A Progressive Case Against Assisted Suicide Laws

WHY PROGRESSIVES AND DISABILITY RIGHTS ORGANIZATIONS ARE OPPOSED TO ASSISTED SUICIDE LAWS
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PROGRESSIVE AND DISABILITY RIGHTS ORGANIZATIONS THAT OPPOSE THE LEGALIZATION OF ASSISTED SUICIDE

Access to Independence – San Diego
American College of Physicians – American Society of Internal Medicine (ACP – ACIM)
American College of Pediatricians
American Disabled for Attendant Programs Today (ADAPT)
American Medical Association (AMA)
American Nursing Association
Association of Programs for Rural Independent Living (APRIL)
Association of Northern California Oncologists (ANCO)
Autistic Self-Advocacy Network (ASAN)
Berkeley Commission on Disability
California Chapter of TASH (CalTASH)
California Disability Alliance (CDA)
California Latino Medical Association
California Medical Association (CMA)
California Foundation for Independent Living Centers (CFILC)
Californians for Disability Rights (CDR)
California Nurses for Ethical Standards
California State Council on Developmental Disabilities
Coalition of Concerned Medical Professionals
Communities Actively Living Independent and Free (CALIF)
Disability Rights Center
Disability Rights Education & Defense Fund (DREDF)

Disability Rights Enforcement Education Services (DREES)
Disability Section of the American Public Health Association
FREED, Center for Independent Living
Independent Living Center of Southern California (ILCSC)
Independent Living Resource Center San Francisco (ILRCSF)
Independent Living Services of Northern California (ILSNC)
Justice for All (JFA)
League of United Latin American Citizens (LULAC)
Medical Oncology Association of Southern California (MOASC)
National Council on Disability
National Council on Independent Living
National Spinal Cord Injury Association
Not Dead Yet (NDY)
Oakland Mayors Commission on Human Relations
Patients Rights Council
Physicians for Compassionate Care
Placer Independent Resource Services, Inc.
Southern California Cancer Pain Initiative
TASH
The Oaks Group
Western Service Workers Association
World Association of Persons with Disabilities (WAPD)
World Institute on Disability (WID)
## PROGRESSIVE/CENTER-LEFT STATES HAVE CONSISTENTLY REJECTED ASSISTED SUICIDE LAWS

Many are familiar with the legalization of assisted suicide in Oregon, Washington and the recent legalization in Vermont. But the truth about legalization efforts is far more telling, as a number of states have consistently rejected legalization.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1992</td>
<td>California voters reject Proposition 161 by a margin of 54% to 46%</td>
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<tr>
<td>1998</td>
<td>Michigan's Measure B fails by a margin of 71% to 29%</td>
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<td>1999</td>
<td>AB 1592 in California dies in committee</td>
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<td>1999</td>
<td>A bill to legalize assisted suicide (SB 677) in New York fails</td>
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<td>2000</td>
<td>Maine voters send Question 1 down in defeat 51% to 49%</td>
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<td>2005</td>
<td>Again, California legislators reject assisted suicide by tabling AB 654</td>
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<td>2006</td>
<td>California's AB 651 fails in committee.</td>
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<td>2007</td>
<td>California lawmakers abandon AB 374 under stiff opposition from progressive groups</td>
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<td>2009</td>
<td>Hawaii's HB 587 fails to make it out of the legislature</td>
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<td>2009</td>
<td>SB 1138 in Connecticut fails</td>
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<td>2012</td>
<td>Massachusetts voters reject Question 2 51% to 49% with progressive opposition</td>
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<tr>
<td>2013</td>
<td>HB 6645 in Connecticut is defeated in the legislature</td>
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<td>2013</td>
<td>Massachusetts again rejects assisted suicide bill H 1998</td>
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<tr>
<td>2014</td>
<td>HB 5326 in Connecticut is referred to committee, killing the bill</td>
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<tr>
<td>2014</td>
<td>HB 1325 in New Hampshire is decisively defeated in the house 219-66</td>
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WHY PROGRESSIVES SHOULD OPPOSE ASSISTED SUICIDE LAWS


*Originally printed Fall 2006

In January the California State Senate begins hearings on AB 651, which would legalize assisted suicide in California. A similar bill was presented in the State Assembly last year but didn't even come to a vote because of overwhelming Democrat and Republican opposition. There is a widespread public perception that those opposed to legalization are religious conservatives, and the logical position for a liberal is in support. But the coalition that's formed to oppose the bill, Californians Against Assisted Suicide, shows a diversity of political opinion that may be surprising to those who have not looked closely at the issue. In opposition are numerous disability rights organizations, generally seen as liberal-leaning; the Southern California Cancer Pain Initiative, a group associated with the American Cancer Society; the California Medical Association; and the League of United Latin American Citizens, the oldest civil rights group in California. Catholic organizations are in the mix, but no person would consider this a coalition of religious conservatives.

This is a diverse coalition representing many groups coming together across the political spectrum. Why?

If patients with limited finances are denied other treatment options by their insurance, they are, in effect, being steered toward assisted death. It is no coincidence that the author of Oregon’s assisted suicide law, Barbara Combs-Lee, was an HMO executive when she drafted it.

“I am an outlier, in that I am a registered Democrat and progressive, as well as a physician who has cared for people with life-threatening conditions for more than three decades. I support universal health care, voting rights, disability rights, women’s rights, Planned Parenthood, gay marriage, alternative energy, and gun control. I yearn to see an end to the war on drugs and the war in Afghanistan. And, I am convinced that legalization of physician-assisted suicide is something my fellow progressives should fear and loathe.”

-Ira Byock Director of palliative care at Dartmouth-Hitchcock Medical Center in Lebanon, N. H.

[Source: the Atlantic, “Physician Assisted Suicide is Not Progressive." Ira Byock, 10/25/12]

“Assisted Suicide legalization is a direct threat to anyone that is viewed as a significant cost liability to public or private healthcare providers.”

-Catharine Campisi PhD., Former Director of the California Department of Rehabilitation

[Source: Letter to Assemblymember Mariko Yamada, February 19th, 2013]
A 1998 study from Georgetown University's Center for Clinical Bioethics underscores the link between profit-driven managed health care and assisted suicide. The research found a strong link between cost-cutting pressure and a willingness to prescribe lethal drugs to patients, were it legal to do so. The study warns that there must be "a sobering degree of caution in legalizing [assisted suicide] in a medical care environment that is characterized by increasing pressure on physicians to control the cost of care."

The California bill is modeled after a nearly identical law that went into effect in Oregon in 1997. A closer look at Oregon highlights the many flaws.

Each year, Oregon publishes a statistical report that leaves out more than it states. For example, several of these reports have included language such as, "We cannot determine whether assisted suicide is being practiced outside the framework of the law." The statute provided no resources or even authority to detect violations. All we know comes from doctors who prescribed the drugs, not family members or friends who probably have additional information about the patients. Doctors that fail to report their lethal prescriptions face no penalty. The state doesn't even talk to doctors who refused to assist the very same patients other physicians later helped to die, though these doctors who first said "no" may have viewed the patients as not meeting legal requirements, important information if one wishes to evaluate the law's outcomes. Autopsies are not required, so there's no way to ascertain the deceased was actually terminally ill, opening the door to another Dr. Kevorkian. The state's research has never reported on several prominent cases inconsistent with the law – these cases came to light only via the media. Last March, an editorial in The Oregonian complained that the law's reporting system "seems rigged to avoid finding" the answers.

We must separate our private wishes for what we each may hope to have available for ourselves someday and, rather, focus on the significant dangers of legalizing assisted suicide in this society as it operates today. This column is sure to bring howls from those already ideologically supportive of legalization, but anyone who wants to look deeper, beyond the simplistic mantras of choice and "right to die," are encouraged to read other articles and testimony.

"As one of countless disabled people who have survived a terminal prediction based on a faulty diagnosis, I can't help but become concerned when the accuracy of a terminal prognosis determines whether someone gets suicide assistance rather than suicide prevention."

-Diane Coleman, J.D., MBA, President and CEO of Not Dead Yet

The news from Barbara Wagner’s doctor was bad, but the rejection letter from her insurance company was crushing.

“The 64-year-old Oregon woman, whose lung cancer had been in remission, learned the disease had returned and would likely kill her. Her last hope was a $4,000-a-month drug that her doctor prescribed her, but the insurance company refused to pay.

“What the Oregon Plan did agree to cover, however, were drugs for a physician-assisted death. Those drugs would cost about $50.”

“It was horrible,’ Wagner told ABCNews.com. ‘I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won’t give you the medication to live.”

[Source: ABC News: Death Drugs Cause Uproar in Oregon, 8/6/08]
On February 19th, 2013, Catherine Campisi, former director for the California Department of Rehabilitation, sent this letter to the Assembly Committee on Aging and Long Term Care Chairperson Mariko Yamada.

Dear Chairperson Yamada and Committee:

As the former Director of the California Department of Rehabilitation (1999-2006) I appreciate the Assembly Aging and Long Term Care Committee taking a critical look at the many issues surrounding "end of life." I would be attending this committee hearing in-person today, but I am out of town due to a family obligation.

I have long been a proponent of increasing access and information to quality counseling, hospice, and palliative care, for those with an illness defined as terminal. However, I am concerned that this topic not be broadened to include a discussion of assisted suicide legalization as part of this continuum of care. For a variety of reasons, assisted suicide legalization poses a very real danger and concern to people living with serious illness or disability.

Looking at the psychological impacts, assisted suicide would have far more potential to do harm than good to individuals facing serious illness or disability that may be defined as terminal. Apart from these concerns, assisted suicide legalization is a direct threat to anyone viewed as a significant cost liability to public or private healthcare providers.

Additionally, I respectfully caution the committee from relying on "end-of-life" data compiled in states like Oregon and Washington, the only states where assisted suicide is currently legal. Neither state mandates data collection or reporting of patients requesting lethal prescriptions, how many are referred for psychological treatment or if they are receiving hospice care. The data collected by the state is submitted by doctors attending these patients.

I am equally concerned about consideration of any data or information provided on the "end of life" issue by the organizations Compassion & Choices and Death with Dignity National Center. Compassion & Choices, formerly known as the Hemlock Society, was created with the intent of passing and supporting assisted suicide legalization efforts. The Death with Dignity National Center’s stated mission is to promote the "right to request and receive a prescription to hasten death." Both organizations have a specific agenda as it relates to "end of life" and are outside mainstream hospice, disability rights and medical organizations.

Thank you for the opportunity to submit to the Committee, and please feel free to call on me as a resource as your discussions on this topic move forward.

With regards,

Catherine Campisi, PhD.

Former Director, California Department of Rehabilitation (1999-2006)
Former Dean of Student Services, California Community Colleges (1999)
Former Chairperson, California State Inter-agency Americans with Disabilities Act Task Force (2000-2003)
Past President, Association on Higher Education and Disability
Pro-Assisted Suicide Society Started Out Advocating for Euthanasia

Compassion & Choices is a well-known assisted suicide advocacy group. Over the years, through various mergers and splits with other groups, the organization that began as the Hemlock Society morphed into Compassion & Choices. Formed in 1980, the Hemlock Society was notorious for its open-faced advocacy for active euthanasia, including lethal injections, even for persons living with disabilities and for those who were not diagnosed as terminally ill.

Such advocacy finds its fullest expression in statements like this, from former Hemlock Society president Faye Girsh: “A judicial determination should be made when it is necessary to hasten the death of an individual, whether it be a demented parent, a suffering, severely disabled spouse or a child.” (PR Newswire, 12/3/97)

Compassion & Choices has been heavily involved in assisted suicide legalization efforts across the country, including efforts in Oregon, Washington and Massachusetts.

Today, Compassion & Choices also promotes the voluntarily stopping of eating and drinking (VSED) for people who are not terminally ill.

The current CEO of the organization, Barbara Coombs Lee, is a former executive for the HMO known as Ethix Corporation, which was later purchased by New York Life Insurance Company. This is no accident as one of the primary reasons for opposition to assisted suicide by disability rights organizations is the volatility that is introduced when profit-driven corporations are given sway over end-of-life care. Coombs Lee actually helped draft the Oregon assisted suicide law (Marilyn Golden, “Why Progressives Should Oppose Assisted Suicide,” Fall 2006).

Compassion & Choices is the primary group behind assisted suicide in the United States; a group that originally started out advocating for active euthanasia.

“Overall, 65% of the readers thought that physician-assisted suicide should not be permitted; the rate among U.S. voters was similar, with 67% voting against physician-assisted suicide.”

-New England Journal of Medicine Survey

[Source; Physician Assisted Suicide-Poll Results, 9/12/13]
A beautiful 29-year-old woman with a rare brain tumor, Brittany Maynard and her tragic death have sparked the on-again, off-again debate about whether assisted suicide should be legalized in this country.

The media frenzy over the Maynard story has made it almost impossible for a legitimate opposing view to be heard, and many people believe that any opposition has to come from religious extremists or right-wing busybodies.

I am neither. As a disability rights advocate for over 40 years as well as a person living with a disability, I am deeply troubled about the Maynard media swarm.

Assisted suicide legalization isn’t about Brittany Maynard. It’s about the thousands of vulnerable ill, elderly and disabled people who will be harmed if assisted suicide is legalized.

A recent report from the Institute of Medicine calls the country’s system of caring for terminally ill people "largely broken," "poorly designed to meet the needs of patients" and refers to Medicare and Medicaid, health care systems designed to meet the needs of the poorest among us, "in need of major reorientation and restructuring."

The idea of mixing a cost-cutting "treatment" such as assisted suicide into a broken, cost-conscious health care system that’s poorly designed to meet dying patient’s needs is dangerous to the thousands of people whose health care costs the most -- mainly people living with a disability, the elderly and chronically ill. Assisted suicide drugs cost less than $300. Compare that with the cost of treating a terminal illness.

This is one of the many reasons every major disability rights organization in the country that has taken a position on assisted suicide is opposed to legalization, along with the American Medical Association, palliative care specialists and hospice workers who know better than anyone that advancements in palliative care have eliminated pain as an issue for patients who receive appropriate care.

Anyone dying in discomfort may legally today, in all 50 states, receive palliative sedation, wherein the patient is sedated and discomfort is relieved while the dying process takes place peacefully. This legal solution does not raise the very serious difficulties that legalizing assisted suicide poses.

Assisted suicide ultimately affects everyone’s health care. In Oregon, where assisted suicide is legal and where Maynard moved to be prescribed the lethal dose, patients have been harmed.
In 2008, cancer patient Barbara Wagner was prescribed a chemotherapy treatment by her doctor, but Oregon's state-run health plan sent a letter which denied coverage of this chemo, yet offered to cover other "treatments," including assisted suicide. The same scenario happened to another Oregon resident, Randy Stroup. The Oregon assisted suicide reports tell us that over 95% of those who supposedly received lethal prescriptions in Oregon had insurance, but how many got a denial like the one sent to Wagner and Stroup?

When assisted suicide is encouraged, it becomes a covered "treatment" and ultimately removes choices from patients.

Assisted suicide's supposed "safeguards" are hollow. Nothing in the Oregon, Washington and Vermont laws prevents an heir or caregiver from suggesting assisted suicide as an option, taking the person to the doctor to sign up and witnessing the consent form. Once the prescription is obtained, with no further witness required, nothing in the law ensures the person's consent or self-administration at the time of death.

With the rising tide of elder abuse in this country, we can’t ignore the dangers of granting blanket legal immunity to all the participants in an assisted suicide.

When voters are given all the facts surrounding assisted suicide, they reject bills to legalize it. This was the case in Massachusetts when Question 2, which would have legalized assisted suicide in the Bay State, was on the ballot in 2012 but was defeated.

In 2014, bills again in Massachusetts, Connecticut and New Hampshire failed because of lack of support in the legislature.

Brittany Maynard's story is incredibly heart-wrenching. When you look at assisted suicide based on one individual, it often looks acceptable. But when you examine how legalization affects the vast majority of us -- especially those most vulnerable -- the dangers to the many far outweigh any alleged benefits to a few.

"Nothing in the Oregon, Washington and Vermont laws prevents an heir or caregiver from suggesting assisted suicide as an option, taking the person to the doctor to sign up and witnessing the consent form. Once the prescription is obtained, with no further witness required, nothing in the law ensures the person's consent or self-administration at the time of death."

-Diane Coleman, J.D., MBA, President and CEO of Not Dead Yet, CNN Opinion, 11/4/2014, drawing from the writings of Margaret Dore, e.g., “What Do We Advise Our Clients?,” King County Bar Association Bulletin, May 2009.
SEN. TED KENNEDY’S WIDOW, VICTORIA KENNEDY, EXPLAINS HER OPPOSITION TO AN ASSISTED SUICIDE LAW

[*Massachusetts Ballot Question 2 was a 2012 initiative to legalize assisted suicide in Massachusetts. It failed with the help of widespread opposition from progressive organizations and leaders.]

October 27th, 2012

By Victoria Reggie Kennedy, widow of Sen. Edward M. Kennedy

There is nothing more personal or private than the end of a family member’s life, and I totally respect the view that everyone else should just get out of the way. I wish we could leave it that way. Unfortunately, Question 2, the so-called "Death with Dignity" initiative, forces that issue into the public square and places the government squarely in the middle of a private family matter. I do not judge nor intend to preach to others about decisions they make at the end of life, but I believe we’re all entitled to know the facts about the law we’re being asked to enact.

Here’s the truth. The language of the proposed law is not about bringing family together to make end of life decisions; it’s intended to exclude family members from the actual decision-making process to guard against patients being pressured to end their lives prematurely. It’s not about doctors administering drugs such as morphine to ease patients’ suffering; it’s about the oral ingestion of up to 100 capsules without requirement or expectation that a doctor be present. It’s not about giving choice and self-determination to patients with degenerative diseases like ALS or Alzheimer’s; those patients are unlikely to qualify under the statute. It’s not, in my judgment, about death with dignity at all.

My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. Question 2 turns his vision of health care for all on its head by asking us to endorse patient suicide - not patient care - as our public policy for dealing with pain and the financial burdens of care at the end of life.

My late husband Sen. Edward Kennedy called quality, affordable health care for all the cause of his life. Question 2 turns his vision of health care for all on its head by asking us to endorse patient suicide — not patient care — as our public policy for dealing with pain and the financial burdens of care at the end of life. We’re better than that. We should expand palliative care, pain management, nursing care and hospice, not trade the dignity and life of a human being for the bottom line.

Most of us wish for a good and happy death, with as little pain as possible, surrounded by loved ones, perhaps with a doctor and/or clergyman at our bedside. But under Question 2, what you get instead is a prescription for up to 100 capsules, dispensed by a pharmacist, taken without medical supervision, followed by death, perhaps alone. That seems harsh and extreme to me.
Question 2 is supposed to apply to those with a life expectancy of six months or less. But even doctors admit that's unknowable. When my husband was first diagnosed with cancer, he was told that he had only two to four months to live, that he'd never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die.

But that prognosis was wrong. Teddy lived 15 more productive months. During that time, he cast a key vote in the Senate that protected payments to doctors under Medicare; made a speech at the Democratic Convention; saw the candidate he supported elected president of the United States and even attended his inauguration; received an honorary degree; chaired confirmation hearings in the Senate; worked on the reform of health care; threw out the first pitch on opening day for the Red Sox; introduced the president when he signed the bipartisan Edward M. Kennedy Serve America Act; sailed his boat; and finished his memoir "True Compass," while also getting his affairs in order, kissing his wife, loving his family and preparing for the end of life.

Because that first dire prediction of life expectancy was wrong, I have 15 months of cherished memories — memories of family dinners and songfests with our children and grandchildren; memories of laughter and, yes, tears; memories of life that neither I nor my husband would have traded for anything in the world.

When the end finally did come — natural death with dignity — my husband was home, attended by his doctor, surrounded by family and our priest.

I know we were blessed. I am fully aware that not everyone will have the same experience we did. But if Question 2 passes I can’t help but feel we’re sending the message that they’re not even entitled to a chance. A chance to have more time with their loved ones. A chance to have more dinners and sing more songs. A chance for more kisses and more love. A chance to be surrounded by family or clergy or a doctor when the end does come. That seems cruel to me. And lonely. And sad.

My husband used to paraphrase H.L. Mencken: for every complex problem, there's a simple easy answer. And it's wrong.

That’s how I feel in this case. And that’s why I’m going to vote no on Question 2.

Victoria Reggie Kennedy is an attorney, health care advocate and widow of Sen. Edward M. Kennedy.

"It’s not, in my judgment, about death with dignity at all.”
KEY OBJECTIONS TO THE LEGALIZATION OF ASSISTED SUICIDE

1. Assisted suicide is a deadly mix with our broken, profit-driven health care system

Financial pressures already play far too great a role in many, if not most, health care decisions. Direct coercion is not even necessary. If insurers deny, or even merely delay, approval of expensive, life-giving treatments that patients need, patients will, in effect, be steered toward assisted suicide, if it is legal.

For example, patients Barbara Wagner and Randy Stroup, Oregonians with cancer, were both informed by the Oregon Health Plan that the Plan won’t pay for their chemotherapy, but will pay for their assisted suicide. Though labeled a free choice, for these patients, assisted suicide was a phony form of freedom.

2. Assisted suicide is dangerous to people with disabilities and many other people in vulnerable circumstances.

As only one example, people with mental illness and depression are given lethal drugs in Oregon, despite the claims of proponents that these conditions disqualify a person. (See testimony by Dr. Gregory Hamilton focusing on problems posed by assisted suicide in Oregon for people with psychiatric disabilities). Other states’ laws and proposals offer no additional protections beyond Oregon’s.

3. Available statistics show that pain is rarely the reason why people choose assisted suicide.

Most people do so because they fear burdening their families or becoming disabled or dependent. But anyone dying in discomfort that is not otherwise relievable, may legally today, in all 50 states, receive palliative sedation, wherein the patient is sedated to the point where the discomfort is relieved while the dying process takes place. Thus, today there is a legal solution to any remaining painful and uncomfortable deaths; one that does not raise the very serious difficulties of legalizing assisted suicide.

4. The supposed safeguards included in the Oregon and Washington State laws don’t really protect patients for many reasons, including these:

   a. If a doctor refuses lethal drugs, the patient or family simply can – and do – find another doctor (“doctor shopping”).
   b. “Six months to live” is often wildly misdiagnosed, opening the dangers of assisted suicide to many who are not terminally ill. (See the DREDF statement on The Fundamental Loophole of Terminal Illness Prognosis)
   c. Nothing in the Oregon law will protect patients when there are family pressures, whether financial or emotional, which distort patient choice.
   d. An article from Michigan Law Review, June 2008, showed how the State of Oregon undermines all the safeguards in the law. Authors Dr. Herbert Hendin and Dr. Kathleen Foley noted, “OPHD does not collect the information it would need to effectively monitor the law and in its actions and publications acts as the defender of the law rather than as the protector of the welfare of
5. Problems with Oregon’s data collection and data soundness, and the lack of any investigations of abuse or meaningful oversight, are so significant as to render conclusions based on those data to be critically flawed.

Oregon doctors are not penalized for failing to report assisting in a suicide, and there is no investigation to see if they have done so. The state does not investigate cases of expansion and complications reported in media, and have admitted, “We cannot determine whether physician assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged actually destroying the underlying data after each annual report. (Regarding abuses that have come to light in Oregon, see handout on Oregon abuses. Regarding the destruction of data, see testimony of Dr. Katrina Hedberg, 9 December 2004, House of Lords, Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence, (London: The Stationery Office Ltd., 2005), 262.)

6. There is research strongly suggesting Oregon has seen a reduction in the quality of palliative care at the end-of-life since the Oregon law went into effect.

An important study published in 2004 in the Journal of Palliative Medicine showed that dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the Oregon law took effect. An op-ed in The Oregonian on July 23, 2004 stated, “The findings call into question the widespread view that pain control at the end of life has improved markedly in Oregon.” (Journal of Palliative Medicine, Volume 7, Number 3, 2004, p. 431)

While it is true that Oregon has shown improvements in some areas of end-of-life care, similar improvements have occurred in other states that have not legalized assisted suicide. As Doctors Kenneth Stevens and William Toffler noted on September 24, 2008 in The Oregonian, many states do better than Oregon. For example, data ranks Oregon 9th (not 1st) in Medicare-age use of hospice; four out of the top five are states that have criminalized assisted suicide.

7. Some 24 states have rejected the legalization of assisted suicide since Oregon passed its law. We should heed their significant public policy concerns.

8. Many key organizations oppose the legalization of assisted suicide.

Including the AMA and its state affiliates; the National Hospice and Palliative Care Organization; many prominent Democrats and progressives including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff; many disability rights organizations and the League of United Latin American Citizens (LULAC, national level).

9. Suicide requests from people with terminal illness are usually based on fear and depression.
As Herbert Hendin, Chief Executive Officer of Suicide Prevention Initiatives (SPI) and Professor of Psychiatry at New York Medical College, stated in Congressional testimony in 1996, "a request for assisted suicide is ... usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognize that ambivalence as well as the anxiety and depression that underlie the patient’s request for death, the patient may become trapped by that request and die in a state of unrecognized terror.” Most cases of depression among terminally ill people can be successfully treated. Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legalized, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

10. International models, particularly the Netherlands, show that assisted suicide cannot be limited to a small, targeted group once Pandora’s box is opened.

See Psychiatric Times, Volume 21, Number 2, February 1, 2004, by Dr. Herbert Hendin at http://www.psychiatrictimes.com/articles/commentary-case-against-physician-assisted-suicide-right-end-life-care. Herbert Hendin, M.D. is Chief Executive Officer of Suicide Prevention Initiatives (SPI) and Professor of Psychiatry at New York Medical College.

RESOURCES

Disability Rights Education & Defense Fund

3075 Adeline Street, Suite 210
Berkeley, CA 94703
510.644.2555
510.841.8645 fax
http://dredf.org/public-policy/assisted-suicide/
info@dredf.org

Not Dead Yet

497 State Street
Rochester, NY 14608
708-420-0539
www.NotDeadYet.org

Patients Rights Council

PO Box 760 – Steubenville, OH 43952
Phone: 740-282-3810 Toll Free: 800-958-5678
www.PatientsRightsCouncil.org