This is the text of a presentation by Dr. Thomas Pitre, M.D., a member of the board of Physicians for Compassionate Care, which he gave in Arizona. A modification of this presentation has been published as: Pitre, Thomas, Lessons from Oregon, *The Linacre Quarterly*, 71:114-125, May 2004. It is an excellent review of the lessons learned regarding physician-assisted suicide in Oregon. This documents many of the dangers and problems with assisted suicide in Oregon.

Lessons from Oregon

Thomas M. Pitre, M.D., N. Gregory Hamilton, M.D.,
and William Toffler, M.D.

I would like to thank Dr. Mike Rock and Arizona Right to Life for the privilege of addressing you this morning on the ever-threatening topic of euthanasia. It is, indeed, an honor to be sharing the podium with Arizona's own Dr. Carolyn Gerster whose dedication and service to the pro-life cause is a tremendous inspiration to me.

I bring you greetings from the Pacific Northwest where I am a practicing urologist in the only state in the nation to have legalized physician-assisted suicide (PAS). I am a on the board of Physicians for Compassionate Care (PCC), which arose in response to the passage of Oregon's Measure 16 in 1994 or as it is better known as the "*Oregon Death with Dignity Act*." Although assisted suicide and euthanasia were practiced in the Netherlands for more than twenty years, it was never legalized, and Oregon thus became the first jurisdiction in the world to legalize PAS. Since then Oregon has become the "model" for the assisted-suicide and euthanasia activists who moved the headquarters for the Compassion in Dying Federation, an outgrowth of the Hemlock Society, into Portland, just after the election. The Dying Federation was directly involved in 79% of the assisted-suicide deaths in the first year the law was in effect.1

I, along with hundreds of my colleagues, who believed in the more than 2000 year old tradition of the Hippocratic Oath - "Thou shall not give any deadly medicine.even if asked," didn't believe, until it was too late, that a public referendum could change the long held ethics of my profession. We came together as PCC, which now has more than 2000 members in over 40 states, and subscribes to the simple ethic that all human life is inherently and equally valuable. PCC puts on annual Compassionate Care Conferences to educate professionals on how to improve pain treatment and palliative care at the end of life while warning of the dangers of PAS and euthanasia. For more information about PCC and how to become a member, which is free, I refer you to our website: www.pccef.org or there are some brochures and a sign up sheet in the back.

At the outset I would like to acknowledge Drs. Greg Hamilton2 and Bill Toffler, co-founders of PCC, for their untiring and ongoing leadership in this battle against the evil of PAS and euthanasia. I am also indebted to Rita Marker3 for her timely article "An Inside Look at the Right to Die Movement," just published in the Autumn 2001 edition of the *National Catholic Bioethics Quarterly* from which I draw frequently in the remarks that follow. Dr. Daniel Sulmasy4, Wesley J. Smith5, and numerous others have been a tremendous source of inspiration to me and I'm sure to anyone trying to articulate a reasoned argument against the emotional

poster cases of intolerable suffering used to argue for the legalization of "aid in dying." The recent position paper of the American College of Physicians-American Society of Internal Medicine with over 90,000 members just published in the August 7, 2001 issue of the *Annals of Internal Medicine*6 is extremely clear, well written and contains an encyclopedic bibliography of more than 100 current references documenting their position against PAS. I have included some of these references in your handout.

Definitions:

Before I begin I would like to clarify our understanding of the terms PAS and euthanasia. Although they are frequently joined together they are not the same and they differ significantly in the final act, without which, the intended death will not occur.

PAS refers to the act of a physician in providing the patient with a legal means of ending their life, for example, prescribing a lethal dose of barbiturates with which the patient then ends his or her life.

Euthanasia differs in that the physician performs the final act that kills the patient, for example, by administering or ordering the administration of a lethal injection.

Background:

Many of you here today I am sure are familiar with the background leading up to the passage of *Oregon's Death with Dignity Act*, but let me review what I consider some of the more important events from which we can begin to draw 12 "lessons from Oregon."

One of the first things that happened, quietly and unknown to most of us in 1980 was the arrival of Derek Humphry in Eugene, Oregon and the formation of the Hemlock Society. Their clear agenda was to legalize euthanasia. After efforts to legalize assisted suicide and euthanasia in numerous state legislatures failed, they turned their efforts to voter initiatives. Around that same time Derek Humphry published his famous suicide manual, *Final Exit*7, in 1991.

Voter initiatives to legalize the new euphemism "aid in dying" were first tried in our northern neighbor, the state of Washington, in 1991 and our southern neighbor, California, in 1992. Both of these pioneer initiatives included both PAS and euthanasia. Successful campaigns defeating them were able to counter their pleas for "choice in determining a peaceful death" as a way out of intractable pain and suffering, by depicting a sinister doctor with a syringe about to kill someone in a nursing home. Also key in the defeat of these earlier initiatives was the clear opposition of their state medical societies, which had significant credibility with the voters who looked to the medical profession for guidance. The verbal engineering, which always precedes social engineering, was well underway even though their first initiatives failed.

Activists from the Hemlock Society went back to the drawing boards and crafted a "softer, gentler" bill for Oregon explicitly prohibiting euthanasia in general and lethal injection in particular to overcome objections raised by the successful campaigns that defeated them in Washington and California. They did this knowing full well that lethal injection would have to

follow through legal challenges for those who could not ingest lethal medication, as I will illustrate with an actual case from Oregon shortly. The illusion of patient control was conveyed and numerous so-called "safeguards" were touted to protect voters from the "slippery slope" arguments that could be so well made from the Dutch experience. A quiet but carefully orchestrated resolution was brought before the Oregon Medical Association by a few doctors, who later became outspoken proponents of Measure 16, that led the OMA not to take a stand on the ballot measure. This in effect conveyed the message that the doctors were questioning the American Medical Association's ethical prohibition against assisted suicide and euthanasia..

Opponents of Measure 16 were portrayed as religious zealots while the proponents portrayed themselves as kind, compassionate and wanting nothing but the right to end intolerable pain by gentle legal means. One of the most compelling ads of their campaign was a 60 second TV commercial that featured Patty A. Rosen, a former nurse who told a story of helping her daughter, who was in intractable pain from advanced thyroid cancer, die peacefully with a lethal overdose of pills she obtained illegally. The problem with the ad was that it wasn't true. Three days before the election it was discovered that she was lying in the ad and that the pills didn't work. She had admitted two years earlier that she had to finish "euthanizing" her daughter with a lethal injection. The voters, however, believed the ads and with a narrow 51-49 % victory enacted the *Oregon Death with Dignity Act*.

Lesson # 1:

Know your enemy.

The people who will bring physician-assisted suicide and euthanasia to Arizona have been planning their strategies and learning from their mistakes since the formation of the Hemlock Society in 1980. They are well organized, well funded, and committed for the long haul.

The *Compassion in Dying Federation is* a national organization with paid staff, which is carefully looking for their next target and planning their best strategy. The Sunbelt states of Florida and Arizona with their significant elderly populations are quite logical targets.

Lesson #2:

As we learned from the Patty A. Rosen story, assisted-suicide proponents are capable of deceit.

For numerous other well-documented examples of their deception I refer you to Rita Markers article referenced in your hand out.

Lesson # 3:

Pro-life members of the Arizona State Medical Association need to be networked, vigilant and prepared to act, before legislative action is proposed. They must affirm the clear ethic upheld by the American Medical Association and recently affirmed by the American

College of Physicians - American Society of Internal Medicine against physician-assisted suicide.

Many pro-life doctors in Oregon had dropped their membership in the OMA when the threat first arrived, because of the OMA's stance on abortion. It is vital that we stay involved in our state medical societies, even though they may espouse some positions contrary to our beliefs. Our voices need to be heard when it comes to life and death issues even if it seems at times that we are "crying in the wilderness."

Oregon experience 1994-1997:

Before the *Oregon Death with Dignity Act* could be enacted as law, a successful legal challenge blocked its implementation for nearly three years before the Oregon Supreme Court finally dismissed the case for "lack of standing."

In the interim Oregon Right to Life and PCC began working hard to get the legislature to repeal Measure 16. PCC members joined their state society and were then able to get the OMA to reverse its previous neutral position and pass a resolution to officially come out in opposition to the existing law as "seriously flawed." Their vote was nearly unanimous 121-1. This played a key role in the legislature, as did the individual and personal testimony of PCC physicians, in convincing members of the Oregon House and Senate of the serious flaws in the *Oregon Death with Dignity Act*. The result was a legislative recommendation for repeal and a return to the voters in 1997 as Measure 51.

Measure 51 required a "yes" vote for passage, which began the uphill struggle. Major funding came from the Catholic Church. The opposition formed a committee called "Don't Let Them Shove their Religion Down your Throat Committee" against Measure 51 which was the sign off of their sound bite commercials aimed at the Catholic Church, which they claimed wanted to "impose their morality on Oregonians." The Catholic Hospital system in Oregon (which was heavily involved in managed care) was opposed to the use of the managed care argument that assisted suicide costs much less than palliative care. This appears to have been misguided. In retrospect this argument has proved one of the most thought provoking in the overall debate. After considering this reality, many individuals who previously had been enthusiasts for assisted suicide at least experience second thoughts. They denounced the legislature as not listening to the will of Oregonians in the 1994 vote.

Oregon is one of the least churched states in the nation, a major point for the Hemlock Society locating its headquarters in the heart of the Northwest. Oregonians pride themselves as innovators and trendsetters, particularly in healthcare, and saw "aid in dying" as progressive. They were successful in getting one of the more persuasive ads against PAS pulled, which undermined the credibility of the entire ad campaign. They played their euphemisms of "death with dignity," "peaceful death," "the right to die," and their ultimate sound bite "choice in dying" like a violin. Despite the fact that we were able to raise nearly five million dollars, to their $800,000, Measure 51 went down even worse than before - 60-40.

The overwhelming rejection of the recall effort, the dismissal of the legal injunction by the Supreme Court, and Janet Reno's misguided interpretation that lethal prescriptions where not a violation of the Federal Controlled Substances Act, finally allowed for legalized killing in our state to begin.

Lesson # 4:

Confused voters favor "choice."

Lesson # 5:

Outside of the liberal media and the politics of a campaign, well-reasoned dialogue can take place and arguments against the evils of assisted suicide and euthanasia can prevail as they did in 1997 at the Oregon Medical Association and the Oregon House and Senate leading to the recall referendum.

The truth of this lesson was also reflected by the example of well-reasoned arguments made before the US Senate leading to a 99-0 vote to ban Medicare funding of assisted suicide and the 9-0 decision of the US Supreme Court finding that there is no constitutional right to PAS.

Lesson # 6:

Broad-based coalitions of support and funding can diffuse the argument of the imposition of religious or moral values.

The example of strong grassroots opposition to California's 1999 "California Death with Dignity Act" illustrates the effectiveness of this strategy, as do the broad based coalitions that were successful in rejecting PAS in Maine and Michigan- again see Rita Marker's article8. In Oregon, we lacked such a broad-based coalition, and were vulnerable to anti-catholic and anti-religious attacks.

Oregon experience since 1997:

Even before the defeat of Measure 51, a task force on the "*Oregon Death with Dignity Act*" had completed a 91-page implementation handbook for healthcare providers. The taskforce was convened by our pro assisted-suicide governor, and consisted of individuals such as Barbara Coombs Lee, one of the law's chief petitioners and now at the helm of the well-funded national organization, "Compassion in Dying," as well as other pro-suicide members. In it the groundwork for allowing lethal injection or "infusions" was already laid9 despite repeated reassurance to Oregonians during the campaign that this could never happen.

Governor Kitzhaber's nationally watched pilot *Oregon Health Plan,* that rations healthcare to the poor, in February, 1998, then included funding of assisted suicide under "comfort care" while refusing to provide adequate funding for mental health services including depression. Oregon tax dollars are now funding PAS just as they fund abortions for the poor.

Cases:

Next I would like to share a few cases that have occurred since legalized PAS has become law in Oregon that are real, documented and illustrate just a few of the problems with assisted suicide.

Individuals suffering from depression and other mental illnesses, who have been singled out by the label *terminally ill,* are made especially vulnerable by laws favoring assisted suicide. This fact is particularly important, since medical studies have demonstrated that seriously ill individuals who desire an early death are usually afflicted with a **treatable** depressive disorder.

The first publicly reported case of doctor-assisted suicide in Oregon was a woman who had been diagnosed as depressed, yet she was given assisted suicide in two-and-a-half weeks from the time she was referred to the Compassion in Dying Federation.10 This woman had a more than twenty-year history of breast cancer. When she eventually developed metastases in her lungs, her physician told her these metastases may eventually prove fatal. At that time, her state had been saturated by frightening portrayals of the normal dying process as exaggeratedly grotesque and terrifying. When she reportedly requested assisted suicide, her regular physician declined to give her a lethal overdose. A second opinion was sought. This doctor, however, concluded that the patient was depressed and needed treatment of her depression, not assisted suicide. He gave her antidepressant medication. She never took it.

Instead of insisting that the patient follow through on treatment likely to alleviate feelings of hopelessness associated with depression, a family member, not the patient herself, sought yet another opinion, this time from the Compassion in Dying Federation. Dr. Peter Goodwin, medical director of that organization, determined over the telephone that he thought the patient was "rational" without ever having actually examined her himself.11 He then gave the patient a referral to a doctor who, like him, had been active in a political campaign promoting the legalization of assisted suicide, Dr. Peter Reagan.12

Oregon law, similar to the Dutch practice, does not require patients to receive psychiatric evaluation before being given assisted suicide. When such an evaluation is obtained, it is at the discretion of the assisted-suicide doctor him- or herself. Even then, the presence or absence of depression or other mental disorder itself is not considered the crucial factor. The Oregon law states that the depression must be thought by the physician to cause "impaired judgment" before the assisted-suicide decision is called into question or postponed. This qualification that the depression must be impairing judgment is unusual since "impairment of judgment" is often a basic characteristic of the disorder. Depression typically causes feelings of hopelessness, either-or thinking and a tendency to overlook possible solutions to problems

The doctors to whom this woman, diagnosed with depression, was referred to by the Compassion in Dying Federation, however, apparently did not consider the patient to have been depressed or to have impaired judgment. So, the eventual psychiatric referral appears to have been made to counter the opinion of the original doctors or because this first case of PAS was destined to be publicized as a so-called "model" case.13 The evaluating psychiatrist was chosen by the same doctor who planned to give the overdose. This psychiatrist approved the assisted suicide after only one visit. This quick judgment was made despite the fact that another doctor had already

diagnosed the patient as depressed and there is no indication that the physician who attempted to treat her depression was consulted to consider the basis of his diagnosis and treatment. Studies show only 6% of Oregon psychiatrists are very confident they can determine in a single visit when depression may be affecting decisions to commit assisted suicide in the absence of a long-term relationship.14 Nevertheless, this life and death decision was made in a single visit by a psychiatrist chosen by the assisted-suicide doctor himself. None of the doctors who carried out the assisted suicide had a long-term relationship with the patient.

Because she was labeled "terminally ill," she could be given assisted suicide by doctors who barely knew her, instead of being given treatment. Standard medical practice requires doctors to respond to suicidal wishes with a thorough evaluation of possible causes of the suicidal wishes and an attempt to remove those causes. Depression is the most common cause of suicidal ideas and feelings15 even among the seriously ill. There has been no demonstrable difference in the causes of suicide in the elderly or ill than in anyone else.

Lesson # 7:

The legalization of PAS stigmatizes those labeled "terminally ill" and exempts them from legal protections of society. It deprives them of the protections against suicidal despair that the rest of us enjoy.

Let me give you another example from Oregon. Mrs. Kate Cheney16 was an elderly, Oregon woman with growing dementia and the diagnosis of a potentially terminal cancer. When her daughter accompanied her to her doctor's appointment to formally request assisted suicide under Oregon's new law allowing such a practice, the doctor did not agree with that course of action.17 It was the daughter, not the patient, who then insisted the mother have a new doctor within her health maintenance organization, Kaiser Permanente. The doctor change for the mother was granted to the daughter. This second doctor was willing to give Mrs. Cheney assisted suicide and arranged for psychiatric for evaluation, because it was standard procedure at this health maintenance organization (HMO) in its assisted-suicide protocol. The psychiatrist, who released a written report to the newspaper, found that Mrs. Cheney had short-term memory deficits and dementia. He also said the assisted-suicide request appeared to be the daughter's "agenda." The daughter who also accompanied Mrs. Cheney to this appointment, "coached her" in her answers, even when the psychiatrist asked her not to do so. The psychiatrist said, "She does not seem to be explicitly pushing for this." She was deemed lacking sufficient capacity to weigh options about assisted suicide; thus, she was not eligible for doctor-assisted suicide. The patient accepted this assessment. Her daughter, however, "became angry." It was the daughter, not the patient, who then "decided on a second competency evaluation." Kaiser HMO apparently authorized this second off- panel mental health evaluation. This new psychologist admitted the patient 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 "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Nevertheless, she approved the assisted suicide.

With two conflicting mental health opinions, the final decision, far from being an "autonomous" decision made in "private" by the patient, came down to yet another Kaiser HMO doctor-

administrator, Robert Richardson, who approved giving a lethal overdose to this elderly woman under pressure from her family. Kaiser Permanente is a fully capitated HMO with a profit sharing plan for its doctors. Such organizations receive compensation for the number of patients enrolled in their system regardless of the cost of their medical care, and it allowed repeated second opinions until the very lowest cost care of all was given-that is no care, but assisted suicide instead. Dr. Richardson may or may not have directly thought of the economic advantages to his organization and his own profit sharing plan in making his decision about Mrs. Cheney. Nevertheless, the existence of an economic incentive program put in place purposefully to induce doctors to reduce medical costs, an incentive system that in this case favored doctor-assisted suicide over expensive medical care, did exist. And why are these profit sharing plans favoring less care set up in managed care companies? Because they work. They influence doctors' decisions.

Outside pressure or influence for assisted suicide is not at all uncommon, once assisted suicide becomes legalized. In fact, in the Netherlands, over half the doctors feel it is fine to actually suggest to a patient who has not requested it, that assisted suicide is an option. The mere inclusion of the option for PAS to a potentially terminally ill patient says to that patient that the doctor no longer sees any value in their life.

Mrs. Cheney was pressured into suicide instead of medical care, because she had been stigmatized by being labeled "terminal." A demented patient who was not labeled "terminal" would have been protected against assisted suicide regardless of any pressure from the family.

The designation of having a "terminal" illness is an arbitrary one, defined in Oregon law as a prediction according to the doctor's judgment that the patient will die within six months. This prediction is notoriously difficult to make. All physicians have known patients who were thought to have a lethal condition for whom the diagnosis was mistaken or who unexpectedly recovered entirely and went on to live productive lives.

Lesson # 8:

Financial incentives for doctors favor assisted suicide.

Lesson # 9:

There are no real safeguards, particularly for the elderly.

The state of Oregon has failed to provide any meaningful oversight of assisted suicide and has done virtually nothing to protect the vulnerable. There have been only three reports and all have been used to whitewash assisted suicide, not to protect patients. The Oregon Health Division review of 1998 reported cases was particularly criticized by national medical experts because of "its failure to address the limits of the information it has available, overreaching its data to draw unwarranted conclusions."18 It carefully avoided providing any useful information. The first publicly reported case of assisted suicide was noted to have been diagnosed with depression, yet the report failed to reveal this fact. Neither did the report mention a known case where finances were one motivating factors in her decision for assisted suicide. The OHD overlooked these

problems and other problems, because it only interviewed the doctors who prescribed the lethal drugs and who therefore had a vested interest in justifying their behavior. The second OHD report also interviewed some family members, but those family members were chosen by the assisted-suicide doctors themselves and were also motivated to justify their recent collusion in a patient suicide.

At least one assisted-suicide attempt resulted in such disturbing symptoms that the family called 911.19 The patient was taken to the hospital and resuscitated. This case apparently was never reported. This instance when a known failed assisted-suicide case was not reported suggests that there is skewed reporting with complications being hidden. The OHD also failed to mention documented dementia in the Kate Cheney case. It did not mention known, multiple and conflicting mental health opinions. Neither did the OHD report that there were any instances of family pressure or coercion, despite the fact that two mental health professionals were known to have found such factors present in the Kate Cheney case. It is not known how many other cases in which such pressures may have played a part. Concerning the issue of economic pressures, OHD only asserted that all the assisted-suicide cases were insured. It provided no information about what the financial arrangements of the insurance companies might be. It did not mention the capitated and profit sharing plan of the Kaiser HMO where Mrs. Cheney died. It did not mention the rationing of health care and the barriers to mental health care on the OHP upon which four cases had to rely. And, it said nothing about how many patients belonged to HMOs which put limits on payments for in-home palliative care at very low amounts, yet fully fund assisted suicide, as Qual Med HMO is reported to do. Instead of gathering useful information, the OHD once again overreached its data and provided unsubstantiated reassurances.

One of the more significant findings in the third report deals with patients' reasons for choosing induced death. As in the previous two reports, fears about loosing autonomy, the ability to participate in enjoyable activities, and control over bodily functions topped the list of reasons. However, for the first time, a clear majority (63%) of those whose deaths occurred in 2000 said they feared becoming burdens on their families, friends and caregivers, compared to 26% in the previous year.

Lesson #10:

In Oregon the "right to die" is becoming the "duty" to die.

Another very disturbing trend is the undermining of palliative care and pain management that has resulted from the erosion the doctor-patient and nurse-patient relationship. The insidious but real practice of **"slow euthanasia"** or more properly **"terminal sedation"** wherein increasing doses of morphine render a patient unconscious and dead within days are going on unnoticed and unreported. This practice distorts the principle of "double effect" by claiming the harmful effect of morphine infusion i.e. death was not the intended effect which was rather the amelioration of pain and suffering.

In a notable exception to appropriate use of morphine, five seriously ill patients in a Sheridan, Oregon, hospice were given excessive doses of morphine by a Michael J. Coons, between November, 1997 and January, 1998, just after the Oregon assisted-suicide law was implemented.

These events were reported in the Oregonian, a local newspaper. The overdoses resulted in the deaths of four of the five patients. Some patients were determined by investigators to have refused pain medication and were given it nonetheless. Another was given repeated narcotic doses when he was unconscious or unresponsive. The one woman who survived had been placed on hospice, which meant that she had been determined to be "terminally ill" and to have less than six months to live, by the nurse who eventually gave her a life threatening overdose. She turns out not to have met criteria for "terminal illness" after all, because two years later, she is still alive. Her experience with the attempts to kill her with a lethal overdose, however, have undermined her trust in the medical care system and at night she makes sure her door is always locked. The other four patients did not live to struggle with their fears.

In Oregon, where the lives of the seriously ill have been devalued by the acceptance of giving some patients overdoses, there was an inordinate delay in the investigation of these cases. Complaints were dismissed by agency after agency, until the persistence of the daughter of one of the victims, finally succeeded, one-and-a-half years later in demanding an inquiry. The daughter of the single survivor said she did not know about the overdose of her mother until it was published in the newspaper, two years later. She was outraged. It is clear then that the erosion of the conditions of trust in the doctor-patient relationship, and more broadly in the complex medical system in which people are actually treated has already begun in the state of Oregon has it has in the Netherlands. And it is already undermining Oregon's pain treatment and palliative care systems.

Lesson # 11:

When doctors and nurses have the ability to kill as well as heal, confidence in the 'doctor-patient' and 'nurse-patient' relationships are compromised.

The US Supreme Court was right when it predicted: ..".what is couched as a limited right to 'physician-assisted suicide' is likely, in effect a much broader license, which could prove extremely difficult to police and contain."20

Let me share one last case. Another of the complications the OHD failed to report. This case reveals the inevitability of allowing lethal injection once protection against assisted suicide is removed. With lethal injection, it is even more obvious than with assisted suicide that power and control is given to doctors, nurses and a complex medical, economic, and social system, not to a patient acting in a hypothetically "autonomous" and "private" manner.

Patrick Matheny21 was a man with amyotrophic lateral sclerosis (ALS), who received through the mail a huge quantity of barbiturates prescribed by an assisted-suicide doctor. When he undertook his assisted suicide with no doctor in attendance, he had difficulty swallowing the contents of the large number of capsules, because of his medical condition and his suicide attempt failed. He tried again the next morning. After he could not complete the second attempt, his brother-in-law said he "helped" him die and complained that Oregon's suicide law discriminates against those who cannot swallow. The body was cremated within a day; consequently, no autopsy could ascertain the cause of death.

Doctors and other citizens demanded that the prosecutor investigate the death, because illegal suffocation of the patient has been the most frequent method of "helping" patients whose attempts fail. The Coos County prosecutor, however, refused to pursue the case, while making comments that individuals who are disabled by being unable to swallow should have the "right" to assisted suicide, as long as they are otherwise qualified. It is clear that the assistance the prosecutor had in mind could include either the plastic bag or lethal injection. In response to further inquiry, Oregon's Deputy Attorney General issued an opinion indicating that lethal injection may need to be accepted once assisted suicide is accepted, because Oregon's assisted-suicide law does not provide equal access to its provisions by disabled people who cannot swallow and may violate the Americans with Disabilities Act. He issued this opinion much to the dismay of advocates for the disabled in Oregon.

What is so important about failed assisted-suicide cases is that they are bound to bring in lethal injection. That is what has happened in the Netherlands.22 That is what the Hemlock Society's Derek Humphry has been demanding as a solution to the problem of inability to swallow and failed attempts. That is the dilemma Dr. Sherwin Nuland raised in the New England Journal of Medicine23-if doctors are going to start carrying out assisted suicides, they will need lethal injection to finish the job-and lethal injection clearly gives power and control to doctors, nurses, and health care systems, not to the patient.

Lesson # 12:

Once the door is open to physician-assisted suicide lethal injection or euthanasia will follow.

The painful lessons I have shared with you today have been shared in the hope that Arizona will never have to suffer the devastating effects of legalized assisted suicide that we endure in Oregon. Don't let your state go down the dangerous path my state alone has gone down. Follow the example of the many, many states that have rejected the deceptions of assisted suicide in their courts and their legislatures and their ballot boxes. Look to the example of courts in Washington state and New York and Florida and Alaska which upheld their laws protecting patients against the dangers of assisted suicide. Follow the example of Michigan, Maine, California and again Washington, which have rejected highly publicized out-of-state assisted-suicide campaigns. Follow the examples of the numerous states that, in the past ten years, have strengthened laws protecting citizens against the seductions of assisted suicide

Affirm the sanctity of life in Arizona and protect your state against the evils of PAS and euthanasia.

Physicians for Compassionate Care

Lesson # 1: Know your enemy.

Lesson # 2: Assisted-suicide proponents are capable of deceit.

Lesson # 3: Pro-Life doctors need to stay involved in organized medicine.

Lesson # 4: Confused voters favor "choice."

Lesson # 5: Well-reasoned dialogue can be effective.

Lesson # 6: Broad based coalitions of support and funding work the best.

Lesson # 7: Physician-assisted suicide (PAS) deprives the terminally ill of protections the rest of us enjoy.

Lesson # 8: Financial incentives for doctors favor assisted suicide.

Lesson # 9: There are no real safeguards, particularly for the elderly.

Lesson # 10: In Oregon the "right to die" is becoming the "duty" to die.

Lesson # 11: When doctors and nurses have the ability to kill as well as heal, confidence in the 'doctor-patient' and 'nurse-patient' relationships are compromised.

Lesson # 12: Once the door is open to physician-assisted suicide lethal injection or euthanasia will follow.

The successful "No on One" campaign recently waged in Maine against a law modeled after Oregon's law circulated a flyer titled:

The Top 10 Dangers: It's Not What you Think

- No family notification required.
- No direct state supervision required to prevent abuse.
- No real safeguards to ensure that a request was voluntary.
- No safeguards to ensure that requests for physician-assisted suicide would be based on sound well-informed decisions.
- No safeguards to ensure that only terminally ill patients could request and receive a physician's assistance in committing suicide.
- No safeguards to ensure that the lethal medication was properly handled and distributed.
- No requirement that physicians be present when their patients take lethal medications, leaving them unattended should complications arise.

- No requirement that a patient actually learn about options other that physician-assisted suicide.
- No requirement that complications, violations, or abuses be reported to law enforcement regulatory authorities.
- Because physician-assisted suicide is inexpensive, health maintenance organizations (HMOs) could encourage a patient to take his/her own life rather than request more expensive palliative care options.

This very effective flyer couldn't be challenged in Maine and it is equally true for the law that exists in Oregon.

Endnotes:

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