

SUICIDE AND PUBLIC POLICY

Testimony to the Subcommittee on the Constitution, Civil Rights and Property Rights Committee on the Judiciary United States Senate

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Chairman Brownback, Senator Feingold, and Honorable Members of the Subcommittee, thank you for inviting me to testify before you today on this most urgent topic. This is an important moment historically in the debate about suicide and assisted suicide.

In 1994, Oregon transformed the crime of assisted suicide into a medical treatment when it passed the Oregon Death with Dignity Act (ODWDA). Since it went into effect in 1997, that law and experience related to it have been widely misunderstood.

Gonzales v. Oregon and the "Ashcroft Directive": Myths and Reality

On November 6, 2001, Attorney General John Ashcroft issued an interpretative ruling known as the "Ashcroft Directive" (Directive), stating that doctors could lose their federal registrations to prescribe federally controlled substances if they used those registrations to prescribe substances for the purpose of suicide.¹ He did so by finding that assisting suicide was not in the public interest and that prescribing for the *purpose* of suicide did not constitute a legitimate medical purpose under the Controlled Substances Act (CSA). The Directive was challenged immediately.

Contrary to widespread misunderstanding, the Directive, if upheld, would *not* have overturned the *practice* of assisted suicide in Oregon. Assisted suicide would have remained legal. Oregon physicians could still have assisted suicides by prescribing substances that are not controlled under federal law.

¹ 66 Fed. Reg. 56,607 (2001)

Passage of the ODWDA approved the *act* of physician-assisted suicide but does not specify the *means* by which the act is to be accomplished. The law permits physicians to "prescribe medication"² for suicide but does not define "medication." Nothing in the law limits "medication" to federally controlled substances, nor does the law specifically provide that federally controlled substances are to be the means for carrying out suicide under the ODWDA. It does not refer to any particular method of inducing death other than precluding the lethal injection, mercy killing and active euthanasia.³

On January 17, 2006, in its 6-3 decision in *Gonzales v. Oregon*,⁴ the U. S. Supreme Court found that Ashcroft had exceeded his authority when he issued his Directive. The decision was not an "endorsement" of Oregon's law, as some have claimed. Instead it was a narrow ruling dealing with the attorney general's authority to determine what is meant by a "legitimate medical purpose."

The Court's majority found that, since the CSA does not explicitly prohibit prescribing for suicide and does not explicitly declare that prescribing for suicide is not a legitimate medical purpose, the attorney general lacked authority to interpret it as doing so. According to the Court, it is not up to the attorney general to determine if suicide is a risk to public health and safety or if prescribing for suicide is a legitimate medical purpose under federal law. Instead, it is up to Congress to do so "by explicit language in the statute."⁵

The Experience in Oregon

In *Gonzales*, the U.S. Supreme Court summarized Oregon's assisted-suicide law:

The statute gives attending physicians a central role, requiring them to provide prognoses and prescriptions, give information about palliative alternatives and counseling, and ensure patients are competent and acting voluntarily. § 127.815. Any eligible patient must also get a second opinion from another registered physician, § 127.820, and the statutes' safeguards require physicians to keep and submit to inspection detailed records of their actions, §§ 127.855, 127.865.⁶

² Or. Rev. Stat. 127.800 to 127.897.

³ Or. Rev. Stat. 127.880.

⁴ *Gonzales v. Oregon*, 126 S. Ct. 904 (2006).

⁵ *Id.* at 924.

⁶ *Id.* at 923.

That summary, containing what are generally referred to as some of the ODWDA's "safeguards," conveys a notion of a carefully written, protective law. However, the experience in Oregon contradicts the effectiveness of safeguards, making it clear that their protective nature is a mere illusion. A telling example of this is contained in the official published transcript of closed door hearings conducted in Oregon by members of the British House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. Committee members traveled to Oregon seeking information regarding Oregon's assisted-suicide law for use in their deliberations about a similar proposal under consideration in Parliament.⁷

After hearing many witnesses claim that there have been no complications associated with more than 200 assisted-suicide deaths, committee member Lord McColl of Dulwich, a surgeon, expressed skepticism. He said, "If any surgeon or physician had told me that he did 200 procedures without any complications, I knew that he possibly needed counseling and had no insight. *We come here and I am told there are no complications. There is something strange going on.*"⁸

Another committee member, Baroness Finlay, also a physician, found the Oregon experience a cause for concern rather than reassurance. Writing in the journal *Palliative Medicine*, she explained that she and others "anticipated that the evidence would sway them towards a legislative change, but in fact after carefully weighing the evidence heard by the Committee, their opinion is that a change in the UK's law on intentional killing would be unwise."⁹

The following contains statistical data from official reports and other published information that contradicts assurances that the ODWDA's safeguards and reporting system are protective. None of the statements below were made by opponents of

⁷ The "Assisted Dying for the Terminally Ill Bill" was defeated in Parliament on May 12, 2006 by a vote of 148 to 100.

⁸ Witnesses' testimony before the committee was published in: *House of Lord Select Committee on the Assisted Dying for the Terminally Ill Bill, [HL]*, Volume II: Evidence, Apr. 4, 2005. (Hereafter cited as HL.) Remarks by Lord McColl, HL, p. 334, Q. 956. (Emphasis added.) Available at: <http://www.publications.parliament.uk/pa/ld200405/ldasy/86/86ii.pdf>. (Last accessed Feb. 23, 2006.)

⁹ I.G. Finlay *et al*, "The House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill: Implications for specialist palliative care," *Palliative Medicine*, Volume 19 (2005), p. 444.

Oregon's law.

The number of reported assisted-suicide deaths may be inaccurate or incomplete

The latest official annual Oregon report indicates that there have been 246 reported assisted-suicide deaths since the ODWDA act went into effect. This reflects an increase of more than 230% since the first year of legal assisted suicide in Oregon.¹⁰ The numbers, however, could be far greater.

- From the time the law went into effect, Oregon officials in charge of formulating annual reports have conceded “*there’s no way to know if additional deaths went unreported*” because Oregon's Department of Human Services (DHS), the agency designated by law to oversee assisted-suicide prescribing, “*has no regulatory authority or resources to ensure compliance with the law.*”¹¹
- The DHS has to rely on the word of doctors who prescribe the lethal drugs.¹² Referring to physicians’ reports, the state reporting division admitted: “For that matter the entire account [received from a prescribing doctor] could have been a cock-and-bull story. We assume, however, that physicians were their usual careful and accurate selves.”¹³

The ODWDA contains no penalties for doctors who do not report prescribing lethal doses for the purpose of suicide.

Data for reports is based on self-reporting by doctors who prescribe lethal drugs

- Asked if there is any systematic way of finding out and recording complications, Dr. Katrina Hedberg, the lead author for several of Oregon's official reports, replied, “Not other than asking physicians.”¹⁴
- Dr. Melvin Kohn, Oregon State Epidemiologist and Administrator of the department that oversees the annual reports about Oregon's law, explained that, in every case that they hear about, “it is the self-report, if you will, of the physician involved.”¹⁵

¹⁰ DHS, “Eighth Annual Report on Oregon’s Death with Dignity Act,” March 9, 2006. (<http://egov.oregon.gov/DHS/ph/pas/docs/year8.pdf>)

¹¹ Linda Prager, “Details emerge on Oregon’s first assisted suicides,” *American Medical News*, Sept. 7, 1998. (Emphasis added.)

¹² Joe Rojas-Burke, “Suicide critics say lack of problems in Oregon is odd,” *Oregonian*, Feb. 24, 2000.

¹³ Oregon Health Division, *CD Summary*, vol. 48, no. 6 (March 16, 1999), p. 2. (<http://www.ohd.hr.state.or.us/chs/pas/pascdsm2.htm>)

¹⁴ Hedberg, HL, p. 263, Q. 597.

¹⁵ Kohn, HL, p. 263, Q. 598.

"Safeguards" are disregarded and no one has been disciplined

- Referring to assisted-suicide cases that were in violation of the law – where only one of the required two witnesses signed the request or where doctors prescribed the lethal drugs without waiting for 15 days as the law requires – Dr. Hedberg said, "[T]here have been a number [of such violations] over the years."¹⁶
- Kathleen Haley, Executive Director of the Oregon Board of Medical Examiners, said four such cases, one involving multiple patients,¹⁷ were reported to the Board of Medical Examiners. This resulted in issuance of two "letters of concern" that are considered "letters of advice." She explained that the letters "are not public and they are not official disciplinary actions."¹⁸

Complications are not investigated or reported

- "[W]e are not given the resources to investigate," Dr. Hedberg said. "[N]ot only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."¹⁹
- David Hopkins, Data Analyst for Oregon's Center for Health Statistics, said, "We do not report to the Board of Medical Examiners if complications occur; no, it is not required by the law and it is not part of our duty."²⁰
- Jim Kronenberg, the Oregon Medical Associations' (OMA) Chief Operating Officer, explained that "the way the law is set up there is really no way to determine that [complications occurred] unless there is some kind of disaster." "[P]ersonally I have never had a report where there was a true disaster," he said. "Certainly that does not mean that you should infer there has not been, I just do not know."²¹

Psychological evaluations are rare

Under the ODWDA, depressed or mentally ill patients can receive assisted suicide if they do not have "impaired judgment."²²

- The decision to refer for a psychological evaluation, Dr. Kohn said, is "up to the docs' discretion."²³
- During the last three years for which reports are available, only six patients – two per year – were referred for a psychological evaluation or counseling before receiving

¹⁶ Hedberg, HL, p. 257, Q. 555.

¹⁷ Haley, HL, p. 323, Q. 889.

¹⁸ *Id.*, Q. 892.

¹⁹ Hedberg, HL, p. 266, Q. 615.

²⁰ Hopkins, HL, p. 259-260, Q. 568.

²¹ Kronenberg, HL, p. 347, Q. 1035.

²² ORS 127.825 §3.03.

²³ Andis Robeznieks, "Assisted-suicide numbers in Oregon," *American Medical News*, Apr. 5, 2004.

prescriptions for suicide.²⁴

- Dr. Peter Rasmussen, who has acknowledged his involvement in Oregon assisted-suicide deaths numbering into the double digits, told *American Medical News* that 75 percent of the patients who come to him are people he has never seen before and that, before writing the prescription for the lethal dose, he spends a minimum of three hours with each patient either in person *or by telephone*.²⁵

Patient's judgment may be impaired when the prescription is filled or taken

- Although the ODWDA requires that a patient be competent when *requesting* a prescription for suicide, it does not contain any provision requiring patient competency at the time the prescription is filled or when the suicide occurs.
- Dr. Hedberg acknowledged that there is no assessment of patients after the prescription is written. "Our job is to make sure that all the steps happened *up to the point the prescription was written*," she said.²⁶ "In fact, after they write the prescription the physician may not keep track of that patient....[T]he law itself only provides for writing the prescription, *not what happens afterwards*."²⁷

No way to track the drugs once they are received

- "[W]e do not have a way to track if there was a big bottle [of lethal drugs] sitting in somebody's medicine cabinet and they died whether or not somebody else chose to use it," explained Dr. Hedberg.²⁸

Self-administration is very broadly interpreted

- Dr. Rasmussen explained that, in one case, he opened 90 capsules – a lethal dose – of barbiturates and poured the white powder into a bowl of chocolate pudding. He gave the mixture to the woman's son who spooned the mixture into his mother's mouth. Another son gave her sips of water to wash the solution down. The woman died twelve hours later.²⁹
- According to Sue Davidson of the Oregon Nurses Association (ONA), a 2002 survey found that nurses were very actively involved in the process and that "some indicated that they had assisted [patients] in the taking of it [the lethal dose]."³⁰

²⁴ DHS, "Eighth Annual Report on Oregon's Death with Dignity Act," March 9, 2006, pg. 23, Table 4.

²⁵ Andis Robeznieks, "Oregon sees fewer numbers of physician-assisted suicides," *American Medical News*, Apr. 4, 2005.

²⁶ Hedberg, HL, p. 259, Q. 566. (Emphasis added.)

²⁷ *Id.* Q. 567. (Emphasis added.)

²⁸ *Id.* p. 262, Q. 591.

²⁹ Jennifer Page, "A Death in Oregon: One Doctor's Story," *Washington Post*, Nov. 3, 1999.

³⁰ Davidson, HL, p. 352-353, Q. 1058.

Lethal drugs do not need to be taken orally

The ODWDA bars a physician from administering a lethal injection to a patient.³¹

However, it does not explicitly specify the route by which the lethal drugs must be taken.

- Barbara Glidewell who educates Oregon Health & Science University (OHSU) patients and their families about "the need for a dying plan and to rehearse the plan"³² said that patients who cannot swallow would "need to have an NG [naso-gastric] tube or G [gastrostomy] tube placement."³³ Then, they could "express the medication through a large bore syringe that would go into their G-tube."³⁴
- Oregon's 2005 *Guidebook for Health Care Professionals* states, "It remains unclear whether the Oregon Death with Dignity Act allows an attending physician to prescribe an injectable drug for the patient to self-administer for the purpose of ending life."³⁵
- Discussing a case in which a man said he helped his brother-in-law take the drugs, Dr. Hedberg said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted...."³⁶

Required life expectancy of six months or less is considered unrealistic or unimportant

- Kronenberg of the OMA said most physicians have told him that trying to predict that a patient has less than six months to live "is a stretch." "Two hours, a day, yes, but six months is difficult to do," he explained.³⁷
- Dr. Rasmussen said life expectancy predictions for a person entering the final phase of life are inaccurate. He dismissed this as unimportant, saying, "Admittedly, we are inaccurate in prognosticating the time of death under those circumstances, *we can easily be 100 percent off*, but I do not think that is a problem. If we say a patient has six months to live and we are off by 100 percent and it is really three months or even 12 months, I do not think the patient is harmed in any way...."³⁸

³¹ Or. Rev. Stat. 127.880.

³² Glidewell, HL, p. 268, No. 3.

³³ *Id.* p. 270, Q. 623.

³⁴ *Id.* p. 275, Q. 653.

³⁵ *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* (2005), developed by The Task Force to Improve the Care of Terminally-Ill Oregonians, convened by The Center for Ethics in Health Care, Oregon Health & Science University; Chapter 10, Pharmacists and Pharmacy-Related Issues, p. 4. Available at: <http://www.ohsu.edu/ethics/guidebook/chapter10.pdf>. (Last accessed Feb. 23, 2006.) The guidebook notes, "The Act specifically states: 'Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection....'" [Chapter 10, p. 4. (Emphasis added.)] It does not specifically state that a patient cannot end his or her own life by lethal injection.

³⁶ Hedberg, HL, p. 267, Q. 621.

³⁷ Kronenberg, p. 351, Q. 1054.

³⁸ Rasmussen, HL, p. 312, Q. 842. (Emphasis added.)

Pain control has become increasingly inadequate

- As of 2004, Oregon nurses reported that the inadequacy of meeting patients' pain needs had increased "up to 50 percent even though the emphasis on pain management has remained the same or is slightly more vigorous....Most of the small hospitals in the state do not have pain consultation teams at all," Davidson of the ONA said.³⁹

Records used in annual reports are destroyed

- Dr. Hedberg said, "After we issue the annual report, we destroy the records."⁴⁰

Doctors decide what "residency" means

- Under Oregon's law, a patient must be a resident of Oregon.⁴¹ Residency can be demonstrated by means that include [but are not limited to] a driver's license or a voter registration, but, according to Dr. Hedberg, "It is up to the doctor to decide" whether the person is a resident. There is no time element during which one must have lived in Oregon. "If somebody really wanted to participate, they could move from their home state," she said. "I do not think it happens *very much*...."⁴²

An assisted-suicide advocacy group facilitates most of Oregon's assisted suicides

- According to Dr. Elizabeth Goy of OHSU, Compassion in Dying (the assisted-suicide advocacy group that merged with the Hemlock Society and is now called Compassion and Choices⁴³) sees "almost 90 percent of requesting Oregonians...."⁴⁴
- Barbara Farmer of the Visiting Nurses Association said, if a person's own doctor doesn't want to participate, "we have advised them to work with Compassion in Dying...."⁴⁵

Is it the intent of Congress that federal registrations be used to facilitate activities such as those described above? Is it the intent of Congress that federal registrations be used for the purpose of facilitating suicide in other jurisdictions if such jurisdictions pass laws similar to, or even more expansive, than Oregon's law?

³⁹ Davidson, HL, p. 357-358, Q. 1098.

⁴⁰ Hedberg, HL, p. 262, Q. 592.

⁴¹ Or. Rev. Stat. 127.860, § 3.10.

⁴² Hedberg, HL, p. 267, Q. 620. (Emphasis added.)

⁴³ The co-director of Compassion and Choices was the chief petitioner for the Oregon law. Currently Compassion and Choices is spearheading a California legislative measure – the "Compassionate Choices Act" (AB 651) – modeled on Oregon's law.

⁴⁴ Goy, HL, p. 291, Q. 768. (Goy is an assistant professor, Dept. of Psychiatry, School of Medicine, OHSU, and has worked with Dr. Linda Ganzini in surveys dealing with Oregon's assisted-suicide law.)

⁴⁵ Farmer, HL, p. 302, Q. 794. (Farmer is Director of Home Care and Manager for Legacy VNA Hospice, part of the Visiting Nurse Association and the Legacy Health System.)

The CSA can be amended to reflect the intent of Congress

Congress has never endorsed suicide. Furthermore, it took one step in refusing to facilitate it by passing the Assisted Suicide Funding Restriction Act of 1997 which precludes the use of federal funding for assisted suicide. Under that provision, *federal* funds may not be used for drugs prescribed for the purpose of suicide. Yet, a state can use state dollars for such a purpose.

For example, Oregon pays for drugs for the purpose of suicide. According to Ann Jackson, Executive Director and primary spokesperson of the Oregon Hospice Association, "The State of Oregon, under the Oregon Health Plan, will buy the medications....The drugs are very inexpensive."⁴⁶

Likewise, a determination by Congress that prescribing federally controlled substances for suicide is not a legitimate medical purpose under *federal* law would leave states free to permit physicians to prescribe any of the thousands of medications that are not federally controlled substances for the purpose of suicide.

In *Gonzales*, the U.S. Supreme Court left the door open for Congress to make a determination that prescribing federally controlled substances for suicide is not a legitimate medical purpose.

There is a wealth of data to support a finding by Congress that prescribing controlled substances for suicide is not a legitimate medical purpose under federal law. Note that such a finding would not prevent states from making their own determinations about the *practice* of physician-assisted suicide. That would remain the subject of an ongoing "earnest and profound debate."⁴⁷ It would, however, provide the necessary clarification that Congress does not endorse suicide and therefore will not permit *federal* registrations to be used to prescribe *federally* controlled substances for suicide.

A state could still determine what is a legitimate medical *practice* within its borders. However, common sense dictates that, since the federal government issues the registrations for prescribing *federally* controlled substance, it may determine which purposes are not legitimate for the use of such registrations. Indeed, as stated above, the U.S. Supreme Court in *Gonzales* noted that Congress explicitly determines the meaning

⁴⁶ Jackson, HL, p. 307, Q. 819. (Jackson is Executive Director and Chief Executive, Oregon Hospice Association. She is also the primary spokesperson for OHA and Oregon hospices about the Oregon law.)

of a legitimate medical purpose under the CSA.

Thus, Congress may wish to consider making such an explicit determination.

George Orwell said, "Sometimes the first duty of intelligent men is the restatement of the obvious." The following are some pertinent facts regarding suicide in the United States.

- In 1999, David Satcher, MD, then Surgeon General of the United States, declared, "Suicide is a serious public health problem."⁴⁸ He noted that suicide was one of the leading causes of mortality in the United States, accounting for nearly 31,000 deaths per year, a number that was more than 50 percent higher than the number of homicides for the same year.⁴⁹
- By 2004, the number of homicides had decreased.⁵⁰ However, the number of suicides had increased to 31,647 – more than 86 *per day*⁵¹ – making the annual number of suicides double that of homicides.
- As of 2005, Oregon has experienced an increase in suicides among people who are 65 and older.⁵² The rate exceeds the national average and does not include suicides falling under Oregon's assisted-suicide law. According to state epidemiologist Dr. Melvin Kohn, "Suicide is a public health problem."⁵³ (As noted above, Dr. Kohn, who is a lead author of several of Oregon's official reports on assisted suicide, is not an opponent of assisted suicide.)
- In *Gonzales*, the U.S. Supreme Court, noted that prevention of drug abuse is central to the CSA and that the "undefined term 'drug abuse' is connected with 'addiction or abnormal effects on the nervous system.'⁵⁴ The Court further observed that "to read prescriptions for assisted suicide as constituting 'drug abuse' under the CSA is discordant with the phrase's consistent use throughout the statute, not to mention its ordinary meaning."⁵⁵

Yet, it takes little more than a tremendous grasp of the obvious to recognize that drugs provided for suicide are connected with "abnormal effects on the nervous system,"

⁴⁷ *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997).

⁴⁸ U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide*, (1999), p. 1.

⁴⁹ *Id.*

⁵⁰ There were 16,137 homicides in 2004. Federal Bureau of Investigation, *Crime in the United States*, (2004), p. 72.

⁵¹ Center for Disease Control, Table 2, Deaths and death rates for 2004. Available at: http://www.cdc.gov.nchs/data/hesta/preliminarydeaths04_tables.pdr#2 (last accessed Apr. 25, 2006).

⁵² Brandon Gee, "Elder suicide has state worried: With Oregon's rate topping the U. S. average, the Department of Human Services readies nine 'strategies of prevention.'" *Oregonian*, Aug. 23 2005.

⁵³ Mary Ann Albright, "Elder suicide rate high in Oregon," *Corvallis Gazette-Times*, Apr. 7, 2006.

⁵⁴ *Gonzales* at 925.

⁵⁵ *Id.* at 924.

unless one considers complete shutdown of the nervous system to be a normal effect of prescribed medication.

When Congress amended the CSA in 1984, it did so, in part, to address the frequency with which prescription drugs were involved in drug-induced deaths. Yet Congress did not explicitly state that prescribing drugs for the specific purpose of inducing death posed a threat to public health and safety. It is likely that, at the time, Congress did not envision the possibility that anyone would consider prescribing for suicide to be a legitimate use of a federal registration.

This shortcoming can be remedied easily with relatively minor changes in the CSA. Such changes could be based on finding that:

- (1) Suicide means the act or instance of taking one's own life voluntarily or intentionally.
- (2) Suicide is a public health threat.
- (3) Prescribing federally controlled substances for suicide runs counter to the public interest.
- (4) Congress does not provide federal registrations for the purpose of facilitating suicide and intends that federal registrations not be used for such a purpose.
- (5) Prescribing for the purpose of suicide does not constitute a legitimate medical purpose under the CSA.

Thank you again for the opportunity to testify before you today. I stand ready to work with the Committee as it continues its consideration of the important issues surrounding the grave public health threat of suicide in the United States.