The Need for a Physician-Assisted Suicide Oversight Committee

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January 16, 2006, marked a victory for Oregon’s physician-assisted suicide advocates. On that day, the U.S. Supreme Court declared in Gonzales v. Oregon that the U.S. Attorney General did not have the authority to proscribe the use of federally regulated controlled substances for assisted suicide authorized under Oregon law.1 Oregon’s voter-enacted Death With Dignity Act (“DWDA”) legalizes physician-assisted suicide and permits Oregon physicians to prescribe lethal doses of controlled substances to certain terminally ill Oregonians.2 Because every prescription written pursuant to the DWDA is for controlled substances, the Supreme Court’s ruling essentially upheld the Oregon law. Gonzales, however, is not an endorsement of the DWDA. The debate over the morality and legality of assisted suicide continues, and the DWDA remains a focal point in the controversy. The DWDA’s opponents condemn the DWDA for what they consider broad, unchecked, discretionary power granted to Oregon physicians. The establishment of a physician-assisted suicide oversight committee would not only serve as a check on a physician’s decision-making ability in these cases, but might also quell criticisms of the DWDA.

In Gonzales, Justice Kennedy concluded that the U.S. Attorney General could not prevent Oregon physicians from prescribing lethal doses of controlled substances to certain terminally ill patients. The Court noted that deference to the Attorney General’s interpretation of the Controlled Substances Act (“CSA”) was inappropriate and that his interpretation exceeded the scope of his authority as delegated by Congress. The Attorney General construed a CSA regulation as prohibiting the use of controlled substances in assisted suicide. The Court refused to defer to the Attorney General’s conclusion because the regulation he interpreted did not give specificity to the CSA; rather, the regulation simply repeated the text of the CSA. Under the CSA, the Attorney General’s duties are limited to promulgating rules that would enable him to efficiently execute his functions and rules regarding drug registration and scheduling. Justice Kennedy held that the Attorney General’s interpretation went beyond the narrow scope of permissible activity mandated by Congress. Justice Kennedy also observed that the Attorney General lacked expertise to make medical judgments and that the Secretary of the Department of Health and Human Services would be better suited to determine the scope of medical practice under the CSA. The Court emphasized the central role of the states in regulating medical practice, concluding that the language of the CSA should be interpreted narrowly so as not to encroach on this traditional state power.

Thanks to the Supreme Court’s ruling, assisted suicide remains an option for certain terminally ill Oregonians. Opponents of the DWDA, however, may continue to attempt to invalidate the law by pointing to the broad deference it grants to the decisions of

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2 OR. REV. STAT § 127.800-.897 (2003).
Oregon physicians. The DWDA requires that controlled substances be administered only to those Oregon residents who have mental capacity, are terminally ill, and are making a voluntary decision. An attending physician must determine whether a patient meets these requirements, and a second physician must confirm the findings of the attending physician before the attending physician may write a lethal prescription.

The unchecked discretion bestowed upon Oregonians’ physicians is troubling for several reasons. First, a physician’s personal beliefs could influence his or her decision to assist suicide. A physician in favor of assisted suicide could be more likely to find that a particular patient meets the mental capacity, terminal illness and voluntariness requirements of the DWDA. Although the DWDA does require a second physician to confirm the findings of the first before a prescription can be written, the attending physician could simply refer the patient to a physician who shares the first physician’s views of assisted suicide and would thus be likely to confirm the attending physician’s views. Second, a physician may not be able to adequately assess the voluntariness of a patient’s decision. For example, poverty might undermine the voluntariness of a patient’s decision because someone who is destitute might not be aware of, or have access to, appropriate palliative care to ease the end of life. Someone in such circumstances might view assisted suicide as a cheap alternative to expensive medications. Furthermore, a patient’s desire not to be a burden on family or friends could also undercut the voluntariness of the decision. In such cases, the patients might appear completely rational, and their decisions might appear to be informed ones. There is simply no way for a physician to know that a patient’s decision is not voluntary in that it is motivated by a lack of financial resources or a desire not to burden others. Third, a physician may not be able to determine whether a patient with a terminal illness will die within six months. The DWDA defines a terminal disease as one that will “within reasonable medical judgment produce death within six months.” Opponents of physician-assisted suicide have noted that it is difficult to predict whether a terminally ill individual will die within six months. It is possible that a physician could misdiagnose a condition as terminal and assist in the suicide of one who has more than six months to live.

The establishment of a physician-assisted suicide oversight committee could quiet the DWDA’s critics. Currently, there is no oversight body that reviews the decision of an Oregon physician to write a prescription for controlled substances. An oversight committee could serve as a check on the broad discretionary power of the physician and
minimize several of the risks that exist in the DWDA. Such a committee should be composed not only of physicians, psychologists and nurses, but should also include members of the general community, including religious leaders. Palliative care experts should also be included on the committee to ensure that both the attending physician and the patient are aware of any available alternative treatment options. The more diverse the group, the more informed and well-thought out the decision is likely to be.

Were such an oversight committee to be established, the following guidelines could be useful: (1) Before a written prescription for a lethal dosage can be given to a terminally ill individual, the attending physician will have to seek the approval of the committee. (2) Once the committee receives the physician’s request, the committee will examine the patient’s file. (3) If the file lacks necessary information, the committee has the option of setting up an interview with the terminally ill patient. (4) If the patient is too ill to meet with the entire committee, the committee can send one of its members to the patient’s home, hospital, etc. for a meeting. (5) Once the committee has the information it needs, it can begin its deliberations. (6) The risk of a terminally ill patient dying before the committee comes to a decision will be minimized by imposing some sort of deadline for the decision. (7) The committee will make sure that the patient is terminally ill, is competent and is making a voluntary choice. (8) The committee may also meet with the physician if it has any questions regarding the patient or the physician’s interactions with the patient. (9) Though unanimity of the committee may not be feasible, a substantial majority of the committee should approve the assisted suicide.

By establishing both an oversight committee and appropriate guidelines, Oregon could reduce the discretionary authority of a physician, eliminating the possibility of a physician ignoring a patient’s best interests and acting on the physician’s personal beliefs. This would ensure that only those who are terminally ill, mentally capable and acting voluntarily could use controlled substances to end their suffering.

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