Top Reasons to Oppose Assisted Suicide

The deadly and dangerous practice of assisted suicide is now legal in five states (Oregon, Washington, Vermont, California, and Colorado) and the District of Columbia, our nation's capital.[1] With new momentum and lots of money, assisted suicide proponents are pursuing an aggressive nationwide campaign to advance their agenda through legislation, ballot measures, litigation, and public advertising, targeting states they see as most susceptible to their message. Some polls indicate that the public is receptive to the general concept of assisted suicide. But the same polls show that when the public learns about the dangers of assisted suicide, especially for those who are poor, elderly, disabled, or without access to good medical care, their views shift against the practice. The following dangers are among the top reasons to oppose assisted suicide.

A DEADLY MIX WITH OUR PROFIT-DRIVEN HEALTH CARE SYSTEM

- Some patients in Oregon and California have received word that their health insurance will pay for assisted suicide but will not pay for treatment that may sustain their lives.[2 & 3]

PUTS VULNERABLE PERSONS AT RISK OF ABUSE AND COERCION

- Once lethal drugs have been prescribed, assisted suicide laws have *no* requirements for assessing the patient's consent, competency, or voluntariness. Who would know if the drugs are freely taken since there is no supervision or tracking of the drugs once they leave the pharmacy and no witnesses are required at the time of death? Despite a reporting system designed to conceal rather than detect abuses, reports of undue influence have nonetheless surfaced in Oregon.[4]
- Elder abuse is considered a major health problem in the United States, with federal estimates that one in ten elder persons are abused.[5] Placing lethal drugs into the hands of abusers generates an additional major risk to elder persons.
- Assisted suicide laws often allow one of the two witnesses to the request for lethal drugs to be an heir to the patient's estate. Therefore, an heir or friends of the heir can encourage or pressure the patient to request lethal drugs and then be a witness to the request.

DANGEROUSLY BROAD DEFINITION OF TERMINAL ILLNESS

- Assisted suicide laws typically appear to limit eligibility to terminally ill patients who are expected to die within six months but don't distinguish between persons who will die within six months *with treatment* and those who will die within six months *without treatment*. This means that patients with treatable diseases (like diabetes or chronic respiratory or cardiac disease) and patients with disabilities requiring ventilator support are all eligible for lethal drugs because they would die within six months without the treatment they would normally receive.

PAIN NOT THE PRIMARY ISSUE

Untreated pain is not among the top reasons for taking lethal drugs. Per official annual state reports, in 2016, 90% of Oregon patients seeking lethal drugs said they were doing so because they were "less able to engage in activities making life enjoyable" and were "losing autonomy," and 49% cited being a "burden" on family, friends or caregivers. And in Washington, 52% cited being a "burden" as a reason, while only 35% cited a concern about pain.

NO PSYCHIATRIC EVALUATION OR TREATMENT REQUIRED

- Despite medical literature showing that nearly 95% of those who commit suicide had a diagnosable psychiatric illness (usually treatable depression) in the months preceding suicide,[6] the prescribing doctor and the doctor he or she selects to give a second opinion are both free to decide whether to refer suicidal patients for any psychological counseling. Per Oregon's official annual

report, from 2013-2016 less than 4% of patients who died under its assisted suicide law had been referred for counseling to check for "impaired judgment."

- If counseling is provided to patients seeking assisted suicide, its goal isn't to *treat* the underlying disorder or depression; it's to determine whether the disorder or depression is *"causing impaired judgment"* [emphasis added].[7] The doctors or counselor can decide that, since depression is "a completely normal response" to terminal illness, the depressed patient's judgment is not impaired.[8]

THREATENS IMPROVEMENT OF PALLIATIVE CARE

- There is compelling evidence that legalizing assisted suicide undermines efforts to maintain and improve good care for patients nearing the end of life, including patients who never wanted assisted suicide.[9]

FOSTERS DISCRIMINATION

- Assisted suicide creates two classes of people: those whose suicides we spend hundreds of millions of dollars each year to prevent and those whose suicides we assist and treat as a positive good. We remove weapons and drugs that can cause harm to one group, while handing deadly drugs to the other, setting up yet another kind of life-threatening discrimination.

There are many more reasons why legalizing assisted suicide is a bad and dangerous idea. For further information, visit **www.usccb.org/toliveeachday** and **www.patientsrightsaction.org.**

1 Montana's highest court, while not officially legalizing the practice, suggested in 2009 that it could be allowed under certain circumstances.

2 Susan Harding, "Health Plan Covers Assisted Suicide But Not New Cancer Treatment," *KVAL News* (published July 31, 2008, updated Oct. 30, 2013) (noting that the Oregon Health Plan will pay for coverage for chemotherapy that cures cancer, but not for chemotherapy drugs that can extend life); Jennifer Popik, "Terminally Ill Oregon Patients Denied Treatment but Reminded They Can Choose Physician-Assisted Suicide" (July 2008), available at http://www.nrlc.org/archive/news/2008/NRL08/Oregon.html.

3 Bradford Richardson, "Assisted-Suicide Law Prompts Insurance Company to Deny Coverage to Terminally Ill California Woman," *Washington Times* (Oct. 20, 2016), http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/.

4 In one case, a woman with cancer committed suicide with a doctor's assistance even though she had dementia, was found mentally incompetent by doctors, and had a grown daughter described as "somewhat coercive" in pushing her toward suicide. Hendin & Foley, *Physician-Assisted Suicide in Oregon*, *supra* at 1626-27.

5 Lachs, Mark S., M.D., M.P.H., and Karl A. Pillemer, Ph.D. "Elder Abuse." Edited by Edward W. Campion, M.D. The New England Journal of Medicine 373 (November 12, 2015): 1947-1956. DOI: 10.1056/NEJMra1404688. http://www.nejm.org/doi/full/10.1056/NEJMra1404688

6 H. Hendin, M.D., *Seduced by Death: Doctors, Patients, and Assisted Suicide* (New York: W.W. Norton, 1998): 34-35.

7 Or. Rev. Stat. § 127.825; Wash. Rev. Code § 70.245.060.

8 See H. Hendin and K. Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective," 106 *Michigan Law Review* 1613-45 (2008) at 1623-4; available at https://docs.google.com/file/d/0BwDPETL1NPnAMmFjZTNjNzctOGU4NS00MTUwLTgxZjAtM2I4NDhlMjA2OTFj/edit?hl=en&pli=1.

9 "Vermont VNA Seeking to Identify Causes of State's Low Hospice Utilization Rates," *Hospice and Palliative Care News*, April 29, 2015, at http://healthrespubs.com/hospice-and-palliative-care-news/2015/04/29/vermont-vna-seeking-to-identify-low-hospice-utilization-rates/. J. Ballentine et al., "Physician-Assisted Death Does Not Improve End-of-Life Care," *Journal of Palliative Medicine* 19 (2016): 1-2.

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