Oregon Suicide Law in Limbo for Now

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Approval of the nation's first physician-assisted suicide law last November has proved the adage "be careful what you wish for." In the aftermath of the Oregon initiative that once again endorsed the state's Death with Dignity Act, physicians and government officials throughout the country are now scrambling to make sense of the law and figure out ways to assure that compliance doesn't lead to liability, both criminal and civil.

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These efforts weren't made any easier when the U.S. Drug Enforcement Administration (DEA) announced two weeks after the November election that physicians who prescribed lethal doses of barbiturates could lose their prescription rights. According to DEA officials, the Controlled Substances Act does not consider a suicide-inducing prescription a legitimate medical purpose. But the Justice Department has balked at joining the DEA in its condemnation of the practice, saying that Attorney General Janet Reno will make the final decision. The DEA, an agency run by the Justice Department, issued its pronouncement without first clearing it with Reno.

Meanwhile, the ambiguity has left physicians up in the air, with the Oregon Medical Association (OMA) advising caution. "The only official word we have is that physicians who prescribe barbiturates for assisted suicide could face sanctions," said Charles Hofmann, M.D., the OMA's president, in a November 19, 1997 New York Times article. "Our recommendation would be to not become involved until this is settled."

Sixty percent of Oregon voters chose not to repeal the physician-assisted suicide law that was originally passed in 1994. Last October, following the U.S. Supreme Court's ruling that essentially turned assisted suicide into a states' rights issue, a federal appeals court set aside an injunction that had kept the initiative from becoming law. State legislators, in an unusual effort to take another bite at the electoral apple, placed the recent ballot measure before voters, asking if they wanted to repeal the law. They didn't.

Enactment of the law has "turned medicine on its head," according to James Boehnlein, M.D., professor of psychiatry at the Oregon Health Sciences University and chair of an Oregon Psychiatric Association task force on assisted suicide. "One is using what has been for centuries instruments of healing, whether it's medication or writing a prescription, and [taking] a physician's knowledge, experience, and professional and state sanctioned abilities and using that as an instrument to hasten actively the death of the patient," he said, speaking personally. "It turns the table and it changes the meaning of writing prescriptions...and there's a danger in that."

Nevertheless, Boehnlein said that physician groups are working on developing standards of practice for evaluating patients who have expressed a desire to commit suicide. Ultimately, the introduction of death as a "treatment option" will fundamentally change discussions with patients and family members surrounding end of life care.

Much of the confusion centers around the fact that voters approved the law before physicians were geared up to handle the terminal patient contemplating suicide. Without sufficient research into issues surrounding "rational suicide," and lacking any training programs to acquaint doctors with the law and the appropriate way to evaluate a patient requesting suicide, the possibilities for profound mistakes exist. If they occur, physicians will face potential malpractice liability in a legal system that has never considered a case involving the negligent treatment of a suicidal, terminally ill patient anywhere in the country.

Under the law, the patient's attending physician and a consulting physician are responsible for determining whether a patient has less than six months to live; and further, that the desire to die is not the result of a mental condition, particularly depression, that has impaired decision-making abilities. A psychiatric or psychological consultation is not necessary unless the two original
physicians determine a referral is necessary. According to Boehnlein, what to teach non-mental health practitioners about terminally ill patients who want to commit suicide is a tricky issue. For instance, doctors' personal feelings about physician-assisted suicide—whether for or against—could have a serious effect on the objectivity of the evaluation. Does this mean that doctors with deeply held personal beliefs should be disqualified from conducting evaluations? Will a physician who "negligently" refuses to authorize an overdose be sued for the pain and suffering of a wrongful life? Or after doctors grant a patient's request, will they end up the defendant in a wrongful death case brought by relatives who may not have been consulted, despite the law's immunity provisions? No one yet knows the answers to these and myriad other questions.

Linda Ganzini, M.D., a psychiatrist at the Veterans Affairs Hospital in Portland and an associate professor of psychiatry at the Oregon Health Sciences University, has researched issues relating to assisted suicide. She said that now that the law is in place, it will define the standard of care for psychiatrists, but it won't answer serious questions about a patient's motivations and decision-making capabilities.

"The psychiatrist's role is to determine if depression or other psychiatric disorder is influencing the judgment of a patient requesting suicide," Ganzini said. "The problem is that psychiatrists are pretty good at diagnosing depression but whether a depression is influencing somebody's judgment is difficult, and we really don't have standards for that."

Since the primary care provider has the option of referral, she added, psychiatrists or other mental health professionals may never even get the chance to evaluate someone who at least appears "lucid and rational and capable of making decisions that seem consistent with their life's value." Ganzini believes referrals will occur when "it is unclear whether depression is influencing a patient's judgment." When she did a survey of Oregon psychiatrists, however, only 6% were very confident that they could make this determination.

Until there is greater clarity, it seems that patients who want to commit suicide will have to wait. Kaiser Permanente, a large HMO with offices in Portland, announced that it intends to comply with the death with dignity law in a "safe and compassionate manner," but said there must be "greater certainty about what guidelines, regulations or restrictions could be imposed by state or federal officials."

"Once that happens," according to a statement released by the company, "we will treat this as a covered benefit for members when prescribed by our physicians in accordance with applicable laws and administrative regulations."

Meanwhile, Oregon newspapers are providing advice for their readers who may want to choose suicide. Despite all the safeguards supposedly built into the law, a November 9, 1997, edition of the Oregonian had simple advice for people who change their minds after taking the overdose: "Call 911 immediately."

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