinal rubric ultimately employed to review Oregon's discrimination between terminally ill and healthy persons, a nontrivial legal argument can be made that the law fails to pass muster. As we saw in chapter 7, the class of the "terminally ill" is discernible only in hindsight: patients in Oregon have waited a year or more after their "terminal" diagnoses to make use of their prescriptions, and physicians have admitted that they cannot be sure of their own "terminal" diagnoses; definitions of terminal illness are thus "inherently unstable."⁸² Why, we might ask, is it reasonable to rest legal distinctions with the effect of life or death on what is admittedly guesswork? Even more fundamentally, we might also ask, what rational basis is there for treating the lives of those who are diagnosed as having less than six months to live any different from any number of other groups of persons—such as the patient suffering irremediable pain, the quadriplegic, Singer's Down's syndrome infant, or Dworkin's incompetent Alzheimer's patient? Can we rationally single out just the "terminally ill"?

Oregon has responded that keeping terminally ill persons alive is singularly inappropriate because doing so "prolong[s] suffering."⁸³ Yet, as we saw in chapter 7, suffering simply is *not* a prerequisite for permission to commit assisted suicide under Oregon's statutory regime; persons who are not suffering are equally free to receive a doctor's help in killing themselves. And in this respect Oregon notably departs from the Dutch who do purport to require some indicia of suffering before allowing assisted suicide or euthanasia. Oregon also invokes themes of patient "autonomy" in defense of its statute. But Oregon rec-

ognizes the goal of preventing suicide only for one group to allow any number of others to thus vindicate the state's goal to die, and the state's interest in groups (e.g., the per se cases). Neither, I have drawn a line or line we might draw must live and who must be picked out w

Not only do we distinguish between the terminally ill and healthy persons, whether the law operates for the purpose of enabling assisted suicide, for example, as the trial court in *Wade* held that terminally ill patients and medical professionals evaluate the state's interest in life. If the state wishes to confine a patient to five days, the patient's mental health expert testimony regime that affects the probability of a mistaken conclusion against the possibility of recovery. As the trial court in *Wade* held, it is rational to not require medical professionals?⁸⁵

As we have seen, we are immunized from the state's faith." Yet physicians are commensurate with the circumstances, and Oregon's holding this standard holds physicians engaged in more than physicians who are not. How does it promote the state's interest if doctors are immunized from those who are not competent?

Likewise, the state's interest in preventing and competence does nothing to assist the state's interest in death—which conclusion is issued. T

recognizes the goal of patient autonomy as a sufficient reason to permit assisted suicide only for one group of persons and adjudges it an insufficient reason to allow any number of other groups to obtain assistance in dying. Oregon's law thus vindicates the autonomy of only *some* persons, and not others, who wish to die, and the state has offered no convincing explanation for excluding other groups (e.g., the permanently disabled, or those suffering from progressive diseases). Neither, I have suggested, is the inability of Oregon to draw such a rational line a fluke or accident. For reasons discussed earlier in this chapter, any line we might draw among human beings for purposes of determining who must live and who may die ultimately seems to devolve into an arbitrary exercise of picking out which particular instrumental capacities one especially likes.

Not only does Oregon's law draw an arguably irrational distinction between the terminally ill and everyone else, one can raise serious questions about whether the law operates in ways that reasonably advance or "fit" its putative purpose of enabling considered and rational autonomous choices in dying. For example, as the trial court in *Lee* noted, under Oregon's law there is no guarantee that terminally ill patients seeking death will have trained mental health professionals evaluate them for competency and signs of depression. Yet, when the state wishes to confine persons with suicidal impulses for a period not to exceed five days, the patient is first entitled under Oregon law to an examination by a mental health expert.⁸⁴ How can one coherently explain and defend a regulatory regime that affords terminally ill patients less protection against the possibility of a mistaken death due to a psychiatric ailment than it affords all patients against the possibility of a mistaken five-day confinement from the same cause? As the trial court in *Lee* asked, "[w]ith death at issue . . . [why] would [it] be rational to not require mental and social evaluations by appropriately trained professionals?"⁸⁵

As we have already seen, too, doctors helping to kill terminal patients are immunized from liability under Oregon's law so long as they act in "good faith." Yet physicians treating nonterminally ill patients are held to a duty of care commensurate with that used by careful physicians in the same or similar circumstances, and Oregon courts have expressly considered and rejected substituting this standard for a "good faith" duty of care.⁸⁶ How can a state rationally hold physicians engaged in hangnail operations to a higher standard of care than physicians who engage in acts deliberately aimed at killing their patients? How does it promote autonomous end-of-life decisions to set up a regime where doctors are immunized from liability even when they negligently kill patients who are not competent or who have not consented?⁸⁷

Likewise, under Oregon's law, physicians must assess patients for consent and competency only at the time the lethal prescription is given; the statute does nothing to assure patient rationality and voluntariness at the actual time of death—which can come months (and perhaps even years) after the prescription is issued. Thus, although Oregon's assisted suicide regime seeks to pro-

mote autonomous self-determination, its law does nothing to assure that such preconditions actually exist at the time death is sought. As a result, there is little to prevent mistake, abuse, or coercion from playing a role after a prescription is issued, and nothing to ensure that patients are in control of their mental faculties at the time of death.⁸⁸ How does it serve the putative goal of autonomous patient decision making to set up a regime that allows people to commit suicide without considering whether they are, in fact, acting freely, competently, and autonomously at the time of the suicide?⁸⁹

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Killing us softly: the dangers of legalizing assisted suicide

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Abstract

This article is an overview of the problems with the legalization of assisted suicide as public policy. The disability community's opposition to assisted suicide stems in part from factors that directly impact the disability community as well as all of society. These factors include the secrecy in which assisted suicide operates today, in states where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangerous potential of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms. Legalizing assisted suicide would augment real dangers that negate genuine choice and self-determination. In view of this reality, we explore many of the disability-related effects of assisted suicide, while also addressing the larger social context that inseparably impacts people with disabilities and the broader public. First, after addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. Third and finally, we explore the ways that so-called "narrow" assisted suicide proposals threaten inevitable expansion. © 2010 Elsevier Inc. All rights reserved.

Keywords: Assisted suicide; Physician assisted suicide; Doctor assisted suicide; Death with dignity; Aid in dying; People with disabilities; Disability; Disability rights; Terminal illness; Chronic illness; Chronic conditions

The legalization of assisted suicide¹ strikes many people, initially, as a cause to support. But upon closer inspection, there are many reasons why legalization is a serious mistake. Supporters focus on superficial issues of choice and self-determination. It is crucial to look deeper. Legalizing assisted suicide would not increase choice and self-determination, despite the assertions of its proponents.

It would actually augment real dangers that negate genuine choice and control.

Because of these dangers, approximately half the states in the United States have either defeated bills to legalize assisted suicide or have passed laws explicitly banning it [1]. In many cases, the bills or referenda were defeated by an opposition coalition spanning the political spectrum from left to right.²

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¹ A note about terminology: The words used in this policy debate are controversial. We use the term "assisted suicide" because it is understood by the public and is used in the legal and medical literature. A clear, specific term is needed. "Aid in dying" could mean anything done to help a dying person, while "death with dignity" has many meanings. The politicization of this terminology is discussed below.

² Coalitions opposing the legalization of assisted suicide typically represent disability rights organizations, physicians and other health care workers, hospice organizations, and Catholics and other right-to-life organizations. In some cases, they also include organizations representing the Latino community, poor people, and workers. Notable opponents include the World Health Organization, American Medical Association and its state affiliates, American College of Physicians—American Society of Internal Medicine, National Hospice and Palliative Care Organization, American Cancer Society, American Geriatrics Society, many other medical organizations, and League of United Latin American Citizens (LULAC). Many prominent Democrats and liberals also oppose legalization, including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff.

Throughout the world, disability rights advocates and organizations are important voices in the opposition to assisted suicide.³ The disability community's opposition is based on the dangers to people with disabilities and the devaluation of disabled peoples' lives that results from assisted suicide. Further, this opposition stems from factors that directly impact the disability community as well as all of society. These factors include the secrecy in which assisted suicide operates today, in states where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangerous potential of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms.

In view of this reality, we address many of the disability-related effects of assisted suicide, while also encompassing the larger social context of assisted suicide that inseparably impacts people with disabilities as well as the broader public. First, after addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. We examine Oregon because its law is copied in proposals through the country, including Washington State, which legalized assisted suicide last year. By detailing significant problems with Oregon's supposed safeguards, we raise some of the dangers of assisted suicide, particularly for people with depression and other psychiatric disabilities. Finally, we explore the ways that so-called "narrow" assisted suicide proposals threaten easy expansion. This article focuses primarily on conditions in the United States, although much of it also applies in other countries.

³ The opposition to the legalization of assisted suicide is often mischaracterized as driven exclusively by religious conservatives, but most current opposition coalitions include many persons and organizations whose opposition is based on their progressive politics. Among those are disability rights groups. These 12 nationally prominent disability organizations have stated their opposition to the legalization of assisted suicide: American Disabled for Attendant Programs Today (ADAPT); American Association of People with Disabilities (AAPD); Association of Programs for Rural Independent Living (APRIL); Disability Rights Education and Defense Fund (DREDF); Justice For All (JFA); National Council on Disability (NCD); National Council on Independent Living (NCIL); National Spinal Cord Injury Association; Not Dead Yet (NDY); TASH; the World Association of Persons with Disabilities (WAPD); and the World Institute on Disability (WID) (updates from NDY staff in personal interview, March 26, 2003) [2]. The Disability Section of the American Public Health Association has also declared its opposition. Many state and local disability community leaders and organizations have further declared their opposition in states where assisted suicide proposals have been introduced. For example, the list for Washington State is available at http://dredf.org/assisted_suicide/Washington_Orgs_Indivs_List.pdf.

Few helped, many harmed: disability prejudice and the damage to society

Legal alternatives available today

The movement for the legalization of assisted suicide is driven by anecdotes of people who suffer greatly in the period before they die. But the overwhelming majority of these anecdotes describe either situations for which legal alternatives exist today or situations in which the individual would not be legally eligible for assisted suicide.

It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn. It is legal to receive sufficient painkillers to be comfortable, and we now know this will not hasten death [3].⁴ And perhaps least understood, for anyone who is dying in discomfort, it is legal in any U.S. state to receive palliative sedation, wherein the dying person is sedated so discomfort is relieved during the dying process. Thus, there is already recourse for painful deaths. These alternatives do not raise the serious difficulties of legalizing assisted suicide.

Moreover, anyone with a chronic but nonterminal illness is not eligible for assisted suicide in either Oregon or Washington State. Anyone with depression that affects his or her judgment is also ineligible. Thus, the number of people whose situations would actually be eligible for assisted suicide is extremely low, yet its harmful consequences would be significant.

Fear, bias, and prejudice against disability

Fear, bias, and prejudice against disability play a significant role in assisted suicide. Who ends up using assisted suicide? Supporters advocate its legalization by suggesting that it is needed for unrelievable pain and discomfort at the end of life. But the overwhelming majority of the people in Oregon who have reportedly used that state's assisted suicide law wanted to die not because of pain, but for reasons associated with disability, including the loss of dignity and the loss of

⁴ According to Herbert Hendin and Kathleen Foley, "We now know that that proper use of pain medications in patients with chronic pain, as well as patients at the end of life, does not hasten death. Studies have demonstrated that dying patients who received morphine lived longer than those who did not receive morphine." Herbert Hendin is chief executive officer and medical director, Suicide Prevention International, and *Professor of Psychiatry*, New York Medical College. Kathleen Foley is *Attending Neurologist*, Memorial Sloan-Kettering Cancer Center; *Professor of Neurology, Neuroscience, and Clinical Pharmacology*, Weill Medical College of Cornell University; and *Medical Director*, International Palliative Care Initiative of the Open Society Institute.

control of bodily functions [4]. Similar reasons are reported in the Netherlands [5].⁵

This fear of disability typically underlies assisted suicide. Janet Good, an assisted suicide advocate who worked with Jack Kevorkian, was clear about this: “Pain is not the main reason we want to die. It’s the indignity. It’s the inability to get out of bed or get onto the toilet. . . [People]. . . say, ‘I can’t stand my mother—my husband—wiping my butt’ [6]. But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will abet suicides because people need help using the toilet [7]?”

The legalization of assisted suicide would occur “within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities” [8]. Already, this prejudice and discrimination play out in life-threatening ways, including pressure by hospital staff on people with disabilities who are nowhere near death to sign Do Not Resuscitate orders and reject life-sustaining treatment [8].⁶ Because of public images that disability is “a fate worse than death,” legalized assisted suicide threatens to create a “two-tiered system”: nondisabled individuals who express suicidal wishes will receive suicide prevention services, while individuals with disabilities will receive lethal prescriptions, resulting “in death to the socially devalued group” [10].

A deadly mix: managed health care and assisted suicide

An ailing system made worse

A significant problem with legalization is the deadly interaction between assisted suicide and profit-driven managed health care. Health maintenance organizations (HMOs) and managed care bureaucracies have often overruled physicians’ treatment decisions because of the cost of care, sometimes hastening patients’ deaths.⁷

⁵ In Oregon, individuals cited concerns “including the loss of autonomy (89.9%), the loss of the ability to engage in activities that make life enjoyable (87.4%), the loss of dignity (83.8%), and the loss of control of bodily functions (58.7%)” [4]. In the Netherlands, the majority of physicians surveyed say the primary reason that patients seek death is “loss of dignity” [5].

⁶ These near-fatal encounters with antidisability prejudice in the health care system are not limited to the United States [9].

⁷ See, for example, the story of Dr. Linda Peeno [11,12]. In 1996, before the U.S. House of Representatives Commerce Committee, she testified, “In the spring of 1987, as a physician [and managed-care executive for the HMO Humana], I caused the death of a man [by denying coverage of a heart transplant] . . . I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was ‘rewarded’ for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards.”

Financial considerations can have similar results in nonprofit health plans and government-sponsored health programs such as Medicare and Medicaid, which are often underfunded. Cost-cutting pressures also shape physicians’ choices. A 1998 study from Georgetown University’s Center for Clinical Bioethics found a strong link between cost-cutting pressure on physicians and their willingness to prescribe lethal drugs to patients, were it legal to do so [13].

The cost of the lethal medication generally used for assisted suicide is about \$300, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment already poses a significant danger. This danger is far greater where assisted suicide is legal. Direct coercion is not necessary. If patients are denied necessary life-sustaining health care treatment, or even if the treatment they need is delayed, many will, in effect, be steered toward assisted suicide.

The deadly impact of legalizing assisted suicide would fall hardest, whether directly or indirectly, on socially and economically disadvantaged people who have less access to medical resources and who already find themselves discriminated against by the health care system. Particularly at risk are individuals in poverty, people of color, older adults, people with progressive or chronic conditions, and terminally ill individuals [8]. As the New York State Task Force on Life and the Law noted, assisted suicide, despite supposed safeguards:

will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those . . . most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered [14].

Deteriorating health care in Oregon

Oregon’s adoption of assisted suicide must be critically examined in relation to its curtailment of Medicaid spending. As Paul Longmore, professor of history at San Francisco State University and a foremost disability advocate on this subject, explained, Oregon instituted “health care rationing for the poor” in the same year that the state’s assisted suicide initiative became law in 1994 [8]. That year, the Oregon Medical Assistance Program (OMAP) ranked over 700 health services and terminated funding for 167 of them. Four years later, when the assisted suicide law went into effect, OMAP directors put lethal prescriptions on the list of “treatments,” categorized as “comfort care.” At the same time, OMAP slashed Medicaid funding for more than 150 services crucial for people with disabilities, people with terminal illnesses, and older adults, while trimming already limited funding for in-home support. In the same year, OMAP attempted, but failed, to limit the funded doses of a powerful pain medication and

successfully put barriers in the way of funding for a path-breaking antidepressant.⁸

The impact of the Oregon Health Plan's drastic limitations became very real to Medicaid recipients Barbara Wagner and Randy Stroup. Wagner, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30% increased survival rate for patients with advanced lung cancer, and patients' 1-year survival rate increased by more than 45%. But the Oregon Health Plan sent Wagner a letter saying the plan would not cover the beneficial chemotherapy treatment "but . . . it would cover . . . doctor-assisted suicide." Stroup was prescribed mitoxantrone as chemotherapy for his prostate cancer. His oncologist said that while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain [15]. Yet Stroup also received a letter saying that the state would not cover his treatment but would pay for the cost of assisted suicide [16].

These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than 5% expectation of 5-year survival. In a July 5, 2009, letter, H. Rex Greene, M.D., former medical director of the Dorothy E. Schneider Cancer Center at Mills Health Center and currently a member of the AMA Ethics Council, called this rule "an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria."

It is often alleged that legalized assisted suicide has improved end-of-life care in Oregon. While it is true that Oregon has shown some improvements, similar improvements have occurred in other states that have not legalized assisted suicide.⁹ And research strongly suggests that Oregon has seen a reduction in the quality of end-of-life palliative care since the Oregon law went into effect. Dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the law

took effect [18]. And several recent studies show inadequate palliative and end-of-life care in Oregon [3].

Broad indirect impacts on health care

Addressing the negative impact of the legalization of assisted suicide on the practice of medicine, the two professional associations representing oncologists in California wrote in 2007 that legalization "strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship." Legalization, they concluded, undermines the "physician's primary directive . . . to *first, do no harm*"; "destroys the trust between the patient and doctor"; and, "[u]nder the pretense of providing compassion," relieves a physician "of his or her primary responsibility . . . to safeguard [patients' lives] and to provide comfort to the suffering. It is the ultimate patient abandonment" [19].

The death of Wendy Melcher in August 2005 illustrates the indirect impact of legalization on medical practice and law enforcement. Two nurses, Rebecca Cain and Diana Corson, gave Melcher large overdoses of morphine and phenobarbital. They claimed that she had requested assisted suicide, but they administered the drugs without her physician's knowledge, in clear violation of the law. Yet no criminal charges have been filed against the two nurses. Proponents of assisted suicide argue that this case has no connection to the Oregon law. But it is a strong indication of the legal erosion of public protections due to assisted suicide. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught" [20].

Supporters of assisted suicide frequently assert, without evidence, that the underground practice of assisted suicide disappears where it is legal. But Melcher's death suggests the opposite, that underground assisted suicide probably does occur, and may in fact be thriving in Oregon in the wake of assisted suicide's legalization, due to the breakdown in legal rules and codes of conduct that elsewhere protect patients.

The failure of safeguards and the case of Oregon

Oregon's Death with Dignity Act initiative, known as Measure 16, narrowly passed in November 1994, but court proceedings delayed its implementation. Then the Oregon legislature, concerned with the dangerous flows of Measure 16, referred it back to the voters for reconsideration in a November 1997 special election. After a campaign in which initiative proponents succeeded in keeping the public's attention away from the proposal's actual problems, Oregon voters legalized assisted suicide [21].

One of the myths about assisted suicide in Oregon is that it is highly regulated and has strong safeguards. As a result of this myth, Oregon's law has been duplicated in bills and referenda proposed in many other states. None have passed except in Washington State, where Initiative 1000 passed in November 2008 and went into effect in March 2009. Although

⁸ One leading proponent of assisted suicide, Barbara Coombs Lee, the author of Oregon's assisted suicide legislation, was very involved in developing the state's current health plan. And former Oregon governor John Kitzhaber, a leading proponent of the plan, openly admitted "only three states spend less per person on health care for the poor" [8].

⁹ Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., noted in 2008 in *The Oregonian* that many states do better than Oregon [17]. For example, the latest data rank Oregon ninth (not first) in Medicare-age use of hospice; four of the top five are states that have criminalized assisted suicide. Stevens is professor emeritus and former chairman of radiation oncology at Oregon Health & Science University (OHSU) and vice-president, Physicians for Compassionate Care Education Foundation (PCCF). Toffler is professor of family medicine at OHSU and the national director of PCCF.

Washington's law follows the Oregon model, the discussion that follows focuses largely on Oregon because assisted suicide has been legal in Washington for less than a year.

The myth of Oregon's effective safeguards claims that the law ensures that patients are competent to make the decision to end their lives, limits assisted suicide to people who are terminally ill, ensures that each request is voluntary, requires that a second opinion be obtained, requires a 15-day waiting period, and requires physicians to inform the state of any lethal prescriptions they write. The safeguards myth further purports that physicians must present patients with the option for palliative care [3]. However, each and every one of these reportedly strong rules is either fundamentally flawed or has been rendered an empty ritual.

Exploring the practice of assisted suicide in Oregon is a means to examine the significant problems with the legalization of assisted suicide. These problems include the myth of free choice and self-determination, the fundamental loophole of terminal illness prognosis, the safeguards in name only, the danger to people with depression and psychiatric disabilities, Oregon's minimal data and fatally flawed oversight, and the questionable circumstances of Oregon deaths.

The myth of free choice and self-determination

Assisted suicide proponents frequently appeal to free choice and self-determination. But in reality, legalized assisted suicide actually diminishes individual choice and control.

Margaret Dore, an elder law specialist, has shown how the Oregon and Washington State assisted suicide laws dramatically undermine patient control:

During the [Washington assisted suicide campaign], proponents touted [assisted suicide] as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient—and no one else—may administer the [lethal dose]." The Act, however, does not say this—anywhere. The Act also contains coercive provisions. . . . It allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose. . . . [It] also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir. This . . . invites coercion.

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose. . . . Someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. . . . Someone

could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi. . .

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected . . . in the event he changes his mind after the lethal prescription is filled and decides that he wants to live [22].

Moreover, there is danger that many people would choose assisted suicide due to external pressure. Elderly individuals who do not want to be a financial or caretaking burden on their families might take this escape. In fact, the percentage of reported Oregon cases attributed to patients' reluctance to burden their families has risen shockingly. It totaled 12% in 1998, but increased to 26% in 1999, then 42% in 2005, and 45% in 2007 [23–26]. Nothing in the Oregon law will protect patients when family pressures, whether financial or emotional, distort patient choice.

Also troubling is widespread elder abuse in the United States. The perpetrators are often family members.¹⁰ Such abuse could easily lead to pressures to "choose" assisted suicide.

Still others may undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. A case in point, Oregon resident Kate Cheney (discussed later) was apparently motivated to take her life by fear of the nursing home where she had just spent an unhappy week. The Oregon law has no "requirement that sufficient home and community-based long-term care services be provided to relieve the demands on family members and ease the individual's feelings of being a 'burden'" [10].

While the proponents of legalization argue that it would guarantee choice, assisted suicide would actually result in deaths due to a *lack* of choice. Real choice would require adequate home and community-based long-term care, universal health insurance, and housing that is available, accessible, and affordable—a full range of social supports largely unavailable today. In a perverse twist, widespread acceptance of assisted suicide could *reduce* pressure on society to provide these very services, thus reducing genuine options further.

The fundamental loophole of terminal illness prognosis

The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear

¹⁰ The National Elder Abuse Incidence Study (NEAIS) was conducted by the National Center on Elder Abuse at the American Public Human Services Association. It showed that, in 1996, 450,000 elders aged 60 and over were abused, according to a study of observed cases. In almost 90% of the elder abuse and neglect incidents with a known perpetrator, the perpetrator was a family member, and two-thirds of the perpetrators were adult children or spouses [27].

distinction between those who are terminally ill with 6 months to live and everyone else. Everyone else is supposedly protected and not eligible for assisted suicide.

But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it is only in the last few weeks of life. With every disease other than cancer, prediction is unreliable [28-31].¹¹ Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad and could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead.

This poses considerable danger to people with new or progressive disabilities or diseases, who may often be misdiagnosed as terminally ill but who, in many cases, outlive these prognoses by years or even decades. People with new disabilities frequently go through initial despondency and suicidal feelings but later adapt well and find great satisfaction in their lives [33-39]. However, the adaptation usually takes longer than the mere 15-day waiting period required by the Oregon and Washington assisted suicide laws. People with diagnoses of terminal illness appear to go through similar stages [14]. In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make an irrevocable choice.¹²

Safeguards in name only

Doctor shopping: all roads lead to Rome

There are many other significant weaknesses in Oregon's safeguards. For example, physicians are not permitted

to write a lethal prescription under a set of inappropriate conditions defined in the law, such as when a patient is incompetent or when a request is involuntary. But in many instances, patients have engaged in "doctor shopping," which can circumvent these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient did not meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and fourth, until someone finally agreed. In fact, in the first three years assisted suicide was legal in Oregon, patients had to ask at least two physicians before receiving lethal drugs in 59% of cases; with the fourth year, officials dropped these disturbing data from the annual reports [41].

To understand how easily the approval-by-two-physicians "safeguard" can also be circumvented, it is important to know that the lead organization advocating for assisted suicide, Compassion & Choices, facilitates most of Oregon's reported assisted suicides, often by referring individuals to assisted-suicide-friendly physicians. In addition, the organization's officers "are the authors [of the law] . . . and [are its] self-proclaim[ed] . . . stewards . . .," as Kenneth R. Stevens, Jr., M.D., reports. Stevens is professor emeritus and former chairman of radiation oncology at Oregon Health & Science University, and vice-president, Physicians for Compassionate Care Education Foundation [42]. Dr. Peter Goodwin, Compassion & Choices former medical director, said that about 75% of reported Oregon assisted suicide deaths through 2002 did so with the organization's assistance [43]. In one example year, during 2003, the group was involved in 79% of these deaths [44]. According to Dr. Elizabeth Goy of Oregon Health & Science University, Compassion in Dying (since renamed Compassion & Choices) saw "almost 90% of requesting Oregonians . . ." [45].¹³ And "in 2008 the proportion of C&C PAS deaths significantly increased to 88% (53/60) of all [OPHD] reported deaths" [42].

The first person reported to die under Oregon law, whose name was not revealed, represents an example of doctor shopping. Her physician and a second physician refused her a lethal prescription. The latter diagnosed her as "depressed." Nonetheless, a physician affiliated with Compassion in Dying wrote the prescription after knowing her only briefly [46].

Another example is Kate Cheney, an 85-year-old woman [47]. She saw two physicians. Her daughter thought the first physician was "dismissive" and requested another opinion.

¹¹ "17% of patients [outlived their prognosis] in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13% of hospice patients around the country outlived their six-month prognoses. . . . When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70% of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*" [32].

¹² Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example [40]. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, physicians often classified him as terminally ill. He experienced severe depression for 2 years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life. How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide?

¹³ Dr. Elizabeth Goy testified before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon's assisted suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament. They held closed-door hearings on December 9 and 10, 2004, and published the proceedings on April 4, 2005.

The second physician ordered a psychiatric evaluation, which found that Cheney lacked “the very high level of capacity required to weigh options about assisted suicide.” Cheney’s request was then denied, and her daughter “became angry.” Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her “choices may be influenced by her family’s wishes and her daughter, Erika, may be somewhat coercive.” Cheney soon took the drugs and died but only after spending a week in a nursing home.

Alternatives: presented but not provided

In the Oregon law, physicians are required to present alternatives to assisted suicide as another safeguard. However, there is no requirement that these alternatives actually be made available to patients, or even that the professional who discusses them fully understands them. Kate Cheney’s case exemplifies this. Further, her case demonstrates the shocking laxness with which safeguards in Oregon are followed. Cheney decided to take the lethal drugs immediately after spending a week in a nursing home to give her family a break from caregiving. The chronology shows that Cheney felt she had only three choices: burdening her family, the hell of a nursing home, or death [10].

After reading about Kate Cheney, Diane Coleman, president and founder of Not Dead Yet, a grassroots disability organization opposed to legalizing assisted suicide, sent a letter to Dr. Robert Richardson, who authorized Cheney’s request for lethal drugs. It stated, in part:

As a long-term care advocate, I have heard for years of Oregon’s claim to operate the most progressive long-term care programs in the country, model programs that emphasize in-home and community-based services, even for the most frail elderly. What in-home services was Ms. Cheney receiving? How is it that Ms. Cheney had to spend a week in a nursing home to give her family respite from caregiving? Did Ms. Cheney and her family know of other respite options? If not, who failed to tell them? How can their actions have been based on the informed consent promised in Oregon’s law? Or did the family choose the nursing home respite option with the knowledge of other alternatives (an even more disturbing possibility)? . . .

There are many ways to resolve the feeling of being a burden on family, and the family’s feelings of being burdened. In what depth were these issues explored? In this context, family relationships are complex, and the emotional dynamics could not realistically be uncovered in a brief consultation [10].

Dr. Richardson did not reply.

Good faith: a safeguard for physicians, not patients

There is one foolproof safeguard in the Oregon and Washington laws. Unfortunately, it is for physicians and other health care providers rather than for patients—the good faith standard. This provision holds that no person will be subject to any form of legal liability, whether civil or criminal, if they act in good faith [48]. However, a claim of a good faith effort to meet the requirements of the law is virtually impossible to disprove. As a result, this provision renders all other alleged safeguards effectively unenforceable.

Even more alarming, for all other medical procedures, physicians are liable under a much stronger legal standard, that of negligence. Yet even negligent practitioners of assisted suicide will not be found to have violated the law as long as they practice in good faith. In an ironic twist, assisted suicide physicians are safer from liability if they cause a patient’s death than if they provide his or her medical treatment.

Herbert Hendin, M.D., and Kathleen Foley, M.D., suicide prevention and end-of-life care experts, offered this analysis.¹⁴

[T]he physician is immunized from civil and criminal liability for actions taken in “good faith” in assisting a suicide . . . even when the physician acts negligently.

Good faith is a troublesome, subjective standard. . . . In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute’s provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate [3].

The danger to people with depression and psychiatric disabilities

Depression and the wish to die

The drive to legalize assisted suicide comes from anecdotes of painful, uncomfortable deaths. Yet available data show that when assisted suicide is legal, those who use it are not typically acting based on

¹⁴ Herbert Hendin is chief executive officer and medical director, Suicide Prevention International and professor of psychiatry, New York Medical College. Kathleen Foley is Attending Neurologist, Memorial Sloan-Kettering Cancer Center; professor of neurology, neuroscience, and clinical pharmacology, Weill Medical College of Cornell University; and medical director, International Palliative Care Initiative of the Open Society Institute.

current pain or other discomfort. As H. Rex Greene, M.D., explained:

Demoralization Syndrome ... is very common in chronic, ... life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon's law, who are consistently reported NOT to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of ... the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates [49].

Greene further noted:

The wish for death is a "cry for help," a reliable sign of depression. How absurd that it would be met with a lethal prescription ... Advances in palliative medicine have made it possible to relieve ... symptoms in virtually all dying patients. ... [49].

Other research supports Greene's conclusion that most patients requesting death do so not based on physical symptoms such as pain but rather based on depression and other forms of psychological distress.¹⁵

¹⁵ The two professional associations representing oncologists in California wrote:

It is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do *not* do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. This has been borne out in numerous studies and reports. For example, ... a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada, ... showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient's expressed desire or support for euthanasia/PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to be suffering from depression or anxiety, but not somatic symptoms such as pain.

An important study from the Netherlands of a cohort of 138 cancer patients with a life expectancy of 3 months or less demonstrated similar findings. In this study, the authors had hypothesized that patients requesting euthanasia would be unlikely to have depressed mood or affect, since it would be expected that such a request would be a well-thought-out decision, particularly since euthanasia has been legal in the Netherlands since 2002. The authors expected that these patients would be more accepting of their terminal diagnosis and therefore better adjusted. What they found surprised them—depressed patients were more than 4 times as likely to request euthanasia as were patients who were not depressed. Over 40% of depressed patients requested euthanasia. Of those who requested euthanasia, about half were depressed [19].

Ignoring what lies beneath: the abandonment of the patient

Addressing the situation of the individual patient, Hendin stated in congressional testimony:

A request for assisted suicide is ... usually made with as much ambivalence as are most suicide attempts. If the physician does not recognize that ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror [50].

As Hendin and Foley also pointed out, when patients requesting a physician's assistance to die "are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears" [3].¹⁶ Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legal, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

N. Gregory Hamilton, M.D., distinguished fellow of the American Psychiatric Association and co-founder of Physicians for Compassionate Care, has demonstrated how Oregon's flimsy safeguards do not protect people with psychiatric and other mental health disabilities. In his 2004 testimony to a British delegation considering a law similar to Oregon's, Hamilton documented the case of Michael Freeland, a man with "a long history of serious depression and previous suicide attempts" who nonetheless received lethal drugs under the Oregon law [52,45]. A recent study confirmed that that some of the reported Oregon cases were patients who were, in fact, depressed [53].

People with depression can receive lethal drugs in Oregon and Washington legally, because they are still technically eligible as long as they are deemed legally competent, that is, "competent and not suffering from a psychiatric or psychological disorder or depression *causing impaired judgment*" [emphasis added] [54,55]. Yet the notion that patients with depression may be considered legally competent to decide to end their lives, merely because the depression does not impair their legal competency—Orwellian at best—is also at variance with the majority of clinical and forensic psychiatrists who believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide [56]. And as Hendin and Foley pointed out, "Reducing the psychiatric consultation to the issue of competency ignores all the

¹⁶ Also: "Contrary to much popular and professional opinion, depression is a treatable condition, even in patients who are terminally ill" [51].

other psychological factors that go into the request for assisted suicide” [3].

One visit, rarely: the impact on the individual

Regarding the supposed safeguard of psychiatric evaluations, the following example indicates how psychological evaluations are misused in Oregon.

In discussing Joan Lucas, an Oregon woman whose evaluating psychologist decided she was competent “on the basis of a single questionnaire administered by her family,” Hendin and Foley explained that when a psychiatric evaluation occurs, it tends to be used to protect clinicians rather than patients:

[The Oregon Public Health Division’s] monitoring procedures do not make it possible for OPHD to evaluate the care Joan Lucas received. To do so OPHD would have to interview Joan’s primary care physician who had refused to assist in her suicide and to assess the quality of her psychological evaluation. Using psychologists or psychiatrists as gatekeepers only to establish a patient’s capacity to make a decision for assisted suicide contributes to *pro forma*, meaningless consultations.

In the Lucas case, we have no way of knowing if Joan Lucas was seriously depressed or if the physician or psychologist was disposed to proceed even if she were. Even more troubling is that OPHD does not seem to want to know about the psychiatric status of patients requesting assisted suicide. Under the current monitoring system, OPHD collects no information from psychiatrists who did not find patients to be competent and has no direct communication with psychiatrists or psychologists who did. Its monitoring reflects a lack of concern with the welfare of depressed patients [3].

Moreover, the Oregon and Washington laws do not require psychiatric evaluations except when physicians determine a patient’s judgment is impaired. This determination is rarely made. Psychiatric evaluation of individuals who are reported to die from assisted suicide dropped from 31% in 1998 to a mere 5% in 2003–2004 [57–59]. In the 2007 Oregon report, *no* Oregon patients underwent a psychiatric evaluation [60,61]. And “over the [following] two years in Oregon, less than 2% of patients committing assisted suicide were referred for psychiatric evaluation” [62].

However, even when it occurs, the psychiatric evaluation is often unreliable or insufficient. Only 6% of Oregon psychiatrists are confident they can diagnose depression after one visit [63], yet the Oregon and Washington definitions of a psychiatric consultation permit one visit only [54,55]. Moreover, as N. Gregory Hamilton, M.D., pointed out, physicians who support

assisted suicide will refer patients to psychiatrists or psychologists who agree with that view, and “the evaluations tend to be *pro forma*,” or else alternative opinions that favor assisted suicide are found, providing no protection for people with depression and psychiatric disabilities [52].

Hendin and Foley illustrated what can happen when effective psychiatric consultation is not provided, in this Oregon example showing how assisted suicide undermines standards of care. A woman in her mid-50s with heart disease, but otherwise with no significant pain or mobility limitations, requested a lethal prescription from her cardiologist. The cardiologist, in turn, referred her to another physician who was willing to write lethal prescriptions. This physician determined she was not terminally ill. But rather than ask about the origins of her suicidal wishes and give her a psychiatric referral, the physician simply told her to see her cardiologist again. Her cry for help unanswered, she committed suicide the following day [3].

Minimal data and fatally flawed oversight

The State of Oregon’s minimal data collection and gross lack of strong oversight of assisted suicide undermine any pretense of rigorous monitoring or strict regulation. A series of problems renders any conclusions based on the data to be critically flawed. Washington’s law contains similarly limited, deeply flawed provisions.

Oregon’s annual reports tell us very little. In reality, we do not know what is happening under the Oregon law due to these problems:

1. **The reporting requirement lacks teeth.** On paper, the law requires physicians to report all lethal drug prescriptions, but sets no penalties if physicians fail to report. Thus, this requirement is not enforced [3].
2. **Noncompliance is not monitored.** The law requires annual statistical reports from the Oregon Public Health Division (OPHD), but OPHD does not monitor underreporting, noncompliance, or violations. Many of Oregon’s reports acknowledge that the state cannot confirm compliance with the law. For example, OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside the law’s framework, stating “[W]e cannot detect or collect data on issues of noncompliance with any accuracy” [24,64].
3. **Important questions go unasked.** Most information in OPHD reports comes from physicians who wrote lethal prescriptions [60,65,66]. However, OPHD does not gather information from important parties other than prescribing physicians—for example, not asking why physicians refused to assist patients in suicide. Physicians who said “no” may have concluded that a patient did not meet legal requirements—essential

information if one truly intends to evaluate the law's outcomes. Nor does OPHD interview family members, friends, nurses, or social workers to learn about the physical and emotional status of those who died, and it does not collect any information from patients prior to their deaths [3,60]. Without these data, no one can know how many requests for assisted suicide are made, why some physicians declined while others agreed, and what transpired in individual cases [3].

4. **There is no investigation of abuse.** The state has no resources or even authority to investigate violations, cases of expansion, and complications reported in the media or documented by others.¹⁷ There is no method for the public to report abuse.

The Oregon Department of Human Services (DHS, of which OPHD is a part) acknowledged in a press release that DHS “has no authority to investigate individual Death with Dignity cases. . .” [67]. As Kenneth R. Stevens, Jr., M.D., added in a July 10, 2009, letter, DHS further lacks the time and desire to investigate. As the years go by, it makes public less and less information.

5. **Secrecy pervades the operation of assisted suicide.**

There is an unnecessarily high level of secrecy about assisted suicide that undermines the public's right to know, as well as any independent, in-depth research. Oregon's law states “the information collected [for the annual reports] shall not be a public record and may not be made available for inspection by the public” (Or. Rev. Stat. § 127.860 3.11.2). Moreover, as Hendin and Foley explained, the statute includes “no provision for an independent researcher or evaluator to study whatever data are available,” and the lack of available data violates medical standards that “require openness about facts, research data, and records to assess the appropriateness of treatment” [3].

The level of secrecy is even more draconian in Washington. An article by John Ruhl, president of the King County (Seattle) Bar Association in 2006, and

William Watts, M.D., president of the King County Medical Society in 2007, discussed the Washington law's extraordinary requirement that on the death certificate, a patient's underlying disease must be listed as the cause of death—even if he or she died from lethal drugs at a time when that disease manifested no symptoms [68].

6. **The underlying data are destroyed annually.** Alarming, officials have acknowledged that OPHD destroys each year's records after it issues the report [69].

Assisted suicide is practiced in secret and without genuine oversight. In this lax context, the examples that come to light in the media and through other means are likely to be only the tip of the iceberg. These problems, in aggregate, belie any allegation by assisted suicide's backers that it is safely regulated.

In a final blow to transparency, rather than correcting any of these fundamental limitations, OPHD responded to pressure from pro-assisted suicide advocates not to use the term “assisted suicide.” OPHD had used this term each year on its website and in its annual reports. But Compassion & Choices, based on polling data that public support for assisted suicide decreases if the word “suicide” appears, successfully pressured OPHD in 2006 to switch to more nebulous terms such as “persons who use the Oregon Death with Dignity Act” [70].

The questionable circumstances of Oregon deaths

Another troubling aspect of how assisted suicide is practiced in Oregon is that there is no monitoring or control once the prescription for lethal drugs is written. Physicians are not required to be present when the drugs are taken. In 2005, for example, physicians were present a mere 23% of the time [19]. No one knows what happens to lethal agents that are not used by patients who originally request them, though Oregon's reports make it clear that some patients died of other causes [71]. The drugs could be stored over time in private homes or workplaces, with no oversight to protect public safety.

As if to underscore this point, Dr. Katrina Hedberg, a lead author of most of Oregon's official reports, testified in 2004:

Our job is to make sure that all the steps happened up to the point the prescription was written. . . . We do not have a way to track if there was a big bottle [of lethal drugs] sitting in somebody's medicine cabinet and they died whether or not somebody else chose to use it [69].

Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health &

¹⁷ Although OPHD has no investigative authority, assisted suicide's defenders have occasionally responded to this critique by pointing out that the annual reports detail 20 referrals made to the Oregon Board of Medicine and 1 referral to the Board of Pharmacy. But no reports suggest that any disciplinary action was ever taken. Such referrals are made when physician-completed questionnaires or interviews involve minor paperwork irregularities such as “incorrectly completed report forms” or “an incomplete written consent.” Yet even these referrals do not constitute a meaningful investigation or a true safeguard, as they depend entirely on self-reporting, they address very minor irregularities, and there has not been disciplinary action. Oregon's second report acknowledges this problem, noting, “Under reporting and non-compliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division” [25].

Science University, said that patients who cannot swallow would “need to have an NG tube or G tube placement . . . [Then, they could] express the medication through a large bore syringe that would go into their G tube” [72]. Dr. David Jeffrey wrote, “The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have [assisted suicide]” [73]. Moreover, Oregon’s 2008 *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* states, “The Oregon [law] does not provide guidance on the degree of assistance with self-administration that may be given by another person” [61]. According to Sue Davidson of the Oregon Nurses Association, a 2002 survey found that nurses are very actively involved in the process and that “some indicated that they had assisted [patients] in the taking of [the lethal dose]” [45].

There is at least one documented example in Oregon in which assistance by others in the dying process has been acknowledged. Discussing a case in which a man said he helped his brother-in-law take the prescribed drugs, Dr. Katrina Hedberg said, “[W]e do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted” [69].

Supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually ingest the lethal agents, and do so quickly, before the drugs’ effects stall the process. Yet, again contrary to the impressions created by assisted suicide supporters, the lethal drugs are not at all simple to take quickly.

As Kenneth R. Stevens, Jr., M.D., explained in conversations on July 8 and August 6, 2009, assisted suicides in Oregon have generally used one of two agents, secobarbital or pentobarbital (Nembutal). Use of secobarbital, a powder, requires a person to take the contents of 90 to 100 large capsules. These capsules cannot feasibly be swallowed, because the individual would fall asleep before ingesting enough to achieve the intended purpose. So the capsules must be emptied into applesauce or pudding, which cannot disguise the very strong and exceptionally bitter, distasteful flavor. Taking a substance to numb the mouth is not necessarily a good way to make the drug more palatable, because it could interfere with swallowing. The other agent, pentobarbital, is only available as an injectable liquid. Four bottles, or approximately 7 ounces of liquid, must be taken to reach the needed dose of 10 grams, and this potion is also exceptionally distasteful.

In at least one known Oregon case, a feeding tube was used.¹⁸ Since the lethal agent can be administered to

a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once the injectable pentobarbital leaves the pharmacy, there is absolutely nothing to prevent it from being used through an intravenous line or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.

This slide away from self-administration is a cause of considerable concern to the disability community, which has known a long history of involuntary euthanasia at the hands of others, whether governments, medical establishments, or families [75-77]. With no controls on the drug after the prescription is filled, and with the possibility of administration through a nasogastric tube or gastrostomy feeding tube, or even through injection by third parties—⊕ how does this scheme protect vulnerable people from abuse, particularly at home?

The official data are ominous. H. Rex Greene, M.D., noted in a March 11, 2009, letter that the Oregon data consistently report 5-minute deaths—and only one victim has survived. He explained that nobody dies within 5 minutes—or even 20 minutes—following oral ingestion of a lethal dose of barbiturates. “About 15% of the Dutch overdoses survive and need to be euthanized,” Greene concluded. “If true, the Oregon numbers suggest they are asphyxiating the patients . . . in violation of the Oregon law.”¹⁹

So-called “narrow” proposals can easily expand

Most supporters claim that assisted suicide will be narrowly limited to people with terminal illness, but these so-called “narrow” proposals, if enacted, can easily expand. As the New York State Task Force on Life and the Law wrote, “Individuals who are not [able to make the choice for themselves], who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of assisted suicide, and no principled basis will exist to deny [it]” [78].

The example of the Netherlands demonstrates clearly that assisted suicide cannot be limited to a small, targeted group once Pandora’s box is open. Although it remained technically illegal until 2002, the Netherlands first began to legally tolerate assisted suicide in the early 1970s,

¹⁸ On March 11, 2007, a *Los Angeles Times* story described David Bradley, a man with esophageal cancer, who moved to Oregon from New Mexico, and underwent assisted suicide in summer 2005 [74]. The lethal substance was poured into his feeding tube.

¹⁹ Other physicians specializing in end-of-life care have also questioned the circumstances of Oregon deaths [19]. Doctors at Physicians for Compassionate Care wrote [62], “The range of time between ingestion and death ranged from 2 minutes to 25 hours. Both of those times are problematic. It is very unlikely that someone would die within 2 minutes of taking an overdose of sleeping medication. Likewise, the major effect of the short-acting sleeping medication would have worn off by 25 hours. So what was the cause of death in these circumstances?”

providing the longest experience with assisted suicide in any country [79–83].²⁰ Today, active euthanasia—physicians giving lethal injections—has almost completely replaced assisted suicide [84].²¹

Frighteningly, assisted suicide and euthanasia have become not the rare exception but the rule for people with terminal illness in the Netherlands. As Herbert Hendin, M.D., explained in congressional testimony, Dutch policies have gradually expanded from assisted suicide to euthanasia for the terminally ill; to euthanasia for the chronically ill; to euthanasia for “psychological distress”; and from voluntary euthanasia to involuntary euthanasia, which “has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves” [50].

Government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands: 50% of Dutch cases of assisted suicide and euthanasia are not reported, more than 50% of Dutch physicians feel free to suggest euthanasia to their patients, and 25% of these physicians admit to ending patients’ lives

without their consent (more than 1000 people each year) [85,86].²²

U.S. assisted suicide advocates, attempting to distinguish the Oregon experience from that of the Netherlands, argue that the numbers of reported users of assisted suicide in Oregon are low. But in fact, the number of people requesting lethal drugs has steadily increased (see Table 1). In the beginning, the numbers were low in the Netherlands as well, but use grew along with social acceptance of the practice, which could happen in the United States.²³

Some of assisted suicide’s supporters, like former Washington governor Booth Gardner, are open about their expansive goals. Gardner hopes his state’s assisted suicide legislation will pave the way for a broader cultural shift and “laws with more latitude” [89]. Thus, the danger of expansion is another reason why it is important to maintain the legal barriers prohibiting assisted suicide.

In light of expansion and other dangers, leading disability rights organizations and advocates in the United States and in many countries, as well as health care providers and many others, will continue to oppose the legalization of assisted suicide and euthanasia. Instead of legalization, we will call for adequate home and community-based long-term care, universal health coverage, and a range of social supports that provide true self-determination for everyone. As Paul Longmore wrote, “Given the absence of any real choice, death by assisted suicide becomes not an act of personal autonomy, but an act of desperation. It is fictional freedom; it is phony autonomy” [8].

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²⁰ Both euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973, although they were against the law until 2002. The Dutch situation between 1973 and 2002 was an outgrowth of a series of court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a Dutch physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother (*Nederlandse Jurisprudentie* 1973, No. 183, District Court of Leeuwarden, 21, February 21, 1973). Her admission that she had given her mother a lethal injection seemed calculated to force public and legal reconsideration of the laws against assisted suicide and euthanasia. While finding Dr. Postma guilty of the crime of mercy killing that was punishable by imprisonment for a maximum of 12 years, the court imposed a 1-week suspended sentence and 1 week’s probation. The Dutch court relied heavily on expert testimony by the district’s medical inspector who set forth certain conditions “under which the average physician thought euthanasia should be considered acceptable.” Inclusion of those conditions formed the basis for subsequent acceptance of euthanasia and assisted suicide in the Netherlands. The guidelines required that the patient must be considered incurable and experiencing subjectively unbearable suffering; the request for termination of life should be in writing; and there should be adequate consultation with other physicians before death could be induced [80]. Other cases followed, each widening the boundaries and further liberalizing the conditions under which euthanasia and assisted suicide, although remaining illegal, would not be punished. Among the cases was the *Alkmaar* case (*Nederlandse Jurisprudentie* 1985, No. 106) in which a woman died after requesting death because “her advancing age and physical condition caused her to be dependent on others, thus leading to psychological suffering.” The case gave rise to the 1986 decision by the Hague Court of Appeals that recognized “psychic suffering” and “potential disfigurement of personality” as grounds for induced death. The courts have also exonerated physicians who assisted in the suicides of a young woman with anorexia nervosa (Amelo, *Tijdschrift voor Gezondheidsrecht*, 1992, No. 19) and a woman who was depressed over the death of her two children and the failure of her marriage (Assen, *Nederlandse Jurisprudentie* 1994, No. 656).

²¹ “Doctors had reported that a total of 2,146 people were euthanised and 152 died in assisted suicides in 2008, while in 33 cases there was a combination of the two practices” [84].

²² Hendin wrote, “The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they ‘terminated the lives of patients without an explicit request’ from the patient. Another third of the physicians could conceive of doing so.”

²³ Once assisted suicide is legal, problems with the ingestion of lethal drugs may create pressure for the legalization of euthanasia. Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick, simple death. The body expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15% to 25% [87,88]. The way to prevent these “problems,” in the view of euthanasia advocates, is by legalizing lethal injections. They could also increase underground euthanasia in the guise of assisted suicide.

Table 1

Eleven-year Breakdown of Reported Requests for Lethal Prescriptions and Reported Assisted Suicide Deaths from Oregon's Annual Reports

Year	Reported Lethal Prescription Recipients	Reported Deaths after Lethal Medication Administration*	Reported Deaths from Underlying Terminal Illness	Reported Alive at Year's End
1 (1998)	24	16	6	2
2 (1999)	33	27	5	2
3 (2000)	39	27	8	5
4 (2001)	44	21	14	11
5 (2002)	58	38	16	6
6 (2003)	67	42	18	10
7 (2004)	60	37	13	12
8 (2005)	64	38	15	17
9 (2006)	65	46	19	11
10 (2007)	85	49	26	13
11 (2008)	88	60	22	12

Total reported lethal prescription recipients: 627.

Total reported deaths after lethal medication administration: 401.

Total reported deaths from terminal illness within 1 year of receiving prescription: 162.

Total reported alive within year of receiving prescription: 101.

* Annual reports note that death total includes patients who received prescriptions in previous years.

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Montana State Legislature

**2013 SESSION
ADDITIONAL DOCUMENT**

This is an

ADDITIONAL DOCUMENT

which was submitted
after the committee hearing
was ended and/or was
submitted late, but regarding
information in the committee
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CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

C.
PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et
PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.
2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.
3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been twelve years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

13. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at *Sherwood*
Oregon, USA
on *September 18,* 2012

NAME: *Jessica Borgo*

A notary in and for the
State of Oregon

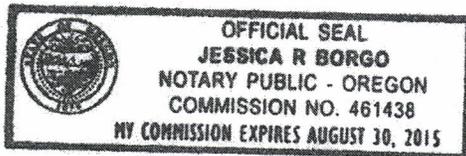
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STATEMENTS OF INTENT FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

- A) without regard to a patient's expected length of life:
 - Inpatient palliative care consultation; and,
 - Outpatient palliative care consultation, office visits.
- B) with an expected median survival of less than one year, as supported by the best available published evidence:
 - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
- C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
 - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

- A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
- B) Surgical decompression for malignant bowel obstruction.
- C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
- D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
- E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

- b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
- 2) Radiological evidence of lack of stricture
- 3) Only covered once during any episode of illness
- 4) FDA approved devices must be used
- 5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision..

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79, 102, 103, 105, 123-125, 131, 144, 159, 165, 166, 168, 170, 181, 197, 198, 206-208, 218, 220, 221, 228, 229, 231, 243, 249, 252, 275-278, 280, 287, 292, 310-312, 314, 320, 339-341, 356, 459, 622

- A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
- B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
- C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
- D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
- E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
- F) CSF (other than pegfilgrastim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
- G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
- H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
- I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Lines 102, 103, 123-125, 144, 159, 165, 166, 170, 181, 197, 198, 207, 208, 218, 220, 221, 228, 229, 231, 243, 249, 252, 275-278, 280, 287, 292, 310-312, 320, 339-341, 356, 459, 586, 622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict \$/QALY (quality adjusted life-year) or \$/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend \$100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

GUIDELINE NOTES FOR THE APRIL 1, 2012 PRIORITIZED LIST OF HEALTH SERVICES

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,166,170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

- A) as a bridge to cardiac transplant;
- B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
- C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

Shipman's career of killing

Britain's worst serial killer Harold Shipman was jailed four years ago for killing 15 of his women patients.

But a public inquiry later decided the 57-year-old had killed at least 215 patients over 23 years.

His death, hanging from bedsheets in his prison cell, means the true extent of his crimes while a trusted family GP in Greater Manchester and West Yorkshire may never be known.

And the families of the victims will never have the satisfaction of an explanation from the mass murderer.

During his three-month trial Shipman never admitted responsibility for his crimes, nor hinted at a motive nor expressed remorse.

'Unparalleled betrayal of trust'

High Court judge Dame Janet Smith, who led the public inquiry into the case, said the doctor's betrayal of trust had been "unparalleled in history".

At her inquiry two years ago she said: "It is possible that he was addicted to killing."

" We kept thinking it looked as though Dr Shipman had done something but it couldn't be and we couldn't believe it "

Angela Woodruff

of his victims, 81-year-old Kathleen Grundy.

Her daughter Angela Woodruff became suspicious after her mother's death and alerted police.

She later told the inquiry: "We kept thinking it looked as though Dr Shipman had done something but it couldn't be and we couldn't believe it."

Soon it became apparent that the doctor entrusted to care for his patients was in fact murdering them, mostly by injecting them with fatal doses of diamorphine.

Mrs Grundy was the last known victim in a long line of patients killed by their GP.

Vulnerable victims

Shipman preyed on vulnerable people, usually choosing women living alone as his victims, who may have been elderly but were not seriously ill.

The killer jab was often administered on home visits.

His oldest victim was a 93-year-old woman and the youngest a 41-year-old man.

Shipman was given 15 life sentences four years ago this month for murdering 15 patients by administering fatal doses of diamorphine and found guilty of forging Mrs Grundy's will.

But the public inquiry heard a fuller account of the number of victims who died at his hands.

Of the 215 victims 171 were women and 44 were men.

Five of these people lived on the same street. Nine lived in the same sheltered housing complex.

Drug addiction

Shipman's first victim was Eva Lyons, killed the day before her 71st birthday in March 1975.

He had been working at the Abraham Ormerod Medical Practice in Todmorden at the time.

Another 71 patients were killed during when Shipman moved to the Donneybrook House group practice in Hyde.

The remaining 143 were murdered after 1992 when Shipman became a solo GP, working in Hyde, Greater Manchester.

Shipman had previously been sacked from a job at another practice after being fined for making out drug prescriptions to feed his addiction to the morphine-like drug pethidine.

The General Medical Council disciplined him, but failed to strike him off.

Dame Janet added: "The way in which Shipman could kill, face the relatives and walk away unsuspected would have been dismissed as fanciful if it had been described in a work of fiction."

Story from BBC NEWS:
http://news.bbc.co.uk/go/pr/fr/-/2/hi/uk_news/3391895.stm

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