WHY PHYSICIAN-ASSISTED SUICIDE IS WRONG AND DANGEROUS

February 25, 2004

1. *Origin and Principles of Physicians for Compassionate Care*
When the voters of Oregon approved the legalization of physician-assisted suicide in 1994, many physicians in Oregon organized themselves into an organization called Physicians for Compassionate Care. As members of this organization we affirm an ethic that all human life is inherently valuable. We affirm that physicians' roles are to heal illness, alleviate suffering, and provide comfort for the sick and dying. We work to ensure appropriate care for our patients, to speak out for the inherent value of human life, and to uphold the time-honored values of our profession. We encourage physicians to: heal the patient; enhance support for patients who cannot be healed; avoid unnecessary therapies that will unduly prolong the dying process; educate health professionals and the public about the dangers of physician-assisted suicide and euthanasia, realizing that they are fundamentally incompatible with our role as healer. We encourage state of the art care for dying patients, including optimal pain management and the recognition and treatment of depression. We work to update health professionals on current pain management technology and palliative care for clinical use to help confront the challenges of serious, chronic and terminal illness with honesty, caring and commitment. We collaborate with other organizations to promote our mission.

2. *Duty and Role of Physicians*
Physicians have the duty to safeguard human life, especially life of the most vulnerable: the sick, elderly, disabled, poor, ethnic minorities, and those whom society may consider the most unproductive and burdensome. Physicians are to use all knowledge, skills and compassion in caring for and supporting the patient. Medicine and physicians are not to intentionally cause death. The patient-physician trusting relationship is the most important asset of physicians and is for the protection of patients.

3. *The Assisted Suicide Movement*
In the United States, it is a very serious crime to assist another person in their suicide; unless you are a physician in Oregon and assisting a terminally ill patient to commit suicide. The proponents of physician-assisted suicide want to change that criminal designation. They desire that physician-assisted suicide be legal in the entire United States. They are working to change state and national laws for that purpose. The focus of this movement: is not on comfort care, is not on pain management, in not on palliative care. Their focus is to make physician-assisted suicide legal.

4. *Who gets the Rights and Protection with Assisted Suicide?*
The legalization of physician-assisted suicide does not give any new rights to patients. Its purpose is to legally protect doctors who write prescriptions for lethal drugs. Legalization of physician-assisted suicide takes away from terminally ill patients, the protection against doctors who order their death by a prescription for deadly drugs. Those who ask for a "right to die" have to give someone else the "power to kill".

5. *Definitions of Physician-assisted Suicide and Euthanasia*
Physician-assisted suicide: A patient self-administers the lethal dose that has been prescribed by a physician. Euthanasia: Active causation of death of a patient by a physician, by lethal injection or other means.

6. *Physician-assisted Suicide is Doctor Ordered Suicide*
A prescription is a written order or directive to the patient. In physician-assisted suicide, a doctor writes a prescription for lethal drugs. In The Netherlands and in Oregon barbiturates (sleeping pills) are being prescribed for this purpose. Morphine-like drugs are not being used for this purpose. Physician-assisted suicide is really doctor-ordered, doctor prescribed, or doctor-directed suicide. When a doctor writes a prescription for physician-assisted suicide, the message to the patient is: your life is not worth living, you are better of dead, I don't value you or your life, I want you dead, I order you to die, I direct you to die. Those who desire a "right to die" are giving to doctors the "power to kill". Assisted suicide is fundamentally incompatible with the doctor's role as healer, comforter and consoler. Assisted suicide is the ultimate abandonment of a patient by a doctor.

7. *What About Concern about Not Wanting to be on Life-Support Technology?*
Being on or off life-support life support has nothing to do with physician-assisted suicide. There is a constitutional right to consent to consent to and refuse medical treatment. You cannot be forced to be on life-support machine. Stopping life-support is very different than physician-assisted suicide.

8. *What about Cancer and Pain?*
There is an inverse relationship between cancer patients experience with pain and their favoring assisted suicide. People with cancer are less in favor or assisted suicide than is the general public. Patients with pain want doctors to kill the pain, not kill the patient. We should focus on improving the care of patients, not on killing them. In Oregon, only a small minority of patients dying of assisted suicide chose it because of fear of pain in the future. This was not because they were having pain. The proponents of assisted suicide acknowledge that pain is not an important reason for legalizing assisted suicide. The message that the proponents of assisted suicide are giving to the public and to patients, is that doctors can do a better job of killing patients than they can of caring for their medical needs. The doctors you don't trust to take care of you

are going to be given the legal power to kill you. My patients have told me that they worry that the doctors will be the judge, jury and executioner of their lives.

9. *Relationship of Depression and Physician-assisted Suicide*
Depression is the leading cause of suicide. There is a direct relationship between depression and favoring physician-assisted suicide. Depression is frequently overlooked in patients with serious physical illness. Depression needs to be diagnosed and properly treated with counseling and medications.

10. *Physician-assisted Suicide Destroys the Trust between Patient and Doctor*
The following is a personal story of Dr. Kenneth Stevens, M.D. "We had been married for 18 years and had 6 children. For three years my wife had been suffering from advancing malignant lymphoma. It had spread from the lymph nodes to her brain, to her spinal cord and to her bones. She had received extensive chemotherapy and radiation treatments. She required considerable pain medication, antidepressants and other supportive measures. In late May, 1982, we met again with her physician to review what more could be done. It was obvious that there was no further treatment that would halt the cancer's progressive nature. As we were about to leave his office, her physician said, "Well, I could write a prescription for an 'extra large' amount of pain medication for you." He did not say it was for her to hasten her death, but she and I both felt his intended message. We knew that was the intent of his words. We declined the prescription. As I helped her to our car, she said, "He wants me to kill myself." She and I were devastated. How could her trusted physician subtly suggest to her that she take her own life with lethal drugs? We had felt much discouragement during the prior three years, but not the deep despair that we felt at that time when her physician, her trusted physician, subtly suggested that suicide should be considered. His subtle message to her was, "Your life is no longer of value, you are better off dead." Six days later she died peacefully, naturally, with dignity and at ease in her bed, without the suggested lethal drugs. Physician-assisted suicide does destroy trust between patient and physician.

11. *Money and Physician-Assisted Suicide*
Derek Humphry, founder of End of Life Choices, has said that assisted suicide can help solve the problems of health care costs. What is cheaper for HMOs or Medicaid programs, assisted suicide or caring for a patient? A newspaper report in 1998, indicated that two assisted suicides paid for by Oregon Medicaid cost $99 for both of them. Oregon has been in an economic and medical crisis. Half of Oregon doctors in 2003 will no longer take care of Oregon Medicaid patients. Significant state budget deficits stopped benefits for many Oregonians in the state's Medically Needy Program in 2003. This resulted in many serious medical problems and even deaths. Loss of mental-illness medications resulted in suicides. Loss of anti-seizure medications resulted in a patient going into a million dollar coma before his recent death. Patients

with HIV/AIDS lost funding for their medications. Patients needing organ-transplants were taken off the transplant list because would not receive state financial support for anti-rejection drugs. Patients lost funding for their pain medications. One of the physicians in our organization received a call from a patient in March, 2003, requesting "assisted suicide". He said he had an 11-year history of chronic pain. He said, "The state has stopped paying for my pain meds because of the Medicaid cutbacks." "If they won't pay for my pain meds, then they might as well pay for my suicide." With the social and financial inequality in our society, assisted suicide poses the greatest risk to those who are poor, elderly, members of a minority group, or without access to good medical matter.

12. *How Do People Die with Assisted Suicide?*
Assisted suicide deaths are a result of acute barbiturate poisoning. The typical drugs are Seconal or Nembutal, ninety to one hundred 100-mgm capsules. The symptoms of acute barbiturate poisoning are: face reddened, then ashy pale, then blue; seizures may occur; respiratory failure with slowed breathing; loss of cough reflex, fluid collects in throat, gurgling with breathing; coma; possibly death. If the person does not die, the following may occur: recover completely; agitation, nightmares, hallucinations, anxiety or abnormal thinking; hallucinations for weeks, Parkinsonism, acute schizophrenia, dementia, or permanent brain damage. The normal duration of action of barbiturates is to have the onset of action in 10 to 15 minutes, with a total duration of 3 to 4 hours. That is why they are called short-acting barbiturates. The Oregon physician-assisted suicide reporting information indicates that for each year from 1998 to 2002, many patients have lived far beyond the usual duration of the barbiturates. The longest time from ingestion of the barbiturates to the time of death was: 11 ½ hours in 1998, 26 hours in 1999, 6+ hours in 2000, 37 hours in 2001, and 14 hours in 2002. This raises the question of actually how are these patients dying, since they are living beyond the duration of action of the barbiturates. Are other devices such as suffocation bags being used in some patients? In Oregon, we are dependent on self-reporting from physicians involved in assisted suicide. The Oregon state Health Department obtains very limited information regarding how these patients die. The Oregon assisted suicide law actually prohibits investigation of many details of the deaths. In The Netherlands which is much more open in their reporting regarding assisted suicide than is Oregon, physician-assisted suicide resulted in complications in 7%, failure in completion of the suicide in 16%, and lethal injection used in 20% of patients.

13. *Assisted Suicide "Safeguards" in Oregon are not being Followed*
"Safeguards" were included in the Oregon physician-assisted suicide law because of the dangers of assisted suicide. The stated "safeguards" include: being capable, not being depressed, no coercion, self-administration, and life expectancy of less than 6

months. Yet, reports in the public press have described that among those who have died from assisted suicide there are: patients who are depressed; patients who are demented; patients and families "doctor-shopping" until they find a doctor who will write a prescription; patients with swallowing problems requiring assistance in taking the medication (not self-administered); coercive family members; doctors being coerced/intimidated into writing the lethal prescription; patients living as long as a year after being determined eligible. A Deputy Oregon State Attorney General wrote that Oregon's assisted suicide law may discriminate against those who are paralyzed and can't swallow. This would lead to lethal injections. A doctor in Oregon unlawfully ordered a lethal injection for a patient; he was not prosecuted, and he had only a two-month suspension of his medical license.

14. *The Conflict of Autonomy and Assisted Suicide "Safeguards"*
The assisted suicide movement exploits autonomy and self-determination as their main argument for the legalization of assisted suicide. "Safeguards" were placed in Oregon's assisted suicide law because assisted suicide is dangerous. The problem with "safeguards" in physician-assisted suicide laws is that they act as a "barriers or roadblocks" for access for those outside the boundaries of the "safeguards". Based on "autonomy" arguments, those outside the boundaries want access to assisted suicide. This is why these "safeguards" are not always being followed, and why the boundaries around assisted suicide have stretched and will continue to stretch like a rubber band. The nature of unbounded autonomy ultimately leads to loss of autonomy; in the future assisted suicide and euthanasia may be the only "choice" for some people.

15. *The Arguments in Favor of Assisted Suicide are Harmful to People with Disabilities*
In describing reasons for assisted suicide, the proponents of assisted suicide demean and demonize people with disabilities. Assisted suicide advocates de-value those who have disabilities, by playing on the "horror of dependency" for those with serious illness. People with disabilities have expressed fear that they may become the next targets of the assisted-suicide movement.