

*Physicians for Compassionate Care  
Education Foundation*

**ASSISTED DYING FOR THE TERMINALLY ILL BILL  
BRITISH HOUSE OF LORDS**

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TO

THE SELECT COMMITTEE ON THE ASSISTED DYING FOR THE TERMINALLY ILL BILL

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Portland, Oregon, USA

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SUMMARY STATEMENT

I have practiced as a radiation oncologist at the Oregon Health & Science University since 1972. I have been Chair of the Department of Radiation Oncology at Oregon's only medical school for 15 years. [I speak for myself, and I do not speak as a representative of that institution.]

My entire medical professional life has been in the evaluation and care of patients with cancer, with an academic perspective. I have had a wonderful career because of my very special patients for whom I have really cared.

Since the passage of Oregon's physician-assisted suicide law in 1994, I have studied it from a scholarly perspective. The more I have learned, the more I realize the significant harm and danger of legalized physician-assisted suicide.

The key points I wish to express are the following, and they are further detailed in the body of this written testimony by me:

- The physician's proper role is not compatible with assisted suicide or euthanasia.
- My personal experience.
- Physician-assisted suicide is really doctor-directed suicide.
- Participating in assisted suicide is strange, and emotionally difficult and harmful for physicians.
- People with disabilities fear legalization of assisted suicide and euthanasia.
- Oregon's assisted suicide law is rarely used and is not needed.
- Uncontrolled physical symptoms rarely influence a desire for assisted suicide.
- There is a direct relationship between depression and favoring assisted suicide.
- The assisted suicide and euthanasia movement exploits autonomy and self-determination as their main arguments.
- Laws that are established by and for controlling people will discriminate against the vulnerable in society.
- Blacks are substantially less likely than whites to favor or participate in physician-assisted suicide or euthanasia.
- The fallacy of "safeguards" is that autonomy and safeguards are not compatible.
- There is secrecy regarding what is happening in Oregon, and there is lack of proper oversight of Oregon's assisted suicide by the Oregon Department of Human Services.
- What I have learned from my correspondence with the Oregon Department of Human Services.
- Oregon doctors are using the injectable form of pentobarbital for assisted suicide.
- Oregon's assisted suicide law has not necessarily improved end of life care in Oregon.
- There are considerable financial and societal dangers from legalized assisted suicide and euthanasia.
- Oregon has a financial crisis, and medical access for the poor is limited and poorly funded.
- The Oregon Medical Association considers Oregon's assisted suicide law to be seriously flawed.
- Oregon's assisted suicide rate is not lower than that of other states.

## THE PHYSICIAN'S PROPER ROLE IS NOT COMPATIBLE WITH ASSISTED SUICIDE OR EUTHANASIA

Physician-assisted suicide represents a reversal of the proper role of physician as "healer, comforter, consoler" to an improper role of helping patients commit suicide. The focus of medical care should be on proper end-of-life care, not on a doctor writing a "prescription" to cause a patient to die.

"Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult to control, and would pose serious societal risks."<sup>(11)</sup> To have compassion means to "suffer with" another person. Physicians should use all of their knowledge, skills and compassion in caring and supporting the patient. There is much experience and literature to assist physicians in caring for patients with terminal illness.<sup>(12)</sup> Medicine's most consistent ethical traditions are healing and comfort. Medicine and physicians are not to intentionally bring about death. Assisted suicide compromises the patient-physician relationship and trust. Trust is the most important asset of physicians. Assisted suicide and euthanasia undermine the integrity of the medical profession.

Physicians have the duty to safeguard human life, especially that of the most vulnerable: the sick, elderly, disabled, poor, ethnic minorities (those that some in society may consider the most unproductive and burdensome). Members of Physicians for Compassionate Care follow an ethic based on the principle that all human life is inherently valuable, and that the physician's roles are to heal illness, alleviate suffering, and provide comfort for the sick and dying; without sanctioning or assisting their suicide.

Those promoting assisted suicide and euthanasia give the false message that doctors can do a better job of killing patients than they can of caring for their medical needs. Unfortunately, society may reap the results of that false belief.

A patient goes to a doctor because the doctor has knowledge and skills that the patient does not have. A patient goes to a doctor knowing that the covenantal patient-doctor relationship prevents the doctor from intending to harm the patient. The doctor enters into that covenantal relationship with the intent that the doctor will not harm the patient. When a doctor participates in physician-assisted suicide or euthanasia, the doctor has broken that covenant.

Michael Freeland who had lung cancer and had obtained lethal medication for assisted suicide, was cared for by both the traditional clinical approach and by an assisted-suicide competency approach. It is evident from his story that he was much better cared for by the traditional clinical care than he was by the assisted suicide competency approach. The traditional clinical approach assumes that suicidal seriously ill individuals are no different from any other suicidal patient, and the wish for death is considered symptomatic of underlying psychiatric illness to be evaluated and

treated. This treatment usually should be provided voluntarily, but when the danger is great, it can be provided involuntarily. The patient's life is always considered worth protecting and talk of suicide is considered a plea for help. The assisted-suicide competency approach agrees with the above underlying assumptions for all patients who are judged to have more than six months to live. Once patients are judged to have less than six months to live, however, they are treated differently. At this point, according to the assisted-suicide competency model, not only does the clinician no longer have an obligation to treat the suicidal symptom as a cry for help and to protect the patient, the doctor actually has the right to help the patient in killing themselves. (13)

I went into medicine 40 years ago with great anticipation, and I have had a wonderful career. I have tried to be a good, knowledgeable and caring physician. I have had wonderful experiences with my patients; they really have blessed me with sweet and great memories. I have learned the truth of the statement by Dr. Francis Peabody 70 years ago, "One of the essential qualities of the clinician is interest in humanity, for the secret of care of the patient is caring for the patient." And I really do care for my patients. My career has been in academic medicine and I see patients daily; totaling about 10,000 patients during my career. The "hard" cases are referred to me, and I have not shrunk from seeing them and caring for them; going to their homes and convalescent centers, as well as seeing them in the clinic and hospital.

My purpose as a cancer doctor is to save lives, and when that is not possible, to provide good supportive care for their pain and palliative needs. My career has been evaluation and care of patients with cancer, specializing in radiation oncology (use of radiation to treat cancers) as a medical scholar.

After physician-assisted suicide became legal in Oregon, I sought to become a scholar of that subject. As I have studied about assisted suicide and euthanasia, I have concluded that they are cancers in the body of medicine and the body of society. They are foreign to our integrity. I and other doctors have become "activated" as an immunologic response to these dangers.

## MY PERSONAL EXPERIENCE

In addition of my many years of providing medical care to cancer patients, I also have personal experience regarding this matter.

We had been married for 18 years and had six children. For three years, my wife had been suffering from advancing malignant lymphoma. It had spread from her lymph nodes to her brain, to her spinal cord and to her bones. She had received extensive chemotherapy and radiation

treatments. She required considerable pain medication, antidepressants, and other supportive measures. In late May 1982, we met again with her physician, to review what more could be done. It was obvious that there was really no further treatment which would halt the progressive nature of her cancer. She was emaciated and very weak.

As we were about to leave the office, her physician said, "Well, I could write a prescription for an 'extra large' amount of pain medication for you." He did not say it was for her to hasten her death, but she and I both felt his intended message. We knew that was the intent of his words. We declined the prescription, since her current pain medication was satisfactory. As I helped her into our car, she said, "He wants me to kill myself!" She and I were devastated. How could her physician, her trusted physician, subtly suggest to her that she take her own life. We had felt much discouragement during the prior three years, but not the deep despair that we felt at that time when her physician subtly suggested that her suicide should be considered. His message to her was, "Your life is not longer of value, you are better off dead." Six days later she died peacefully, naturally, with dignity and at ease in her bed, without the suggested medication.

That experience made me realize the great importance of trust between the patient and the physician and why we are to do no harm.

## PHYSICIAN-ASSISTED SUICIDE IS REALLY DOCTOR-DIRECTED SUICIDE

Consider the phrase "physician-assisted suicide". What does the physician do in "physician-assisted suicide"? The physician writes a prescription for lethal drugs. What is a prescription? Medically and legally a prescription is a directive or order from the doctor for a patient. For instance, in a hospital the doctor's prescription is called the doctor's orders. Therefore, "physician-assisted suicide" is a euphemism for "physician-directed suicide". That is really what it is.

Pieter Admiraal, M.D., the leader of Holland's euthanasia movement was quoted in American Medical News in 1997: "You will never get accustomed to killing somebody." Dr. Admiraal said he knows polls indicate American physicians are more apt to support the idea of giving a lethal prescription over giving a lethal injection because they would feel less directly responsible for the death. But he dismisses the distinction as "so silly" and 'so American-style'. He likens the writing of a prescription to 'giving a patient a loaded gun and just asking them not to shoot before you leave the house.' 'Both methods,' he said, 'are legally and morally the same.' " ([14](#))

How can we as physicians who care for patients, order and direct the death of patients? Patients come to us for proper medical advice and they usually follow that advice. We care for our patients

because we value them. When a doctor writes a prescription for lethal drugs for a patient, we are telling that patient, "I don't value you, you are better off dead, I want you dead, your life is not worth living, I order you to die, and I direct you to die". This message that is being communicated by the doctor to the patient needs to be acknowledged by the doctor, by the patient and by society.

It is too dangerous to give to the medical profession the power to kill patients. It destroys the inherent trust that exists between the patient and the physician. Physician-assisted suicide devalues the inherent value of human life. It desensitizes us towards any type of suicide.

Dr. Leon Cass has written the following, "Even the most humane and conscientious physicians psychologically need protection against themselves and their weakness and arrogance, if they are to care fully for those who entrust themselves to them. A physician-friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: 'Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.' My friend's horror at the thought that he might be tempted to kill his patients, were he not enjoined from doing so, embodies a deep understanding of the medical ethic and its intrinsic limits." [\[5\]](#)

## PARTICIPATING IN ASSISTED SUICIDE IS STRANGE, AND EMOTIONALLY DIFFICULT AND HARMFUL FOR PHYSICIANS

In 1998, the first year of Oregon's Death with Dignity Act, fourteen physicians wrote prescriptions for lethal medications for the 15 patients who chose physician-

assisted suicide. The official report observed that: "For some of these physicians, the process of participating in physician-assisted suicide exacted a large emotional toll, as reflected by such comments as, 'It was an excruciating thing to do.it made me rethink life's priorities', 'This was really hard on me, especially being there when he took the pills', and 'This had a tremendous emotional impact.' Physicians also reported that their participation led to feelings of isolation. Several physicians expressed frustration that they were unable to share their experiences with others because they feared ostracism by patients and colleagues if they were known to have participated in physician-assisted suicide." [\[6\]](#)

Dr. Peter Reagan's description of his experience with "Helen" was the first widely publicized account of assisted suicide in Oregon. This account reveals his emotional and psychological concerns. As Helen was dying from his prescribed lethal medication "The three of us (Dr. Reagan and Helen's son and daughter) sat around her bed talking quietly about the emotional struggle we'd

each been through." Regarding his thoughts and emotions leading up to writing the lethal prescription, Dr. Reagan wrote, "I had to accept that this really was going to happen. Of course I could choose not to participate. The thought of Helen dying so soon was almost too much to bear, and only slightly less difficult was the knowledge that many very reasonable people would consider aiding in her death a crime. 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." This is an example of a doctor feeling intimidated and coerced by the family and patient to participate in assisted suicide. In writing about Helen's expressed appreciation for his role in the assisted suicide, Dr. Reagan wrote, "I thanked her and then turned away with my tangle of emotions". "That afternoon, I was sitting at my kitchen table with my file folder of her materials. Then I wrote the prescription for the 90 secobarbital. I hesitated at the signature and stared out the window. I tried to imagine deciding to die. I couldn't succeed in putting myself in Helen's place. Whenever I tried, I experienced a sadness much more profound than what I saw in her." "I slept badly. I dragged myself out of bed and onto my bicycle to take the prescriptions to her house." (17)

The extent of Dr Reagan's personal concerns is exemplified by his editorial inclusion of the following: "Experience in the Netherlands suggests that doctors are profoundly affected by an act of physician-assisted suicide. Gerrit Kimsma, a Dutch family physician and medical ethicist, writes with colleagues that some professionals become dysfunctional and may require a lot of time to recover." (18)

Further insight into Dr. Reagan's experience is found within an earlier newspaper interview in 1998 (the first year of legalized assisted suicide in Oregon) of a then anonymous doctor whose story, and description of patient and doctor, later matched that of "Helen" and Dr. Peter Reagan:

"Q: What did you learn from the experience?

A: I think the most important thing is for doctors to understand how huge of an experience it's going to be for them and that they must have ways of dealing with it for themselves.

Q: How did you feel the day that your patient planned to use the medication?

A: I would look out the window that day and try to imagine what it would feel like to take leave of the Earth that day - and it was a pretty nice day - and the sadness that that thought induced in me and I couldn't find it in my patient. And that was a profound experience

Q: Should the physician be there until the person dies?

A: In the time since, I have become more and more aware of how important it is that the doctor be there. And the reason for you to be there is not because the family needs you, but so you can take responsibility for what you did.

Q: What about the death was a struggle for you?

A: A big piece is grief. A big piece is a funny sort of ambivalence where a person says, 'Really nice to have met you. Really nice to have gotten to know you a little better. Where's the medicine?' I have a feeling of responsibility that I can't say I'm entirely proud of. I did what I felt was right, given bad choices. But frankly, maybe I'm kidding myself a little bit, but it's better to not feel good about this..I have to admit, I am blown away by how different this felt than a natural death. And I am still not clear on what to make of that. Just the suddenness of it. It's shocking to have somebody go from telling a family story to being dead. It's a strange, strange, strange transition.

Q: Would you do this again?

A: Well, on the one hand, I would say I hope I don't have to, but on the other hand, I would say I have certainly seen an example where it was the right thing to do for me and for the patient, and if I found myself in the same situation again, I would probably do it. Before the law went into effect, I had one specific request in my life from a person who would have qualified, and he died absolutely white-hot furious because I refused. He died in fury over a period of weeks. And when he was admitted to a nursing home and I went to see him frequently, because I felt I owed it to him, there was nothing but fury that he had for me. I wouldn't do that again." ([\[9\]](#))

In a newspaper interview in 2001, the same reporter wrote, "Perhaps the most intense soul-searching over the law has been done by some doctors who have participated in it. Dr. Peter Reagan, the primary physician in the first publicly described case in 1998, said the experience changed his feelings about assisted suicide. If he were dying, 'I made a commitment that I wouldn't ask my own doctor' to help in this way, Reagan said, 'because it's a lot to ask.'"

"Reagan, a family practice doctor, said his patient's steadfast desire to cut short her days with terminal cancer despite his efforts to address her needs was disquieting. And having success defined as her ability to take her own life was strange, he said." ([\[10\]](#))

Dr. Reagan described his troubled feelings in the reversal of his role as a healer, to his role in assisting Helen in her suicide. There is a sense of isolation. In Dr. Reagan's first comments to the public and press, he was concealed by anonymity. It was difficult for him to find others with whom to discuss his troubled experience of assisted suicide.

The hesitancy and reluctance of doctors to participate in assisted suicide in Oregon is exemplified by an e-mail sent out Aug. 6, 2002 by Kaiser Permanente NW's regional ethics service. It asked for doctors who were willing to act as attending physicians if a person requesting assisted suicide to notify Kaiser Administrator Robert Richardson, MD. According to the e-mail, the HMO needed the information because a patient had asked about assisted suicide and no physician could be found to

process the request. ([\[11\]](#)) This HMO organization was promoting assisted suicide more than its doctors were.

## PEOPLE WITH DISABILITIES FEAR LEGALIZATION OF ASSISTED SUICIDE AND EUTHANASIA

Disability Rights advocates are appalled at the negative assisted suicide message regarding seriously ill people with disabilities. The proponents of assisted suicide and euthanasia demean and demonize those with disabilities; by playing on the "horror of dependency" and by suggesting that there are conditions worse than death. Those with disabilities fear they may be the next targets of assisted suicide and euthanasia. They have formed national organizations such as "Not Dead Yet", a national disability rights group that opposes the legalization of assisted suicide and euthanasia. They know that life with a disability can be a fulfilling and enjoyable life. In the critical period following a neurological injury, many people who now enjoy their lives have reported that they could easily have been swayed to choose "death". They view the legalization of assisted suicide and euthanasia as a threat to their human rights. ([\[12\]](#))

## OREGON'S ASSISTED SUICIDE LAW IS RARELY USED AND IS NOT NEEDED

Six years of experience with legalized assisted suicide in Oregon has shown that approximately only one in a thousand of all deaths are from assisted suicide. It is rarely used and is not needed. Greater emphasis and resources should be directed to pain and palliative care, and not using those resources for assisted suicide.

## UNCONTROLLED PHYSICAL SYMPTOMS RARELY INFLUENCE A DESIRE FOR ASSISTED SUICIDE

Those favoring physician-assisted suicide perpetuate falsehoods and myths in the media regarding the care of patients with terminal illness in order to bias the public in favor of physician-assisted suicide. Physician-assisted suicide is promoted based on fear of uncontrolled pain in the terminally ill. A patient with cancer is presented as the "poster-child" patient requiring physician-assisted suicide because their pain could not be controlled. However, we have learned that this is not true. Uncontrolled physical symptoms such as pain rarely influence a desire for assisted suicide. The experience with patients dying from assisted suicide in Oregon has shown only a small

minority have chosen it because of concern about inadequate pain control, and this was not necessarily because they were experiencing pain.([13])

There is actually a significant inverse relationship between cancer patients' experience with pain and their desire for, or favoring of, physician-assisted suicide or euthanasia. Researchers at the Dana-Farber Cancer Institute published in 1996, their results and analysis of interviewing 155 cancer patients, 355 cancer physicians, and 193 members of the public regarding their attitudes and experiences in relations to euthanasia and physician-assisted suicide. Cancer patients in pain were more likely to find euthanasia and physician-assisted suicide unacceptable. Patients with pain were more likely to trust a doctor less if euthanasia or physician-assisted suicide were mentioned as part of a discussion of care at the end of life. Patients with pain do not view euthanasia or physician-assisted suicide as the appropriate response to poor pain management. Cancer patients in pain may be suspicious that if euthanasia or physician-assisted suicide are legalized, the medical care system may not focus sufficient resources on provision of pain relief and palliative care. There is a conflict: the general public is more in favor of euthanasia and physician-assisted suicide than are those who have painful cancer.([14])

Patients in pain want the pain killed, not the patient.

#### THERE IS A DIRECT RELATIONSHIP BETWEEN DEPRESSION AND ASSISTED SUICIDE

In contrast to the inverse relationship between patients' experience with pain and their feeling that physician-assisted suicide or euthanasia is acceptable, these Dana-Farber researchers found a direct relationship between patients with depression and their having favorable feelings about euthanasia and physician-assisted suicide.

#### THE ASSISTED SUICIDE AND EUTHANASIA MOVEMENT EXPLOITS AUTONOMY AND SELF-DETERMINATION AS THEIR MAIN ARGUMENTS

Physicians in Oregon who have participated in physician-assisted suicide have described their patients as: independent, self-directed, lack of reliance on others, dreaded dependence, determined, in-charge, strong-willed, stubborn, prideful, very opinionated, eccentric, crusty, solitary odd ducks, outspoken, forthright, adamant, uncompromising, very demanding.([15]) These patients have been described as being extreme in their desire for continuing their coping mechanism of control in their dying as they have in control of their life. The doctor who assisted in the suicide of a woman, was quoted as saying that talking to her was "like talking to a locomotive", it was like "talking to Superman when he's going after a train. ([16])

Consider the situation of a fiercely independent, controlling person who finally faces Death. What is that person to do? What do they do with death when they have always had control of their life? With physician-assisted suicide, they now try to control death. How do they try to do this? They do it by attempting to control the doctor. By getting the doctor to give up his medical ethics, and write a prescription for lethal drugs to cause their death.

Those who say, "my life is not worth living", are probably unaware of how that phrase echos the "lebensunwerten Lebens" (life unworthy of Life) that was promoted by a jurist and a psychiatrist in Germany eighty years ago. Their work "The Permission to Destroy Life Unworthy of Life" (Die Freigabe der Vernichtung lebensunwerten Lebens) argued that "unworthy life" not only included the incurably ill, but also large segments of the mentally ill, feebleminded, and retarded and deformed children. They professionalized and medicalized the entire concept, and they stressed the therapeutic goal of that concept: destroying life unworthy of life is "purely a healing treatment" and a "healing work". ([17]) This escalated into the Genocide of the 1930s and 1940s in Nazi Europe. Doctors prescribing lethal medications for assisted suicide in Oregon have publicly referred to assisted suicide as "healing".

#### LAWS THAT ARE ESTABLISHED BY AND FOR CONTROLLING PEOPLE WILL DISCRIMINATE AGAINST THE VULNERABLE IN SOCIETY

So why should society fear a law that appears to be used primarily by controlling people? Society should always fear laws that are established by and for controlling people. History has taught us that once such laws are established, then the poor and vulnerable are discriminated against.

The New York Task Force on Life and the Law stated: "No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of service in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care." ([18])

#### BLACKS ARE SUBSTANTIALLY LESS LIKELY THAN WHITES TO FAVOR OR PARTICIPATE IN ASSISTED SUICIDE OR EUTHANASIA

A survey in Michigan in 1994 showed that blacks were less likely to favor physician-assisted suicide or euthanasia than whites. Blacks, in greater proportion than whites, want to maximize the length of their lives. Any "premature" termination of life is resisted by blacks far more than by whites. ([19])

A survey of family members of recently deceased Oregonians (deaths from June 2000 to March 2002) was conducted to determine the prevalence of physician-assisted suicide support, consideration or requests by those deceased. This survey excluded those dying of legal physician-assisted suicide. Fifteen percent of black decedents and 35% of white decedents were in favor of assisted suicide. Eighteen percent of whites personally considered assisted suicide, whereas none of the 62 black decedents considered it. ([20])

There have been no black deaths among the 171 legal assisted suicide deaths during the first six years in Oregon; 97% of assisted suicide deaths were white and 3% were Asian. (13) According to 2003 Census estimates, 87% of Oregonians are white, 3% are Asian, 1.6% are black. ([21])

#### THE FALLACY OF SAFEGUARDS:

#### AUTONOMY AND BOUNDARIES ARE NOT COMPATIBLE

The proponents of physician-assisted suicide laws speak of the "safeguards" in the Oregon law that supposedly limit access to physician-assisted suicide. These "safeguards" are considered to be necessary because assisted suicide is dangerous and unsafe for the public. However these so-called "safeguards" are really boundaries, restrictions or "fences" around legalized physician-assisted suicide. They can be considered as a means of protection against "misuse", but also as a barrier for access for those outside these boundaries. These "safeguards/boundaries" in Oregon's assisted suicide law include: limited to those with a terminal illness (<6 months to live), mentally capable, age  $\geq 18$  years, lethal drugs taken by mouth (eliminates lethal injection), and self-administration, euthanasia (lethal injection) is not permitted.

When the "controlling" people who want assisted suicide face the "safeguards" of legalized physician-assisted suicide, many of them find they do not qualify for assisted suicide. So what do they do? They attempt to get around or "stretch" the safeguards so they will qualify. However these so-called boundaries will become elastic, they are elastic already. These "safeguards" have already stretched, and will continue to stretch like a rubber band, to match public opinion.

Reported cases of the stretching of physician-assisted suicide "safeguards" include:

A woman (Kate Cheney) who was originally told she did not qualify because psychiatric evaluation found she was not mentally competent, however at the insistence of her daughter, her HMO had her get an other opinion which led to her having physician-assisted suicide.([22])

It is unfortunate and remarkable that only 5% of the patients dying of assisted suicide in 2003 received psychological evaluation. (13)

A man (Patrick Matheny) with ALS had been unsuccessful in a prior attempt to swallow the lethal drugs he had received. His brother-in-law said that the following day, Mr. Matheny used a straw to suck down some of the mixture from a glass but then began having trouble swallowing. "It doesn't go smoothly for everyone" the brother-in-law said. "For Pat it was a huge problem. It would have not worked without help." His brother-in-law did not elaborate how he helped Mr. Matheny to die. How the brother-in-law helped was never investigated; the body was cremated within a day. ([23]) The deputy Oregon state attorney general, suggested that the Oregon physician-assisted suicide law may discriminate against those who are paralyzed or on life support and they can't swallow. ([24])

The public has the mistaken opinion that all Oregon patients have died after independently taking several pills. A 1999 article in the Washington Post described how Dr. Rasmussen, a cancer doctor in Oregon, opened 90 capsules - a lethal dose - of barbiturates and poured the white powder into a bowl of chocolate pudding. ([25]) He gave the mixture to the son of a woman with ALS, who spooned the mixture into his mother's mouth. Another son gave her sips of water to wash the solution down. The woman died 12 hours later. She did not mix the contents of the 90 capsules into the pudding or raise the spoon to her mouth; all she did was swallow. Is that self-administration? Consider how easy it would be for an unsuspecting incapacitated patient to be given lethal drugs in a similar manner, without the patient being aware of what was happening.

Although he did not die from lethal medication, an Oregon man with ALS had considered that "If I get to the point where I can't swallow, I can still take the medication and put it in my feeding tube."([26]) Yet the law says it is to be ingested orally.

Although illegal, in 1996, an Oregon doctor killed a patient with lethal injection.([27]) This case was never criminally prosecuted by the county district attorney because of the atmosphere in Oregon, in which he did not feel a conviction could be obtained. Some Oregon state legislators supported that doctor. The Oregon State Board of Medical Examiners temporarily suspended his medical license for two months. ([28]) Thus, although physician-ordered euthanasia remains illegal in Oregon, for practical purposes it is dealt with lightly.

The Oregon law states that "coercion and undue influence on a patient to request lethal drugs" is a Class A felony. What is undue influence? This certainly opens the legal door for other to influence a patient to choose physician-assisted suicide. A psychologist evaluating Kate Cheney (who later died of assisted suicide) recorded: that Kate's "choices may be influenced by her family's wishes and her daughter may be somewhat coercive."(22)

Eligibility for Oregon's assisted suicide requires being terminally ill; defined in the Oregon law as having an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within 6 months. There is always uncertainty in prognosticating the length of remaining life. Physicians have difficulty in diagnosing terminal illness, and estimating how long a person has to live. A review of characteristics and survival of 6451 Medicare hospice patients reported that 15% survived beyond 6 months. ([29])

Non-terminally ill Oregonians are receiving prescriptions for lethal drugs. Analysis of the Oregon Health Division's fifth and sixth year annual reports reveals that one of two patients who had received a prescription for lethal drugs in 2001 had died in 2003, and the other patient was still alive at the end of 2003, more than two years later.(13,[30])

Some Oregon doctors are writing lethal prescriptions for patients with diseases that they do not usually care for. For instance Dr. Peter Rasmussen, a cancer doctor, has publicly described his experience in writing lethal prescriptions for at least two patients with ALS. Why is a cancer doctor caring for patients with a non-cancerous neurological condition?

Doctor-shopping for assisted suicide is evident in the Kate Cheney case. (22) That there are doctors specializing in assisted suicide and writing prescriptions for multiple patients, is evident from the unofficial information obtained and reported by Don Colburn of the Oregonian in March 2004. In 2003, twenty seven doctors wrote one prescription, eight doctors wrote two prescriptions, six wrote three prescriptions and one doctor wrote six prescriptions. ([31])

An example of the desire to reduce the restrictions from Oregon's assisted suicide "safeguards" was expressed by Marcia Angell, a former executive editor of The New England Journal of Medicine and a supporter of doctor-assisted suicide, in the June 1, 2004, New York Times when she said: "I am concerned so few people [in Oregon] are requesting it [physician-assisted suicide]. It seems to me that more would do it. The purpose of a law is to be used, not to sit there on the books." ([32])

A very troubling account of an assisted suicide case in Oregon has been promoted in a Compassion in Dying publication. Jake Harris had melanoma in his brain and is described as having "motor skills that were dissolving", "cognitive abilities were showing signs of slippage" with "parts of his brain blinking off". With him in this condition, a friend made arrangements for them to meet with his doctor whom they "were counting on to prescribe". The friend describes taking him to the clinic and "the doctor came in and tried to explain how writing the prescription could be a risk to his practice. The doctor said he was sorry." "The examination room had no windows. It was a small space for three people to breathe in and out. A small room for such a huge amount of disappointment and sadness, such a weight of silence. Finally, the doctor said, "Okay, I'll do it." He had tears in eyes as he began the paperwork." This case illustrates a patient who is questionably competent, a friend who is making the arrangements with the doctor, a doctor who has indicated his unwillingness to write the prescription, but who in an intimidating atmosphere does write the prescription with tears in his eyes as an indication of his emotions. This doctor was intimidated and coerced by the friend to do what he did not want to do. It is a damning example of the type of coercion used by an organization that supposedly promotes "choice". ([33])

#### THERE IS SECRECY REGARDING WHAT IS HAPPENING IN OREGON AND THERE IS LACK OF PROPER OVERSIGHT OF OREGON'S ASSISTED SUICIDE BY THE OREGON DEPARTMENT OF HUMAN SERVICES

A wall of secrecy cloaked in anonymity really does surround what is happening with physician-assisted suicide in Oregon. Several Oregon physicians have publically acknowledged their participation in assisted suicide, but the majority of prescribing physicians have remained anonymous. Why is physician-assisted suicide still cloaked in the secrecy of anonymity if it is such a good thing.

In a study from the Netherlands, problems with inability of the patient to take all the medications, failure of completion of the assisted suicide or complications occurred in 21 of 114 (18%) physician-assisted suicide cases. In all 21 cases, the physician decided to administer a lethal medication (euthanasia). ([34])

Those aware of the data from the Netherlands are surprised that more complications are not being reported in the Oregon Department of Human Services Annual Reports. ([35]) In Oregon, information is self-reported to the state by the prescribing doctors. Yet in only 29% of the cases were they present when the patients took lethal drugs in 2003, and that does not necessarily mean that they stayed with the patient until death occurred. So how do doctors, especially the 71% who were not present with the patient, know about the circumstances surrounding those deaths? They get information second- or third-hand from others who were there. The result is we really don't know how those patients are dying.

Complications with assisted suicide do occur in Oregon. The sixth annual report describes a patient who drank one-half of the prescribed medication and, about 30 seconds later, vomited one-third of what was consumed. This patient is reported to have lived another 48 hours before dying. (13) Yet patients surviving beyond six hours are unlikely to die from short-acting barbiturate. Such instances are clearly assisted suicide failures and lead to more questions. What is the true cause of death? Where is the so-called death with dignity?

The Oregon Health Division's first annual report on physician-assisted suicide stated: "The Oregon Health Division is charged with collecting information under the Death with Dignity Act but is also obligated to report any cases of noncompliance with the law to the Oregon Board of Medical Examiners. Our responsibility to report noncompliance makes it difficult, if not impossible, to detect accurately and comment on underreporting. Furthermore, the reporting requirements can only ensure that the process for obtaining lethal medications complies with the law. We cannot determine whether physician-assisted suicide is being practiced outside the framework of the Death with Dignity Act."(136) The initial candor of the Oregon Health Division regarding the information they obtain is well expressed as: "For that matter, the entire account could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves." (137) Such candor has not been the rule for subsequent annual reports. As was stated in the final sentence of the first year report: "Future reports may not, however, contain the level of detail provided in this first study." Unfortunately for the public, how prophetic.

Following the publication of the Oregon Health Department's first annual report on physician-assisted suicide, The Oregonian newspaper editors wrote: "If everything's OK with Oregon's assisted-suicide law, why are there so many unanswered questions about it? The state's recent study of last year's assisted suicide cases offers little in the way of significant detail --- especially regarding the mental and emotional states of the patients involved. As the Matheny case demonstrates, the cloak of privacy prevents the public from knowing exactly what happens in difficult cases." (138)

After the brother-in-law of Patrick Matheny said he helped Mr. Matheny die in 1999, Katrina Hedberg, Deputy Epidemiologist with the Oregon Health Division stated: "Our investigation really stops after the writing of the prescription. It's beyond our authority to investigate what's happening in every one of these." (24)

A reporter for The Oregonian newspaper reviewed the Oregon Health Department's sixth annual report and added information that was not in the published report. He reported that "of the 42 doctors who wrote prescriptions for assisted suicide last year [2003], 27 wrote one, eight wrote two and six wrote three. One doctor wrote six." (31) When I asked Mr. Colburn how he learned that information, he informed me that he had received it from the Department of Human Services (previously known as Oregon Health Division). He had received selected information that was not in the published public report.

## CORRESPONDENCE WITH THE OREGON DEPARTMENT OF HUMAN SERVICES

In an attempt to answer questions that I had, and to obtain additional information which I felt the Department of Human Services should provide to the public, I wrote four letters to the personnel at that state agency on the dates listed, and received three response letters as listed:

Dec. 4, 2003 - Response from Darcy Niemeyer of OHD on Dec. 23, 2003

Jan. 24, Feb. 5, 2004 - Response from Darcy Niemeyer on Feb. 17, 2004

April 2, 2004 - Response from Darcy Niemeyer on May 4, 2004.

(My letters and Ms. Niemeyer's letters in response are attached.)

The December letters indicate that after 1998, Oregon doctors participating in assisted suicide are recording on death certificates the underlying disease as the cause of death. There is nothing recorded on the physician-assisted suicide death certificates that indicates death is from lethal drugs or assisted suicide. Ms. Niemeyer acknowledges that "there is nothing in the law that requires the prescribing physician to follow patients until they have died". Physician oversight of assisted suicide appears to legally end when the prescription for lethal drugs has been written. Since there no death certificate record to document physician-assisted suicide death, the Department of Human Services appears to use a circuitous method of later contacting physicians who have sent in physician-assisted suicide prescribing forms.

On January 24, 2004, after studying the Department of Human Services first five annual reports, I realized that they were not consistent in how they had presented the number of doctor's who had written prescriptions for lethal drugs. Information had been reported in some years, but not in other years. On that date, I sent Ms. Niemeyer the following table and asking her to fill in the "\*"

spaces. I thought this was fairly basic information and would be easy for the Department of Human Services to obtain and provide. (I have since included the data for the 2003 year in this table.)

Year	# of prescriptions written	# of doctors writing prescriptions for lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior year/s	# of PAS deaths in year	# of doctors writing prescriptions for those who died from ingesting lethal drugs	# of these doctors (prior column) who had written prescriptions for lethal drugs in prior year/s
1998	24	*	no prior year	16	14 of 15 deaths in 1st year report	no prior year
1999	33	22	6	27	*	*
2000	39	*	*	27	22	*
2001	44	33	*	21	*	*
2002	58	33	*	38	*	*
2003	67	42	*	42	30	*
2004						

\* Information not available in Department of Human Services published annual reports.

I was shocked to learn from her 2/17/2004 letter that they were not able to produce the basic information that I had requested, and that they had destroyed identifying data from 1998, 1999 and 2000. The Office of Disease Prevention and Epidemiology did provide information for both the 3rd and 6th column in the above table for the first time in the sixth year annual report for 2003. I remain incredulous that Oregon's health epidemiology agency is doing such a substandard collection, evaluation and reporting of basic physician-assisted suicide statistics. I am dismayed that they have destroyed basic raw data from the first three years. The state agency that was to provide information to the public on the "Oregon Experiment" has not fulfilled its responsibility to the public. For instance, they provided for the 1999 year, the number of prescribing doctors who had written prescriptions for lethal drugs in the prior year. Why are they not able and willing to provide that information for the subsequent years?

Although she did not adequately answer my final question in my Jan. 24, 2004 letter, the sixth year report published on March 10, 2004 did clarify what I was questioning: one of two patients receiving lethal prescriptions in 2001 who were still alive at the end of 2002, had died during 2003 and the other patient was still alive at the end of 2003 (1+ and 2+ year longevity, respectively, after receiving lethal prescriptions).

My February 5, 2004 letter was written because doctors participating in Oregon's physician-assisted suicides were publicly saying that they were prescribing liquid pentobarbital as the lethal drug. Knowing that pentobarbital is only available as an injectable liquid, I enquired regarding if the Department of Human Services was monitoring the form of the lethal drugs. Her February 17, 2004 response indicates the Department of Human Services was not aware that a liquid injectable form of pentobarbital was being prescribed and used for assisted suicide.

## OREGON DOCTORS ARE USING THE INJECTABLE FORM OF PENTOBARBITAL FOR ASSISTED SUICIDE

The use of pentobarbital in a liquid had been publicly reported in December 2001 in a Texas newspaper. ([\[39\]](#))

We learned from the 6th year annual report that in 2003, 37 of the 42 deaths were from pentobarbital; 41 of 129 deaths from 1998 to 2002 were from pentobarbital. (13) It is important to understand that pentobarbital is only available in a liquid formulation. It is officially named "pentobarbital sodium injection, USP; Nembutal sodium solution". Its only indication and usage is as an intra-muscular or intra-venous injection. It is not designed or FDA authorized for oral ingestion. Its concentration is 100 mgm per 2 ml solution. A lethal volume would be about 200 ml.

Both this liquid pentobarbital, and the powder form of secobarbital, are very bitter and vile-tasting. We are told that prior to patients swallowing the lethal barbiturates, they are pre-medicated anti-nausea medication and with oral anesthetics to numb their mouth and throat, although this will interfere with tongue and swallowing function. Swallowing such lethal medications is truly "bitter medicine".

Now that this form of lethal barbiturate is being used, than there is nothing to prevent its use by lethal injection, which is illegal in Oregon.

Visualize the following: The doctor writes a prescription for four 50 ml. bottles of pentobarbital, each bottle containing 2.5 gm of pentobarbital for a total of 10 gm of pentobarbital. The prescription is filled and the liquid pentobarbital is dispensed by the pharmacist to the patient. The patient takes the pentobarbital home. Once that injectable form of barbiturate leaves the pharmacy,

there is absolutely nothing to prevent that liquid from being given to the patient by injection. It is only designed for injection. The pro-assisted suicide people may say, "It is only being given orally". But there is absolutely no way to prevent its use as a lethal injection. This means that we now have no protection against euthanasia by lethal injection.

## OREGON'S ASSISTED SUICIDE LAW HAS NOT NECESSARILY IMPROVED END OF LIFE CARE IN OREGON

Some pro-assisted suicide proponents erroneously claim that the legalization of physician-assisted suicide has made Oregon a leader in the care of dying patients and in the use of pain medication. They make a similar erroneous claim that the physician-assisted suicide law in Oregon has become the national catalyst for reform in end-of-life care.

Americans for Integrity in Palliative Care submitted data to the June 2003, American Medical Association Annual meeting that confirms that the facts do not support a claim that legalization of physician-assisted suicide has made Oregon a leader in the use of pain medication. In 1992, two years prior to the passage of Oregon's physician-assisted suicide law in 1994, Oregon ranked third highest in the nation in the per capita use of morphine. It has ranked from 1st to 6th highest per capita use in the years 1993 to 2002. Laws against assisted suicide pose no threat to aggressive use of pain medication. Between 1992 and 2000, 11 U.S. states enacted new laws that ban intentionally assisting suicide, or that strengthen or clarify existing bans, with statutory language affirming the use of medications to control pain even when this may unintentionally increase the risk of death. Data from the Drug Enforcement Administration on morphine use for these 11 states (Iowa, Kansas, Kentucky, Louisiana, Maryland, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee and Virginia) show that per capita use of morphine subsequently increased in every case. In these states, the average increase in the use of morphine was 47%; in three states, morphine use doubled. ([\[40\]](#))

( A copy of this report is attached.)

A study in Oregon indicated that those dying between June 2000 and March 2002 were approximately twice as likely to be in moderate or severe pain or distress, as compared to patients dying during the time from November 1996 and December 1997. (Oregon's physician-assisted dying law became operational in January 1998.) The authors note end-of-life care resources have been stretched more thinly in Oregon. Medicare patients in Oregon have among the lowest reimbursement in the United States during the last 6 months of life and that had fallen significantly during the study period. They note that end-of-life care in Oregon was already resource lean and had become more so. In nursing homes, the amount of money that the average nursing facility loses per Medicaid patient per day had tripled during the study period. Comparing 1996 to 2002, the

number of Oregonians dying while enrolled in hospice increase from approximately 8000 to 13,000, while the median stay is a week shorter and the mean number of nursing visits per patient had decreased from 16 to 12.7. They note the negative impact of overstretching nursing resources on pain management. They also noted that although Oregon is consistently among the highest purchasers of opioid per capita and has consistently increased its purchasing over the study period, the largest academic medical center recently found that these increases were not going to patients dying in that hospital.([41], [42]) Those who erroneously blame the increase in the 2000-2002 years patients' pain and distress on U.S. Attorney General Ashcroft's DEA directive on November 6, 2001 fail to realize that only one-fourth of the June 2000 to March 2002 time period occurred following the date of the Attorney General's directive.

Last Acts, the U.S.'s "largest coalition to improve care and caring at the end of life", published a state-by-state "report card" in November 2002. They gave Oregon "mixed" ratings on end-of-life care. They reported that few (39%) Oregon hospitals offer hospice programs, giving Oregon a "D" grade. Oregon received the lowest possible grade "E", for its low number of hospitals (20%) that reported providing palliative care programs. Less than one third of Oregon residents over age 65 who died in Oregon used hospice care in the last year of their lives. The average length of hospice care in the state was 24 days, which is well below the 60 days considered necessary for the maximum benefit from the program. ([43])

(A copy of Last Acts' November 18, 2002 Press Release Report for Oregon is attached.)

A survey of Oregon physicians who had received requests for assisted suicide, found that patients who seek to end their lives by assisted suicide value their independence even more than they fear pain. Some patients appeared more willing to consider palliative or hospice care only after the issue of assisted suicide was settled. One doctor summarized: "They're really not able to talk or think about things like hospice care until they know that his other issue has been taken care of. It is almost a kind of condition for them to get palliative care to know that there is something to let them out of it if they get stuck." Some patients started talking about assisted suicide with their doctors within minutes of learning of their diagnosis. One doctor described a patient who was very weak and whom he felt was within a couple days of losing consciousness just from dehydration. She had the 15-day wait and she had 4 days before the medicine could be prescribed. After he told her that he didn't think she would last for 4 days consciously and to take the lethal medicine, she sort of struggled into a sitting position, asked her husband for a glass of water and said, "I'll get the fluids down somehow." This doctor said, "See, this is the paradox, this is where you learn that lesson about the control issue --- she actually reversed the natural dying process to prolong her suffering, in order to be in control, to push the button herself." (15)

In a newspaper interview regarding this published report, Ann Jackson, executive director of the Oregon Hospice Association, indicated that the small group of patients who opt for doctor-assisted

suicide sends hospice a warning. "In effect, they've said no to hospice," Jackson said. "either they don't believe we in hospice can meet their needs, or we're not meeting their needs." ([44])

Her views about the adequacy of hospice in this published interview are contrary to Ms Jackson's other public comments that all is well with hospice in Oregon.

THERE ARE CONSIDERABLE DANGERS WITH ASSISTED SUICIDE AND EUTHANASIA BECAUSE OF FINANCIAL CONSIDERATIONS.

WHAT IS CHEAPER FOR HMOS OR MEDICAL PROGRAMS FOR THE POOR? ASSISTED SUICIDE OR CARING FOR THE PATIENT.

OREGON HAS A FINANCIAL CRISIS AND MEDICAL ACCESS FOR THE POOR IS LIMITED AND POORLY FUNDED

The World Health Organization Expert Committee "Cancer Pain Relief and Palliative Care" had a major recommendation that: "Member states [nations] not consider legislation for physician assisted suicide or euthanasia until they had assured for their citizens the availability of services for pain relief and palliative care." ([45]) Leaders of states or nations must seriously evaluate how adequately they are providing such services to all of their citizens before they consider legalization of physician-assisted suicide and euthanasia.

Derek Humphry, co-founder of the Hemlock Society and longtime advocate of assisted suicide and euthanasia, has argued that economics makes sense for euthanasia. He proposed that the economic realities of expensive end-of-life care, and politicians concern about budgets and finances, make physician-assisted suicide and euthanasia practical options. ([46])

Access to health care in Oregon is dependent on the health insurance and financial status of the patient. There is now very limited health access for the vulnerable poor of Oregon. The unfortunate and death-causing realities of severe cutbacks in Oregon's medical support of its financially poor and medically and psychologically ill, really hit home in late 2002 and throughout 2003. The following Oregon newspaper articles are representative:

"Lapses in the state's mental health system have contributed to at least 94 deaths in 3 ½ years, an inquiry by The Oregonian finds." ([\[47\]](#))

"State budget game is 'playing with people's lives', AIDS patients lament" [when faced with loss of state financial support for antiviral drugs for the poor]. ([\[48\]](#))

"Officials want to know whether the man's death at a Salem Hospital unit is linked to the end of a medication benefits program." [A man with a mental illness shot himself to death in the state mental psychiatric center, after he stopped taking his medicines because they were no longer reimbursed by the state.] ([\[49\]](#))

"Ill patients who may not be able to pay for post-operation drugs are being 'temped-off' organ transplant waiting lists." [Financially poor patients who had been on organ-transplant waiting lists were removed from the lists because the state of Oregon would not pay for post-transplant anti-rejections medications.] ([\[50\]](#))

" 'This notice is about an important change', the letter from the state began - A few weeks later, Farrah was dead." [A 22-year old woman with a mental illness committed suicide after the state of Oregon withdrew Medicaid funding for her anti-psychotic medications.] ([\[51\]](#))

"Douglas Schmidt, 36, suffered a massive seizure [stroke] eight days after he ran out of his [anti-seizure] medication due to Oregon's cuts in benefits." ([\[52\]](#)) His anti-seizure medication had cost \$13 per day. His hospital bill for the first five weeks of his hospitalization totaled \$272,364. The total hospital and convalescent home cost was felt to likely be in the \$1 million range. He died after 8 months. ([\[53\]](#)) The Oregonian editorial of November 19, 2003 stated: "He and Oregon taxpayers were victimized by the state's decision to cut health care service for the poor." ([\[54\]](#))

In Oregon, the state Medicaid program will pay for physician-assisted suicide at a time when the same program has withdraw financial support for many poor seriously ill people. As described previously, the Oregon Medicaid program in 2003 withdrew financial support for medications for many Oregon Health Plan patients, including life-preserving anti-rejection medications of those planning on organ transplants, and for antiviral medications for patients with AIDS. Some financially poor Oregonians with mental illness committed suicide after they lost state financial support of their anti-depression and anti-psychotic medications.

Oregon State budget financial information publically announced in December 2004 indicates that state financial support for the poor will continue to be cut. More than 50,000 people have been cut from the Oregon Health Plan, which covers low-income people who are not eligible for regular Medicaid. The state is moving to trim the Health Plan rolls by another 25,000 people by June 2005 to keep the state budget balanced. ([\[55\]](#))

Society should fear insurance carriers and HMOs that may find it cheaper to have patients die than to pay for their medical needs. The cost of assisted suicide is exemplified by a newspaper article in March 1999, which indicated that the state of Oregon had refunded \$60 of U.S. Federal funds that had been used to pay the costs of two physician-assisted suicide deaths. The total Medicaid costs of the two deaths was \$99; \$49.50 per death. ([56])

Even Oregonians who have Medicare or Medicaid health coverage find that they cannot access medical care. A 2003 year survey of Oregon doctors conducted by the Oregon Medical Association, the state Office of Medical Assistance Programs (OMAP), and the state Office of Health Policy and Research found that about one half of the doctors don't accept Medicaid patients or limit the number they see; and nearly 40% of doctors would not see Medicare patients or do so only on a limited basis. ([57]) A more recent survey of Oregon doctors reported in November 2004 showed that medical access had become worse. In 2004, almost 60% of primary care physicians either limit (41%) or do not see (18%) Medicaid patients; more than 40% of primary care physicians limit or do not see Medicare patients. ([58])

#### THE OREGON MEDICAL ASSOCIATION CONSIDERS OREGON'S ASSISTED SUICIDE LAW TO BE SERIOUSLY FLAWED

As a member of the House of Delegates of the Oregon Medical Association, I participated in the discussions and vote that led to the following Resolutions by the House of Delegates during the April 25-27, 1997, 123rd Annual Meeting in Eugene, Oregon.

The final resolutions are the following:

**"Amended and Adopted Substitute - in lieu of RESOLUTIONS NO. 10 AND 15:**

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RESOLVED, OMA affirms its policy in support of and advocacy for compassionate and competent palliative care at the end of life; and

FURTHER RESOLVED, OMA acknowledges that medical efforts to Eliminate irreversible and extreme pain and suffering at the end of life are an appropriate medical response that may result in hastening the patient's death; and

FURTHER RESOLVED, OMA acknowledges the patients' legitimate right To autonomy at the end of life, but does not accept the proposition that death with dignity may only be achieved through physician-assisted suicide; and

FINALLY RESOLVED, OMA specifically opposes Measure 16 as seriously flawed. ([\[59\]](#))

Those Resolutions passed with a vote of 122 to one.

As far as I know, as a member of the OMA House of Delegates, those Resolves have never been rescinded.

## OREGON'S ASSISTED SUICIDE RATE IS NOT LOWER THAN THAT OF OTHER STATES

In recent months, there has been a false claim that because of legalized assisted suicide, Oregon's rate of physician-assisted suicide is one fourth the rate of physician-assisted suicide in other states. The source of this erroneous information originated in an article by doctors Ganzini and Dobscha, published in June 2004. ([\[60\]](#)) They correctly reported that Oregon's physician-assisted

suicide rate is approximately one in one thousand deaths from all causes. (13) However, they erroneously reported that the rate of physician-assisted suicide deaths for other states was one in 250 deaths. This rate of one in 250 deaths in other states was foolishly based on an article reporting on a survey of 988 terminally ill patients from among 6 states (Oregon not included) who were interviewed regarding their attitudes and desires related to euthanasia and physician-assisted suicide. At the time of publication of that article, 256 patients had died, one of whom died from physician-assisted suicide. ([61]) It is impossible, and completely unscientific, to claim a valid physician-assisted suicide rate based on a single event (one assisted suicide death) taken from a survey of non-representative sampling of patients in six locations. If physician-assisted suicide death rates are to be compared, then the rates should be based on comparable populations. They erroneously compared Oregon's physician-assisted suicide death rate per deaths from all causes, with Emanuel et al's surveyed patients who were all terminally ill; these are not comparable populations! The rate of illegal physician-assisted suicide in other states cannot be established from Emanuel et al's article. There is no evidence that legalization of physician-assisted suicide in Oregon has decreased the rate of physician-assisted suicide. ([62])

## REFERENCES

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- [1]. American Medical Association statement on Physician-Assisted Suicide, [www.ama-assn.org/ama/pub/printcat/8459.html](http://www.ama-assn.org/ama/pub/printcat/8459.html))
- [2]. Woodruff R: Palliative Medicine, Third Edition, 1999, Oxford University Press.
- [3]. Hamilton NG, Hamilton C: Competing paradigms of responding to assisted-suicide requests in Oregon: Case report. American Psychiatric Association Annual Meeting Symposium on Ethics and End-of-Life Care: New Insights and Challenges, New York City, May 6, 2004. (available at [www.pccf.org](http://www.pccf.org), May 6, 2004)
- [4]. Gianelli DM: Dutch euthanasia expert critical of Oregon approach. American Medical News. September 15, 1997.
- [5]. Kass LR: "I will give no deadly drug": Why doctors must not kill. In The Case Against Assisted Suicide, For the Right to End-of-Life Care. Edited by K Foley and H Hendin, Baltimore - Johns Hopkins University Press, 2002, p 30.
- [6]. Chin AE, Hedberg K, Higginson GK, Fleming DW: Legalized Physician-Assisted Suicide in Oregon - The First Year's Experience. N Engl J Med. 1999;340:577-83.
- [7]. Reagan P: Helen. The Lancet 1999;353:1265-67.
- [8]. Thomasma D: Asking to die; Inside the Dutch debate about euthanasia. Editor. Dordrecht. Kluwer Academic 1998:291-293.

9. Hoover E. Doctor who assisted suicide shocked by the suddenness. The Oregonian Newspaper. June 14, 1998.

10. Barnett EH. Oregon's assisted-suicide law inspires better care, many doctors say. The Oregonian Newspaper. Nov. 14, 2001. (Hoover and Barnett are the same reporter.)

11. Robeznieks A. HMO query reignites assisted-suicide controversy. Am Medical News. Sept. 4, 2002.

[12]. Coleman D: Assisted suicide and disability. Human Rights 2000;27:6-8.

[13]. Sixth Annual Report on Oregon's Death with Dignity Act, Oregon Department of Human Services, March 10, 2004, [www.ohd.hr.state.or.us/chs/pas/ar-index.cfm](http://www.ohd.hr.state.or.us/chs/pas/ar-index.cfm).

[14]. Emanuel E., et al: Euthanasia and physician-assisted suicide: Attitudes and experiences on oncology patients, oncologists, and the public. The Lancet 347:1805-1810, 1996.

[15]. Ganzini L, Dobscha SK, Heintz RT: Press, N: Oregon physicians' perceptions of patients who request assisted suicide and their families. J Palliative Medicine 2003;6:381-390.

[16]. Hoover E: Two deaths add new angle to debate. The Oregonian March 26, 1998; Two die using suicide law. The Oregonian March 27, 1998.

[17]. Binding K, Hoche A: The Permission to Destroy Life Unworthy of Life (Die Freigabe der Verichtung lebensunwerten Lebens: Ihr Mass and irhe Form) 1920. Leipzig: F. Meiner. (Cited in Lifton RJ: The Nazi Doctors: Medical Killing and the Psychology of Genocide. 1986. Basicbooks, p. 46.)

[18]. The New York State Task Force on Life and the Law: When Death is Sought: Assisted suicide and euthanasia in the medical context. May 1994. Health Education Services, P.O. Box 7126, Albany, NY 12224.

[19] Lichtenstein RL, Alcser KH, Corning, AD, Bachman JG, Doukas DJ: Black/white differences in attitudes toward physician-assisted suicide. J Nat Med Assoc 1997;89:125-133.

[20] . Tolle SW, Tilden VP, Drach LL, Fromme EK, Perrin NA, Hedberg, K: Characteristics and proportion of dying Oregonians who personally consider physician-assisted suicide. J Clin Ethics 2004;15:111-118.

- [21]. U.S. Census Bureau. Oregon QuickFacts. <http://quickfacts.census.gov/qfd/states/41000.html>
- [22]. Barnett EH: Is mom capable of choosing to die. The Oregonian, October 17, 1999.
- [23]. Barnett EH: Man with ALS makes up his mind to die. The Oregonian, March 11, 1999.
- [24]. Barnett EH: Coos Bay inquiry finds no evidence of foul play in assisted suicide. The Oregonian, March 13, 1999.
- [25]. Jennifer Frey: A death in Oregon: One doctors' story. Washington Post, November 3, 1999.
- [26]. Compassion in Dying, Edited by Lee, BC, 2003, NewSage Press, Troutdale, Oregon, p 9.
- [27]. Woodward S: Corvallis doctor accused of 'active euthanasia'. The Oregonian, July 21, 1996.
- [28]. American Medical News. Ore. Board sanctions physician for 'active euthanasia'. August 11, 1997.
- [29]. Christakis NA, Escarce JJ: Survival of Medicare patients after enrollment in hospice programs. N Eng J Med 1996;335:172-178.
- [30]. Fifth Annual Report on Oregon's Death with Dignity Act, Oregon Department of Human Services, March 6, 2004. [www.ohd.hr.state.or.us/chs/pas/ar-index.cfm](http://www.ohd.hr.state.or.us/chs/pas/ar-index.cfm).
- [31]. Colburn, D: Assisted suicide total in 2003 edges higher. The Oregonian. March 10, 2004.
- [32]. Schwartz J, Estrin J: In Oregon, choosing death over suffering. The New York Times, Science Times, June 1, 2004.
- [33]. Klare S: Jake Harris in Compassion in Dying, Edited by Lee BC (Troutdale, Oregon: NewSage Press), 2003, p 102.
- [34]. Groenewoud JH, van der Heide A, Onwuteaka-Philipsen BD, Willems DL, van der Maas, PJ, van der Wal G: Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. New Eng J Med 2000; 342:551-556.
- [35]. Nuland SB: Physician-assisted suicide and euthanasia in practice. New Eng J Med 2000;342:583-584.
- [36]. Chin AE, Hedberg K, Higginson GK, Fleming DW: Legalized physician-assisted suicide in Oregon - The first year's experience. N Eng J Med 1999;340:577-83.
- [37]. CD Summary, A year of dignified death, Oregon Health Division, March 16, 1999, Vol 48, No. 6.

[38]. The Oregonian Editorial: Ambiguity and suicide. March 14, 1999.

[39]. Jacobson S.: Revisiting assisted suicide: Federal action renews debate over Oregon's Death With Dignity Act. The Dallas Morning News, 12/17/2001.

[40]. Americans for Integrity in Palliative Care: Written testimony presented to the American Medical Association Annual Meeting, June 10, 2003. (Copies attached with Dr. Stevens' testimony)

[41]. Fromme EK, Tilden VP, Drach LL, Tolle SW: Increased family reports of pain or distress in dying Oregonians: 1996 to 2002. J. Palliative Medicine 2004;7:431-442.

42. Tolle SW, Hickman S, Tilden VP, Bubalo JS, Fromme EK: Trends in opioid use over time: 1997 to 1999. J Palliat Med 2004;7:39-45.

[43]. Last Acts, Press Release, November 18, 2002.

[44]. Colburn, D: Suicide: Study is the first based on interviews. The Oregonian. June 12, 2003.

[45]. World Health Organization, Cancer Pain Relief and Palliative Care, Report of a WHO Expert Committee (Geneva:1990), 11-12.

Reported in Foley K: Compassionate care not assisted suicide, in The Case Against Assisted Suicide. Edited by Foley K, Hendin H (Baltimore: Johns Hopkins University Press), 2002, p 293-294.

[46]. Barnett EH: Economics makes case for euthanasia, Derek Humphry argues. The Oregonian. December 2, 1998.

[47]. Roberts M: Did they have to die? The Oregonian. December 29, 2002.

[48]. Bellotti M: Difficulties, even death, stalk needy. The Portland Tribune. February 3, 2003.

[49]. Roberts M, Zaitz L: State looks at suicide of patient, loss of drug aid. The Oregonian. March 7, 2003.

[50]. Colburn D: Cuts split medical standards. The Oregonian. March 30, 2003.

[51]. Roberts M: Life Interrupted. The Oregonian. May 4, 2003.

[52]. O'Neill P: Man's crisis follows state's. The Oregonian. March 9, 2003.

[53]. Colburn D: Man who lost state aid taken off ventilator. The Oregonian. November 17, 2004.

- [54]. The Oregonian Editorial. The Death of Douglas Schmidt. The Oregonian. November 19, 2004.
- [55]. Beggs, CE: Governor proposes small school aid boost, new lottery games. The Associated Press. December 1, 2004.
- [56]. The Associated Press. Oregon will refund \$60 after suicides. The Oregonian. March 30, 1999.
- [57]. Colburn D: Half of doctors rejecting the poor. The Oregonian. September 25, 2003.
- [58]. Survey shows patient access problem grows. The Scribe. Published by the Medical Society of Metropolitan Portland. November 19, 2004.
- [59]. Digest of Actions. 123rd Annual Meeting. Oregon Medical Association. April 25-27, 1997.
- [60]. Ganzini L, Dobscha SK: Clarifying distinctions between contemplating and completing physician-assisted suicide. J Clin Ethics. 2004;15:119-122.
- [61]. Emanuel EJ, Fairclough DL, Emanuel, LL: Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. JAMA. 2000;284:2460-2468.
- [62]. Stevens KR, Toffler WL: Comparing Oregon's physician-assisted suicide rate with that of other states - A response. J Clin Ethics 2004; Vol 15, (accepted for publication, December 2004).

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