2015

Assisted Suicide Advocacy Kit
FACTS on ASSISTED SUICIDE

Terminal prognosis are often wrong. Individuals outlive their diagnoses by months and even years. Assisted suicide legislation leads people to give up on treatment and lose good years of their lives.

Assisted suicide legalization has failed more times than it has succeeded. There have been over 140 legalization attempts in the past 20 years, yet only 3 states have actually legalized it through legislative or voter action.

If assisted suicide is made legal, it quickly becomes just another form of treatment and as such, will always be the cheapest option. This is troublesome in a cost-conscious healthcare environment. Oregonian Barbara Wagner was denied coverage of her cancer treatment but received a letter from the Oregon Health Plan that stated the plan would cover assisted suicide. Another Oregon resident, Randy Stroup, received an identical letter, telling him that the Oregon Health Plan would cover the cost of his assisted suicide, but would not pay for medical treatment for his prostate cancer.

Assisted suicide poses a threat to those living with disabilities or who are in vulnerable circumstances. When assisted suicide becomes an option, pressure can be placed on these individuals to take that option.

The mental heath and other safeguards in Oregon and Washington have proven to be hollow as they are easily circumvented. Patients are not required to receive a lethal prescription from their attending physician and can “doctor-shop”.

Nothing in the Oregon or Washington style laws can protect from explicit or implicit family pressures to commit suicide or personal fears of “being a burden.” There is also no requirement that a doctor evaluate family pressures the patient may be under.

Oregon’s data on assisted suicide is flawed, incomplete and tells us very little. The state does not investigate cases of abuse, and has 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 destroying the underlying data after each annual report.¹ (Regarding abuses brought to light in Oregon, see this handout)

Prescription requests from terminally ill individuals for suicide drugs are often based on fear and depression. Most cases of depression among terminally ill people can be successfully treated. Yet primary care physicians are generally not experts in diagnosing depression. Nothing in the Oregon or Washington assisted suicide laws compel doctors to refer patients for evaluation by a psychologist or psychiatrist to screen for depression or mental illness.

Under Oregon and Washington law, there is nothing to compel doctors to encourage a patient to notify family members as a support system to aid in the process or even be present.

¹ 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.)
Countries such as the Netherlands, where assisted suicide has been legal for decades, show that assisted suicide cannot be contained or limited to the terminally ill.  
(See Dr. Herbert Hendon commentary, click here)

Barbiturates do not assure a peaceful death

Barbiturates are the most common substances used for assisted suicide in Oregon and Washington. Overdoses of barbiturates are known to cause distress and have associated issues:

- Extreme gasping and muscle spasms
- While losing consciousness, a person can vomit and then inhale the vomit
- Panic, feelings of terror and assaultive behavior from the drug-induced confusion
- Failure of drugs to induce unconsciousness
- A number of days elapsing before death occurs or death does not occur
Abuses in States with Assisted Suicide Laws

- Oregonian Barbara Wagner was denied coverage of her cancer treatment but received a letter from the Oregon Health Plan that stated the plan would cover assisted suicide. The drugs for her cancer treatment were around $4,000 a month and the assisted suicide pills were less than $100. (Source: ABC News, Death Drugs Cause Uproar in Oregon, 8/6/08) [http://abcnews.go.com/Health/story?id=5517492]

- Another Oregon resident, Randy Stroup, received an identical letter, telling him that the Oregon Health Plan would cover the cost of his assisted suicide, but would not pay for medical treatment for his prostate cancer. (Source: Fox News, Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care, 7/28/08 [http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care/]

- Kate Cheney, 85, died of assisted suicide under Oregon’s law even though she had early dementia. Her personal physician declined to provide the lethal prescription. Her managed-care provider found another physician to prescribe a lethal dose of drugs. When counseling to determine her capacity was sought, a psychiatrist concluded that she was not eligible for assisted suicide since she was not explicitly seeking it, and her daughter seemed to be coaching her to do so. Nevertheless, Kate Cheney soon received and used the lethal drugs.

- Michael Freeland, 64, had a 43-year history of acute depression and suicide attempts. Yet, when Freeland and his daughter went to see a doctor about arranging a legal assisted suicide, the physician said he didn’t think that a psychiatric consultation was “necessary.” Oregon’s statistics for the last four years show that only 2% of patients were referred for a psychological evaluation or counseling before receiving their prescriptions for lethal drugs. [4]

- Patrick Matheny 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 DHS 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.

- Contrary to proponents’ claims, legalizing assisted suicide does not guarantee patients a quick and peaceful death. Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett described one botched assisted suicide. “The man was at home. There was no doctor there,” she said. “After he took it [the lethal dose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she called 911.” He was taken to a local Portland hospital and revived.

- David Prueitt took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices (formerly the Hemlock Society). 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.” [6]

- The first known assisted-suicide death 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, had refused to prescribe the lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying—became involved in the case and referred the woman to a doctor willing to write the prescription.

- The following cases indicate legal erosion associated with legalized assisted suicide. Wendy Melcher[10] 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.”[11] Annie O. Jones, John Avery and three other patients were killed from an illegal overdose of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[12]

Endnotes


[9] 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.


The Danger of Assisted Suicide Laws

By Marilyn Golden
October 14, 2014

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.

*Marilyn Golden is a senior policy analyst with the Disability Rights Education and Defense Fund.*
The Social Effects of Suicidal Behavior

If there is a “right to assisted suicide,” why would such a right be restricted only to those in the throes of terminal illness?

By Dr. Aaron Kheriaty, MD and Dr. Paul McHugh, MD

In the wake of Brittany Maynard’s highly publicized death, many advocates are pressing for the legalization of physician-assisted suicide for patients in the throes of terminal illness. The claim to such a right raises many questions, not the least of which is this: if there is a “right to assisted suicide,” why would such a right be restricted only to those in the throes of terminal illness? What about the elderly person suffering a slow but non-terminal decline, or the young adult in the throes of depression, demoralization or despair?

Once we adopt the principle that assisted suicide is acceptable, then the fences erected around it—having six months to live, or having mental capacity, for example—are inevitably arbitrary. These restrictions will eventually be abandoned, as the situation with assisted suicide in Belgium and the Netherlands demonstrates: to cite just a few examples, in Belgium assisted suicide has been granted to a man with “untreatable depression” and to a prisoner suffering “psychological anguish;” in the Netherlands, assisted suicide has been granted to a woman because she did not want to live in a nursing home.

As psychiatrists, we see patients every day who demonstrate suicidal thinking and behavior, people whose life stories are every bit as heartbreaking as Maynard’s, and whose “reasons” for suicide may seem every bit as compelling. And yet, as medical professionals, we are duty-bound to intervene on their behalf, to take measures to prevent such persons from taking their own lives.

The recent debates on physician-assisted suicide have largely ignored what research in psychiatry and the social sciences has demonstrated about suicide. We know, for example, that suicide is typically an impulsive and ambivalent act; we know that it requires not just suicidal intent but easy access to means.

The number-one suicide “hot spot” in the world is the Golden Gate Bridge in San Francisco, where 1,400 people have died. A journalist tracked down the handful of individuals who had survived the jump and asked them what was going through their minds during the four seconds when they were falling. Every one of them responded that they regretted the decision to jump, with one saying, “I realized that all the problems in my life that I thought were unsolvable were actually solvable – except for having just jumped.”

Suicidal individuals typically do not want to die; they merely want to escape what they perceive as intolerable suffering. When comfort or relief is offered, in the form of more adequate treatment for depression, better pain management, or more comprehensive palliative care, and more effective care for the elderly, as described in Dr. Atul Gawande’s splendid new bestselling book, Being Mortal (Metropolitan Books, 2014). When death becomes inevitable and further medical interventions become excessively burdensome, hospice and palliative care offer compassionate alternatives to assisted suicide or euthanasia.
We know that the vast majority of suicides are associated with clinical depression or other treatable mental disorders; yet alarmingly, less than 6 percent of the 752 individuals who have died by assisted suicide under Oregon’s law were referred for psychiatric evaluation prior to their death. This constitutes gross medical negligence. We also know that there is a “social contagion” aspect to suicide, which leads to copycat suicides – particularly for well-publicized cases portrayed by the media with romanticized overtones. Some have called Maynard’s death “courageous” and “inspiring,” but we worry that her death will indeed “inspire” other vulnerable individuals – particularly the young – to follow her example. Many would like to believe that Maynard’s death was a purely private and personal affair, affecting only her and her family. But given what we know about suicide’s social effects, and given the media portrayal around her death, we anticipate that her decision will influence other vulnerable individuals to choose likewise.

Suicide rates constitute a public health crisis; suicide is currently the second leading cause of death among adolescents and young adults (behind motor vehicle accidents) and the 11th leading cause of death overall in the U.S. Not all suicides can be prevented, but many can, and our collective efforts at suicide risk reduction have the capacity to save many lives. The social acceptance of physician-assisted suicide will undermine these efforts and place vulnerable individuals at risk.

Dr. Aaron Kheriaty is an Associate Professor of Psychiatry and Director of the Program in Medical Ethics at the UC Irvine School of Medicine. Dr. Paul McHugh is a University Distinguished Professor of Psychiatry at Johns Hopkins University.
Who’s Really Hurt by Assisted Suicide?

By Diane Coleman
November 4, 2014

A beautiful 29-year-old woman with a rare brain tumor, Brittany Maynard and her tragic death have sparked the on-again, off-again debate about whether assisted suicide should be legalized in this country.

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

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

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

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

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

Assisted suicide drugs cost less than $300. Compare that with the cost of treating a terminal illness.

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

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

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

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

The same scenario happened to another Oregon resident, Randy Stroup. The Oregon assisted suicide reports tell us that over 95%
of those who supposedly received lethal prescriptions in Oregon had insurance, but how many got a denial like the one sent to Wagner and Stroup?

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

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

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

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

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

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

_Diane Coleman, J.D., MBA, is the President and CEO of Not Dead Yet, a national disability rights group._
For additional messaging, training or questions on this content, please contact:

Tim Rosales
929.244.3297
info@patientsrightsaction.org
www.patientsrightsaction.org
@PRAfund
https://www.facebook.com/PatientsRightsAction

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