Euthanasia Prevention Coalition
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Depression and physician-assisted suicide

By Alex Schadenberg

People in Washington State need to be aware that if the I-1000 assisted suicide Initiative is passed, people who experience depression will not be effectively protected under "Oregon Style" safeguards.

The recent study, available at *BMJ.com* entitled: "Prevalence of depression and anxiety in patients requesting physicians aid in dying: cross sectional survey," proves that 26% of people in Oregon who were part of the study and who requested assisted suicide were experiencing depressive disorders. Even though many of those people were incompetent or unable to "freely choose" assisted suicide, they were given a prescription for lethal drugs and died by ingesting those drugs.

The study by Linda Ganzini, Elizabeth R. Goy, and Steven K Dobscha - British Medical Journal - BMJ 2008; 337:a1682: states in its conclusion:

> "Our study suggests that most patients who request aid in dying do not have a depressive disorder. However, the current practice of the Death with Dignity Act in Oregon may not adequately protect all mentally ill patients, and increased vigilance and systematic examination for depression among patients who may access legalised aid in dying are needed. Tools for screening for depression such as those used in our study are easy to administer and may help to determine which patients need further evaluation by a mental health professional. Further study is needed to determine the effect of treatment of depression on the choice to hasten death."

What is important about this study is that the authors do not oppose physician assisted suicide, but are rather concerned about the implications of such a law.

Since the Oregon law was enacted to allow assisted suicide for adults who are competent, terminally ill, and voluntarily choosing to end their life, therefore this study is important based on the fact that a person who is depressed is usually incompetent or unable to exercise free choice.

The Euthanasia Prevention Coalition believes that physician assisted suicide directly threatens the lives of the most vulnerable in our society. That doesn't mean that, if legal, only vulnerable people die by assisted suicide, but rather a vulnerable person, which includes but is not limited to people who are experiencing symptoms of depression or a cognitive impairment, are more likely to die by assisted suicide than the general population of terminally ill people.

Ganzini et al, studied 58 patients in Oregon who requested assisted suicide. Most of these people were dying of cancer or ALS - Lou Gehrig's disease.

They specifically studied patients who had requested assisted suicide:

> "We surveyed participants had taken active steps to pursue a physician's aid in dying in one of the few jurisdictions where it is legal - all either explicitly requested aid in dying from a physician or contacted Compassion and Choices for information on the Oregon Death with Dignity Act. Before death, almost half had obtained a prescription for a lethal drug under the law."

Of the 58 people who participated in the study, 26% (15) were independently diagnosed with depression.

The study stated:

> "Among patients who requested a physician's aid in dying, one in four had clinical depression. However, more than three quarters of people who actually received prescription for lethal drugs did not have a depressive disorder. Our findings also indicate that the current practice of legalised aid in dying may allow some potentially ineligible patients to receive a prescription for a lethal drug; two of those who ultimately died by lethal ingestion had depression at the time that they received a prescription for a lethal drug and died by ingestion the drug. A third patient was depressed at the time that she requested a physician's aid in dying and probably received her prescription; she was successfully treated for her depression before she died by lethal ingestion."

Further to the concern in Oregon that people with depressive disorders are dying by assisted suicide the authors acknowledge that:

> "In a study of 321 psychiatrists in Oregon only 6% were very confident that in a single evaluation they could adequately determine whether a psychiatric disorder was impairing the judgement of a patient requesting assisted suicide. In a study of 290 US forensic psychiatrists, 58% indicated that the presence of major depressive disorder should result in an automatic finding of incompetence for the purpose of obtaining assisted suicide."

Proponents of assisted suicide will say that since there are

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I-1000 - Prescription for coercion not freedom

By John Ruhl and William Watts, M.D.
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Since Oregon passed its physician-assisted-suicide law in 1994 — the only state to do so — similar ballot measures and legislative bills have been introduced in 21 other states, some multiple times. Every single one has failed.[1] The American Medical Association and state medical associations in 49 states, including Washington, oppose the legalization of assisted suicide, and the Oregon Medical Association has supported repeal of Oregon's statute.[2]

Initiative 1000 would legalize physician-assisted suicide in Washington.[3] Regardless of one's opinion as to the propriety of assisted suicide as a concept, we urge voters to reject I-1000 because it would subject poor, disabled and other vulnerable patients to dangerous outside pressures to end their lives prematurely, could not effectively be monitored or policed, and is deeply contrary to the role of health care providers as healers.

"Freedom" to be coerced

Proponents of I-1000 are promoting it as a measure that would expand the liberty of individuals to make choices about their healthcare. But this kind of "liberty," like the "liberty" to work a 70-hour work week without overtime pay or the "freedom to choose" to sell one's labor for less than the minimum wage, cannot be viewed in a vacuum. The proposed "freedom to choose" physician-assisted suicide would expose vulnerable citizens — especially poor or disabled patients — to new and dangerous pressures that they are shielded from under current law.

Former dean of the University of Washington School of Nursing, Rheba de Tornyay, has framed the dilemma succinctly:

"Those who suffer prolonged problems and people with disabilities ... fear — reasonably, I believe — that a profit-preoccupied medical establishment combined with emotionally and financially stressed families would press them to accept death, regardless of the heralded safeguards laws would contain."[4]

The "liberty" promised by backers of I-1000 would do little or nothing to alleviate patients' very real and legitimate fears of coercion. The coercion need not be flagrant or calculating, but merely implicit. For example, a son could be going through financial difficulties and, because dad has some assets, he could consciously or unconsciously nudge dad toward suicide. Such coercive pressures might not be discernible to persons outside the family.

Conflict of interest: heir as witness

The witness provision in the proposed act illustrates how it would mask, not prevent, coercion. Section 3(2) provides that a patient's own heir could be one of the two witnesses who would certify that the patient was not "coerced" into requesting the lethal drugs. This is a useless safeguard for any dependent patient who is unable to voice feelings of coercion in front of his or her heir. By contrast, the Washington will statute directly discourages similar conflicts of interest for witnesses of wills. If an "interested witness" (i.e., heir) serves as a witness to a person's will, there arises a rebuttable presumption that the witness procured the bequest by "duress, menace, fraud, or undue influence."[5]

No witness required at patient's death

The most gaping procedural omission in I-1000 is that there is no requirement that any health care provider (or anyone at all) witness and verify that the patient actually ingested the lethal dose knowingly and voluntarily. This leaves the door open for very serious abuse that no other purported safeguard in the act could prevent.

Patient unknowingly may ingest lethal drugs

The initiative allows physicians to prescribe lethal drugs that the patient "may self-administer"[6] — a curious phrase not used in the Oregon act. The initiative defines the term "self-administer" to mean "ingest."[7] If one replaces "self-administer" with "ingest," a patient's "ingestion" of the lethal drug would be legal even if the patient was unaware of what he or she was ingesting.

Others may administer lethal drugs to patient

The use of the word "may" in the vague phrase, "may self-administer," leaves the phrase so broad that it allows for scenarios in which someone other than the patient "may" administer the lethal drugs to the patient — even if the patient is unconscious.

Reporting, enforcement and verification deficiencies

It would be virtually impossible for the State's bureaucracy to discover abuse — whether at the time of prescription or at the time of death — because I-1000 gives the State no adequate enforcement mechanisms.[8] Ferreting out victims of abuse would be even more difficult because the patient's death certificate would be required to "list the underlying terminal disease as the cause of death"[9] rather than suicide.

Nor would the press or public be able to verify the accuracy of the State's summary statistical reports, because I-1000 provides specifically that "[e]xcept as otherwise required by law, the information collected [regarding compliance with

I-1000] is not a public record and may not be made available for inspection by the public."[10]

I-1000 contradicts physicians' role as healers

In 2007, the Washington State Medical Association adopted a resolution supporting quality end-of-life care "without participation in hastening death or providing a means for patients to hasten their own death" and restating its prior position that physicians should not "intentionally cause death."[11] In a July 2, 2008 press release, WSMA President Dr. Brian Wicks stated, "We believe physician-assisted suicide is fundamentally incompatible with the role of physicians as healers.[12]

Likewise, in September 2007, the Washington Hospice and Palliative Care Organization adopted a resolution stating that it "does not support the legalization of physician aid in dying." The National Hospice and Palliative Care Organization adopted a similar resolution in 2005. The reason why the concept of assisted suicide has very little historical precedent is that it runs contrary to the basic principles of the health care profession.

Washington voters should reject I-1000

Initiative is unnecessary

Assisted-suicide legislation would be an unnecessary anachronism in Washington. Recent major improvements in pain management and hospice care allow terminally ill patients effectively to manage their own pain and symptoms and spend the final stage of their lives in peace with their loved ones. Paradoxically, the assisted-suicide debate has been a major stimulus for the medical community in improving end-of-life health care management.

Conclusion

I-1000's flawed procedures would expose vulnerable adults to the risk of coercion to end their lives prematurely, would require no witnesses or other meaningful safeguards for patients at the moment of death, and would place health care providers squarely at odds with their role as healers.

Notes

[1] See http://dredf.org/assisted_suicide/Failed_attempts.pdf.

[2] See Washington State Medical Association press release, July 2, 2008, at http://www.wsma.org/press-room_detail.cfm?nid=373.

[3] The complete text of Initiative 1000 can be reviewed at the website of the Washington Secretary of State, at http://www.secstate.wa.gov/elections/initiatives/text/i1000.pdf.

[4] Rheba de Tornyay, "Proposal is reckless, unnecessary," *Seattle Post-Intelligencer*, August 25, 2008, http://seattlepi.nwsource.com/opinion/376408_antidignity26.html.

[5] RCW § 11.12.160(2).

[6] Section 2(1).

[7] Section 1(12): "'Self Administer' means a qualified patient's act of ingesting a medication to end his or her life ... ."

[8] For example, Section 15(1)(b) imposes no penalty whatsoever for failure to report information to the State and merely provides: "In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report."

[9] Section 4(2).

[10] Section 15(2). *The Oregonian* recently made the same criticism of Oregon's statute: "Oregon's physician-assisted suicide program has not been sufficiently transparent. Essentially, a coterie of insiders run the program, with a handful of doctors and others deciding what the public may know. We're aware of no substantiated abuses, but we'd feel more confident with more sunlight on the program." "Washington state's assisted-suicide measure: Don't go there," *The Oregonian* Editorial Board, September 20, 2008, http://www.oregonlive.com/opinion/index.ssf/2008/09/washington_states_assistedsuic.html.

[11] "Doctors divided on assisted suicide," September 22, 2008, http://seattletimes.nwsource.com/html/localnews/2008194843_death22m.html.

[12] See, supra, note 2.

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Second International Symposium on Euthanasia and Assisted Suicide

May 29-30, 2009

Plan to attend the Second International Symposium on Euthanasia and Assisted Suicide at the National Conference Center (close to Dulles International Airport and Washington DC). Co-sponsors are the Euthanasia Prevention Coalition, Physicians for Compassionate Care, Not Dead Yet, the Care Not Killing Alliance and No Less Human in the UK.

This event will follow on the success of the First International Symposium, held in Toronto, which featured almost every leader on the issues of euthanasia and assisted suicide.

We have already received commitments from leading speakers in the UK, the Netherlands, Belgium, the U.S.A. and Canada.

This will be the most important conference held to date on euthanasia and assisted suicide. You will leave with important information about the current issues and a clear understanding of how we are proceeding.

Questions about BMJ editorial on Ganzini study

By Alex Schadenberg

I was dismayed by the editorial in the *British Medical Journal* - written by the Dutch researcher and oncologist Marije L. van der Lee of the Helen Dowling Institute. Based on this editorial, it appears that we can expect that the new response by the euthanasia lobby to the relationship between euthanasia/assisted suicide and depression is to acknowledge that the relationship exists but to deny that it is important.

Van der Lee writes in the editorial:

> "Determining whether depression impairs the judgement of a patient requesting assisted suicide is more complex, because depressed patients are not necessarily incompetent. ... Ganzini and colleagues report that only 6% of psychiatrists in Oregon were confident they could adequately determine in a single evaluation whether a psychiatric disorder impaired the judgement of a patient requesting assisted suicide. Doctors who have known their patient for some time can often determine their patient's level of competency. In the Netherlands and Oregon, consultation with a second doctor is already standard procedure, so a psychiatrist should be consulted only when the patient's ability to make a decision is in doubt."

Van der Lee is saying that people who are depressed will make requests for euthanasia and assisted suicide but having a depressive disorder does not make the person incompetent. Further to that, she seems to be saying that since there is a requirement of having a second doctor agree to a request for euthanasia or assisted suicide, then the likelihood of someone who is incompetent dying by lethal injection or ingestion is minimal at best.

It appears that she is simply creating a new paradigm for the fact that there is a direct correlation between people suffering from depression and dying from euthanasia. It is easier to write the concerns off as trivial than recognize the serious problem for what it is.

Van der Lee also rejects the concerns of the study that Ganzini acknowledged that stated:

> "In a study of 290 US forensic psychiatrists, 58% indicated that the presence of major depressive disorder should result in an automatic finding of incompetence for the purpose of obtaining assisted suicide."

Van der Lee also ignores the fact that, last year in Oregon, of the 49 people who died by assisted suicide, none was referred for a psychiatric or psychological assessment, even though the Ganzini study notes at least two people who participated in the study were depressed when they died from ingesting lethal drugs. This fact should further concern van der Lee because her own 2005 study agrees with the Ganzini study that 17% of those in the study who died by euthanasia or assisted suicide were depressed. We can assume that in the Netherlands very few people are referred for a psychiatric or psychological assessment before they are injected with death.

Van der Lee's 2005 study showed that a correlation exists between the incidence of depression with requests for euthanasia in the Netherlands – "Euthanasia and depression: a prospective cohort study among terminally ill cancer patients" - *Journal of Clinical Oncology*, Vol 23, No 27 (September 20), 2005: pp. 6607-6612

Her study states:

> "... we hypothesized that depressed mood would show an inverse association with requests for euthanasia. Our clinical impression was that such requests were well-considered decisions, thoroughly discussed with healthcare workers and family. We thought the patients requesting euthanasia were more accepting their impending death and we therefore expected them to be less depressed. To our surprise, we found that a depressed mood was associated with more requests."

Further to that, she stated:

> "Opposition stems partly from the perspective of suicide as a symptom of mental illness and the tendency to extend this view of suicide in the physically healthy onto euthanasia and physician-assisted suicide in the terminally ill."

In other words, van der Lee conducted her 2005 study to counter the opposition to euthanasia that has been expressed concerning the connection between people with depression and requests for euthanasia and assisted suicide.

A further concern is whether van der Lee is capable of effectively responding to the Ganzini study at all.

One may conclude that van der Lee is attempting to cover up the reality of the relationship between depression and euthanasia/assisted suicide rather than analyze the Ganzini findings. We must remain aware of the new directions and verbal gymnastics that the euthanasia lobby incorporates.

Van der Lee has introduced the new idea that depression is not a reason *not to prescribe* death for vulnerable patients.

The editorial by Marije L. van der Lee in the British Medical Journal: BMJ 2008;337:a1558

Depression and physician assisted suicide

(continued from page 1)

safeguards in Oregon that mandate that someone who has a depressive disorder or cognitive illness must receive a psychiatric or psychological assessment before receiving a prescription for lethal drugs, that these few cases may simply represent an oversight by the physician.

The reality is that of the 49 cases of assisted suicide in Oregon last year, none of them were referred for a psychiatric or psychological assessment.

In other words, safeguards in Oregon are either ignored or completely ineffective and this study proves it.