

# Medical Ethics Advisor™

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— Compliance forms for the Oregon Death with Dignity Act  
— Oregon Nurses Association guidelines on assisted suicide

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## The State of Assisted Suicide in the U.S.

### Increase in debates, state bans don't change central fact: It's coming

*Polls show public wants assisted suicide option*

*Our holding permits this debate to continue, as it should in a democratic society. — U.S. Supreme Court*

With the flourish of a pen when writing the majority opinion in June 1997, the U.S. Supreme Court set the stage for what has been — and continues to be — a tumultuous journey in reaching an agreeable solution to assisted suicide in this nation.

It's been almost two years since the U.S. Supreme Court declined to find the laws against assisted suicide unconstitutional. The court's refusal cleared the way for Oregon to enact its Death with Dignity Act, first approved by voters in 1994 but blocked from implementation through court challenges. In keeping with the wishes of the Supreme Court justices, states are continuing the debate, and there's no indication that the controversy is waning. For instance:

- At least 37 states have explicitly criminalized the act of assisted suicide through legislation, with several states debating the issue in current legislative sessions, including California, Hawaii, and Maryland.

- Last November, voters in Michigan rejected by a 3-1 margin a ballot measure to legalize assisted suicide. Organizers on both sides say the battle is not over.

- In December 1998, two terminally ill Alaskans challenged that state's ban on assisted suicide, saying they wanted control over end-of-life decisions and the option of hastening death. The case, known as *Sampson and Doe v. State of Alaska*, is being sponsored by the Portland, OR-based Compassion in Dying Federation.

- In February, the Oregon Health Division, also in Portland, published in the *New England Journal of Medicine* its highly anticipated report on the results of the law's first year.<sup>1</sup> Contrary to the predictions of critics, patients choosing assisted suicide were neither poor nor in extreme pain.

1. Oregon's Death with Dignity Act, which has been in effect for a year, has revealed findings different from what critics feared, according to Katrina Hedberg, MD, medical epidemiologist at the Oregon Health Division in Portland and author of the first year's report. Findings revealed that:
  - A. Indigent and extremely ill patients were the primary candidates for choosing physician-assisted suicide.
  - B. Finances and fear of pain did not appear to be critical considerations in the choice of physician-assisted suicide.
  - C. Physicians failed to comply with provisions of the Death with Dignity Act by not reporting patients who chose assisted suicide.
  - D. All of the above
  
2. According to Peter A. Rasmussen, an oncologist in Salem, OR, the call for assisted suicide hasn't come from the medical community or medical ethicists, but from:
  - A. Providers
  - B. Patients
  - C. Pain management critics
  - D. All of the above
  
3. A result from the discussion about assisted suicide in Oregon, according to Barbara Coombs Lee, FNP, JD, executive director of Compassion in Dying Federation and co-author of Oregon's Death with Dignity Act, is that:
  - A. Health care expenditures have not increased or decreased dramatically.
  - B. Caregivers are more receptive to discussing the option with patients.
  - C. Patients become more knowledgeable regarding palliative care during end-of-life care.
  - D. All of the above
  
4. When patients first mention assisted suicide, physicians and providers should, according to Barbara Coombs Lee, do the following:
  - A. Discuss the issue with family members.
  - B. Contact a social worker or chaplain.
  - C. Review and optimize the treatment of pain.
  - D. All of the above

"Our findings revealed that finances and fear of pain did not appear to be critical considerations in the choice of physician-assisted suicide," notes **Katrina Hedberg**, MD, medical epidemiologist at the Oregon Health Division and author of the report. **(For additional information on characteristics of those patients who chose assisted suicide, see related article, p. 51. For compliance forms required by the Death with Dignity Act, see insert.)**

- A class-action federal lawsuit filed in Detroit in March could dramatically alter the legal landscape. The lawsuit seeks to establish a federally protected constitutional right to be free from "unbearable and irremediable" suffering due to a medical condition. In effect, this right would allow for assistance with death and protect physicians and other providers from prosecution.

- Finally, the fourth trial — and first conviction — of Jack Kevorkian, the retired pathologist turned right-to-die crusader, occurred in late March 1999. While critics and supporters disagree over the ethical and moral issues of Kevorkian's actions, both agree the conviction does not end the debate. As the baby-boomer generation ages, the issue will become even more prominent and may lead to more uncertainty.

In fact, the only certainty emerging from the assisted suicide debate so far is the fact that many predictions about the effects of legalization have proved false. A growing acceptance of assisted suicide and increased awareness about better pain management could mean you'll face the issue of assisted suicide sooner than you think. It might take several years, but the U.S. Supreme Court no doubt will rule on a case where the issue of personal liberty is at stake — and the Court always rules in favor of personal liberty, predicts **Peter A. Rasmussen**, MD, an oncologist in Salem, OR.

Here's why the tide is changing in the assisted suicide debate:

### 1. Public opinion is changing.

While a majority of physicians and providers disagree with a patient's right to request assistance with suicide, public opinion on the matter favors legalization of assisted suicide. A Cable News Network poll conducted last summer, for example, found 79% of respondents in favor of Oregon's law, compared with 15% who opposed the law.

“The call for assisted suicide hasn’t come from the medical community or medical ethicists. Patients are driving this,” says Rasmussen, who has had two patients request assisted suicide since the law was enacted. A majority of physicians in Oregon support the right of the patient to assisted suicide but don’t want to participate, he adds.<sup>2</sup>

Getting the hospital’s ethics committee to start dialogue on the subject was a little more difficult, however. “I work in a public hospital, so if a patient requests assisted suicide, that’s OK, but it’s not talked about among staff,” he explains. “It was difficult for us to reach a consensus on a policy. The only way to ensure that staff didn’t feel like they were getting into an uncomfortable position was to let them know that a patient mentioned suicide, but some of the nursing staff threatened to quit. It’s definitely an evolving process.”

Public opinion on Kevorkian seems equally divided. An ABC News poll conducted among a random national sample of 518 adults following the conviction showed 55% disagreeing with the jury’s verdict to convict and 39% agreeing. Additionally, an ABC News poll conducted last summer showed 52% of Americans supporting assisted suicide in general and 44% opposing it.

A survey conducted in July 1998 by GLS Research in San Francisco found that Americans support assisted suicide by a 3-1 margin: 69% in favor, 23% opposed. The survey was conducted for the Compassion in Dying Federation. (For more results, see story, p. 52.)

### 2. Palliative care is improving.

Because of discussions about assisted suicide, patients become more knowledgeable regarding palliative care during end-of-life care, says **Barbara Coombs Lee**, FNP, JD, executive director of Compassion in Dying Federation and co-author of Oregon’s Death with Dignity Act. “I believe the phenomenon of improved care in Oregon results from an increased awareness of state-of-the-art palliative care on the part of physicians, and an empowered, educated patient group.” (For more suggestions on improving palliative care, see story, p. 53.)

“Patients in Oregon are aware suffering is not a necessary part of the dying process, and physicians respond to the expectation that symptoms will be alleviated,” says Coombs Lee.

Patients should never consider assisted suicide because they fear untreated pain, she asserts. In fact, when patients first mention assisted suicide, physicians and providers should review and optimize the treatment of pain, she says.

Patients in Oregon are benefiting from a continuum approach to end-of-life care, she says. “We’re second in the country in utilization of morphine. Of those 15 people who chose assisted suicide, 74% were in hospice. That’s an incredible penetration rate. The national penetration rate is 17%.”

Regardless of how patients arrive at the decision to employ assisted suicide, it’s important to ensure that physicians and patients are comfortable with the decision, she adds. “We discuss the ethics of the situation, and we offer alternatives. But if it looks like the last resort is to assist the patient in their death, then we all can do it without risk.”

### References

1. Chin A, Hedberg K, Higginson G, et al. Legalized physician-assisted suicide in Oregon — The first year’s experience. *NEJM* 1999; 340:577-583.
2. Lee MA, Nelson HD, Tilden VP, et al. Legalizing assisted suicide — Views of physicians in Oregon. *NEJM* 1996; 334:310-315. ■

## Patients choosing assisted suicide defied predictions

*Critics expected patients to be poor, in pain*

**E**pidemiologists at the Oregon Health Division in Portland collected information on patients who received prescriptions for lethal medications during the first year of the state’s Death with Dignity Act. The researchers compared the group that chose assisted suicide and took the lethal medications with a group that died from similar illnesses but did not receive a lethal medication. Physicians treating both groups were interviewed.

“Our findings revealed that finances and fear of pain did not appear to be critical considerations in the choice of assisted suicide. Instead, persons who chose assisted suicide were primarily concerned about personal autonomy and control over the manner in which they died,”

says **Katrina Hedberg**, MD, medical epidemiologist at Oregon Health Division and author of the report.

Critics of Oregon's law predicted it would prey on the state's indigent population and patients experiencing extreme pain. That's not been the case, says **Barbara Coombs Lee**, FNP, JD, executive director of Compassion in Dying Federation in Portland and co-author of Oregon's Death with Dignity Act. "I believe Oregon's law reflects the right balance between safeguards and access. By that I mean there are sufficient safeguards to protect society and vulnerable populations from potential abuse, yet not so many safeguards that terminally ill patients cannot surmount the barriers to access," Coombs Lee explains.

This information was collected between Jan. 1, 1998, and Dec. 31, 1998:

- Prescriptions for lethal medications were filled for 23 persons. Fifteen died after taking medications, six died from their illnesses, and two were alive as of Jan. 1, 1999.
- Assisted suicide accounted for five of every 10,000 deaths in Oregon.
- The average age of the 15 patients who took the medication was 69. All were Caucasian. Eight were male. Thirteen were diagnosed with cancer. Seven were from the Portland metropolitan area. Twelve were high school graduates.
- Assisted suicide was not disproportionately chosen by terminally ill patients who were poor, uneducated, uninsured, fearful of the financial consequences of their illnesses, or lacking end-of-life care.
- The primary factor distinguishing persons in Oregon who chose assisted suicide was the importance of autonomy and personal control.
- Similar lethal medications were prescribed. The average time to unconsciousness was five minutes, ranging from three to 20 minutes. The average time to death was 26 minutes, ranging from 15 minutes to 11.5 hours.
- Physicians who took part in the suicide process represented multiple specialties and a wide range of age and years practicing. Interviews revealed that for some, the process exacted a large emotional toll.

The Oregon Health Division is legally required to collect information regarding compliance with the act and to make the information available annually, notes Hedberg. "Our reporting role is a

neutral one. It is critical that we have accurate data so that informed ethical, legal, and medical decisions can be made."

One problem that will become less common as the law gets older is getting the physician to agree to assist the patient, Coombs Lee says. During the first year of Oregon's law, six of the 15 patients who died from lethal medications did not receive the medication from the first physician they asked.

As a result, the patients changed physicians — in compliance with the law — to physicians who would assume responsibility for their care and participate in the Death with Dignity Act if deemed appropriate, she adds. "More physicians will come to feel comfortable with their responsibilities under the act, and more patients will inquire early in a relationship with a physician, so there is unlikely to be a mismatch between the values and beliefs of the physician and those of the patient," she explains.

"We tell people that following diagnosis of a terminal illness is no time to change physicians, so having a frank conversation about end-of-life options early in the relationship, while you are still healthy, is desirable." ■

## Americans say, 'Keep your laws off my body'

### *Sentiment growing in favor of legalization*

Americans overwhelmingly oppose attempts by Congress to prohibit physicians from prescribing medication terminally ill patients can take to end their lives. In fact, 72% oppose any federal legislative involvement, while only 26% support it.

That's one finding from a random survey of 1,000 U.S. residents in July 1998. The survey was conducted by GLS Research in San Francisco on behalf of Portland-based Compassion in Dying. Other findings include the following:

- 69% support the legalization of physician assistance in dying, while 23% oppose it.
- 66% favor Oregon's Death with Dignity Act, and the same percentage would be inclined to support a similar law in their own states.
- 10% feel decisions about the appropriateness of medical procedures should be made at the

federal level — either by Congress or the U.S. Drug Enforcement Agency.

- 76% agree Congress should not be involved in regulating legal drugs prescribed by physicians to their patients.
- 90% agree it should be up to local physicians and medical boards, not the federal government, to determine what is appropriate treatment for the terminally ill.
- 69% agree with the following statement about end-of-life care: “When a person is dying of a terminal disease, he should be allowed by law to request and receive help from his physician to end his life.”

**75% oppose Congress taking action to overturn Oregon’s Death with Dignity Act.**

- Of those registered to vote, 68% overall support the previous statement. 70% of those who claim to be Independents agree with the statement; 68% of Democrats agree; and 59% of Republicans agree.
- 74% agree with the statement, “People in the final stages of a terminal disease who are suffering and in pain should have the right to get help from their doctor to end their life if they so choose.”
- 75% oppose Congress taking action to overturn Oregon’s Death with Dignity Act.
- 80% agree with the statement that “since Oregon voters overwhelmingly approved the state law allowing terminally ill patients in Oregon to get a prescription for medication to end life, Congress should respect the will of these voters and not try to overturn Oregon’s law.”
- 76% agree with the statement, “It is not appropriate for Congress to get involved in regulating legal drugs prescribed by physicians to their patients.”
- 72% oppose “federal legislation that would prohibit physicians from prescribing medications that terminally ill patients could request to end life.”
- 93% agree that “Physicians should be allowed to prescribe whatever medication they feel is necessary to alleviate the pain of terminally ill patients in their final days.” ■

## It can happen sooner than you think

*Prepare to deal with issue of assisted suicide*

Changing public opinion combined with improved awareness of palliative care means your facility might be facing the issue of assisted suicide sooner than you think.

“It’s an issue of personal liberty, and the U.S. Supreme Court will rule in favor of personal liberty. It might not be next year, but it will happen in the next several years,” predicts **Peter A. Rasmussen**, MD, an oncologist in Salem, OR. Rasmussen has had two patients request assisted suicide since Oregon’s Death with Dignity Act went into effect.

“Assisted suicide is such a scary topic that most states will be watching Oregon for several years. The federal government might go as far as outlawing assisted suicide, but that would likely be overturned through any decision by the courts,” he explains.

In the meantime, there’s plenty an ethics committee can do to improve end-of-life care in the institutions they serve, says **Ronald A. Carson**, director of the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston.

“Because Jack Kevorkian makes better press than down-to-earth discussions of how to improve the conditions of dying in America, we have had insufficient public dialogue about humane dying. That situation is now changing as people whose family members have had to endure more suffering than was necessary and advocates for the dying get organized,” Carson says.

Improve end-of-life care by taking the following steps, Carson recommends:

- **Get involved.**

Become a member of Americans for Better Care of the Dying, a national charitable organization dedicated to public education and public policy advocacy. Carson also suggests getting two of the group’s publications, *Handbook for Mortals: Guidance for People facing Serious Illness* and *The Advocate’s Guide to Better End-of-Life Care*. (For more information, contact Americans for Better Care of the Dying, 2175 K St. N.W., Washington,

DC 20037. Telephone: (202) 530-9864. Fax: (202) 467-2271. Email: caring@erols.com. Web: <http://www.abcd-caring.com>.)

Another organization dedicated to improving end-of-life care is Last Acts, a national coalition that has published a report from its palliative care task force. Last Acts is funded through the Princeton, NJ-based Robert Wood Johnson Foundation. (Contact the Robert Wood Johnson Foundation, Route 1 and College Road E., P.O. Box 2316, Princeton, NJ 08543-2316, E-mail: [mail@rwjf.org](mailto:mail@rwjf.org). Web: [www.lastacts.org](http://www.lastacts.org).)

Carson also suggests joining the Robert Wood Johnson Community-State Partnership to Improve End-of-Life Care in your state. Four grants have been implemented with an additional 13 in the planning stage. (Contact Myra Christopher, director of the Community-State Partnerships program, Midwest Bioethics Center, 1021-1025 Jefferson St., Kansas City, MO 64105-1329. Telephone: (816) 221-1100. E-mail: [bioethic@midbio.org](mailto:bioethic@midbio.org).)

- **Do some research.**

Find out what Americans think, Carson recommends. An analysis of values and opinions on end-of-life care and assisted suicide is available from American Health Decisions' *Quest to Die with Dignity* report. (Contact American Health Decisions, P.O. Box 599, Appleton, WI 54912-0599.) ■

## Should insurers cover assisted suicide?

### *Oregon's health plan raises ethical concerns*

More than a year after the Oregon Health Services Commission voted to include physician-assisted suicide (PAS) as a covered medical service, the debate continues over the ethics of paying to cause a patient's death when other medical treatments receive no coverage.

The Oregon Health Plan, the state's Medicaid plan, is unique from other Medicaid programs because it uses a prioritized list of medical diagnoses and treatments as a basis for coverage decisions. Depending on the amount of money the state budgets for the plan, the commission sets a cutoff line at a particular level on the list.

The plan currently has a list of 745 medical services, and the cutoff is at line 574. Lower-priority services, those with a number higher than 574, are not covered.

According to information released by the Salem-based Oregon Department of Human Resources in March 1998, assisted suicide ranks 206th on the list, along with palliative care.

"Some curative treatments for cancer are not covered, some hernia operations are not covered, rehabilitation for stroke victims is not covered. They are on the list but are not funded. Under the Oregon Health Plan, there are currently 171 recognized medical services that are not funded, but they will fund physician-assisted suicide?" says **Gregory Hamilton**, MD, PhD, a Portland psychiatrist and president of the organization Physicians for Compassionate Care, which has opposed the legalization of assisted suicide.

### *Unfairly influencing the poor?*

The public health plan isn't all that's worrisome, Hamilton adds. Many private health plans that will pay for assisted suicide also significantly limit payments for hospice care and home health. One plan Hamilton has contacted caps home health payments, for example, at a \$1000 maximum, he says. "I don't think that it is the intent of those involved in making these decisions to herd the poor and disabled into committing suicide, but the result of the funding is that it does herd the poor and disabled into considering suicide as an option."

Despite Hamilton's and others' objections, the data gathered on the Oregonians who requested the assisted suicide option in the past year indicate that such concerns are exaggerated, says **Ted Falk**, JD, PhD, an Oregon health care attorney who has published several articles on coverage issues and PAS.

The Oregon Health Division's special report *Legalized Physician-Assisted Suicide in Oregon — The First Year's Experience*, compared the experience of the 23 patients (15 who died after taking the medications, six who died of their underlying illness, and two who did not take the medication and were alive as of Jan. 1, 1999) with that of a control group who were similar in illnesses, race, sex, rural or urban residence, level of education, and insurance coverage.<sup>1</sup>

The study's findings indicate that none of the case patients or control patients "expressed concern to their physicians about the financial impact of their illness." The study authors also found no difference between case and control patients with respect to insurance coverage at the time of death. They concluded that the choice of assisted suicide was not associated with health insurance coverage. "Because end-of-life care is expensive and, in contrast, physician-assisted suicide is cheap, much of the political opposition to physician-assisted suicide arises from the fear that health plans will try to 'kill off' their members to lower costs," he says. "I think that is kind of overstating the risks, to the point of almost being fanciful."

In addition to moral objections, health plans would not want to be seen as encouraging their members to choose assisted suicide because it would damage their reputations, Falk says.

In reality, health plan executives don't consider the ethics of assisted suicide to be an issue they should deal with, he adds. "This is a huge, emotional issue in terms of political agenda, but in terms of health plans, it is a very minor one. In most cases, if the plan offers a prescription drug benefit, the medications used would be covered under that benefit. There would be some question as to whether the plan would even know what the drugs were used for. And, given the modest expenditure of resources required, it is probably not something they screen for."

The main coverage issue to be concerned with, Falk says, is the availability of a mental health screening to the patient considering assisted suicide. "The sponsors of the law, I think, have come to conclude that it was a mistake not to require a mental health evaluation. But many of the professional organizations urge that a mental health evaluation be done in all cases in order to screen out depression."

The Oregon Death with Dignity Act requires that the patient's primary physician and consulting physician confirm a diagnosis and prognosis. In addition, the law requires screening to determine if the patient is mentally capable of the decision to end his or her life. If either physician believes the patient's judgment is impaired by depression or another disorder, the patient must be referred for counseling.

There is definitely a question about whether patients would be able to get coverage for mental

screening, considering that many health plans have separate requirements for obtaining mental health services. "Many health plans don't cover mental health exams to determine competency," Falk explains. "They cover mental health diagnoses and treatment."

On the other hand, because the screening typically would require one visit with a mental health professional, it might go "below the radar screen" of what the plan would flag as not meeting mental health guidelines. "A lot of plans don't apply their more rigorous screenings for mental health services until the member has reached five or more visits. It depends on the specific contractual arrangements of the plan."

### *Assisted suicide not that expensive*

Falk acknowledges that a patient seeking coverage of extensive home health or hospice care would attract significantly more attention from the health plan than a patient choosing assisted suicide. "I think you would have to struggle to use \$500 worth of resources in a typical case of physician-assisted suicide. In many cases, you could be talking about one visit to the primary care doctor, a visit to a mental health professional, and a prescription of drugs. That would most likely be below the level that would attract audits."

In contrast, because end-of-life care can be extraordinarily expensive, health plans might place significant requirements in terms of prior authorization for coverage, Falk notes. "Prior authorization is used for medical procedures which are of doubtful efficacy or very expensive, or they tend to be overused, or there is a significant cost difference to be achieved."

Far from being concerned only with cost issues, however, Falk says the law has prompted health plans to begin to take an extended look at end-of-life care so patients are not pushed into an assisted suicide option out of desperation, he says. "It is my perception, but I believe we have seen, for example, that hospice coverage has become more widespread since the passage of this law. And I think that is a logical response."

With assisted suicide now legal in Oregon, there exists a natural cost incentive for health plans to support assisted suicide over other, more expensive "treatment" options, says **Nelson Lund, JD**, professor of law at George Mason

University Law School in Fairfax, VA, and an expert on assisted suicide. Protecting patients from unscrupulous cost shifting is extremely difficult, he says. "It's very hard to think of a law that could make a distinction between legitimate cost-cutting by an insurance company in long-term care and cancer treatments and an illegitimate cost reduction. Inevitably, you will have these pressures develop."

Insurance companies exert an enormous amount of pressure on health systems as a whole and on individual physicians, he says. "Once strong incentives are created through cost cutting through the managed care system, you naturally are going to get more of the cheaper treatments and less of the expensive treatments. That has to be true; that's why things are done."

Although protections are written into Oregon law, physicians will face subtle pressures to view patients' options as more limited than they otherwise may consider them, Lund says. "Even though the law requires a diagnosis of less than six months to live, that is an incentive for the physician to say, 'This person has only six months to live.' Once eliminating the patient is considered a form of treatment, the economic incentives are there that I think are unstoppable."

### References

1. Chin AE, Hedberg K, Higginson GK, et al. Legalized physician-assisted suicide in Oregon — The first year's experience. *N Engl J Med* 1999; 347:577-582.

### Additional reading

- Rojas-Burke J. Oregon's poor slip through safety net of health coverage. *The Oregonian*, March 29, 1999.
- Rojas-Burke J. Survey gives Oregon Health Plan high marks. *The Oregonian*, Feb. 3, 1999. ■

### SOURCES

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## Guidelines help nurses balance medicine, morals

When Oregon voters legalized assisted suicide with the Death with Dignity Act in October 1997, the attention in the medical community was focused largely on the role and responsibilities incurred by physicians treating the seriously ill. However, the state's nurses also were faced with a unique ethical challenge.

The law specifies that only a physician can legally initiate the process designed to allow a patient to take his or her own life. But what about the nurse's role in that patient's care? Nurses are often the ones in close, day-to-day contact with patients. What if they receive a request for information about the patient's rights under the new law? And what if the nurse's personal beliefs conflict with the patient's wishes? Must he or she participate in carrying out the patient's request? What kind of information should the nurse be able — or required — to provide?

Those are some of the issues the Portland-based Oregon Nurses Association (ONA) attempted to resolve with a position paper and guidelines for nurses on the new law. (**See guidelines, inserted in this issue.**)

"The guidelines were designed to address the practice concerns of nurses who choose to be involved with patients who use this law and those who choose not to be involved in that care," says **Susan King**, the ONA staff member who worked with the organization's 20-member task force to develop the guidelines.

"The task force also wanted to assert the patient's self-determination as the primary guiding principal for any nurse's approach," she adds. "As with the general public, ONA members are not universally supportive of the Death with Dignity Act."

The task force comprised 20 nurses from acute, long-term, and community-based care areas, she says. Although the task force referred to documents and position statements from the American Nurses Association (ANA) in Washington, DC, and other organizations, it mostly relied on information from its Code for Nurses and on personal experience in caring for terminally ill patients, King adds.

“When we started getting into this, we found that almost every professional [nursing] association in the world said, ‘Don’t participate in physician-assisted suicide,’” says **Bonnie Driggers**, RN, assistant hospital director in the oncology unit at Oregon Health Sciences University (OHSU) Medical Center in Portland and a member of the task force.

“That’s fine for [those organizations]. But this is now legal here. The patient is making a legal request, and we have to give advice to the nurses,” she says.

The key issues involve the nurses’ responsibility to ensure patients receive adequate information about all available treatment options; maintain patient confidentiality; and have a clear understanding of their obligations to patients under the law. They also must be able to limit their role in the assisted suicide of a patient if assisted suicide conflicts with their own moral code, Driggers explains.

### ***‘Participation’ broadly defined***

In keeping with the policy of the ANA and other national and international organizations, the ONA adopted a definition of participation in assisted suicide that precluded the nurse from actually giving the lethal medication to the patient.

“The word *participate* in the ONA document really looks at administering the medications, although the law really does not allow that,” Driggers notes. The act specifically states that patients themselves must take the medication.

The ONA guidelines are able to guide nurses in their “participation” in a patient’s care and still bar them from participating in the actual assisted suicide.

The ONA guidelines permit nurses to discuss treatment options, including options under the new law, with patients. At OHSU, however, the policy is to have a single person designated to advise patients on these issues after they make a request for information about the Death with Dignity Act, Driggers says.

“The person we have designated is somebody who knows how to advise patients on how to talk to their physicians about it, who knows what our system policies and procedures are, and somebody who also can coach physicians about their

rights and responsibilities when they receive a request,” she explains.

This policy eliminates the prospect of a nurse who is opposed to assisted suicide being placed in the position of offering advice to the patient. “Our whole focus is to ensure that patients get hooked up with someone who is willing to talk to them about what the law says, explore the meaning behind their request, and help them in coming to a decision.”

This method also helps protect the patient’s confidentiality if only one person deals with the request after it is made, she adds. “I recently had a provider come up to me and say that we had had a request. I asked how it came to her attention, and she said a float nurse had been working with a patient, the patient had made a request for information. The nurse then contacted the appropriate person in our system. She knew the policy and that she could not talk to the patient and she could not talk to anyone else about that situation.”

One of the complicated areas the guidelines clarify is what a nurse should do if a patient requests assisted suicide and the nurse feels he or she morally cannot participate in that act. “We have a conscientious practice policy here at OHSU,” notes Driggers. “It applies in the area of abortion, assisted suicide, and withdrawal of life support. We state that any physician or provider has the right to say, ‘I cannot participate in this procedure.’ The policy is procedure-based, not patient-based, she emphasizes.

The ONA document stressed that nurses were not permitted to abandon the care of the patient, but they did not have to be the clinician responsible for withdrawing life support or attending when death under assisted suicide occurs, Driggers says. “We do allow a transfer of care if the clinicians are opposed,” she notes. “The document answers the questions of ‘What do I have to do?’ ‘What can I do?’ and ‘What can’t I do?’”

### **SOURCES**

- **Bonnie Driggers**, RN, Oregon Health Sciences University Medical Center, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098.
- **Susan King**, Oregon Nurses Association, 9600 S.W. Oak St., Suite 550, Portland, OR 97223-6599.

Looking ahead, the Oregon Board of Nursing is working on developing nursing curriculum that deals with assisted suicide, says Driggers, who is also on a board task force examining these issues. “We will have to make people understand what the regulatory implications of assisted suicide are. “For example, what can a nurse be sanctioned for?” she asks.

The board also is focusing on enhancing the state’s curriculum on end-of-life care. “That is truly needed, and I think that even nurses across the country believe that is needed,” she notes. ■

### Are we sliding down the slippery slope?

*Debate shifts to possible link with euthanasia*

Even with the results of the yearlong Oregon Health Division study apparently showing the Death with Dignity Act functioning as intended, many Oregon health providers and ethics experts across the nation remain concerned about the long-term effects of such legislation.

“I think the law passed for reasons that are very different than why people are choosing to use it,” says **Bonnie Driggers**, RN, assistant hospital director in oncology at Oregon Health Sciences University.

“All of the news media in Oregon and Washington focused on pain at the end of life as the main issue. And if you look at data from the Netherlands and you look at the data that was published by the Oregon Health Division, the primary reason for choosing physician-assisted suicide is pain unrelated to physical discomfort. It is suffering related to dependency or a loss of control over your life. And in the Oregon population, it is very disturbing to see the number of

people who do not have a support system, who are single and that sort of thing,” explains Driggers.

Driggers says she does not speak publicly about how she voted on the bill but finds it disturbing. Data from the first year, in her opinion, show that people voted in favor of the law as a means to avoid severe pain at the end of life, yet that’s not the main reason people are choosing to die.

“I think the reason is that Oregon in the last five years has done such a fine job in addressing pain and end-of-life issues in general,” she says. “Data obtained from the Netherlands shows the same thing, that pain is not at the top of the list, but people who haven’t looked at the data think it is, and they have rationalized it.”

An ongoing shift in the clinical definition of futile care in combination with the legalization of assisted suicide also has the potential to marginalize the needs of the elderly, severely ill, and disabled, asserts **Nelson Lund**, JD, professor of law at George Mason University School of Law in Fairfax, VA.

The traditional doctrine of futile care is that it is unethical to provide treatment that will do no good, Lund explains. “For instance, if a patient came to you with insomnia and asked you to amputate his feet, you would not do so because it would have no effect. An everyday example is patients who go to their physicians with a viral infection and ask for an antibiotic.”

However, in academic circles, there is a movement to reconceptualize futile care to include quality of life criteria when considering continuing life-saving treatment in critically ill patients, says Lund.

“Some people want to redefine futile care to say, ‘Well, even though this treatment will prolong the patient’s life, we don’t think that life under these circumstances is worth living, we’ll call it futile care and end treatment,’” Lund explains.

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That debate, however, is not solely academic, says **Gregory Hamilton, MD**, a practicing Portland psychiatrist and president of Physicians for Compassionate Care, a group that opposed the legalization of physician-assisted suicide. “We get more calls about that than we do about physician-assisted suicide. You have half the family wanting to continue treatment, and the person who has the legal power of attorney doesn’t want to.”

Hamilton cites two separate cases in his own experience of patients who wanted to continue to receive artificial feeding and hydration, but their physician providers independently determined that to be futile care and wanted such treatment withheld.

In one case, the family was able to get a court order to have the feeding and hydration restored. In the other case, the patient died. These experiences drive his concern about the legalization of assisted suicide and the power that physicians already have over their patients’ decisions.

“What happens is once you devalue the lives of the seriously ill by stigmatizing them and depriving them of the same protection against discouragement and suicidal ideation that the rest of us have — we who are not burdened with the diagnosis of being terminally ill — they are treated like second-class citizens,” he says. “When you treat the seriously ill or any class of people as if they are separate under the law and don’t have the same protections, you erode the right of everyone.”

### ***Comparing Oregon to the Netherlands***

Lund acknowledges that there are several protections written into Oregon law specifically to outlaw euthanasia, but very similar protections written into measures allowing assisted suicide in the Netherlands have had little effect, he contends.

“In the Netherlands, they never formally repealed the statute against physician-assisted suicide, but they do have this policy of nonprosecution. They have said they won’t prosecute physicians who do the following things, these include specific reporting requirements, getting a second opinion, etc.,” says Lund. “Many physicians there ignore these requirements, and they are tolerated.”

In 1990 in the Netherlands, there were 5,859 reported cases of euthanasia with the patient’s

consent — including 400 cases of reported physician-assisted suicide — and 5,941 cases of euthanasia without the patient’s consent, according to a report provided to The Hague in 1991.<sup>1</sup>

A separate government survey of physicians that same year, known as the Rummelink Report, reported 2,300 cases of voluntary euthanasia with 400 cases of physician-assisted suicide, and an additional 1,000 cases of involuntary euthanasia.<sup>2</sup>

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Questions or comments? Call **Kevin New** at (404) 262-5467.

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