

➤ Hearing Records ... HR

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WISCONSIN STATE  
LEGISLATURE ...  
PUBLIC HEARING  
COMMITTEE RECORDS

**2007-08**

(session year)

**Senate**

(Assembly, Senate or Joint)

Committee on  
Public Health, Senior  
Issues, Long Term  
Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

**COMMITTEE NOTICES ...**

➤ Committee Reports ... CR

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➤ Executive Sessions ... ES

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➤ Public Hearings ... PH

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➤ Record of Comm. Proceedings ... RCP

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**INFORMATION COLLECTED BY  
COMMITTEE FOR AND AGAINST  
PROPOSAL ...**

➤ Appointments ... Appt

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Name:

➤ Clearinghouse Rules ... CRule

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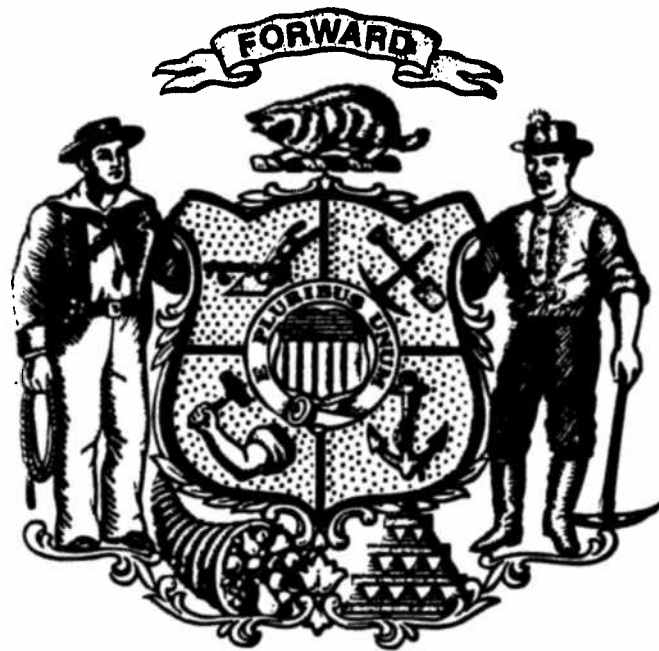
➤ Hearing Records ... HR (bills and resolutions)

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➤ Miscellaneous ... Misc

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Five Oregonians to Remember  
Charles J. Bentz MD, FACP  
January 9, 2008

SB 151 ?

Wisconsin is facing legislation similar to Oregon's Death with Dignity Law. While pro-suicide groups cite the "great success" of the Oregon experience, everyone in Wisconsin needs to hear the real record. Here are the cases of five Oregonians, all part of the public record, for whom the tragedy of doctor-assisted suicide was all too real.

*Patients with dementia are being killed: The case of Kate Cheney*

Mrs. Kate Cheney was an elderly Oregon woman with growing dementia and a diagnosis of a potentially terminal cancer. Her daughter, Erika, asked her primary physician for assisted suicide. This physician found the patient incompetent and denied this initial request. A second opinion was obtained by a psychiatrist who found that Mrs. Cheney had short-term memory deficits and dementia, and that this 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. Concerning the patient, the psychiatrist observed, "She does not seem to be explicitly pushing for this." Thus, the psychiatrist concluded that the patient lacked sufficient capacity to weigh options about assisted suicide and she was ineligible for doctor-assisted suicide. The daughter, however, would not take 'no' for an answer, and sought a second mental health evaluation where the patient could not even remember when she was diagnosed with terminal cancer, although it had only been within the last three months. It was noted by this second mental health opinion that the patient's "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive". The pressure directed at Ms. Cheney from her family was so great that her own motivations could not clearly be distinguished from those of her daughter's. Despite these facts, this Kaiser patient had a home visit by her "managed care" administrator who decided she was a good candidate for assisted suicide and sought out a physician who could write for a lethal prescription. Fifteen days later she died from this lethal barbiturate overdose, and this 'psychiatric evaluation' was no protection for her.

*Depressed patients are given the means to commit suicide: The case of Michael Freeland*

Michael Freeland, a 63-year-old cancer patient, had been haunted by thoughts of suicide since his early 20's when he made his first suicide attempt. In March 2000, his doctor diagnosed him with lung cancer and the following year he sought out, and was given a lethal dose of medication by a 'Compassion & Choices' physician. Subsequently, Mr. Freeland was hospitalized with depression and because of both suicidal and homicidal thoughts. The attending psychiatrist, declared that Mr. Freeland was incompetent and said "The guns are now out of the house, which resolves the major safety issue." Yet, the same report claimed, "He keeps this [the lethal barbiturate overdose] safely at home." Two weeks before his death, members of Physicians for Compassionate Care (PCC), an organization which promotes palliative care, found Mr. Freeland alone, in pain, dehydrated, and suffering from painful constipation. He was depressed, confused, and afraid to take his pain medication and was about to take the lethal overdose because of pain. He had called his suicide doctor and this "Compassion & Choices" physician offered to sit with him while he took the lethal overdose. The PCC members, on the

## Five Oregonians to Remember

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January 9, 2008

other hand, encouraged him to take his pain medication and arranged for 24-hour attendant and receive an infusion pump for better pain care. Several weeks later, Mr. Freeland died comfortably, just having reconciled with his daughter and without taking the lethal drugs.

### *Patients are euthanized in the name of 'assisted-suicide': The case of Clarietta Day.*

Dr. Gallant saw an unconscious patient in the Corvallis Emergency Department who had suffered a stroke. The patient's daughter decided that her mother would be better off dead and asked Dr. Gallant to remove life support. He did so but the patient kept breathing. He then gave serial doses of valium and morphine to this unconscious patient (in no pain) trying to stop her breathing. This didn't work. Then he placed a magnet over her pacemaker in a deliberate effort to stop her heart. This, too, did not cause her to die. He then gave her a massive dose of succinylcholine, a drug that paralyzes all of the body's muscles including the breathing muscles. This medication should not be given any patient unless breathing is supported artificially because it will paralyze all of the body's breathing muscles, as it did in this case. The patient died within minutes of being deliberately and completely paralyzed by Dr. Gallant. The Oregon Board of Medical Examiners chose to reprimand Dr. James Gallant for unprofessional and dishonorable conduct and suspended his license for 60 days for engaging in active euthanasia with respect to his patient, Clarietta Day, who died as a result of a lethal injection administered by a nurse. No criminal charges were ever filed in connection with the patient's death and this doctor continues to practice. The Oregonian, in reporting on this act of active involuntary euthanasia, called Dr. Gallant's action a "case of assisted suicide".

### *Nurses are now getting into the act: The case of Wayne Melcher*

Two nurses gave an overdose to a patient, Wayne (Wendy) Melcher, who had throat cancer. One nurse admitted that she was following the "plan" that had been developed by the patient for his own suicide. The nurses acted independently without following hospice protocol or even asking for any physician directive or order in giving overdoses of two different drugs. This assisted suicide effort was never reported to the Oregon Health Division as is required by the assisted suicide law. As one of the nurses is reported to be having a relationship with Melcher's significant other, there is a clear conflict of interest. After this action of direct and intentional medical killing, these two nurses continue to practice in the State of Oregon.

### *Attempts at assisted suicide are failing: The case of David Pruitt*

David Pruitt, a man from Oregon with lung cancer, obtained from a physician the standard lethal overdose by prescription, and when he felt it was time, he took the entire amount. He went to sleep for 65 hours and woke up saying "What the hell happened? Why am I not dead?" He was so unnerved by the experience that he didn't want to go through it again. He died naturally nearly two weeks later.

Five Oregonians to Remember  
Charles J. Bentz MD, FACP  
January 9, 2008

*Why remember these 5 Oregonians?*

The annual reports from Oregon's Department of Human Services need to be interpreted cautiously because reporting is voluntary and only assisted suicide enthusiasts report. Oregon DHS officials have acknowledged that all of the reported information may be "cock and bull" for all they know. We may never fully understand what has gone on with other cases as Oregon DHS officials have acknowledged in writing that they have actually destroyed identifying information in the name of "privacy" and in what many others have called a "shroud of secrecy."

The facts in these five Oregon cases are part of the public record and beyond dispute. Clearly, all is not well in Oregon and the statements by the proponents of physician-assisted suicide (that everything is going well) are patently false and deliberately deceptive. In all likelihood, these five tragically flawed cases represent only the tip of the iceberg of those who have been directly or indirectly harmed by this misguided law.

Wisconsin needs the full story of how Oregonian's lives are being adversely affected by the assisted suicide law. This law has created an environment where demented and depressed patients are medically killed, nurses are taking matters into their own hands, and involuntary euthanasia is being practiced in the name of assisted suicide.

Wisconsin needs to know that doctors in Oregon continue to stand in opposition to the practice because of the inherent conflict of interest for the medical profession and for society.

- Doctor assisted suicide undermines trust in the patient-physician relationship
- Doctor assisted suicide changes the role of the physician in society from the traditional role of healer to that of the executioner
- Doctor assisted suicide endangers the value that society places on life, especially for those who are most vulnerable and who are near the end of life.

Respectfully submitted,

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SB 151?

January 15, 2008

To all of my physician colleagues who are deliberating on the question of doctor-assisted suicide in Wisconsin.

I am an internal medicine physician practicing in Portland, Oregon, and I would like to share with you a story about one of my patients.

Recently, I was caring for a 76 year-old man when I made the diagnosis of malignant melanoma, found a metastasis in his shoulder, and referred him to both medical and radiation oncologists for evaluation and therapy. I had known this patient and his wife for more than a decade. He was an avid hiker, a very popular hobby here in Oregon. As he went through his chemotherapy and radiation therapy, he became less able get out and hike, which caused a depression, documented by his radiation oncologist.

At his final visit with his medical oncologist, he expressed a wish for doctor-assisted suicide. Rather than taking the time and effort to address his depression, or ask me to respond to his depression as his primary care physician and as someone who knew him, the medical oncologist called me and asked me to be the "second opinion" for his assisted-suicide. The oncologist told me that secobarbital, a barbiturate used in anesthesia, "works very well" for patients like this and had prescribed this many times.

My reply was that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told the oncologist that that addressing his underlying issues would be better than simply prescribing a lethal medication. Unfortunately, my concerns were ignored, and two weeks later my patient was dead from a lethal overdose prescribed by this oncologist. I obtained a copy of his death certificate which listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician. What happened to this patient, who was weak and vulnerable at the end of his life, raised several important questions that I have had to answer, and that you in Wisconsin need to understand as you deliberate this question for your citizens:

1. Who can you trust? If you send a patient to a colleague and expect excellent care, do you have to specifically ask "Will you kill my patient when he becomes depressed at end of life?"
2. What does the request for 'assisted-suicide' mean? Suicidal ideation used to be interpreted as a cry for help, and the only help my patient received was a lethal prescription intended to kill him.
3. What could I have done to help this patient? I had referred him to a specialist, a person who I trusted, and the outcome proved to be fatal. My patient's needs were not met. If my colleague had bothered to find out more about him and worked with him to treat his depression, or had my colleague taken time to help my patient find meaning and new ways to function, perhaps things would have turned out differently.

Physicians and health care workers in Wisconsin, is this where you want to go? Is this what you want to become? Please learn the real lesson from the Oregon experience of doctor-assisted suicide. Despite all of the so-called "safeguards" in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record. This however is not the worst of it. In my opinion, the tragedy of Oregon is that instead of doing the right thing, which is to provide excellent care, patient's lives are being cut short by physicians who are not addressing the issues underlying patient suicidality at the end of life. This change in the direction of our profession, after 2400 years of "Do No Harm", has me concerned. This should concern Wisconsin as well.

Respectfully submitted,

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# Pro-Life Wisconsin



*Defending them all...*

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For immediate release  
January 22, 2008

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## **Senate Committee to Hear Assisted Suicide Bill**

*Pro-Life Wisconsin to send message that Wisconsin stands for life, not death*

The Senate public health committee will hold a public hearing Wednesday, January 23, on Senate Bill (SB) 151, legislation legalizing physician-assisted suicide (PAS) in Wisconsin. Pro-Life Wisconsin strongly opposes SB 151 and will publicly testify against the bill.

"Any attempt to target the vulnerable in Wisconsin through assisted suicide will be resisted with every fiber of our being," said Peggy Hamill, state director of Pro-Life Wisconsin. "Assisted suicide, no matter how compassionate it may seem on the surface, is nothing more than a cruel lie. To the terminally ill, it tells them that there is no meaning to their life and that when they become a 'burden' to others suicide is the easiest answer for everyone. It also robs them of something integral to the human spirit – hope. Real compassion takes time and commitment. It means standing by someone and bearing their burden."

Senate Bill 151, authored by Senator Fred Risser (D-Madison) and Representative Frank Boyle (D-Superior), would "permit certain individuals to make written requests for medication for the purpose of ending their lives." It would legalize assisted suicide for people over the age of 18 who have a "terminal disease" and who make a written request to their attending physician for medication to kill themselves. A physician who refuses to participate in the assisted suicide must make a good faith attempt to transfer the patient to another physician whom he or she knows will help kill the patient. If the physician does not make an attempt to transfer, he or she may be charged with "unprofessional conduct."

"In a stark denial of reality, the bill states that requesting and taking prescribed medication to end your life does not constitute 'suicide,'" said Hamill. "If this isn't suicide, I don't know what is. Pro-lifers will stand strong on Wednesday to expose the deadly truth about this legislation. We will send a strong message to our elected officials that we will not allow the state to sanction the destruction of the vulnerable disabled, elderly, depressed or other marginalized lives around us," said Hamill.

In the State of Oregon, where assisted suicide is legal, Kaiser Permanente Northwest HMO has not merely permitted doctors to assist in patient suicides – it has actively solicited its doctors to participate in this deadly practice. In August of 2002, a Kaiser executive e-mailed a memo to more than 800 Kaiser doctors recruiting PAS-doctor volunteers. According to Portland psychiatrist Gregory Hamilton, MD, this email represents the first step down the slippery slope of killing patients to save money.

"In an age of soaring healthcare costs and cutbacks, how much longer until the 'right to die' becomes the 'duty to die?'" said Matt Sande, Pro-Life Wisconsin's Director of Legislation. "How much longer until those considered a 'burden' on society are systematically denied healthcare and life-saving measures in order to cut costs? The great state of Wisconsin can do better than assisted suicide."

A 2002 study of the impact of Oregon's "Death with Dignity Act" revealed that ninety percent of Oregon assisted-suicide patients change their minds. According to Dr. Susan Tolle, director of the Center for Ethics in Health Care at Oregon Health and Science University and head of the study, most people who ask their doctor about assisted suicide are simply depressed or fearful of pain. If properly counseled and treated, 90% choose to continue living.

"Right to die" forces routinely speak of patients dying in intractable pain. They call killing oneself a "basic human right" that should be constitutionally protected. Yet medical studies show that virtually all pain can be alleviated at the end of life. A study by the World Health Organization found that 95 to 100 percent of the pain experienced by people at the end of life can be adequately controlled.

"Instead of killing the pain, these 'right to die' activists focus on killing the patient," said Sande. "Few of them seem enthusiastic about educating healthcare professionals about the amazing advances in palliative care."

The public hearing will take place in Room 411 South of the State Capitol Building at 10:00 a.m.



*Gene Green  
Baptists For Life of WI*

COMMITTEE ON PUBLIC HEALTH, SENIOR ISSUES, LONG TERM CARE AND PRIVACY.  
SENATE BILL 151

Assisted Suicide and Euthanasia

January 23, 2008

Chairperson and ladies and gentleman of this committee. I count it a great privilege to be able to speak my opinion before you today on this very important matter. As Executive Director for Baptists for Life of Wisconsin, as a Pastor, as an American and as a resident of this great State of Wisconsin I am honored to be here today.

I speak in opposition to SB 151 for several reasons. Down through the centuries, until recently, medical doctors took the Hippocratic Oath which says "First Do No Harm." Doctors were to comfort and to heal, and not to kill. To give medication for one to take one's own life is nothing more than "Terminal Sedation" or a form of killing or premeditated murder. If we tolerate just a little bit of deliberate death, albeit with "safeguards," we contribute to the "culture of death." Terminal sedation does not offer patients more control at the end of life. It offers only death. I quote from a pamphlet entitled "Euthanasia, when the doctor kills the patient. By J.C. Willke, MD.

"Patients, who are dying, do go on to die. While the proponents of euthanasia constantly speak about such cases, these are not their target at all.

They are, rather those who somebody thinks ought to die, but who won't . . . the biologically tenacious. Commonly, such people are not in pain, and not on life support systems but are, by some judgments, a burden to society. These are people with strokes, multiple sclerosis, Lou Gehrig's disease, head injuries, quadriplegia, etc.<sup>1</sup>

Holland legalized euthanasia, which has now become almost routine in that country. Of the 130,000 people who die annually in Holland, up to 20,000 are either killed or helped to die by doctors, and as many as one-half did not ask to die. The Dutch Patient's Association placed a warning in the press that, in many hospitals, patients are being killed without their will or knowledge, or the knowledge of their families, and advised the patients and their families to carefully inquire on every step in the treatment, and when in doubt, to consult with a reliable expert outside the hospital.<sup>2, 3, 4.</sup>

I also oppose this bill because though most doctors do an excellent job in diagnosing illness and prognosis, they are frequently wrong when a person will die. Many of us know of people where the medical profession gave the patient a year to live, and they died within a month, or the doctor gave the patient six months to live, but they have been healed of their disease and are alive and well two years later. .

How many people ask to die so as not to be a burden upon their loved ones? How voluntary is voluntary when the patient feels unspoken pressure from family members and loved ones to not be a financial, emotional or time burden to anyone? Because of the rising costs of health care and the rising number of elderly and those of us over 65 years of age, good palliative care may decrease if assisted suicide or euthanasia are an option. – In Holland, comforting and easing care to terminally ill has largely disappeared.

Patients can be misdiagnosed, and could make an irreversible decision to die based on the wrong information. A study in the Netherlands found that 65% of family physicians are of the opinion that a doctor may offer the choice of euthanasia to a patient who has not asked for it. Patients are often influenced by their doctor, and a vulnerable patient may feel there are not other alternatives if his or her doctor recommends death. Patients with terminal or serious illnesses change their minds. If they don't feel well, they want to die, if they feel well they want to live. Patients may become depressed with their diagnosis and request death, not knowing that their quality of life can improve with proper care.

If we in the State of Wisconsin endorse assisted suicide and euthanasia, we will be teaching violence to an already violent society. Call it what you may, but assisted suicide and euthanasia are nothing less than a violent crime of pre-meditated murder, though legislation may make it "legal."

We have heard the arguments which support "embryonic stem cells research" telling us of its great potential to find cures for diseases, that a cure for some disease or injury may be "just around

the corner.” Whose to say that the a cure for the patients illness or disease is not “just around the corner.”

Rather than giving a patient the choice to kill himself or herself, we can and must assure them that their worst fears will not be realized.

1. They need not to suffer nor die in pain, as there is proper pain management available
2. They will never be a burden to anyone, as someone will be there with love and compassion to minister to them.
3. They will not die alone, as someone will be there with them.

Killing is not caring, and assisted suicide and euthanasia are marked by a lack of commitment, promising only that death will be swift and painless and final. I must remind each of you that each one of you are terminally ill, we are all going to die someday. And the Word of God the Bible says “*It is appointed unto man once to die, and then the judgment.*” Hebrews 9:27 God is the One who decides when it’s someone’s time to die. “*Seeing his days are determined the number of his months is with thee, thou hast appointed his bounds that he cannot pass* (Job. 14:5)

Mark Blocker says it well “We should not permit tragic circumstances to become opportunities to shape the concepts of autonomy and human dignity into rationalizations that justify “mercy killing.” It is unwise to press for legalization of physician-assisted suicide when so few people are aware of alternatives like good hospice. In fact, focusing all our effort on the debate whether or not we should legalize the practice misses the most important issue, how to improve care for dying individuals. . . . Should we acquiesce to the clarion call to make physicians into killers, we will not only abandon our love ones and our duty to care for them, but we will have unleashed the worst tendencies of modern life- the tendency to cushion selfishness and inhumanity under the soft pillow of compassion and humanitarianism. Are we going to spend all our effort, time and resources in public policy and courtroom litigation, and use so little of our time, energy and financial resources to improve care for the dying?”<sup>5</sup>

Are we as a society going to set a standard for “quality of life?” and then when that “quality of life” is no longer possible but it is actually a benefit to bring about death, as to remain alive is a burden to oneself, and to society?

My fellow Wisconsinites, the logic which supports abortion, that a baby is not needed, or is severely “defective” has taken us down the slippery slope to physician assisted suicide and euthanasia for others lacking “quality of life.” We are becoming no better than Hitler’s Nazi Germany where people were murdered and done away with because they were not wanted, needed or were inferior.

If death is an acceptable solution to unwanted, unwelcomed or deformed pre-born babies, it is an equally valid response to pain and suffering at the end of life. The State has a compelling interest in protecting human life, we provide policeman to protect our cities and make our streets safe, and that interest will be lost if we begin to recognize privately arranged killings.

Lawmakers, if you legalize assisted suicide and euthanasia, do not have a doctor do it. He is to “do no harm.” Rather have an executioner do it.

When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assisted suicide generally disappears.

Committee persons, I stand in opposition to SB 151. Thank you for listening to me and/or reading my testimony today. If you have questions, I will be glad to try to answer them.

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#### Footnotes

1. J.C. Willke. *Euthanasia, When the doctor kills the patient*. Hayes publishing Company. ,Inc. 6304 Hamilton Ave., Cincinnati, Ohio 45224. p.3.
2. R. Fenigsen, “*Involuntary Euthanasia in Holland*”, Wall Street Journal, Sept. 30, 1987.
3. J. Willke, “*How Doctors Kill Patients in Holland*”, Nat’l Right to Life News, May 23, 1989
4. J. Bopp et al. “Euthanasia in Holland”, *Issues in law & Medicine*, vol. 1, no. 1. Spring ‘89, pp. 455-487.
5. M. Blocker, “The Right to Die, Moody Press, Chicago, 1999. p.13.





My name is Robert Woodson. I am a Professor of Medicine Emeritus at the University of Wisconsin School of Medicine and Public Health. I feel distinctly privileged to address this Committee today on the proposed Senate Bill 151.

As in most areas where members are called on to legislate, one easily recognizes that this issue is complex, with advantages and disadvantages on both sides.

I have spent my professional life in the subspecialty of Hematology. This is the discipline that cares for malignancies of the blood and blood forming organs – notably leukemia, Hodgkin’s disease, the lymphomas, multiple myeloma, and others.

Happily, in 2008, we are able to cure a growing percentage of these malignancies with drugs. However, the majority of our patients still eventually succumb. The commonest pattern is complete remission with initial treatment, often with several years of excellent health, then a relapse, then more treatment and benefit, then relapse after a shorter period of time. Thus we have the enormous privilege of working with people over many years and have become wonderfully good friends with them and their families. We care for each other deeply. But the road we walk together is difficult, and it almost always becomes more difficult with time.

Yet, in the 40 years that I have been doing this, I have received only one request for termination of life. Just one, in a specialty that deals principally with malignancy. That one request was from an elderly woman. This was probably 20 plus years ago, well before Oregon, and we explained that what they were asking for was not possible. So we took care of her compassionately, lovingly until the end came. Importantly, I was not able to figure out how much of this request was truly her own idea and how much she was influenced by her daughters, who were very adamant.

[What I have gained from my work is a keen appreciation of the unique benefits that accrue to families facing death in terms of expressing love to each other. This may be a tough time, but is also a precious time. Some families are in need of reconciliation, and I have witnessed embraces after estrangement. Every family has bonds that can be strengthened through extending love to each other and observing, up very close, a reality of life. So I never miss the opportunity to talk with people about the unique privilege of allowing suffering and approaching death to bring them together as a family in a new way. And I marvel as I watch it unfold. While I can recall only one family that requested assisted suicide, I could not begin to count how many have experienced love and healing and wonderful closure. It would be wrong for us to offer the option of preempting this time. It is as much a part of life as birth, and we should not actively interfere with it. Furthermore, and unlike most of human history when people coped, we have the real gift of morphine to give, and give generously, when it is needed. And, unlike ending life, the dose of morphine can be decreased every now and then, when important communication needs to occur. Morphine does not leave guilt in its wake.

And I should quickly add that being against physician-assisted suicide does not mean that one has to engage in measures that prolong life. Many patients opt against more treatment when the chance of major benefit is slim, and it is with this doctor's blessing.]

[Another point. Every time I pass a certain store here in Madison, I am reminded of the owner's wife, a woman in her 40s with acute leukemia. We discharged her to die at home at her request, her bone marrow still showing lots of leukemia long after the final chemotherapy ended. There was no hope. To my great surprise, she turned up in my clinic several years later. She had been trekking in the Himalayas in Nepal! If she asked for help in ending her life, any doctor would have thought there was zero chance of recovery and signed the paper. Doctors regularly see the unexpected.]

Another point. You will find that most doctors will have ~~nothing to do with this~~. Why? Because we want to be our patients' advocates. We don't want them to worry that we will abandon them, that we will have a second agenda of holding down health costs. We want them to trust us.

Now my last and most important point. What troubles me the most about physician-assisted suicide is the likelihood that some persons will feel an obligation to select this option. Why? Because of their own generosity, or money, or because of pressure from a dysfunctional family, or pressure from third party payers. It is a certainty that this will happen once the door is open. And we will never be able to determine when people are going along with the idea when they don't want to. There will be a maze of dynamics

that no neutral person can penetrate. All of you know by now that innocent people have wound up on death row.

In summary, for all of the above reasons, I believe the risks of this legislation significantly outweigh its benefits.

Thank you.



Thank you for the opportunity to speak here today. My name is Dr. Patrick Sura. I am a Family Physician in River Falls Wisconsin and have been in practice for over 20 years. I am here to give some thoughts and testimony in opposition to ~~Senate Bill 151~~, the bill that deals with physician assisted suicide. My first observation is that this legislation is not needed. The so called "Death with Dignity" Bill has been unnecessary for the past 14 years that some form of this bill has been introduced and debated. There is no outcry for this legislation. Physicians do not want this bill. This bill is designed to limit its victims to over age 18 of sound mind and "terminal" diagnosis. The supposed safeguards of this bill are merely stepping stones to an expansion of the right to die. Our country establishes rights for our citizens and works at not allowing discrimination to occur. The "rights" of one group will be expanded to other groups in due time. The Slippery Slope of this bill will occur. What is initially hailed as a "Right to die" for few will become an "obligation to die" for many.

The collision of morals and ethics with fears, feelings, and finances will lead to blurring of boundaries and increased legislative challenges as well as an erosion of the trust in the care provided by the many fine and honorable and ethical physicians in this state. The publicity of this bill seems politically motivated and diverts time and money from more important issues and opportunities. Let's see a bill to fund critical projects such as Free Health clinics like those functioning in River Falls and Menomonie and other communities. Let's see funding for hospice and palliative care and address other issues for the uninsured and the needs of our vulnerable children. We would see bipartisan support and voter support as well as support from the medical community for the true needs of our state. Stop funding "pet projects" of powerbrokers in government and if you are going to raid the Patient compensation fund to balance the budget at least earmark the money for the health related issues of our state residents.

In my personal experience of 20 years as a Wisconsin trained and licensed physician includes dealing with patients requesting assistance in hastening their death. Some of those patients have been "terminal" while others have simply grown tired of living, of feeling burdensome to others, or simply tired of battling disease processes and the frailties of aging. Most of these requests are a call for some help from caring providers. I have treated a 60 year "Terminal male" for his depression after he wanted his life to end. He watched his grandson graduate from college and his granddaughter get married. Would it have been a death with dignity- and yes a psychiatrist is supposed to evaluate every request but this diagnosis can be missed. And do depressed people have less rights than the non depressed and can we discriminate against the free will of someone in pain from someone in possibly worse pain from Rheumatoid arthritis ?? A slippery slope or is it irrational fear mongering?

Another patient is a 52 year old woman with pain she can no longer live with and asks for help because she does not want to shoot herself. A Cry for help —not a desire to die!! She gets pain control and lives several additional months and spends valuable time with her family and her faith. Medicine can control pain in nearly 100% of cases. Hospice physician and palliative care workers are not asking for help to terminate their patients.

Recently I helped care for a 48 year old woman dying of breast cancer after a 10 year battle with the disease. She outlived her "Terminal " diagnosis several times and ultimately died a very peaceful and

## Death With Dignity Bill Hearing –January 23,2008

natural death in the presence of her family. This was achieved by caring and compassion from nurses, social workers, clergy, and physicians. The dying process was inevitable and it is a very emotionally draining experience but allows friends and family to “say goodbye” in a natural way without intent to hasten death by intervention. Many tears were shed by relatives and simply by acquaintances but there was a peace that everyone felt about the life that had ended through a natural process.

Trust in healthcare providers and physicians is critical and this bill undermines the current ethical standards that physicians should be accountable to from their profession and its guiding associations. There will be nurses or doctors that would embrace this bill (usually for a profit) and want to be known as “Agents of Mercy” or the next Dr. Kevorkian but that does not make it right.

Most doctors work hard at treating patients with kindness and compassion and a respect for life and want everyone to live a full and productive and comfortable life. This law is in conflict with what is taught in medical schools across the country. Everyone including legislators and lawyers can help to make the dying process an experience that should not be feared but embraced as a natural end to our life on Earth. We are all “Terminal” and deserve to “Die with Dignity”. We cannot legislate that right. We should support the people and the processes that already work with families and patients to provide this every day.

I could tell stories of patients that have helped me to develop as a physician and to improve my care of others. Educating physicians in End of Life care may need to be improved so we can help patients to enjoy their life and be loved by a caring family that will let them pass beyond this earth when the time comes. We should not be choosing the time as that raises additional ethical issues of reasons that others may choose to hasten a loved one’s death. Not part of the bill and I am sure there are some who disagree with me.

I have a friend and physician colleague who was diagnosed with brain cancer of the worst type and prognosis. He outlived his initial “Terminal” diagnosis and was working as a physician again in a profession he loved. He then had an inevitable recurrence and was unable to work and faced additional physical and emotional challenges. He was kept at home with the aid of a loving wife and 4 children. His disease progressed further but his faith never wavered. I had the privilege of travelling with him on I believe his last independent outing away from his family. We drove to Green Bay to see the Packers play his favorite team, the Detroit Lions. As we drove we discussed his life and his approaching death. He was an amazing person yet asked for minimal assistance. At the game we enjoyed the aura and the atmosphere and the rain at Lambeau Field. He was not a dying man at that stadium but another football fan living a Dream. Would a law legalizing Physician assisted suicide change the expectation for patients or would society change its expectations to promote “easing a family’s burdens” by hastening one’s death?? Would it alter the dying process and the safeguards and the rights of individuals to seek assistance?? My friend died a very dignified and peaceful death surrounded by his family. Others do the same every day.

I encourage the legislators to reject the propose law and all of its tenets. Realize the risks of this bill and for citizens of this great State. We look to you for leadership and you will be accountable for your

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actions. I appreciate the opportunity to voice my opinion on this issue and would like to see time and energy and money spent on other issues. Please vote No for Senate Bill 151. Thank you.

Patrick D. Sura,M.D.

[psura@rfmc.org](mailto:psura@rfmc.org)





January 23, 2008  
Joy Kragenbrink on Senate Bill 151

Hello my name is Joy Kragenbrink. I'm opposed to Senate Bill 151. Before I tell you why, let me introduce you to my sister, Melissa, who is going to speak for me because I want to be clearly understood. I want to make it quite clear though, that these are my words.

Life has value and meaning even when it is lived in pain. I'm passionate about this because I live in almost constant pain or discomfort. And have my entire life. Yet I am able to encourage the people around me with my happy countenance. I look people in the eye and smile. This improves the quality of their day, and mine! Here are three reasons why I'm opposed to Senate Bill 151: this bill undermines the value of life, every day of a terminal patient's life is important, and a lifespan is unpredictable.

First, this bill undermines the value of life. There can be a fine line between being terminally ill and chronically ill. As a disabled person, I know that complications from my disability could cause my condition to become terminal. Actually, this applies to a lot of people with disabilities who I know. This is a vulnerable segment of society since many disabled people already feel they are a burden to their families and caregivers as well as society. If this bill is passed, people in the disabled community could begin to feel a subtle pressure to relieve society of the burden they now perceive their life to be. They may feel like it is their duty. Passing this bill would undermine the value of life.

My second point is that the remaining days of a terminal patient's life are important. I would like to tell you about my dad. He died a painful death of cancer at thirty-one years old. This was after years of fighting for his life. I watched him influence the lives of the people around him for good during this time. Every moment that he lived was another moment that he gave to me. I remember him because he fought for his life. He taught me that life is to be treasured, pain and all.

My final point is that doctors do not always accurately predict a patient's lifespan or the subsequent quality of life. This is why. Four people in my immediate family survived and lived full lives far beyond a doctor's expectations. First, I was born three months premature and weighed one pound twelve ounces at my lowest. I also had a brain hemorrhage shortly thereafter. In the eyes of my physician, the odds of my survival were extremely slim and there would be no subsequent quality of life if I actually survived. My twin brother, Luke, had even more complications than I did. At two weeks old he had open heart surgery and his lungs were repeatedly collapsing. Like me, he had low odds of survival. He is now living a perfectly normal life. At our birth, my mom was also not expected to survive due to uncontrollable hemorrhaging. Yet again, contrary to doctors' expectations, my mom miraculously survived. The fourth, and final example of life being sustained beyond doctor's expectations is, as I mentioned earlier, my dad. He lived years beyond what his doctors expected. All four of us are grateful for each day we have lived. This tells me that our quality of life is pretty good even though none of us were expected to survive.

As I read this bill, I kept seeing the phrase "die with dignity". I can't help but wonder why the focus is on "death" with dignity. Instead we need to focus on pouring our energies into ways of making a person's last days of life comfortable and dignified. Even though I am physically disabled, even though I am not able to do the things most people can do, and even though I live with pain, my life impacts the people around me, and I will continue to do this until the day I die. I chose to LIVE with dignity.

I urge you to oppose Senate Bill 151. Thank you.



SB 151 ?

Testimony Before the  
The Senate Health, Human Services, Insurance,  
and Job Creation Committee

January 23, 2008

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## INTRODUCTION

Thank you for the opportunity to address this committee on behalf of Not Dead Yet, a national disability rights group that opposes legalization of assisted suicide and euthanasia, and thank you also to the Wisconsin Not Dead Yet members whose circumstances prevent them from being here.

I'm especially grateful to be here today because of the ways the political culture war has often been used to exclude and marginalize the disability community in the public debate on these issues. Not Dead Yet formed in 1996 when grassroots disability activists saw Jack Kevorkian acquitted in the assisted suicides of two disabled women. We recognized the need to stop a well-funded and media savvy political movement that had been building its successes over the dead bodies of people with disabilities for over a decade.

And we'd like to emphasize the bipartisan nature of disability concerns. While conservatives disagree with assisted suicide, they have their own way of rationing health care to our detriment. For those who depend on publicly funded health care, federal and state budget cuts pose a very large threat. In fact, some of the cuts we've faced, such as in states that have cut Medicaid services for people who use ventilators or feeding tubes, are nothing less than back door euthanasia. So we're speaking to all parties here.

## WHAT'S DISABILITY GOT TO DO WITH IT?

Assisted suicide is supposedly about terminal illness, not disability, so many question disability groups "meddling" and trying to "take away" what they see as the general public's right to choose physician assisted suicide.

Most people realize that they have a good chance of becoming terminally ill before their life is over. But many don't realize that they have an almost equal likelihood of passing through stages of chronic illness and disability before they are "terminal."

The disability experience is that people who are labeled "terminal," based on a medical prediction that they will die within six months, are — or almost inevitably will become — disabled. Furthermore, virtually all so-called "end-of-life care" issues — access to competent health care, adequate pain relief, in-home personal care and flexible, consumer-directed supports, peer counseling, family support — have been disability rights issues for decades.

The question we should ask is why do some people ask for assisted suicide and some doctors choose to provide it? In fact, although intractable pain has been marketed as the primary reason for enacting assisted suicide laws, the reasons

Oregon doctors actually report for issuing lethal prescriptions are the patient's perceived "loss of autonomy," "loss of dignity" and "feelings of being a burden." These feelings arise when a person acquires physical impairments that necessitate relying on other people for help in tasks and activities formerly carried out alone. These are fundamental disability issues.

Unfortunately, popular culture has done virtually nothing to educate the public about how people with severe disabilities actually live autonomous and dignified lives. Our lives are portrayed as tragedies or sensationalized as heroism, but the real life issues and coping methods that most people will need if they live long enough are left out of the picture. No wonder people who acquire disabilities in the course of a significant illness or through accidents so often see death as the only viable solution.

### THIS IS NOT ABOUT THE EXISTING RIGHT TO REFUSE TREATMENT

Physician assisted suicide should not be confused with the issue of whether doctors can force unwanted medical procedures on us. It's important to be clear that the right to refuse unwanted medical treatment was affirmed by the U.S. Supreme Court in 1990, long ago.

### THE PROBLEM OF PHYSICIANS AS ASSISTED SUICIDE'S GATEKEEPERS

Proponents of legalized assisted suicide assert that laws and regulations will help prevent abuses. But the law's only ironclad safeguard is the civil and criminal immunity granted to physicians. This is the lowest culpability standard possible, even below that of "negligence," which is the minimum legal standard governing other physician duties. The Oregon safeguards are set up to fail.

The individual's request for assisted suicide is necessary, but not sufficient, to get it. In effect, the Oregon Law gives physicians the power to judge whether a particular suicide is "rational" or not based on his or her prejudice or devaluation of the individual's quality of life, and then to actively assist certain suicides based on that judgment. This should be viewed as a violation of the Americans with Disabilities Act, which prohibits discrimination based on disability.

As Oregon reports on physician-assisted suicide make clear, the state has not been able to assess the extent of non-reporting or noncompliance with the law's purported safeguards, but only obtains brief interviews with physicians who file their paperwork. There are no enforcement provisions in the law, and the reports themselves demonstrate that non-terminal people are receiving lethal prescriptions. As the Oregonian stated in March 2005 in "Living with the dying 'experiment,'" examining the case of David E. Prueitt who woke from his assisted suicide after two weeks and did not try again, "The rest of us . . . still need an answer from a system that seems rigged to avoid finding one."

## EXISTING FUTILITY POLICIES ALREADY INVOLVE INVOLUNTARY EUTHANASIA

Another big reason for concern about physicians as gatekeepers in the context of active assisted suicide is that they already engage in practices involving involuntary passive euthanasia under futility policies. A 1999 Journal of the American Medical Association article recommended that hospitals develop futility guidelines, whereby the hospital takes the patient and family through so-called hearings with ethics committees to persuade them to refuse treatment and, if that doesn't work, they may just deny treatment anyway, as "futile." Financial pressures have grown to the point that, increasingly, physicians make medical decisions to withhold treatment in open and direct opposition to the decision of the patient, their surrogate or their advance directive under what are called futility policies.

Basically, the bioethicists have warped so-called "end-of-life" care into life-ending non-care for some people. The bioethicists have had hundreds of millions of grant dollars to work with, and they've used it to build public policies on guardianship and futile care into a steamroller that's decimating the civil and constitutional rights of people whose lives are viewed as too marginal or costly to support. Once assisted suicide is legal, what is to prevent a shift toward involuntary practices in this context as well?

## FALSE CHOICE, FORCED CHOICE

The third year case of Kate Cheney, reported in detail in the Oregonian (Barnett, E.H. "Is Mom Capable of Choosing to Die?" 10/17/99), provides an important example of disability concerns. Mrs. Cheney's physician was concerned that she had early dementia and that her daughter might be pressuring her toward assisted suicide, so he referred her for a psychological consultation. The first consultant found that Mrs. Cheney's assisted suicide would not be voluntary because of pressure from her daughter, but a second referral concluded that her suicide would be voluntary in spite of pressure from her daughter. The lethal prescription was issued, but Mrs. Cheney didn't take it until after her family put her in a nursing home for a week so they could have respite from care-giving. So Mrs. Cheney was presented with the following so-called "choice": be a burden on family, go to a nursing home, or commit suicide.

Why, disabled people ask, do we see so many news stories lately about the burdens we impose on our caregivers, and so few articles about the nation's ability to provide the long-term care people really need and want? If the values of liberty dictate that society legalize assisted suicide, then legalize it for everyone who asks for it, not just the devalued old, ill and disabled. Otherwise, what looks like freedom is really only discrimination.

## ELDER SUICIDE

We also think we should look at the fact that Oregon has the fourth highest elder suicide rate in the country. Perhaps one of the most important questions raised by the Oregon experience is whether legalizing these individual assisted suicides has a broader social impact. Does it matter that a society accepts the disability-related reasons that people give for assisted suicide, the supposed loss of dignity, then declares the suicide rational and provides the lethal means to complete it neatly? Does it harm people who are not deemed eligible for assisted suicide under the current version of the law but still experience the same sense of loss? In the face of constant social messages that needing help in everyday living robs one of dignity and autonomy, makes one a burden and justifies state sponsored suicide, maybe Oregon's elders have taken this disgusting and prejudicial message to heart.

What looks to some like a choice to die begins to look more like a duty to die to many disability activists.

## CONCLUSION

Disability concerns are focused on the systemic implications of adding *assisted* suicide to the list of "medical treatment options" offered to seriously ill and disabled people. The disability rights movement has a long history of healthy skepticism toward medical professionals who are assisted suicide's statutory gatekeepers. Our skepticism has grown to outright distrust since the values of managed care have dominated the health care scene. Anyone who asserts that money will not influence the treatment options offered to people, or that the impact of out-of-pocket costs on a individual's family will not influence the individual's or their family, is at best unrealistic and at worst dishonest.

Pro-assisted suicide advocates call it "choice" but, with or without so-called safeguards, the so-called "autonomy" of assisted suicide is not being offered to healthy, non-disabled people. According to the U.S. Surgeon General, 16 of every 17 suicide attempts fail, and most don't try again. (U.S. Public Health Service, "The Surgeon General's Call to Action to Prevent Suicide," Washington, D.C.: U.S. Government Printing Office, 1999.) Assisted suicide is not about parity in the opportunity for suicide. It's about a government and a health care system guaranteeing that certain suicides don't fail. That's discrimination.

The wish for an easy and certain method of suicide under some circumstances is understandable. But that wish must be weighed against the certainty of increasingly routine medical killing of older and disabled people. Whether or not any one of us worries about inevitable abuses affecting us personally, the lives of those who will be affected are not an acceptable price for legalizing this practice.



Regardless of our abilities or disabilities, none of us should feel that we have to die to have dignity, that we have to die to be relieved of pain, or that we should die to stop burdening our families or society. For years you've heard from the right to die and the right to life movements. It's time to listen to the disability rights movement. We offer a very different vision, as well as the practical know-how and leadership to help build a society and a long term care system in which no one feels like a burden, and everyone has real choice, not the false "choice" of assisted suicide.



**Scott Harold Southworth**  
**District Attorney of Juneau County, Wisconsin**

**Testimony Before the Senate Committee on Public Health, Senior Issues,  
Long Term Care and Privacy on 2007 Senate Bill 151**

**January 23, 2008**

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Mr. Chairman,

My name is Scott Harold Southworth, and I serve as the District Attorney of Juneau County. I'm also the proud father of a disabled Iraqi orphan who suffers from cerebral palsy.

I vehemently oppose SB 151 and its legalization of assisted suicide because it will target the poorest, weakest and most vulnerable members of our society for state-sponsored murder.

It takes very little prodding to convince someone suffering from a debilitating or painful disease that death remains their best and only hope. Thus, assisted suicide is merely euthanasia dressed in sheep's clothing. Most importantly, the only real difference between euthanasia and genocide is the number of victims who die at the hands of those who want a particular group of people removed from society.

Genocide begins with less insidious acts, and the targets of persecution are always those without power: the disabled, racial and ethnic minorities, religious minorities and political dissidents. For example, the Nazi Holocaust began with laws requiring Jews to wear the Star of David on their shoulder, scientific studies on the disabled, and the compiling of the names of known homosexuals. Those initial efforts then blossomed into the outright murder of Jews, Slavic people, gay men, Jehovah's Witnesses, political dissidents, Christian leaders, and the physically or mentally disabled. Millions of people died as a result of laws designed to make German society more "comfortable."

Throughout history, hate and bigotry spurred laws in other nations around the world allowing for the near destruction of whole cultures, including Africans at the hands of Western slave traders, Albanian Muslims at the hands of the Serbs and the present-day genocide of Christians in the Sudan at the hands of Islamic extremists.

Mr. Chairman, I have no doubt that you abhor the idea of genocide and that you intend for this legislation to provide comfort to those suffering from a disease.

However, your intentions cannot control the evil that this legislation invites. Once the Pandora's Box of assisted suicide, euthanasia and genocide is opened, it is difficult – if not impossible – to close.

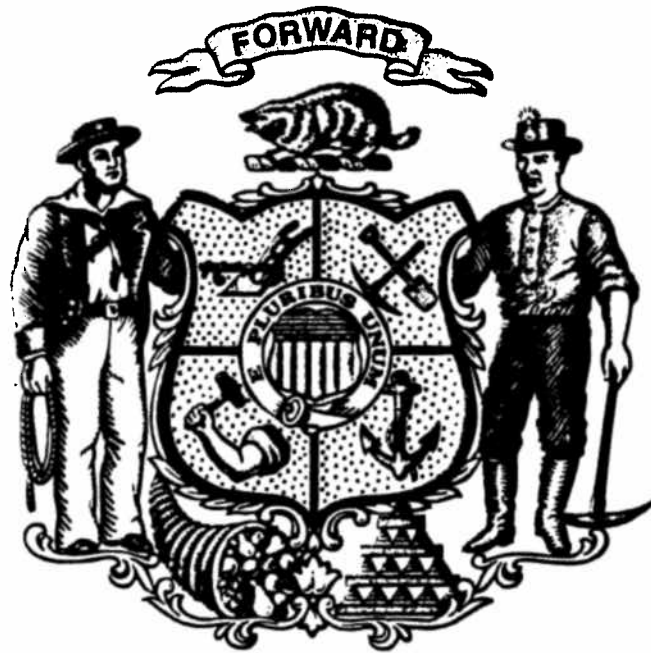
As a district attorney, I can assure you that this legislation will require extraordinary investigative and prosecutorial resources as we attempt to root out those who violate their Hippocratic Oath in order to murder someone else. As the father of a disabled Arab child, I am frightened by the message this legislation sends to the weak, the vulnerable and the minorities of our society.

Assisted suicide is the seed of genocide, and we must remain vigilant in order to protect the dignity of every person, including those of every race, ethnicity, religious belief, sexual orientation, political affiliation, and mental or physical handicap. If we do not protect everyone, we cannot protect anyone.

Gentlemen, if this bill ever comes up for a vote, I urge you to vote no. However, I would ask you, Mr. Chairman, to reconsider your position on this issue. In your capacity as an elected legislator, you have the power to serve as a voice for all minority groups. I urge you to retract this bill from legislative consideration and take a stand on the side of life.

Thank you.

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# Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Committee on Public Health, Senior Issues, Long Term Care and Privacy  
Senator Tim Carpenter, Chairperson

FROM: Mark Grapentine, JD – Senior Vice President, Government Relations  
Jeremy Levin – Government Relations Specialist

DATE: January 23, 2008

RE: Opposition to Senate Bill 151

On behalf of the more than 11,000 members of the Wisconsin Medical Society, thank you for this opportunity to register opposition to Senate Bill 151. Our opposition follows a basic belief that a physician has the role of a healer. While SB 151 may come with the most humane of intentions, ultimately it is in direct conflict with the physicians' role and their relationship to their patients. The Society and the American Medical Association have policies addressing this issue:

ETH-020

**Euthanasia:** The Wisconsin Medical Society believes that the intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth. (HOD, 0404)

## **E-2.21 Euthanasia**

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the report "Decisions Near the End of Life," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996.

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Thank you again for the opportunity to provide this testimony. If you have any further questions or need additional information, please feel free to contact Mark Grapentine at [markg@wismed.org](mailto:markg@wismed.org) or Jeremy Levin at [jeremyl@wismed.org](mailto:jeremyl@wismed.org). Both can be reached at (608) 442.3800.