A Primer on
Assisted Suicide Laws

PATIENTS RIGHTS ACTION FUND

DREDF

Presented by Patients Rights Action Fund and Disability Rights Education & Defense Fund

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Introduction

Disability, illness, dying and death can be complex issues to discuss and think about – especially as it impacts ourselves or our loved ones. All of these issue areas factor significantly into the topic of Assisted Suicide.

What is Assisted Suicide? Webster defines Assisted Suicide as: "suicide committed by someone with assistance from another person."

Practically speaking, Assisted Suicide is the act in which a person is prescribed, by a physician, a lethal overdose that they will ingest at some time in the future to end his or her life. While some current laws include provisions like a prognosis of six months or less to live, or that this overdose must be self-administered, legislation has been proposed to remove these minimal protections for vulnerable people.

In thinking about this complex and often personal issue of Assisted Suicide, we ask that you separate private wishes or experiences and, rather, focus on the significant risks of legalizing Assisted Suicide in a diverse society – including individuals with chronic illness and disability that is not terminal if managed, non-English speaking households, economic difficulty, and limited healthcare specialist access.

We have created this brief issue primer for anyone who wants to look deeper, beyond the simplistic mantras of choice and "right to die," or religion.

Consider these points:

- The deadly mix between assisted suicide and profit-driven managed healthcare;
- HMO's and managed care bureaucracies have overruled physicians' treatment decisions,sometimes hastening patient death;
- The cost of lethal medication generally used for assisted suicide is far cheaper than the cost of treatment for most long-term medical treatments;
- The incentive to save money by denying treatment already poses a significant danger. This danger could be far greater if assisted suicide is legal; and
- If patients with limited finances are denied other treatment options by their insurance, they are, in effect, being steered toward assisted suicide.
- While proponents claim there has never been a problem or abuse where assisted suicide is legal, there are many well-documented problems and abuses; see Appendix H, page 25.

National Medical, Disability Rights and Other Progressive Organizations

That Oppose Assisted Suicide Laws

American Academy of Neurology
AAN

American College of Medical Quality
ACMQ

American Association of People with Disabilities
AAPD

American Disabled for Attendant Programs Today
ADAPT

American College of Physicians – American Society of Internal Medicine
ACP – ACIM

American Medical Association
AMA

American Medical Directors Association
AMDA

American Nurses Association

The Arc of the United States

Association of Programs for Rural Independent Living
APRIL

Autistic Self-Advocacy Network
ASAN

Disability Rights Center

Disability Rights Education & Defense Fund
DREDF

Disability Section of the American Public Health

League of United Latin American Citizens
LULAC

National Council on Disability
NCD

National Council on Independent Living
NCIL

National Hospice & Palliative Care Organization
NHPCO

National Organization of Nurses with Disabilities
NOND

National Spinal Cord Injury Association
Not Dead Yet
NDY

Patients Rights Action Fund

Patients Rights Council

Association for Persons with Severe Handicaps
TASH

United Spinal Association
USA

World Association of Persons with Disabilities
WAPD

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. In California, Stephanie Packer and two patients of Dr. Brian Callister have encountered the same kind of problem. 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. (*Read testimony by Dr. Gregory Hamilton, focusing on problems posed by assisted suicide in Oregon for people with psychiatric disabilities, online or turn to Appendix E on page 19.*)

Other states' laws and proposals offer no additional protections beyond Oregon's; they often contain even fewer protections.

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, as detailed by the Disability Rights Education & Defense Fund. (*See Appendix F on page 23.*)

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 handful of states where assisted suicide is permitted don't really protect patients for many reasons, including these:

a. If a doctor refuses lethal drugs because the doctor believes the patient is not eligible under the law, the patient or family simply can – and does – find another, willing doctor to fill the deadly script ("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 online or turn to Appendix G on page 24.*)

c. Nothing in the Oregon-style 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 terminally ill patients."[1]

5. Problems with assisted suicide 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.

No one is held accountable for failing to report assisting in a suicide, and there is no investigation to see if they have done so. Oregon officials have admitted this problem; "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. (*See Appendix H on page 25.*)

6. Some 30 states have rejected the legalization of assisted suicide (*see Appendix I on page 30*), contained in roughly 175 different proposals, since Oregon first passed its law.

Many are familiar with the few locations that have assisted suicide laws (*See Appendix I)*. But the truth about legalization efforts is far more telling, as approximately 30 states have consistently rejected legalization. Despite what proponents say, there is significant, widespread, bipartisan opposition to assisted suicide.

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

Including, but not limited to the American Medical Association; the National Hospice and Palliative Care Organization; many prominent Democrats and progressives, many disability rights organizations and the nation's oldest Latino civil rights group, the League of United Latin American Citizens (LULAC).

[1]Read *Michigan Law Review, June 2008, Physician-Assisted Suicide in Oregon: A Medical Perspective by Dr. Herbert Hendin and Dr. Kathleen Foley online, https://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf.* Herbert Hendin is Chief Executive Officer of Suicide Prevention Initiatives (SPI) and Professor of Psychiatry at New York Medical College. Kathleen Foley is Attending Neurologist, Memorial Sloan-Kettering Cancer Center; Professor of Neurology, Neuroscience, and Clinical Pharmacology, Weill Medical College of Cornell University; and Medical Director, International Palliative Care Initiative of the Open Society Institute.

8. 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."

Depression among terminally ill people can be successfully treated. Yet, assisted suicide laws do not mandate any psychiatric or psychological evaluation or consultation. Most doctors that prescribe assisted suicide drugs are generally not experts in diagnosing depression or mental health difficulties.

International models, such as the Netherlands and Belgium, show that assisted suicide cannot be limited to a small, targeted group. Once Pandora's box is opened, the arbitrary limits purportedly included for protection of the vulnerable are challenged as unnecessary 'barriers' and eroded. This is discussed extensively by Dr. Herbert Hendin in his article, The Case Against Physician Assisted Suicide in the Psychiatric Times, Volume 21, Number 2, February 1, 2004. (*See Appendix J on page 35.*)

Assisted Suicide Drives Decisions Based on Cost

Insurance Company Offers 'Death Drugs' As Alternative to Cancer Treatment

ABC News: Death Drugs Cause Uproar in Oregon / 8.6.08

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.'"

Who's Really Hurt by Assisted Suicide?

CNN Opinion / 11.4.14
by Diane Coleman, President and CEO of Not Dead Yet, a national grassroots disability rights group

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.

> "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."

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.

"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."

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.

Who's Behind Assisted Suicide Laws?

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.

> "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."
>
> **Faye Girsh**
> Former Hemlock Society President

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 efforts to pass assisted suicide laws across the country, including 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," BeyondChron, April 12, 2005*).

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

Resources

Patients Rights Action Fund
16 Vandeventer Avenue, 1st Floor
Princeton, NJ 08542
https://patientsrightsaction.org

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

Appendix A

*Sen. Ted Kennedy's Widow, Victoria Kennedy, Explains Her Opposition to an Assisted Suicide Law**

Cape Cod Times / 10.27.12
by Victoria Reggie Kennedy, widow of Sen. Edward M. Kennedy

**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.*

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 healthcare 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 healthcare; 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.

> "It's not, in my judgement, about death with dignity at all."

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.

Appendix B

Terminally Ill Mom Denied Treatment Coverage - But Gets Suicide Drug Approved

New York Post / 10.24.16
by Andrea Peyser

Stephanie Packer wants to be the face of a Right to Live movement — for as long as she draws breath.

"I just want to spend every last second with my kids," Packer, a terminally ill, married mother of four kids, ages 7 through 13, tells me.

Nearly two years ago, Brittany Maynard, at just 29 years old, became the face of the Right to Die movement now sweeping across the United States. In Oregon, surrounded by loved ones, she took her own life, legally, before a brain tumor could do it for her, with a self-administered overdose of physician-prescribed barbiturates. I supported her choice to end her agony.

But at what cost?

Packer struggles to open her eyes each blessed morning. And the cultural landscape to which she wakes has shifted dramatically of late into one of pro-death. In June, her home state of California enacted a law permitting doctor-assisted suicide. And something terrible happened.

Premature passing away with medical help is now widely seen as preferable to painful, prolonged living, Packer says. But she'll fight to live with every last labored gasp drawn from her oxygen tube before ultimately accepting a natural end.

"I want my kids to see that death is a part of life," she says.

At age 29, Packer was diagnosed with scleroderma, a chronic autoimmune disease that causes scar tissue to form in her lungs. A doctor told her she had three years to live. Now 33, she has outlived the death sentence.

But as her condition deteriorates, she's finding little support for her fight to stay alive.

Since California's End of Life Option Act took effect, attitudes expressed by sick members of support groups she's run or been involved with have changed to the grim. Where once members exchanged messages of hope, "people constantly are talking about, 'We should be doing this [dying].' "

"I just wanted no part of it," says Packer, a devout Roman Catholic.

Then her doctors suggested that switching to another chemotherapy drug might buy her time. Her medical insurance company refused to pay. She says she asked if the company covered the cost of drugs to put her to death. She was told the answer is yes — with a co-payment of $1.20.

"My jaw dropped."

Months later, after Packer threatened to tell her story to the media, the drug was approved. Sean Crowley, media relations director for Compassion & Choices, a "death with dignity" advocacy group, told me that treatment delays or rejections are "not uncommon" in the cost-conscious insurance industry.

"We're heartbroken for this woman," Crowley says. "People battle drug companies every day. They go through awful pain and suffering just to get well. We think people should be able to do whatever they want" — including continuing to live.

"There's a bright line that shouldn't be crossed," Jennifer Lahl, founder and president of The Center for Bioethics and Culture Network, tells me. Patients are entitled to refuse medical care, Lahl points out. But "doctors shouldn't be killers. They should be healers." Lahl co-produced, co-directed and co-wrote a documentary in which Packer presents her case against aid in dying — "Compassion and Choice DENIED."

Doctors legally may help aid the deaths of mentally competent adults believed to have six months or less to live in Oregon, Washington state, Vermont, California and Montana. A proposal to join them is on Colorado's ballots in the Nov. 8 election, and similar initiatives are being considered in the Council of the District of Columbia and the New Jersey and New York state legislatures.

Assisted suicide is also available in Canada, Japan, Colombia and parts of Europe. Last year, a severely depressed 24-year-old woman received government approval to obtain a lethal injection in Belgium. The woman reportedly changed her mind and decided to live.

Lawmakers in the Netherlands are considering a proposal to allow older people who don't suffer from terminal illnesses, but feel they have "completed life," access to aid in dying.

Madness.

For Stephanie Packer, the only route to a dignified demise is to battle to the finish. I applaud her bravery.

I wish everyone would back her choice.

Appendix C

Lawmakers Rush to Reintroduce End-of-Life Options Act, But Haste Makes Bad Policy

GeriPal: A Geriatrics and Palliative Care Blog / 8.21.15
by Laura Petrillo, MD

The End of Life Options Act, which would legalize physician-assisted suicide, was stalled in the California legislature earlier this summer and seemingly shelved until next year. But in a surprise move, lawmakers introduced a new bill with the same purpose on Tuesday, during a special session on healthcare financing called by Governor Brown. The new bill would bypass the Assembly committee where SB128, the former bill, was stalled for lack of support.

The issue that lawmakers are trying to rush through the legislative process is not a trivial one— the bill would give physicians the power to prescribe medication with lethal intent to terminally ill patients, a fundamental shift in the role of medicine to date. This is an issue that deserves deep contemplation, expert and community input, and thorough vetting to ensure the safety of everyone who might be affected. Instead, the lawmakers found a way to charge ahead in a special session and bypass the members of the Assembly who had hesitation about the bill.

Geripal community, whatever your philosophical views on assisted suicide, take a moment to think about how the most vulnerable members of our society might be at risk if assisted suicide were legal in your state, and if you have concerns, speak up now. Many states have bills that have been introduced in the past year to ride the Brittany Maynard momentum, though none has successfully become a law, yet.

Here are the groups of people at greatest risk, should assisted suicide become legal under laws modeled after the Oregon Death with Dignity Act:

Older adults. Under the California SB128, the burden of ensuring that patients are acting autonomously, have capacity to make decisions, and are free from coercion, falls to the physician who receives the patient's initial written and oral requests. At the moment, the bill states that requests must come from individuals, not their surrogate decision makers or advance directives, though there is a troubling clause that individuals can communicate "through a person familiar with the individual's manner of communicating," which could mean anything. There is no discussion of what to do in the case of cognitive impairment or dementia, which may present subtly in conversation or on exam, and there are no requirements for assessment of the patient's mental status or oversight at any point after the medication is prescribed, leaving patients open to coercion from family or caregivers as their disease progresses. For a fascinating story that illustrates how dementia muddies the timing of a fully autonomous exit, check out Sandy Bem's story.

Lonely adults. In the Netherlands, where assisted suicide and euthanasia have been socially acceptable for longer than in the U.S., the condition of terminal illness, defined in SB128 as a doctor's estimate of prognosis six months or less, is not the only reason that people can choose to end their lives. In a study that came out last week from a Netherlands euthanasia clinic, 6.8% of patients whose requests for euthanasia were granted had the only "medical" condition of being "tired of living," and the type of suffering named by 49% of recipients was loneliness. The slippery slope argument is often dismissed, but prominent ethicists Barron Lerner and Arthur Caplan warned that "the European data are particularly relevant for the United States." Indeed, in Oregon, an amendment was proposed to the Death with Dignity law earlier this year to extend the prognosis criteria from 6 to 12 months, underscoring the permeability of the hard line for what constitutes a terminal illness.

Disadvantaged socioeconomic groups. Despite the increased access to healthcare from the Affordable Care Act, patients and their families are still financially burdened by their medical care, and the proportional effect of this is greatest on the poorest members of society. Data from Oregon and Washington indicate that 40% of people who use assisted suicide express concern about being a burden on family, and 3% of people cite the financial implications of treatment as a reason for seeking assisted suicide. The response to this stress should not be to hand over lethal medication, but to redouble our efforts to increase access to good quality care for dying patients (and for everyone, all throughout life). The fact that the new assisted suicide bill was introduced in a healthcare financing session brings to mind the terrible implication that assisted suicide could save money for the entire healthcare system, though that was unlikely the intent of the lawmakers.

Patients with psychiatric illness. As with decision-making capacity, the burden of evaluating patients for mental illness falls to the original provider who receives the request, and the language in the bill is casual: "If there are indications of a mental disorder, the consulting physician shall refer the individual for a mental health specialist assessment." Unfortunately, in Oregon, despite the finding of a 2008 study by Ganzini et al in BMJ that 26% of Oregonians who requested assisted suicide met criteria for depression, only 3 out of 105 people who died by assisted suicide in Oregon in 2014 were referred for a psychiatric evaluation. Besides the depressed individuals, the legalization of assisted suicide puts the greater community of people suffering from mental illness at risk, by condoning the idea that suicide is acceptable when people have decided life is not worth living for them. Suicide contagion is a real phenomenon, and there has been a concerning rise in the rate of all suicides in Oregon since legalization of assisted suicide. For a dramatic view of how legalization of assisted suicide can change a society's attitude toward protection of people with mental illness, I recommend this story about euthanasia in Belgium: (*http://www.newyorker.com/magazine/2015/06/22/the-death-treatment*).

Proponents of "Death with Dignity" and SB128 believe that assisted suicide is for a select group of people who want to make an independent, personal choice to control the circumstances of their death, which would otherwise be a gruesome process with inevitable suffering.

For a public already anxious about death, and unfamiliar with its final stages, this can be compelling. But this is an unrealistic portrayal of death— the vast majority of patients can actually achieve the level of control and relief from suffering that they hope for through existing hospice and palliative care services. Proponents still insist that even with adequate access to palliative and hospice care (which not every patient yet has), there is a role for assisted suicide for some patients. That may be— but we owe it to our patients to think about at what cost. Evidence from Europe and even Oregon demonstrate that introducing the option of assisted suicide opens a pandora's box of far-reaching consequences, with the greatest implications for our most vulnerable members of society.

We have an obligation as healthcare providers to keep our patients safe, and we can't afford to rush the decision about whether assisted suicide is sound public policy. Please use your voice. To take action in California, write to your Assembly member and Governor Brown.

Appendix D

Aid in Living, Not Dying

The Baltimore Sun / 2.24.16
by Samantha Crane

Around the country we have seen a concerted effort by special interest groups to promote the legalization of physician-assisted suicide, including legislation introduced in Maryland. Although these groups claim to be speaking for people with chronic illnesses and disabilities, no major nationwide disability rights groups support physician-assisted suicide. In fact, these laws make people with disabilities more vulnerable and reinforce the damaging perception that life with a disability is "undignified" and not worth living.

Although assisted suicide advocates claim that their legislation is about terminal illness and not disability, many of the arguments presented in favor of such physician-assisted suicide legislation here and around the country assert a supposed "indignity" in needing help to eat, move, breathe or take medications. These arguments are rooted in a belief that it is better to die than to depend on others for assistance.

This belief is so pervasive that many people who become disabled find themselves struggling with suicidal thoughts. These thoughts may stem from the feeling that one is a burden on family members, fear of being placed in an institutional setting like a nursing home, or isolation as a result of lack of in-home supports. Moreover, people with disabilities are at heightened risk of abuse, isolation and exploitation.

Instead of addressing these significant risks, this assisted suicide legislation actively exacerbates them by reinforcing the perception that life with a disability or progressive disease is not worth living. This perception not only can lead to preventable deaths by suicide, but it also can create significant or even fatal barriers to accessing health care and needed services. Last year, Maryland passed legislation banning disability discrimination in organ transplants, after some Maryland transplant centers openly stated that they would not serve people with significant developmental or mental health disabilities. But discrimination in other health care contexts continues, as more and more people with disabilities are being denied even basic care for treatable illnesses, including food and water, with medical providers citing their supposedly low quality of life as justification to hasten their deaths. This essentially amounts to opportunistic, involuntary euthanasia of people with disabilities.

> "The answer, however, is to make sure that people with illness-related disabilities are receiving the supports they need in order to live — not to create a new fast track toward death."

As a disability rights advocate, I recognize that our health care system is failing people with disabilities, including disabilities caused by terminal illnesses. The answer, however, is to make sure that people with illness-related disabilities are receiving the supports they need in order to live — not to create a new fast track toward death. People need at-home supports and services in order to stay at their homes while allowing their family members to work and participate in the community — even before they qualify for hospice care. They also need advanced palliative care options, including pain relief and counseling. These supports recognize the value and dignity of all individuals, including those who need help with day-to-day care.

Even those who are expected to die within six months — as the proposed law would require — deserve suicide prevention, not assistance. The disability community is full of people who, with the right care and support, have outlived "six-month" prognoses by decades. Several friends of mine have outlived terminal prognoses by over 30 years. In Oregon, where the law also requires that patients be expected to live less than six months, many patients are still alive six months or more after

receiving the lethal prescription.

People with significant disabilities, including people with life-threatening diagnoses, do not need to die to have dignity. Instead, they need access to the things that help them make the most of their remaining time: palliative care, respectful in-home supports, counseling and assistive technology to maximize autonomy. Let's focus on aid in living, not "aid in dying."

Appendix E

Testimony of Dr. Gregory Hamilton

Distinguished Fellow of the American Psychiatric Association
Co-founder of Physicians for Compassionate Care
Author of Self and Others, From Inner Sources and The Self and the Ego in Psychotherapy

to The Select Committee on the Assisted Dying for the Terminally Ill Bill

Portland, Oregon / 12.10.04

Summary Statement

As a psychiatrist in the only state to allow assisted suicide and co-founder of Physicians for Compassionate Care, an organization providing education about caring for the seriously ill, I urge defeat of the Assisted Dying for the Terminally Ill Bill. This bill is quite different from the Oregon assisted-suicide law in that it allows for euthanasia if a patient cannot take an oral overdose, a practice not allowed in Oregon. Such a practice opens the door to euthanasia without consent as is so common in the Netherlands. The Assisted Dying for the Terminally Ill Bill, however, is like the Oregon law in that it lacks adequate protections for depressed patients. Experience in our state clearly demonstrates that once assisted suicide is institutionalized there can be no effective protection for the mentally ill. The first case of assisted suicide (Hamilton and Hamilton, 1999, attached), the Kate Cheney case (Foley and Hendin, 2002, Hamilton, 2002, attached) and the Michael Freeland case (Hamilton and Hamilton, 2004, attached), among others, demonstrate that mentally ill patients have been given overdoses in Oregon. Two of those cases were found lacking competence to consent to assisted suicide. Still, not one instance of assisted suicide being given for actual untreatable pain has been demonstrated. Psychological and social reasons predominate. Even if unbearable suffering is to be included as a criterion in the bill under consideration, it serves no protective function. Experts repeatedly have demonstrated that physical pain can always be relieved using modern pain management techniques. However, when laws permit assisted suicide, the adequacy of pain care can actually diminish, as scientific reports in the Netherlands and Oregon indicate.

Oregon Law Allows Assisted-Suicide of the Depressed

Well-respected studies demonstrate that virtually all patients with a high desire for assisted suicide display symptoms of depression or irrational hopelessness (1). Nevertheless, the Oregon law (2) does not require that the patient receive a psychiatric evaluation. Only if the doctor intending to write the prescription for overdose or the consultant believes that the patient has seriously impaired judgment due to their mental disorder is there any requirement for referral to a psychiatrist. In actual practice, few patients requesting assisted suicide are ever referred for such an evaluation. The percentage sent for mental health consultation prior to assisted suicide in Oregon has steadily dropped over six years to only 5% (3) although it is known that these patients may suffer from depression or other mental disturbance (1). When such a referral is made, it is made to a psychiatrist or psychologist chosen by the assisted-suicide doctor and the evaluations tend to be pro forma; so they provide no protective function at any rate. Even if an opinion disallows assisted suicide in a depressed or demented patient, seeking alternative opinions until one that favors assisted suicide can be found is permitted (4-6). Thus, the law provides no effective protection for the mentally ill.

The guidebook for Oregon assisted suicide emphasizes that mental health consultation, when required at all, should be "a form of a competency evaluation, specifically focused on capacity" (7, p 30) to make a decision. Ganzini and Farrenkopf, who authored the mental health section state, "The evaluation should focus on assessing the patient's competency and factors that limit competency such as mental disorders, knowledge deficits, and coercion" (7, p 30). When it comes to diagnosing a psychiatric disorder, however, these authors insist that the presence of a mental disorder does not disqualify a patient from assisted suicide. While acknowledging that depression may affect a patient's judgment about assisted

suicide they emphasize, "The presence of depression does not necessarily mean that the patient is incompetent" (p 31). This opinion is at variance with the majority of forensic psychiatrists, who believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" (8, p595) to make decisions about assisted suicide.

In Oregon, as in the Netherlands, there is no obligation to treat depression or any other mental illness even when one is found. The guidebook concludes, "If the mental health professional finds the patient competent, refusal of mental health treatment by the patient does not constitute a legal barrier to receiving a prescription for a lethal dose of medication" (7, p31).

The guidebook mentions the importance of determining the presence or absence of coercion as a part of competence determination. As these guidelines are applied, however, coercion is narrowly defined. Such was the case in the widely discussed assisted suicide of Kate Cheney (4-6), an eighty-five-year old cancer patient with growing dementia, whose psychiatrist believed she was being pressured by her family; nevertheless, she was given assisted suicide in Oregon.

Mistreatment of Psychiatric Patients Under Oregon Law

The inevitable mistreatment of psychiatric patients once assisted suicide is legalized can be illustrated best by the case of Michael Freeland (9). This is the first reported case of a patient legally prescribed assisted-suicide drugs for which medical records were made available. A complete copy of the medical paper presented at the American Psychiatric Association scientific meeting, May, 2004, is appended to this testimony.

Mr. Freeland, a man in his early 60's, reported that he recently had been diagnosed with terminal lung cancer. He felt devastated and said he might as well begin planning his funeral. He had a long history of serious depression and previous suicide attempts. While he was diagnosed with depression, given antidepressant medications, and even placed in a psychiatric hospital against his wishes by some doctors, another doctor, an assisted-suicide activist, gave this man deadly overdose drugs without even a cursory psychiatric examination and did nothing to retrieve those drugs after a county court declared him incompetent to make his own medical decisions. All these rather shocking facts are documented in his medical record and in the Multnomah County Court. Yet, no mention of this abuse of assisted suicide appeared in the Oregon Department of Human Services (DHS) report, a report judged by many as entirely lacking in providing effective oversight (4-6).

Meanwhile, the adequacy of his pain and palliative care deteriorated to the point he experienced excruciating pain, became dehydrated and delirious, and could not care for himself. When Physicians for Compassionate (PCC) care volunteers checked on him, he reported that his assisted-suicide doctor had offered to sit with him while he took the overdose. It was the volunteers who had to insist that he receive adequate pain care, including an infusion pump and 24-hour attendant care. With this help, his suffering abated as did his wish to take the overdose the assisted-suicide doctor had left with this confused and desperate man. Had it not been for the intervention of PCC volunteers, he may well have taken the overdose has have other depressed and demented patients, such as the first case of assisted suicide and Kate Cheney.

Other Mentally Ill Patients Given Assisted Suicide

Mr. Freeland's case serves as only one illustration of a much more widespread problem. The problem initially appeared with the very first reported case of assisted suicide. This woman with a decades-long history of breast cancer requested assisted suicide. Her own doctor did not think such an action would be appropriate, so she was referred to another doctor known to be open to the possibility of assisted suicide. This doctor diagnosed her with depression and prescribed antidepressant medications. Rather than allowing this potentially helpful treatment to proceed, however, the family found a politically active assisted-suicide doctor, who gave this unfortunate woman a lethal overdose after having known her little more than two weeks. She did not receive adequate psychiatric care, as described in the medical literature (10).

Unlike the first assisted suicide reported, in the case of Mrs. Kate Cheney, who also carried a diagnosis of mental illness, a psychiatrist actually found her demented and lacking competence to consent to assisted suicide. That psychiatrist said seeking a lethal overdose was the daughter's, not the patient's, agenda. When the daughter became angry, it was she who demanded another opinion from Kaiser Permanente health maintenance organization, which, like publicly funded clinics in any country, could benefit financially when patients receive overdoses instead of living out their years. At any rate, a clinic administrator funded another opinion. This psychologist admitted Mrs. Cheney could not even remember when she was diagnosed with terminal cancer although it had only been within the last three months. She also wrote that the patient's decision may have been influenced by her family's wishes and her daughter may have been coercive. Nevertheless, she approved the assisted suicide. Mrs. Cheney also died by a lethal overdose.

OHD reports did not reflect these abuses of the assisted-suicide law. In fact, the official enthusiasm for protecting the assisted-suicide law and its practitioners (11) has left the depressed and mentally ill without any protection.

Assisted Suicide is Not Needed to Alleviate Suffering

The truth is that assisted suicide and euthanasia are simply not needed. So, why put the mentally ill and vulnerable at risk? And, why risk allowing individuals to be given a lethal injections against their will as commonly happens in the Netherlands (12)?

Since implementation of doctor-assisted suicide in Oregon, on average 99.9% of patients die without recourse to taking an overdose; and the other 0.1% could, too, without uncontrollable pain, given modern palliative care techniques. Not one case of assisted suicide has been documented as resulting from actual untreatable pain (3). High on the list of reasons for assisted suicide are psychological and social concerns-fear that being less functional means they are less valuable as human beings, fear that people who care for them may find them a burden and so on. As a large study conducted by a world-famous cancer institute reported in the Journal of the American Medical Association, "Among patients who were neither depressed nor hopeless, none had high desire for hastened death" (1, p2910).

When fear of possible pain is listed in the Oregon statistics, the report (3) buries in a footnote the fact that patients are not necessarily in pain at all; they merely fear future pain. It seems curious that the assisted suicide doctors have not reassured these individuals that their pain can be treated, as has Doctor Chevlin, a nationally noted palliative care doctor, in his book, Power over Pain (13). As the American Medical Association stated concerning the reasons Oregon assisted-suicide doctors said their patients gave for taking an overdose, "the issues expressed by patients in Oregon can be addressed without physician-assisted suicide" (14). However, as the Freeland case demonstrates, the assisted-suicide doctors do not seem to be in the business of addressing these concerns. In fact, since implementation of assisted suicide in Oregon, an important scientific report has demonstrated a decrease in the quality of pain care in this state (15), a failure which is similar to that in the Netherlands (12).

Assisted suicide simply is not needed and it puts vulnerable individuals at risk of their lives. That is why over ten states have strengthened their laws against assisted suicide and not one state has followed Oregon into this unnecessary and risky practice. That is why I urge you to defeat this misleading and dangerous Bill, the Assisted Suicide for the Terminally Ill Bill, because it is unnecessary-and it is dangerous.

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Appendix F

Depression and the Wish to Die

From: "Why Assisted Suicide Must Not Be Legalized" Disability Rights Education & Defense Fund (DREDF)
https://dredf.org/public-policy/assisted-suicide/

The drive to legalize assisted suicide comes from anecdotes of painful, uncomfortable deaths. Yet available data shows that when assisted suicide is legal, those who use it are not typically acting based on current pain or other discomfort. As H. Rex Greene, M.D., stated in 2006:

"... the psychosomatic literature [describes] ... Demoralization Syndrome, which is very common in chronic, ... life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon's law, who are consistently reported NOT to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of what might come in the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates."

Greene also stated:

"The wish for death is a 'cry for help,' a reliable sign of depression. How absurd that it would be met with a lethal prescription. Such an act violates professional standards of palliative care as much as if I were presented with a suicidal patient and handed her a gun or drove her to the Golden Gate Bridge. ... "What this legislation neglects is the fact that advances in palliative medicine have made it possible to relieve ... symptoms in virtually all dying patients. The argument that five to ten percent of dying patients experience intractable symptoms relies on outdated data. (Of course, the victims of the Oregon law were not imminently dying or suffering intractable pain; they were suffering from depression and despair.) Those patients who are truly at the end-of-life need access to excellent palliative and hospice care, not a lethal overdose."[1]

Other research supports Greene's conclusion that most patients requesting death do so not based on physical symptoms such as pain or nausea, but rather based on depression and other forms of psychological distress.[2]

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[1] Greene, Letter to the Council on Ethical Affairs, 2005, https://dredf.org/public-policy/assisted-suicide/opposition-to-neutrality-on-ab-651/.

[2] The two professional associations representing oncologists in California wrote: In this debate, it is critical to recognize that, contrary to popular belief, most patients requesting physician-assisted suicide or euthanasia do not do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. This has been borne out in numerous studies and reports. For example, a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient's expressed desire or support for euthanasia/PAS. See Association of Northern California Oncologists and Medical Oncology Association of Southern California, Position Statement on Physician-Assisted Suicide and Opposition to AB 374, April 16, 2007, available at https://dredf. org/public-policy/assisted-suicide/position-statement-on-assisted-suicide/. The statement cites ME Suares-Almanzor et al., "Attitudes of Terminally Ill Cancer Patients about Euthanasia and Assisted Suicide: Predominance of Psychosocial Determinants and Beliefs Over Symptom Distress and Subsequent Survival," Journal of Clinical Oncology, Vol. 20, 2002, pp. 2134-41 and E.J. Emanuel, "Depression, Euthanasia, and Improving End-of-Life Care," Journal of Clinical Oncology, Vol. 23, 2005, pp. 6456-8.

Appendix G

The Fundamental Loophole of Terminal Illness Prognosis

From: "Why Assisted Suicide Must Not Be Legalized" Disability Rights Education & Defense Fund (DREDF)
https://dredf.org/public-policy/assisted-suicide/

The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear distinction between those who are terminally ill with six months to live, and everyone else. But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it's only in the last few weeks of life. With every disease other than cancer, prediction is unreliable.[1] The affected group could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead of them. This poses considerable danger to people with new or progressive disabilities or diseases, who may often be misdiagnosed as terminally ill but who in many cases outlive these prognoses by years or even decades. Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in our lives.[2] However, the adaptation usually takes considerably longer than the mere fifteen-day waiting period required by assisted suicide proposals and the Oregon and Washington laws. People with new diagnoses of terminal illness appear to go through similar stages.[3] In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make the final choice, one that is irrevocable.

Dr. Richard Radtke, who was a well-known academic oceanographer in Hawaii, provides one such example. Dr. Radtke had a very disabling form of muscular sclerosis for over 40 years. In the period after his diagnosis, doctors often classified him as terminally ill. He experienced severe depression for two years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Yet with an extremely limiting disability, he had a successful academic career, was a happily married father, remained the president of a charitable foundation in retirement, and was grateful for the length and varied experiences of his life, until he died of natural causes in 2012.4 How many such individuals is our society prepared to sacrifice as collateral damage from the legalization of assisted suicide?

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Appendix H

Assisted Suicide Abuses and Complications from Oregon, Washington State and California

Disability Rights Education & Defense Fund (DREDF)
https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf

Under Oregon and Washington State's lax oversight, these are some of the documented abuses and complications that have come to light. This list also includes some of the harms and dangers that accompany assisted suicide laws.

"We are not given the resources to investigate [assisted suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."

Dr. Katrina Hedberg
Oregon Department of Human Services

Doctor Shopping Gets Around Any "Safeguards"

- **Kate Cheney**,[1] 85, died by assisted suicide under Oregon's law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

- **The first known assisted suicide death**[2] under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Initially, two doctors, including her own physician who believed that her request was due to depression, refused to prescribe lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying, although originally called The Hemlock Society—became involved in the case and referred the woman to a doctor willing to write the prescription.

- Dr. Peter Goodwin, former Medical Director of Compassion & Choices, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's assistance.[3] In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.[4] According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying sees "almost 90 percent of requesting Oregonians..."[5] "In 2008 the proportion of reported C&C PAS deaths significantly increased to 88 percent (53/60) of all reported deaths."[6] And in 2009, 57 of the 59 reported assisted suicide deaths were Compassion & Choices clients. But then they ceased to provide further information.[7]

Depression and Psychiatric Disability

- **Michael Freeland,**[8] age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn't think that a psychiatric consultation was

"necessary." But the law's supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years post-diagnosis. Oregon's statistics for the years 2011 - 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs.[9] N. Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric Association, demonstrated how Oregon's flimsy safeguards do not protect people with psychiatric and other mental health disabilities.[10] Moreover, a majority of clinical and forensic psychiatrists believe "that the presence of major depressive disorder should result in an automatic finding of incompetence" to make decisions about assisted suicide.[11] And only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit,[12] yet the Oregon and Washington State definitions of a psychiatric consultation permit one visit only,[13]

- **Absence of psychiatric consultation**: This case is about what can happen when competent psychiatric consultation is not provided. "[A] woman in her mid-fifties with severe heart disease . . . requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. She was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered ... his responsibility ended. ... [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed her self the next day."[14]

Economic Pressures and Coercion

- **Linda Fleming**, the first to use the WA state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death[15]. But we are told by proponents that financial pressures have never played a role.

- **Thomas Middleton** was diagnosed with Lou Gehrig's disease, moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited $90,000 into her own account.[16] It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.

Self-Administration

- **Patrick Matheny**[17] received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services 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 ..." The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.

- **Another anonymous patient**: Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS [physician assisted suicide]."[18] Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement ... [Then, they could] express

the medication through a large bore syringe that would go into their G tube."[19] Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove[20]. Yet, supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually swallow the lethal agents.

Deadly Mix Between Our Broken Health Care System & Assisted Suicide

- **Barbara Wagner & Randy Stroup**: What happened to these patients underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. **Wagner**, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients' one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment "but ... it would cover ... [among other things,] physician-assisted suicide." **Stroup** was prescribed Mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication's benefit has been shown to be "not huge, but measurable"; while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain.[21] Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of, among other things, his physician-assisted suicide.[22]

  These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five-year survival. H. Rex Greene, M.D., retired, former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, CA and formerly a member of the AMA Ethics Council, called this rule "an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria."[23] Though called free choice, when insurers won't pay, assisted suicide is a phony form of freedom.

  Similar examples have emerged in California, when insurers have denied patients with terminal illness a more expensive medical treatment, but are ready to pay for their assisted suicide. The most prominent was that of Stephanie Packer. Her story can be found in Appendix B on page 13.

Breakdown in Rules Attendant to Changing the Law

The following cases were caused by **legal erosion and the breakdown in rules and codes of conduct** associated with assisted suicide laws, rules and codes that elsewhere protect health care patients.

- **Wendy Melcher**[24] died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge, in clear violation of Oregon's law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[25]

- **Annie O. Jones, John Avery, and three other patients** were killed by illegal overdoses of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[26]

Medical Complications

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often

ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.[27]

- **Peaceful death?** Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett28 described one botched assisted suicide. "The man was at home. There was no doctor there" ... . "After he took it [the lethal dose], he began to have ... physical symptoms ... that were hard for his wife to handle. Well, she called 911." He was taken to a local Portland hospital and revived, then to a local nursing facility. "I don't know if he went back home. He died shortly – some ... period of time after that ... ."

  Commenting on this botched assisted suicide case, The Oregonian editorial columnist David Reinhard observed, "The Health Division knows nothing [about this case], ... through no fault of its own. Why? Because the doctor who wrote the prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law] reporting requirements are a sham."

- **David Prueitt**[29] took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."[30]

Impacts by Doctors and Their Quality of Care

- **Kathryn Judson** wrote of bringing her seriously ill husband to the doctor in Oregon. "I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought)," she wrote. "To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher."[31] According to prescribing doctors, 40% of people who died by assisted suicide reported feeling like a burden on family and caregivers as a reason for requesting lethal drugs.[32]

- **By contrast: Jeanette Hall** of Oregon was diagnosed with cancer in 2000 and told she had six months to a year to live. She knew about the assisted suicide law, and asked her doctor about it, because she didn't want to suffer. Her doctor encouraged her not to give up, and she decided to fight the disease. She underwent chemotherapy and radiation. Eleven years later, she wrote, "I am so happy to be alive! If my doctor had believed in assisted suicide, I would be dead. ... Assisted suicide should not be legal."[33] Unfortunately, not all doctors are like Jeanette Hall's.

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[1] DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005; Erin Barnett, A family struggle: Is Mom capable of choosing to die? Oregonian, Oct. 17, 1999.

[2] Erin Hoover and Gail Hill, Two die using suicide law; Woman on tape says she looks forward to relief, Oregonian, March 26, 1998; Kim Murphy, Death Called 1st under Oregon's New Suicide Law, Los Angeles Times, March 26, 1998; and Diane Gianelli, Praise, criticism follow Oregon's first reported assisted suicides, American Medical News, Apr. 13, 1998.

[3] Transcript of tape of Peter Goodwin, Oregon, January 11, 2003, Presentation at 13th National Hemlock Society Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9 – 12, 2003, Bahia Resort Hotel, San Diego, California.

[4] Compassion in Dying of Oregon, Summary of Hastened Deaths, data attached to Compassion in Dying (now called Compassion and Choices) of Oregon's IRS Form 990 for 2003.

[5] Dr. Elizabeth Goy of Oregon Health and Science University (OHSU) is an Assistant Professor in the Department of Psychiatry, School of Medicine, OHSU. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon's assisted-suicide law. They held closed-door hearings on December 9 and 10, 2004 and published the proceedings on April 4, 2005. House of Lords Select Committee on the Assisted Dying for the Terminally Ill. Bill, Assisted Dying for the Terminally Ill Bill [HL] Vol. II: Evidence (London: The Stationery Office Limited, 2005), p. 291, Question 768, (accessed March 10, 2015).

[6] Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, The Proportion of Oregon Assisted Suicides by Com-passion & Choices Organization.

[7] Stevens, Concentration of Oregon's Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians.

[8] N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report , presented at the American Psychiatric Association Annual Meeting, New York, New York, May 6, 2004. and N. Gregory Hamilton, M.D., Testimony to the Select Committee on the Assisted Dying for the Terminally Ill Bill , House of Lords, Portland, Oregon, December 10, 2004.

[9] Oregon Death with Dignity Act Annual Reports , Oregon Health Authority Public Health Division.

[10] Hamilton, op. cit.

[11] Linda Ganzini, M.D., Gregory B. Leong, M.D., Darien S. Fenn, Ph.D., J. Arturo Silva, M.D., and Robert Weinstock, M.D., Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists, American Journal of Psychiatry, Vol. 157, April 2000, pp. 595 and 598.

[12] L. Ganzini, et al., Attitudes of Oregon Psychiatrists Towards Assisted Suicide, Amer-ican Journal of Psychiatry, Vol. 153, 1996, pp. 1469 – 75.

[13] Revised Code of Washington 70.245.010; Oregon Legislative Statue 127.800 §1.01.

[14] N. Gregory Hamilton, Oregon's Culture of Silence, in The Case against Assisted Suicide: For the Right to End-of-Life Care, supra note 2, at 175, 188.

[15] First Death for Washington Assisted-Suicide Law, New York Times, 5/23/2009, (accessed March 10, 2015).

[16] Sawyer Arraigned on State Fraud Charges , KTVZ.com, Sept. 7, 2011.

[17] Erin Hoover, Dilemma of assisted suicide: When? Oregonian, Jan. 17,1999 and Erin Hoover, Man with ALS makes up his mind to die, Oregonian, March 11, 1999.

[18] Dr. David Jeffrey, Winston Churchill Fellow, 2006, Physician-assisted suicide v Palliative Care: a Tale of Two Cities , (accessed July 13, 2009).

[19] Letter from Barbara Glidewell, included in testimony transcript, House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, Assisted Dying for the Terminally Ill Bill [HL] Vol. II, p. 268, number 3; p. 270, question 623; p. 275, question 653.

[20] Kenneth R. Stevens, Jr., M.D., personal communication to Marilyn Golden, Disabili-ty Rights Education & Defense Fund, July 8, 2009; information on lethal drugs based on data taken from Oregon Public Health Division, Death with Dignity Act Annual Reports.

[21] Kenneth R. Stevens, Jr., M.D., Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients—Paying to Die But Not to Live , Physicians for Compassionate Care Educational Foundation, June 6, 2008, (accessed July 9, 2009).

[22] Dan Springer, Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care , Fox News, July 28, 2009, (accessed July 9, 2009).

[23] H. Rex Greene, M.D., personal communication to Marilyn Golden, Disability Rights Education & Defense Fund, July 5, 2009.

[24] Pressure Increases on Suspected Nurses – Alleged Players in Assisted Suicide May Be Prosecuted; Others, Too, Portland Tribune, September 7, 2007.

[25] Another case for nursing reform , Editorial, Portland Tribune, July 10, 2007, accessed March 15, 2015.

[26] Nursing Chaos – Is Oregon State Board of Nursing Protecting Nurses at the Expense of Public Safety, Portland Tribune, May 7, 2006.

[27] Ezekiel J. Emanuel, Elisabeth R. Daniels, Diane L. Fairclough, et. al, The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians, Journal of the American Medical Association, Vol. 280, No. 6, August 12,1998, p. 512; and Derek Humphrey, Letter to the Editor, New York Times, December 3, 1994.

[28] Barrett made her remarks during a Physician-Assisted Suicide: Counseling Patients/Clients presentation at Portland Community College in December 1999. Audiotape on file with author. Also David Reinhard, The pills don't kill: The case, First of two parts, Oregonian, March 23, 2000 and David Reinhard, The pills don't kill: The cover-up, Second of two parts, Oregonian, March 26, 2000.

[29] Associated Press, Assisted suicide attempt fails, March 4, 2005.

[30] Oregon Dept. of Human Services, Press Release, March 4, 2005.

[31] Kathryn Judson, Assisted Suicide? "I was afraid to leave my husband alone again with doctors and nurses," Letter to the Editor, Hawai'I Free Press, February 15, 2011, accessed March 15, 2015,

[32] Oregon Death with Dignity Act Annual Reports , Oregon Health Authority Public Health Division.

[33] Jeanette Hall letter to the editor , Boston Globe, October 4, 2011, accessed June 1, 2012.

Appendix I

30 States Have Rejected the Legalization of Assisted Suicide

Patients Rights Council

The following information comes primarily from the Patients Rights Council. See Attempts to Legalize Euthanasia/Assisted-Suicide in the United States at http://www.patientsrightscouncil.org./site/failed-attempts-usa for up-to-date information.

In the United States, Oregon was the first state to legalized doctor-prescribed suicide. At that time, assisted-suicide advocates predicted that there would be a rapid "domino effect," and other states would soon follow Oregon's lead. But they were wrong. It took fourteen years before another state legalized the practice, and, even then, only after advocates spent a whole year preparing the campaign and raising millions of dollars to insure the victory they so desperately wanted. That state was Washington, the state consultants said was demographically most like Oregon and, therefore, most likely to favor assisted suicide.

In May 2013, Vermont passed an assisted suicide law and in September 2015, California passed a doctor-prescribed suicide bill.

But, since Oregon legalized assisted suicide in 1994, many states have rejected assisted-suicide measures, some multiple times. Since January 1994, there have been more than 175 legislative proposals in more than 35 states. With the exception of Washington's, Vermont's and California's bills, all bills that are not currently pending were either defeated, tabled for the session, withdrawn by sponsors, or languished with no action taken.

Here is a listing, by state, of all the ballot initiatives (since 1991) and all the legislative measures (since 1994) to legalize euthanasia and/or doctor-prescribed suicide in the U.S.

Ballot Initiatives that Passed

Oregon – 1994
Ballot Measure 16 (Oregon Death with Dignity Act) passed on November 8, 1994, by the narrow margin of 51% to 49%. By legalizing physician-assisted suicide, the ballot measure transformed the crime of assisted suicide into a medical treatment.

Washington State — 2008
Ballot Initiative 1000 (Washington Death with Dignity Act) passed on November 4, 2008, by a vote of 58% to 42%. The Washington law is virtually identical to Oregon's assisted-suicide law.

Colorado - 2016
Colorado voters passed an Oregon-style assisted suicide ballot initiative in 2016 by a vote of 65% to 35%

Ballot Initiatives that Were Defeated

Washington State – 1991
Ballot Initiative 119, which would have legalized "aid-in-dying" (both doctor-administered euthanasia and doctor-prescribed suicide), was defeated by a vote of 54% to 46%.

California – 1992
Proposition 161, a ballot initiative that would have legalized euthanasia and physician-assisted suicide failed by a vote of 54% to 46%.

Michigan – 1998
Measure B, which would have legalized physician-assisted suicide, was overwhelmingly rejected by a margin of 71% to 29%.

Maine – 2000
Question 1, the "Maine Death with Dignity Act," patterned after the "Oregon Death with Dignity Act" would have legalized physician-assisted suicide. It was defeated by voters 51% to 49%.

Massachusetts — 2012
Question 2, the "Massachusetts Death with Dignity Act," patterned after the "Oregon Death with Dignity Act" would have legalized doctor-prescribed suicide. It was defeated by voters 51% to 49%.

Legislative Measures since January 1994

With the exception of Vermont and California, all bills that are not currently pending were either defeated, tabled for the session, withdrawn by sponsors, or languished with no action taken.

Alaska
HB 371 (1996)
HB 99 (2015)

Arizona
SB 1007 (1996)
HB 2167 (1999)
HB 2454 (2003)
HB 2564 (2004)
HB 2311, HB 2313 (2005)
HB 2372, HB 2357 (2007)
HB 2387 (2008)
HB 2347, SB 1136 (2016)
HB 2336 (2017)

California
AB 1080, AB 1310 (1995)
AB 1592 (1999)
AB 654 (2005)
AB 651 (2006)
AB 374 (2007)
SB 128 (2015)
AB 15 (2015) passed & signed into law

Colorado
HB 95-1308 (1995)
HB 96-1185 (1996)
HB 15-1135 (2015)
SB 16-025 & HB-16-1054 (2016)

Connecticut
HB 6928, SB 334 (1995)
HB 6083 (1997)
SB 1138 (2009)
HB 6645 (2013)
Raised Bill No. 5326 (2014)
Raised Bill No. 7015 (2015)
HB 6024 (2017)
HB 6238 (2017)

Delaware
HB 150 (2015)

District of Columbia
B21-0038 (2015) pending
Passed DC Council 12/16

Hawaii
SB 2095 (1998)
HB 418, HB 347, SB 981, SB 692,
HB 1155, SB 1037 (1999)
HB 2491, SB2749, SB 709 (2001)
HB 2487, SB 2745 (2002)
HB 862, SB 391 (2003-2004)
HB 1454, SB 1308 (2005)
HB 3013, SB 2900 (2006)
HB 675, SB 800, SB 1995 (2007)
HB 587, HB 806, SB 1159 (2009)
HB 803, HB 1383, HB 1165 (2011)
HB 606 (2013)
HB 1255 (2015)
SB 2373 (2016)
HB, 201, HB 150, HB 550 (2017)
SB 357, SB 1129 (2017)

Illinois
HB 601, SB 948 (1997)

Indiana
SB 273 (2017)

Iowa
HB 2425 (2006)
House File 65 (2015)
SF 2051 (2016)
SF 215 (2017)

Kansas
HB 2068 (2013)
HB 2108 (2013)
HB 2120 (2017)

Louisiana
SB 128 (1999)

Maine
HB 552 (1995)
LD 916 (1996)
HB 663 (1997)
IB 3, IB 10 (1999)
LD 1065 (2013)
S.B. 452 (LD 1270) (2015)
SP 113 (LD 347 (2017)

Maryland
HB 933, HB 474 (1995)
SB 676, HB 1021 (2015)
HB 404 (2016)
HB 370 (2017)
SB 254 (2017)

Massachusetts
H 3173 (1995)
H 1543 (1997)
H 1468 (2009)
H 2233 (2011)
H 3884 (2012)
H 1998 (2013)
H 1991 (2015)
SD 744 (2017)
HD 950 (2017)

Michigan
HB 4134 (1994)
SB 640 (1995)
SB 653 (1997)
HB 5474 (1998)
HB 5802 (2016)

Minnesota
SF 1880 (2015)

Mississippi
HB 1023 (1996)
SB 2283 (2017)

Missouri
HB 307 (2015)
HB 1919 (2016)
HB 524 (2017)

Montana
SB 220 (2013)
SB 167 (2011)
SB 220 (2013)
SB 202 (2015)

Nebraska
LB 1259 (1996)
LB 406 (1997)
LB 70 (1999)
LB 1056 (2016)
LB 450 (2017)

Nevada
SB 336 (2015)

New Hampshire
HB 339 (1996)
HB 1433-FN (1998)
SB 44 (1999)
HB 304 (2009)
HB 513 (2011)
HB 1325 (2014)
SB 426 (2016) (study bill only)

New Jersey
A 3328, S 2259 (2012)
A 2270, S 382 (2014)
A 2451, S 2474 (2016)

New Mexico
SB 446 (1995)
HB 814 (2009)
HB 171 (2017)
SB 252 (2017)

New York
S 1683, S 5024-A, A 6333 (1995)
SB 4834 (1999)
SB 677 (2001)
AB 9360 (2012) withdrawn
AB 02129 (2015)
S 3685 (2015)
S 5814 (2015)
A 5261 (2015)
A 5261-C (2016)
A 10059 (2016)
A 2383 (2017)
S 3151 (2017)

North Carolina
HB 611 (2015) pending

Oklahoma
HB 1673 (2015)

Pennsylvania
HB 1435 (2007)
SB 404 (2009)
SB 431 (2011)
SB 1032 (2013)
HB 2548 (2014)
SB 549 (2015)
HB 943 (2015)
SB 238 (2017)

Rhode Island
SB 2985 (1995)
SB 2869 (1998)
SB 2763 (2001)
HB 7428, SB 2766 (2006)
HB 6080 (2007)
H 5507 (2015)
H 7659 (2016)

Tennessee
SB 1362 (2015)

Utah
HB 391 (2015)
HB 264 (2016)
HB 0076 (2017)

Vermont
H 335 (1995)
H 109 (1997)
H 493 (1999)
H 318, S 112 (2003-2004)
H 168 (2005-2006)
H 44, S 63 (2007)
H 455, S 144 (2009)
H 274, S.103 (2011-2012)
S 77 (2013) passed 5/13

Washington
SB 5596 (1995)
SB 6576 (1998)
SB 6843 (2006)

Wisconsin
AB 174, SB 90 (1995)
AB 32, SB 27 (1997)
AB 297, SB 124 (1999)
AB 417, SB 184 (2001)
AB 348, SB 169 (2003)
AB 507, SB 224 (2005)
AB 298, SB 151 (2007)
SB 28, AB 67 (2015)

Wyoming
SB 7 (2004)
HB 0119 (2015)
HB 0122 (2017)

Appendix J

The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care

Psychiatric Times / 2.1.04
by Herbert Hendin, MD
Herbert Hendin is Chief Executive Officer and Medical Director, Suicide Prevention International. He is widely considered an international expert on suicide prevention.

Euthanasia is a word coined from Greek in the 17th century to refer to an easy, painless, happy death. In modern times, however, it has come to mean a physician's causing a patient's death by injection of a lethal dose of medication. In physician-assisted suicide, the physician prescribes the lethal dose, knowing the patient intends to end their life.

Giving medicine to relieve suffering, even if it risks or causes death, is not assisted suicide or euthanasia; nor is withdrawing treatments that only prolong a painful dying process. Like the general public, many in the medical profession are not clear about these distinctions. Terms like assisted death or death with dignity blur these distinctions, implying that a special law is necessary to make such practices legal--in most countries they already are.

Compassion for suffering patients and respect for patient autonomy serve as the basis for the strongest arguments in favor of legalizing physician-assisted suicide. Compassion, however, is no guarantee against doing harm. A physician who does not know how to relieve a patient's suffering may compassionately, but inappropriately, agree to end the patient's life.

Patient autonomy is an illusion when physicians are not trained to assess and treat patient suffering. The choice for patients then becomes continued agony or a hastened death. Most physicians do not have such training. We have only recently recognized the need to train general physicians in palliative care, training that teaches them how to relieve the suffering of patients with serious, life-threatening illnesses. Studies show that the less physicians know about palliative care, the more they favor assisted suicide or euthanasia; the more they know, the less they favor it.

What happens to autonomy and compassion when assisted suicide and euthanasia are legally practiced? The Netherlands, the only country in which assisted suicide and euthanasia have had legal sanction for two decades, provides the best laboratory to help us evaluate what they mean in actuality. The Dutch experience served as a stimulus for an assisted-suicide law in Oregon--the one U.S. state to sanction it.

I was one of a few foreign researchers who had the opportunity to extensively study the situation in the Netherlands, discuss specific cases with leading Dutch practitioners and interview Dutch government-sponsored euthanasia researchers about their work. We all independently concluded that guidelines established by the Dutch for the practice of assisted suicide and euthanasia were consistently violated and could not be enforced. In the guidelines, a competent patient who has unrelievable suffering makes a voluntary request to a physician. The physician, before going forward, must consult with another physician and must report the case to the authorities.

Concern over charges of abuse led the Dutch government to undertake studies of the practice in 1990, 1995 and in 2001 in which physicians' anonymity was protected and they were given immunity for anything they revealed. Violations of the guidelines then became evident. Half of Dutch doctors feel free to suggest euthanasia to their patients, which compromises the voluntariness of the process. Fifty percent of cases were not reported, which made regulation impossible. The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they "terminated the lives of patients without an explicit request" from the patient. Another third of the physicians could conceive of doing so.

An illustration of a case presented to me as requiring euthanasia without consent involved a Dutch nun who was dying painfully of cancer. Her

physician felt her religion prevented her from agreeing to euthanasia so he felt both justified and compassionate in ending her life without telling her he was doing so. Practicing assisted suicide and euthanasia appears to encourage physicians to think they know best who should live and who should die, an attitude that leads them to make such decisions without consulting patients--a practice that has no legal sanction in the Netherlands or anywhere else.

Compassion is not always involved. In one documented case, a patient with disseminated breast cancer who had rejected the possibility of euthanasia had her life ended because, in the physician's words: "It could have taken another week before she died. I just needed this bed."

Since the government-sanctioned Dutch studies are primarily numerical and categorical, they do not examine the interaction of physicians, patients and families that determines the decision for euthanasia. Other studies conducted in the Netherlands have indicated how voluntariness is compromised, alternatives not presented and the criterion of unrelievable suffering bypassed. A few examples help to illustrate how this occurs:

A wife, who no longer wished to care for her sick, elderly husband, gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to have his life ended; the doctor although aware of the coercion, ended the man's life.

A healthy 50-year-old woman, who lost her son recently to cancer, refused treatment for her depression and said she would accept only help in dying. Her psychiatrist assisted in her suicide within four months of her son's death. He told me he had seen her for a number of sessions when she told him that if he did not help her she would kill herself without him. At that point, he did. He seemed on the one hand to be succumbing to emotional blackmail and on the other to be ignoring the fact that even without treatment, experience has shown that time alone was likely to have affected her wish to die.

Another Dutch physician, who was filmed ending the life of a patient recently diagnosed with amyotrophic lateral sclerosis, says of the patient, "I can give him the finest wheelchair there is, but in the end it is only a stopgap. He is going to die, and he knows it." That death may be years away but a physician with this attitude may not be able to present alternatives to this patient.

The government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands when 50% of Dutch cases of assisted suicide and euthanasia are not reported, more than 50% of Dutch doctors feel free to suggest euthanasia to their patients, and 25% admit to ending patients' lives without their consent.

Euthanasia, intended originally for the exceptional case, became an accepted way of dealing with serious or terminal illness in the Netherlands. In the process, palliative care became one of the casualties, while hospice care has lagged behind that of other countries. In testimony given before the British House of Lords, Zbigniew Zylicz, one of the few palliative care experts in the Netherlands, attributed Dutch deficiencies in palliative care to the easier alternative of euthanasia.

Acknowledging their deficiencies in end-of-life care, the Dutch government has made an effort to stimulate palliative care at six major medical centers throughout the country in the past five years in the hope of improving the care of dying patients. Simultaneously, initiatives for training professionals caring for terminally ill patients were undertaken. More than 100 hospices were also established.

Even if the Dutch experience suggests that engaging physicians in palliative care is harder when the easier option of euthanasia is available, for a significant number such training has become a welcome option. A number of physicians who received the training have publicly expressed their regrets over having previously euthanized patients because they had not known of any viable option. Such expressions of regret would have been inconceivable five years ago.

Developments of the last five years may be having a measurable effect. In contrast to a 20% increase in euthanasia cases from 1991 to 1995, the number of euthanasia cases in 2001 was no greater than in 1995. If education of Dutch doctors by palliative care instructors is successful, a gradual reduction in the number of cases of assisted suicide, euthanasia and involuntary euthanasia cases will be a measure of that success.

Oregon is experiencing many of the same problems as the Netherlands but is not doing nearly as much to combat them. Although legalizing only assisted suicide and not euthanasia, Oregon's law differs from the Dutch in one respect that virtually builds failure into the law.

Intolerable suffering that cannot be relieved is not a basic requirement for

assisted suicide in Oregon as it still is in the Netherlands. Simply having a diagnosis of terminal illness with a prognosis of less than six months to live is considered a sufficient criterion. This shifts the focus from relieving the suffering of dying patients desperate enough to consider hastening death to meeting statutory requirements for assisted suicide. It encourages physicians to go through the motions of offering palliative care, providing serious psychiatric consultation or making an effort to protect those vulnerable to coercion.

In Oregon, when a terminally ill patient makes a request for assisted suicide, physicians are required to point out that palliative care and hospice care are feasible alternatives. They are not required, however, to be knowledgeable about how to relieve either physical or emotional suffering in terminally ill patients. Without such knowledge, the physician cannot present feasible alternatives. Nor are physicians who lack this knowledge required to refer any patient requesting assisted suicide for consultation with a physician knowledgeable about palliative care.

The inadequacy of palliative care consultation in Oregon was underscored by a survey of Oregon physicians who received the first 142 requests for assisted suicide since the law went into effect. In only 13% of cases was a palliative care consultation recommended, and we do not know how many of these recommendations were actually implemented.

Two Oregon cases illustrate how compromised the offer of palliative care can become. The first patient, referred to by her physician as "Helen," was the first known case of physician-assisted suicide in the state. The case was publicized by the Compassion in Dying Federation, an advocacy organization for physician-assisted suicide.

Helen, an Oregon woman in her mid-80s, had metastatic breast cancer and was in a home-hospice program. Her physician had not been willing to assist in her suicide for reasons that were not specified and a second physician refused on the grounds that she was depressed.

Helen called Compassion in Dying and was referred to a physician who would assist her. After her death, a Compassion in Dying press conference featured a taped interview said to have been made with Helen two days before her death. In it, the physician tells her that it is important she understand that there are other choices she could make that he will list for her--which he does in only three sentences covering hospice support, chemotherapy and hormonal therapy.

Doctor: There is, of course, all sorts of hospice support that is available to you. There is, of course, chemotherapy that is available that may or may not have any effect, not in curing your cancer, but perhaps in lengthening your life to some extent. And there is also available a hormone which you were offered before by the oncologist, tamoxifen, which is not really chemotherapy but would have some possibility of slowing or stopping the course of the disease for some period of time.

Helen: Yes, I don't want to take that.

Doctor: All right, OK, that's pretty much what you need to understand.

A cursory, dismissive presentation of alternatives precludes any autonomous decision by the patient. Autonomy is further compromised by the failure to mandate psychiatric evaluation. Such an evaluation is the standard of care for patients who are suicidal, but the Oregon law does not require it in cases of assisted suicide.

Physicians must refer patients to licensed psychiatrists or psychologists only if they believe the patients' judgment is impaired. A diagnosis of depression per se is not considered a sufficient reason for such a referral. However, as with other individuals who are suicidal, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. In any case, studies have also shown that non-psychiatric physicians are not reliably able to diagnose depression, let alone to determine whether the depression is impairing judgment.

Not all of the factors justifying a psychiatric consultation center on current depression. Patients requesting a physician's assistance in suicide are usually telling us that they desperately need relief from their mental and physical suffering and that without such relief they would rather die. When they are treated by a physician who can hear their desperation, understand their ambivalence, treat their depression and relieve their suffering, their wish to die usually disappears.

The psychiatric consultation as envisioned by the Oregon law is not intended to deal with these considerations. It is only concerned with the more limited issue of a patient's capacity to make the decision for assisted suicide to satisfy the requirement of informed consent. The story of Joan Lucas, whose suicide was also facilitated and publicized by Compassion in Dying, points out how such a gatekeeper role encourages seeking psychological or psychiatric

consultation to protect doctors, rather than patients.

Lucas, an Oregon patient with amyotrophic lateral sclerosis, attempted suicide. Paramedics were called to her house, but her children sent them away, explaining, "We couldn't let her go to the ambulance. They would have resuscitated her."

Lucas survived her attempt and was assisted in suicide 18 days later by a physician who gave interviews about the case to an Oregon newspaper on condition of anonymity. He stated that after talking with attorneys and agreeing to help aid Lucas in her death, he asked her to undergo a psychological examination. "It was an option for us to get a psychological or psychiatric evaluation," he told the newspaper. "I elected to get a psychological evaluation because I wished to cover my ass. I didn't want there to be any problems."

The doctor and the family found a cooperative psychologist who asked Lucas to take the Minnesota Multiphasic Personality Inventory (MMPI). Because it was difficult for Joan to travel to the psychologist's office, her children read the true-false questions to her at home. The family found the questions funny, and Joan's daughter described the family as "cracking up over them." Based on these test results, the psychologist concluded that whatever depression Joan had was directly related to her terminal illness--a completely normal response. His opinion is suspect, the more so because while he was willing to give an opinion that would facilitate ending Joan's life, he did not feel it was necessary to see her first.

Data from patient interviews, surveys of families of patients receiving end-of-life care in Oregon, surveys of physicians' experience and data from the few cases where information has been made available suggest the inadequacy of end-of-life care in Oregon.

Oregon physicians have been given authority without being in a position to exercise it responsibly. They are expected to inform patients that alternatives are possible without being required to be knowledgeable enough to present those alternatives in a meaningful way, or to consult with someone who is. They are expected to evaluate patient decision-making capacity and judgment without a requirement for psychiatric expertise or consultation. They are expected to make decisions about voluntariness without having to see those close to the patient who may be exerting a variety of pressures, from subtle to coercive. They are expected to do all of this without necessarily knowing the patient for longer than 15 days. Since physicians cannot be held responsible for wrongful deaths if they have acted in good faith, substandard medical practice is encouraged, physicians are protected from the consequences, and patients are left unprotected while believing they have acquired a new right.

The World Health Organization has recommended that governments not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for their citizens. All states and all countries have a long way to go to achieve this goal.

People are only beginning to learn that with well-trained doctors and nurses and good end-of-life care, it is possible to avoid the pain of the past experiences of many of their loved ones and to achieve a good death. The right to such care is the right that patients should demand and the challenge that every country needs to meet.

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Thank You!

Thank you for your time and consideration on this important issue.
If you have questions or would like to learn more, please contact us:

Patients Rights Action Fund
16 Vandeventer Avenue, 1st Floor
Princeton, NJ 08542
609.759.0322
https://patientsrightsaction.org

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

A special thanks to Diane Coleman and her staff at
Not Dead Yet
for their help in the production of this piece.