



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

MARGARET M. O'NEILL BUILDING
410 FEDERAL STREET, SUITE 1
DOVER, DE 19901

VOICE: (302) 739-3620
TTY/TDD: (302) 739-3699
FAX: (302) 739-6704

MEMORANDUM

DATE: June 26, 2015

TO: All Members of the Delaware State Senate
and House of Representatives

FROM: Ms. Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: H.B. 150 (Assisted Suicide)

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 150 which, consistent with the synopsis, would allow a competent terminally ill "patient" the ability to request medication to end the patient's life.

Council is appreciative of the opportunity provided by the prime sponsor to critique a draft version of H.B. 150 prior to introduction. This resulted in multiple technical improvements in the bill, including the inclusion of specific citations; enhanced conflict of interest protections applicable to witnesses (lines 55-65, 305-308); reconciliation with pharmacy law (line 95); and requirement that cause of death be listed as underlying illness (line 105, based on Maryland law). However, the Council opposes the proposed legislation and believes that the bill may be a first step towards expanding the authorized involuntary termination of life of individuals with disabilities and significant health impairments by guardians, third parties, or government. Attached please find supporting documentation: *A Progressive Case Against Assisted Suicide Laws and Physicians Should be Healers, Not Death's Assistants*. In addition, SCPD would continue to appreciate being included if any future discussion occurs regarding this important and sensitive issue.

Thank you for your consideration and please contact SCPD if you have any questions regarding our position on the proposed legislation.

cc: Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

PRESENTED BY

DREDF: Disability Rights Education & Defense Fund

A Progressive Case
Against
Assisted Suicide Laws

WHY PROGRESSIVES AND DISABILITY RIGHTS ORGANIZATIONS
ARE OPPOSED TO ASSISTED SUICIDE LAWS

CONTENTS

National Progressive & Disability Rights Organizations That Oppose the Legalization of Assisted Suicide	2
Progressive/Center-Left States Have Consistently Rejected Assisted Suicide Laws ...	3
Why Progressives Should Oppose Assisted Suicide Laws	4
Assisted Suicide Drives Decisions Based on Cost	6
Who's Really Hurt by Assisted Suicide?	7
Who's Behind Assisted Suicide Laws?	9
Sen. Ted Kennedy's Widow, Victoria Kennedy, Explains Her Opposition to an Assisted Suicide Law	10
The Danger of Assisted Suicide Laws.....	12
Key Objections to the Legalization of Assisted Suicide	14
Resources.....	16

NATIONAL PROGRESSIVE & DISABILITY RIGHTS ORGANIZATIONS THAT OPPOSE THE LEGALIZATION OF ASSISTED SUICIDE

American Disabled for Attendant Programs Today
(ADAPT)

Disability Section
of the American Public Health Association

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

Justice for All (JFA)

American College of Pediatricians

League of United Latin American Citizens (LULAC)

American Medical Association (AMA)

National Council on Disability

American Nursing Association

National Council on Independent Living

Association of Programs for Rural Independent Living
(APRIL)

National Spinal Cord Injury Association

Autistic Self-Advocacy Network (ASAN)

Not Dead Yet (NDY)

Disability Rights Center

Patients Rights Council

Physicians for Compassionate Care

Disability Rights Education & Defense Fund
(DREDF)

TASH

Disability Rights Enforcement Education Services
(DREES)

World Association of Person with Disabilities (WAPD)

World Institute on Disability (WID)

PROGRESSIVE/CENTER-LEFT STATES HAVE CONSISTENTLY REJECTED ASSISTED SUICIDE LAWS

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

1992

California voters reject Proposition 161 by a margin of 54% to 46%

1998

Michigan's Measure B fails by a margin of 71% to 29%

1999

AB 1592 in California dies in committee

1999

A bill to legalize assisted suicide (SB 677) in New York fails

2000

Maine voters send Question 1 down in defeat 51% to 49%

2005

Again, California legislators reject assisted suicide by tabling AB 654

2006

California's AB 651 fails in committee.

2007

California lawmakers abandon AB 374 under stiff opposition from progressive groups

2009

Hawaii's HB 587 fails to make it out of the legislature

2009

SB 1138 in Connecticut fails

2012

Massachusetts voters reject Question 2 51% to 49% with progressive opposition

2013

HB 6645 in Connecticut is defeated in the legislature

2013

Massachusetts again rejects assisted suicide bill H 1998

2014

HB 5326 in Connecticut is referred to committee, killing the bill

2014

HB 1325 in New Hampshire is decisively defeated in the house 219-66

WHY PROGRESSIVES SHOULD OPPOSE ASSISTED SUICIDE LAWS

By Marilyn Golden, Senior Policy Analyst for the Disability Rights Education & Defense Fund – www.DREDF.org

*Originally printed Fall 2006

In January the California State Senate begins hearings on AB 651, which would legalize assisted suicide in California. A similar bill was presented in the State Assembly last year but didn't even come to a vote because of overwhelming Democrat and Republican opposition. There is a widespread

the Atlantic

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

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

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

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

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

[Source: Letter to Assemblymember Mariko Yamada, February 19th, 2013]

public perception that those opposed to legalization are religious conservatives, and the logical position for a liberal is in support. But the coalition that's formed to oppose the bill, Californians Against Assisted Suicide, shows a diversity of political opinion that may be surprising to those who have not looked closely at the issue. In opposition are numerous disability rights organizations, generally seen as liberal-leaning; the Southern California Cancer Pain Initiative, a group associated with the American Cancer Society; the California Medical Association; and the League of United Latin American Citizens, the oldest civil rights group in California. Catholic organizations are in the mix, but no person would consider this a coalition of religious conservatives.

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

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



Assisted Suicide Proposal is Dangerous Prescription

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

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

[Source: NJ.com, "Opinion: N.J. Assisted Suicide Proposal is Dangerous Prescription," 8/10/2013]

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

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

Each year, Oregon publishes a statistical report that leaves out more than it states. For example, several of these reports have included language such as, "We cannot determine whether assisted suicide is being practiced outside the framework of the law."

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

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



Assisted Suicide Drives Decisions Based on Cost

INSURANCE COMPANY OFFERS 'DEATH DRUGS' AS ALTERNATIVE TO CANCER TREATMENT

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

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

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

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

[Source: ABC News: Death Drugs Cause Uproar in Oregon, 8/6/08]

WHO'S REALLY HURT BY ASSISTED SUICIDE?



November 4, 2014

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.

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.

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 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.

Assisted suicide drugs cost less than \$300. Compare that with the cost of treating a terminal illness. This is one of the many reasons every major disability rights organization in the country that has taken a position on assisted suicide is opposed to legalization, along with the American Medical Association, palliative care specialists and hospice workers who know better than anyone that advancements in palliative care have eliminated pain as an issue for patients who receive appropriate care.

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

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

Assisted suicide ultimately affects everyone's health care. In Oregon, where assisted suicide is legal and where Maynard moved to be prescribed the lethal dose, patients have been harmed.

In 2008, cancer patient Barbara Wagner was prescribed a chemotherapy treatment by her doctor, but Oregon's state-run health plan sent a letter which denied coverage of this chemo, yet offered to cover other "treatments," including assisted suicide.

The same scenario happened to another Oregon resident, Randy Stroup. The Oregon assisted suicide reports tell us that over 95% of those who supposedly received lethal prescriptions in Oregon had insurance, but how many got a denial like the one sent to Wagner and Stroup? When assisted suicide is encouraged, it becomes a covered "treatment" and ultimately removes choices from patients.

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

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

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

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

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

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

-Diane Coleman, J.D., MBA, President and CEO of Not Dead Yet, CNN Opinion, 11/4/2014, drawing from the writings of Margaret Dore, e.g., "What Do We Advise Our Clients?," King County Bar Association Bulletin, May 2009.

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.

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

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

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

The current CEO of the organization, Barbara Coombs Lee, is a former executive for the HMO known as Ethix Corporation, which was later purchased by New York Life Insurance Company. This is no accident as one of the primary reasons

for opposition to assisted suicide by disability rights organizations

is the volatility that is introduced when profit-driven corporations are given sway over end-of-life care. Coombs Lee actually helped draft the Oregon assisted suicide law (Marilyn Golden, "Why Progressives Should Oppose Assisted Suicide," Fall 2006).

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

"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

[Source: PR Newswire, 12/3/97]

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

-New England Journal of Medicine Survey

[Source; Physician Assisted Suicide-Poll Results, 9/12/13]

SEN. TED KENNEDY'S WIDOW, VICTORIA KENNEDY, EXPLAINS HER OPPOSITION TO AN ASSISTED SUICIDE LAW

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

CAPE COD TIMES

October 27th, 2012

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

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

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

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

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

only two to four months to live, that he'd never go back to the U.S. Senate, that he should get his affairs in order, kiss his wife, love his family and get ready to die.

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

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

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

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

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

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

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

But if Question 2 passes 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.

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

THE DANGER OF ASSISTED SUICIDE LAWS

October 14, 2014

By Marilyn Golden

Senior Policy Analyst, Disability Rights Education & Defense Fund

My heart goes out to Brittany Maynard, who is dying of brain cancer and who wrote last week about her desire for what is often referred to as "death with dignity."

Yet while I have every sympathy for her situation, it is important to remember that for every case such as this, there are hundreds -- or thousands -- more people who could be significantly harmed if assisted suicide is legal.

The legalization of assisted suicide always appears acceptable when the focus is solely on an individual. But it is important to remember that doing so would have repercussions across all of society, and would put many people at risk of immense harm. After all, not every terminal prognosis is correct, and not everyone has a loving husband, family or support system.

As an advocate working on behalf of disability rights for 37 years, and as someone who uses a wheelchair, I am all too familiar with the explicit and implicit pressures faced by people living with chronic or serious disability or disease. But the reality is that legalizing assisted suicide is a deadly mix with the broken, profit-driven health care system we have in the United States.

At less than \$300, assisted suicide is, to put it bluntly, the cheapest treatment for a terminal illness. This means that in places where assisted suicide is legal, coercion is not even necessary. If life-sustaining expensive treatment is denied or even merely delayed, patients will be steered toward assisted suicide, where it is legal.

This problem applies to government-funded health care as well.

In 2008, came the story that Barbara Wagner, a Springfield, Oregon, woman diagnosed with lung cancer and prescribed a chemotherapy drug by her personal physician, had reportedly received a letter from the Oregon Health Plan stating that her chemotherapy treatment would not be covered. She said she was told that instead, they would pay for, among other things, her assisted suicide.

"To say to someone: "We'll pay for you to die, but not for you to live" -- it's cruel," she said.

Another Oregon resident, 53-year-old Randy Stroup, was diagnosed with prostate cancer. Like Wagner, Stroup was reportedly denied approval of his prescribed chemotherapy treatment and instead offered coverage for assisted suicide.

Meanwhile, where assisted suicide is legal, an heir or abusive caregiver may steer someone towards assisted suicide, witness the request, pick up the lethal dose, and even give the drug -- no witnesses are required at the death, so who would know? This can occur despite the fact that diagnoses of terminal illness are often wrong, leading people to give up on treatment and lose good years of their lives. True, "safeguards" have been put in place where assisted suicide is legal. But in practical terms, they provide no protection. For example, people with a history of depression and suicide attempts have received the lethal drugs. Michael Freeland of Oregon reportedly had a 40-year history of significant depression, yet he received lethal drugs in Oregon.

These risks are simply not worth the price of assisted suicide.

Available data suggests that pain is rarely the reason why people choose assisted suicide. Instead, most people do so because they fear burdening their families or becoming disabled or dependent.

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 at which the discomfort is relieved while the dying process takes place peacefully. This means that today there is a legal solution to painful and uncomfortable deaths, one that does not raise the very serious problems of legalizing assisted suicide.

The debate about assisted suicide is not new, but voters and elected officials grow very wary of it when they learn the facts. Just this year alone, assisted suicide bills were rejected in Massachusetts, New Hampshire, and Connecticut, and stalled in New Jersey, due to bipartisan, grassroots opposition from a broad coalition of groups spanning the political spectrum from left to right, including disability rights organizations, medical professionals and associations, palliative care specialists, hospice workers and faith-based organizations.

Assisted suicide is a unique issue that breaks down ideological boundaries and requires us to consider those potentially most vulnerable in our society.

All this means that we should, as a society, strive for better options to address the fear and uncertainty articulated by Brittany Maynard. But if assisted suicide is legal, some people's lives will be ended without their consent, through mistakes and abuse. No safeguards have ever been enacted or proposed that can properly prevent this outcome, one that can never be undone.

Ultimately, when looking at the bigger picture, and not just individual cases, one thing becomes clear: Any benefits from assisted suicide are simply not worth the real and significant risks of this dangerous public policy.

“...If assisted suicide is legal, some people's lives will be ended without their consent, through mistakes and abuse. No safeguards have ever been enacted or proposed that can properly prevent this outcome, one that can never be undone.”



KEY OBJECTIONS TO THE LEGALIZATION OF ASSISTED SUICIDE

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

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

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

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

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

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

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

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

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

terminally ill patients.” (Michigan Law Review, June 2008, [Physician-Assisted Suicide in Oregon: A Medical Perspective by Dr. Herbert Hendin and Dr. Kathleen Foley.](#)) 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.

5. Problems with Oregon’s data collection and data soundness, and the lack of any investigations of abuse or meaningful oversight, are so significant as to render conclusions based on those data to be critically flawed.

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

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

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

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

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

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

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

9. Suicide requests from people with terminal illness are usually based on fear and depression.

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

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

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

RESOURCES

Disability Rights Education & Defense Fund

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

Not Dead Yet

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

Patients Rights Council

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

Physicians should be healers, not death's assistants

Delaware Voice Dr. Nancy Fan and Dr. Richard Henderson 8:11 p.m. EDT June 5, 2015



Throughout history and across all cultures, the physician has traditionally been regarded in the role of healer. Since the inception of the Hippocratic Oath well over 2,000 years ago, physicians are trained in the healing arts and to uphold the ethical standards of the profession. Over time, the Oath has been modified and updated, but always based upon the core values of providing compassionate care for the patient and promoting health and wellness.

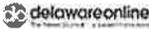
Now, in the 21st century, some people might consider the concept of living by an "oath" outdated. However, for physicians who are caring for patients every day and for the new physicians who have just graduated from medical school, it is more than just mere words. It is symbolic of the ultimate commitment to the patient-physician relationship and it influences our medical care and decision-making at every level.

In this legislative session, Rep. Paul Baumbach has introduced House Bill 150, "Death with Dignity." The bill, which is temporarily tabled, would legalize the act of any physician who wishes to assist patients with actively ending their life, when they have a diagnosis of a terminal illness with the prognosis of less than six months to live. Currently only three states in America have such a legal precedent – Oregon, Vermont and Washington. This clear absence of a national consensus can be seen as an indication of the lack of support for such an extreme measure.

Regardless of what title is used to describe this concept – "Euthanasia", "Death with Dignity" or "Physician Assisted Suicide" – it represents the same to physicians. It is asking us to condone and participate in a process that is inherently antithetical to our training and purpose.

We respect Rep. Baumbach's right to introduce such legislation and we commend him for creating an open dialog about end-of-life care. However, we believe this legislation will distract and ultimately harm the equally important conversation about end-of-life care that we must have. Rather than having the physician serve in a capacity of assisting a patient with ending their life, we need to first consider and embrace other factors that give patients compassion, comfort and a life with dignity, even at what appears to be the end of life.

With advancements in modern medicine, it would be ideal that no one should ever suffer emotionally or physically. It is critical that the medical profession redouble its efforts to ensure that patients with terminal illnesses are provided optimal treatment for their pain and other discomfort. Physicians must resist the tendency to withdraw physically and emotionally from these patients. As the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. A greater reliance on palliative and hospice care, either in the patient's home or environment of choice, as determined by the patient, may successfully alleviate the emotional and physical suffering of patients at the end of life.



Click below to activate your subscription for as low as

\$29 / YEAR

Get 24/7 access how and where you want it –
on your desktop, smartphone & tablet

ACTIVATE MY \$29 OFFER

Requests for physician assisted suicide should be a signal to the physician and our society that the patient's needs are unmet and should prompt further evaluation to determine what factors may be influencing such a request by the patient. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be considered crucial to this evaluation and any discussion and planning of end of life care.

End of life decisions are immensely personal and must not be a product of or a decision made by politicians or government. Delawareans currently have very powerful tools to assist them in planning their end-of-life care and to ensure they have a life and a death with dignity. Using the power of Advance Directives, Living Wills, and a DMOST – a Delaware Medical Orders Scope of Treatment (legislation supported by the Medical Society of Delaware and recently signed into law by Gov. Markell), people have the framework for a practical and effective plan to make their wishes known. This is the discussion that must move forward.

For these reasons, the Medical Society of Delaware, after careful and thoughtful review of this issue, strongly opposes any bill to legalize physician assisted suicide. Our respect for our patients, their requests for death with dignity and our profession as physicians demands that we continue in the role as healer.

Dr. Nancy Fan is president of the Medical Society of Delaware. Dr. Richard Henderson is chair of the Government Affairs Committee, Medical Society of Delaware.

Read or Share this story: <http://delonline.us/1Mcvvx9>

Delaware Spine Studies 



Do you have Low Back PAIN?

Now seeking **volunteers** for participation in a **low back pain research study!**

Volunteer Today

Contact us at (302) 831-7142

TOP VIDEOS



<http://delonline.com/opinion/2893001742001/2628>
Opinion: Arizona isn't crazy enough to target gay kids
[/videos/opinion/2893001742001](http://delonline.com/videos/opinion/2893001742001)
00:55