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2007-08

(session year)

Senate

(Assembly, Senate or Joint)

Committee on
Public Health, Senior
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Care and Privacy

(SC-PHSILTCP)

(FORM UPDATED: 07/02/2010)

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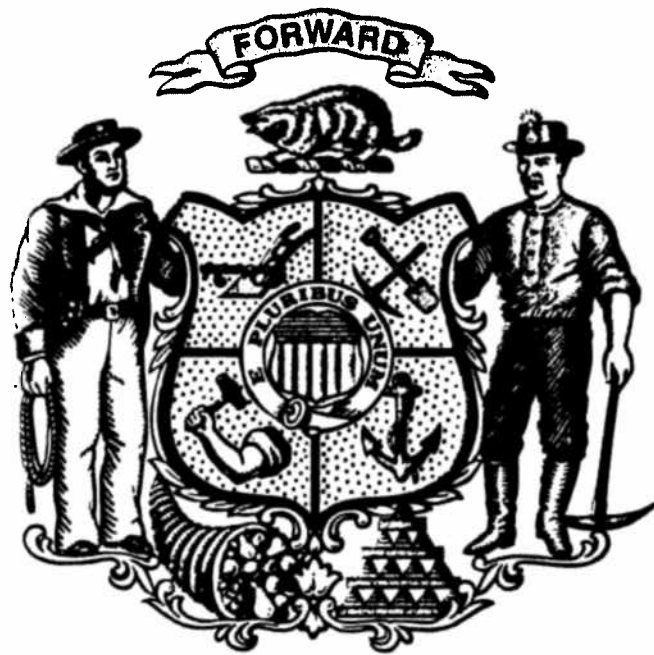
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MINISTRY HEALTH CARE

Sponsored by Sisters of the Sorrowful Mother

Submitted testimony of Joseph Jarabek, MD on behalf of Ministry Health Care

In opposition to Senate Bill 151, related to physician assisted suicide (PAS)

Submitted to the Senate Committee on Public Health, Senior Issues, Long-term Care and Privacy

Wednesday, January 23, 2008

Palliative (adjective): *alleviating pain and symptoms without eliminating the cause.*
Encarta Dictionary, English, North America

Thank you for allowing me to submit written testimony on behalf of Ministry Health Care, in opposition to Senate Bill 151. I am caring for my patients in Stevens Point today and appreciate the opportunity to share these written comments with you.

I am a physician who is Board-certified in both Geriatrics and Internal Medicine. I practice medicine in the Central Region (Stevens Point) of Ministry Medical Group-Ministry Health Care. Additionally, I am the Medical Director of two area nursing homes. In my career, I have cared for many dying patients. Providing palliative care – medical treatment for a patient facing great pain and death – also almost always involves and requires communication with family members as well.

You will certainly hear comments about physician assisted suicide (PAS) being inconsistent with the practice of medicine, and you will hear from some who will position PAS as part of providing care for dying patients. In addition to the moral aspects of the issue, I am concerned that the ready-availability of PAS may actually make it more challenging to deliver the exceptional end-of-life care that we would all want for our loved ones and for ourselves.

Many physicians have received questions about, if not outright requests for, PAS from their patients. In one national sample 18% of all physicians and 50% of oncologists reported receiving requests for PAS.¹ How do we answer such requests?

The task of medicine is to *care*, even when it cannot *cure*. As healers, physicians are called to maintain or restore health whenever possible, but when our patients can not be cured, we are called to journey *with* them, to treat pain and other physical symptoms, and

¹ Emanuel EJ, Fairclough DL, Daniels ER, et al. Euthanasia and physician-assisted suicide: attitudes and experiences among oncology patients, oncologists, and the general public. *Lancet* 1996;347:1805-1810

to address suffering of all kinds. In other words, we are called to promote a kind of healing, even as death draws near.

I am pleased to be part of Ministry Health Care, a large Catholic health care system, sponsored by the Sisters of the Sorrowful Mother. Our system includes 15 hospitals (*note: includes Affinity Health, co-sponsored by Wheaton Franciscan Healthcare*), dozens of clinics and a number of affiliated services including Kidney Care and Home Care. Our delivery services include rural and underserved portions of central and northern Wisconsin, extending west into Minnesota, and east to Door County. We serve a significant number of Medicare and Medicaid patients, and we provide care to the uninsured, above and beyond the required emergency care as required by federal law.

The *Ethical and Religious Directives for Catholic Health Care Services*² tell us that, as witness to our faith...

Catholic health care institutions will be a community of respect, love, and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness. One of the primary purposes of medicine in caring for the dying is the relief of pain and the suffering caused by it.

In Directive 61 the Bishops are quite explicit:

Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die.....Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life, so long as the intent is not to hasten death.....

It doesn't seem right to simply oppose something without offering something preferable in its place. What health care providers can offer is **excellent symptom management** with specialists in the practice of palliative medicine, and a team approach that involves professionals who can competently address depression and suffering in all of its forms: physical, spiritual, psychological, and social. A patient raising the issue of PAS gives us an opportunity to explore the root causes and fears prompting the request and address them, to explain to the patient and family that burdensome treatments need not be accepted, to provide education on all of the options for pain control and other symptom management, and most importantly to offer assurances of our unending commitment to providing care.

Thank you, Senators, for allowing me to share my thoughts today. I respect the task before you, and hope that you will not open the door for physician-assisted suicide in Wisconsin.

² ERD. 2001. *Ethical and Religious Directives for Catholic Health Care Services*. Washington, DC: US Conference of Catholic Bishops



Testimony to Senate Public Hearing on SB 151, January 23, 2007

My name is Dr. Franklin Smith. I am a practicing physician living and working in the Delafield area. I serve as Vice President of the Milwaukee Guild of the Catholic Medical Association and today I speak on behalf of the Milwaukee Guild, which is opposed to 2007 Senate Bill 151, a so-called, Death with Dignity Act, more properly called, a Physician Assisted Suicide bill.

Why is this a bad bill for the people of Wisconsin? At a time when people are the most vulnerable, when they are afraid to die, it tells them, take the easy way out, you don't want to suffer. This is a huge step to take – the creation of a choice for death will inevitably create an obligation to die for many. It will say, "You don't want to be a financial burden on your family, do you? You should get out of the way and make room for others." *This* is not compassion. Compassion is solidarity and commitment; compassion requires effort to love a patient, to suffer along with a patient. It's not as easy as swallowing a suicide pill.

This bill is bad because it poisons the doctor – patient relationship. The doctor - patient relationship is a sacred alliance that reassures the patient, "My doctor will fight for me to sustain my life and obtain a cure, and if my life cannot be preserved, my doctor will offer comfort and relief of pain and stand by me in my suffering." But, on the other hand, "What if my doctor also helps kill people, where does that leave me, can I trust him or her? If my doctor says there's nothing more we can do, is this true, or is he just tired of me and my complaining? Does he just want to get rid of me?"

This bill is bad because it creates other conflicts of interest in the question of deciding whether the patient lives or dies. Money is one of the biggest. In today's climate of controlling health care costs and managed care, it's a lot cheaper to an insurer if the

patient just checks out than if they have to keep paying for his or her care.

This bill is so extreme that, even if you accept the premise that physician assisted killing can be good, the bill creates an imbalance, pushing death over life, killing over caring. The bill will hold harmless actions to help kill patients, but punish doctors who won't participate, either by direct or indirect action. Why would this carefully crafted bill push such a bias? Because the framers of this bill know doctors don't want to kill their patients. The framers are set on forcing doctors to do their lethal bidding. What is it about legislators who are so determined to push their agenda that they are set on reprimanding and punishing doctors for refusing to violate their own consciences?

In fact, in contrast to the intention of this bill, conscience protection is enshrined in the First Amendment of the United States Constitution, and in Article 1, Section 18 of the Wisconsin Constitution, which states, "Any control of or interference with conscience rights shall not be permitted."

What do the national medical organizations say? The nation's second-largest medical organization, the American College of Physicians – American Society of Internal Medicine, has declared its opposition to the legalization of physician assisted suicide. They said, "Physician-assisted suicide should not become part of standard medical care. Its routine practice would raise serious ethical and other concerns, undermining the patient-physician relationship and the trust necessary to sustain both the relationship and the role of the medical profession in society" and "We must solve the problems of inadequate care at the end of life, not avoid them through practices such as physician-assisted suicide."

The American Medical Association, the nations largest medical organization, has made it's opposition to physician assisted suicide clear:

Their official policy, H-140.952 states, "Physician assisted suicide is fundamentally inconsistent with the physician's professional role." And "Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary."

Their Code of Medical Ethics E-2.211 on Physician Assisted Suicide states, "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks".

I would also like to point out the use of euphemism and imprecise language in the bill. In addition to the misleading term, "death with dignity", the term, "terminal disease" is problematic, even adding the qualification of "causing death within 6 months". When a patient with an incurable cancer asks me, "How much time do I have?," I can give them statistics of average survival, but the range is so broad, I tell them that as soon as we predict time we are proven wrong.

I also reassure them that, with all the progress modern medicine has made, we have excellent pain medications and treatment options, but I encourage them, up front, to tell us if their pain relief is not adequate so that we can intervene. And I tell them that this phase of life, while it is frightening, is often the most productive and the most meaningful time to connect with loved ones, friends and the things that mean the most to them in life.

Finally, I understand why the so-called "death with dignity" movement seeks to eliminate the use of the term, "suicide". They have found that people recoil at the term, that it has overtones of violence and irrationality. Unfortunately, you can't change the meaning of the English language by this bill, any more than you can legislate a repeal of the law of gravity, simply by saying, "Taking medication under a fulfilled request for medication and

this chapter does not, for any purpose, constitute suicide”.

In summary this is a bad bill. It is built on fear, rather than compassion. It says it preserves dignity in dying, but it will really be about preserving dollars by promoting death. It purports to offer choice to patients, but it is really about penalizing doctors who won't go along with the new game plan. Why would you want to force someone to do something they don't want to do, and that they know is wrong? It is poison to the sacred relationship between Wisconsin doctors and patients. When all doctors are required to kill, only killers will become physicians. That is not the kind of doctor I want for my medical care.

Thank you very much.





**Agudath
Israel
of America**
אגודת ישראל באמריקה

8170 NORTH McCORMICK BLVD., SUITE 103 • SKOKIE, IL 60076 • 847-674-4000 • FAX: 847-674-4044

Rabbi Yehiel M. Kalish
*National Director of
Government Affairs*

TESTIMONY

TO: Honorable Members of the Committee on Public Health, Senior Issues, Long Term Care and Privacy

FROM: Sheba Seif, Legislative Assistant, Agudath Israel of America, Midwest Region.

SUBJECT: SB 151 – Death with Dignity

DATE: January 23, 2008

Mister Chairman and Honorable Members of the Committee,

My name is Sheba Seif. I live in Chicago, Illinois and I work as a Legislative Assistant for Agudath Israel of America, Midwest Region. Agudath Israel is the largest public policy and social services organization in the Orthodox Jewish community. With national headquarters in New York, a branch in Washington, D.C., and the Midwest Regional Headquarters located in Skokie, Illinois, we represent thousands of constituents across the United States, including Milwaukee.

Thank you for giving me the opportunity to testify before you as an opponent to SB 151. This bill permits an individual to request medication from his/her attending physician for the purpose of ending the individual's life.

It is a basic principle of Jewish law and ethics that man does not possess absolute title to his life or body. Agudath Israel believes that recognition of this teaching has served as one of the pillars of civilized societies throughout the generations. The reason we are speaking out on this bill, however, is due to the dangerous outcomes that legalizing assisted suicide will have on public policy.

Our reasoning includes the following:

- ◆ **CREATION OF A DUTY TO DIE:** This bill will create a duty to die in a vulnerable population. A patient may be forced to weigh his/her right to live against the burden he/she places upon family, friends and society by choosing to live. Such burdens can be either financial or emotional and can greatly influence someone whose illness has already placed him/her in a compromised, dependent, and vulnerable position.

- ◆ **POTENTIAL FOR ABUSE:** Legalizing assisted suicide creates an enormous potential for abuse, despite the “safeguards” which purportedly would prevent such abuses. For example:
 - The increasing costs of end of life healthcare would provide an incentive for caretakers and/or health insurance companies to “promote” assisted suicide, especially to the poorest and most vulnerable of our patients; those without the means and the stamina to withstand pressure, both subtle and not so subtle.
 - The safeguards require the individual to be acting voluntarily in a request for medication to end his/her life. How will anyone know if the patient is acting voluntarily or if he/she is being coerced? Even the patient may not realize that he/she is being coerced.
 - Once the medication has been delivered, family members may take matters into their own hands. There are no provisions in this bill for overseeing and monitoring the administering of the medication.
 - The provision requiring the referral of the individual for review and counseling makes no mention as to the number of sessions required in order for the psychiatrist or psychologist to fully address the situation. The infrequency of psychiatric evaluation or no counseling evaluation at all, renders the provision of informed decision uncertain.

- ◆ **ARE WE TARGETING THE RIGHT POPULATION?** SB 151 proposes that only terminally ill patients may be assisted in ending their life with the assistance of a physician. It would seem that the chronically ill or persons with a disability, who are looking at many years of suffering with no hope of palliation, are more in need of an “out” than the terminally ill. Nevertheless, the legislature recognizes that it would be unethical, and in fact criminal, to advocate assisted suicide for these groups. Clearly, the legislature should not be deciding who has a right to end their life and who does not.

- ◆ **INVOLVING PHYSICIANS IN ASSISTED SUICIDE:** Assisted suicide presents many problems for the medical profession. Physicians have been taught to save life and make life more comfortable for their patients. Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own Hippocratic mandate and undermine public confidence in the medical profession.

Section 156.07 (9) of SB 151 states that if a physician refuses to fulfill the requestor’s request for medication, he must make a good faith attempt to transfer the requestor’s care and treatment to another physician who will fulfill the requestor’s request for medication. “Doctor shopping” will ensure that the patient’s request be fulfilled - if not by one doctor, then by another!

A request for assisted suicide should be viewed as a cry for help, and should invite compassion and care, not a lethal prescription.

Thomas Jefferson wrote, “[T]he care of human life and happiness, and not their destruction, is the first and only legitimate object of good government.”

Agudath Israel of America urges you to vote against this bill.

Thank you for your time. I am available for any questions.

Sheba Seif

Phone (847) 674-4000
 Mobile (773) 870-5808



Testimony of Julie A. Grimstad, Executive Director
Life is Worth Living, Inc.
3008 Della Street
Stevens Point, WI 54481
lifeisworthliving@sbcglobal.net

January 23, 2008

Dear Chairman Carpenter and Members of the Senate Committee on Public Health,
Senior Issues, Long Term Care and Privacy:

Thank you for this opportunity to testify in opposition to SB 151, which would legalize physician-assisted suicide (PAS) in Wisconsin.

Suicide by any other name is still suicide.

This bill declares, "Taking medication under a fulfilled request for medication under this chapter does not, for any purpose, constitute a suicide." This is a blatant lie. *Webster's Third New International Dictionary* (unabridged) defines suicide as "the act...of taking one's own life voluntarily and intentionally." At least let's be honest

A request for medical assistance to kill oneself must be understood as a cry for help, not as a choice to be honored.

Suicidal thoughts and expressions often arise from difficult situations of suffering, loneliness, lack of economic prospects, depression and anxiety about the future. Add a serious illness to any of these difficulties and a person is particularly vulnerable to the suggestion that he or she might be better off dead. That suggestion is inherent in a law that permits a physician to provide a patient with the means to commit suicide.

Advocates of PAS often cite Oregon's 10-year experiment with PAS to reassure us there is nothing to fear. Contradicting that claim is a 2006 report by British palliative care expert Dr. David Jeffrey (available at www.wcmt.org.uk/reports). During the course of conducting research, Dr. Jeffrey uncovered a number of disturbing unreported PAS cases in Oregon, including:

- A patient was told by his doctor that "you have ALS...this is awful...you should consider physician-assisted suicide." The patient was "devastated."
- A patient with cancer was told by a doctor that "it was going to be a painful way to die" and advised him to take advantage of the PAS law. The patient took the lethal drugs, but did not die quickly. His wife couldn't handle the situation, so a pro-assisted suicide organization sent two men to sit with the man until he died the next morning. The wife became profoundly depressed and attempted suicide herself.

How voluntary is PAS when you are not offered any hope or other options? And, when so many people have inadequate access to medical care, it is cruel to offer death as a "choice." Let's fix our medical system, not eliminate those who need medical care.

If PAS for those with terminal illness is legalized, the “right to die” is likely to become a perceived “duty to die.”

Family members and friends who support the suicide of a terminally ill patient reinforce the notion that the person’s life has lost all meaning and is a “burden.” Furthermore, with concern mounting over containing medical costs, seriously ill patients are made to view themselves as drains on society. Legalizing PAS will not ensure death with dignity; rather, it will contribute to the devaluation of the lives of people who require “too many resources.” I fear that suicide will become the logical expectation of a system that prizes cost savings over people.

Advocating death as a solution to pain is unethical and extreme.

The American Medical Association adamantly opposes transforming assisted suicide into a medical treatment. The Hippocratic Oath contains this promise: “I will give no deadly medicine to anyone if asked, nor suggest such counsel.”

We have the medicine and technology to effectively control pain. While some barriers exist to their implementation, efforts should be made to remove those barriers, not to legalize PAS. Instead of trying to legalize killing patients who are in pain, legislation should be aimed at making sure all physicians are taught, and use, effective pain management.

Moreover, SB 151, modeled after Oregon’s law, merely requires that the patient be diagnosed to have a disease that will cause death within six months. It does not mention pain as a requirement for receiving a prescription for a lethal dose of drugs. Oregon physicians who have assisted suicides report that most patients did not seek PAS because of pain, but because they feared becoming a burden, being unable to engage in enjoyable activities, and other non-pain-related concerns.

Bottom line: Legalizing PAS does not change a form of homicide into a medical treatment; rather, it turns the law into an accessory to homicide.



Submitted testimony of **Michael T. Claessens, M.D.**, Palliative Medicine physician,
M320 Galvin Avenue, Marshfield, WI, 54449,

in opposition to

Senate Bill 151, "Death with Dignity,"

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

January 23, 2008.

Ladies and gentlemen, thank you for allowing me to submit written testimony in opposition to Senate Bill 151 that proposes the legalization of physician-assisted suicide (PAS). I just heard about this bill less than five days ago, and my patient care responsibilities preclude my being present with you in Madison. The views herein expressed are my own views and are not intended to represent my employer.

Allow me first to outline my background as one familiar with the issues outlined in this bill. I am a physician specialist in Palliative Medicine, the subspecialty focused on identifying, addressing, and treating areas of suffering for patients seriously ill or dying, and their loved ones. Importantly, I have had requests made to me for PAS or euthanasia. I am certified by the American Board of Internal Medicine and the American Board of Hospice and Palliative Medicine. My training has been at Dartmouth College in religion and philosophy, the University of Minnesota Medical School, Dartmouth-Hitchcock Medical Center in internal medicine, and with palliative care pioneers at McGill University and the University of Ottawa Institute of Palliative Care. I have co-authored scientific papers on the care of the suffering and dying. Since 1999, I have practiced full time Palliative Medicine in Marshfield, Wisconsin. However, I believe my most important qualification to speak to this bill is that I spend my days, and at times my nights, at the bedside of the suffering and dying, where my most important skill is listening to my patients.

The purpose of my testimony today is to oppose Senate Bill 151 based on the following:

- (1) PAS is inconsistent with the physician's responsibility to heal and care for his or her patients;
- (2) PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity;
- (3) PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia; and
- (4) The bill, as written, is pragmatically untenable even if it were acceptable in principle.

I will include for each of my first three points stories of real persons for whom I have personally cared.

First, PAS is inconsistent with the physician's role as healer, not only violating the oaths most of us have taken as professionals but effectively abrogating the special trust patients and society may have had in us. The Hippocratic Oath states that its adherents, "Will give no deadly medicine to any one if asked, nor suggest any such counsel..." Hippocrates was a Greek physician, circa 400BC, who objected to the medical culture of his day, in which euthanasia was commonplace, and wrote his oath that affirms the sacredness of life and the doctor's duty to protect it. Essential elements of the oath include the following: transcendence – the recognition of the need for a power over and above mankind; teaching within a moral ethos; a high value of human life; the importance of trust between practitioner and patient; collegiality in support of not pressuring practitioners to act against their consciences; and integrity, supporting that purity of motive and beneficence would guide practice.¹ These issues of trust and integrity are particularly important at a time of great vulnerability for the patient. When a patient is sick, suffering, and perhaps dying, his family and he often are looking for guidance from a health care team that is familiar with the issues they face (present and future), will listen to them, and will advise them in a trustworthy manner. They want to believe what is succinctly stated in a 15th century French proverb, that the practitioner will, "cure sometimes, heal often, and comfort always."

I would like to illustrate my first point with a story that I believe demonstrates integrity, caring and patient trust. The patient was a middle-aged man for whom I cared while still a resident in internal medicine. He had lung cancer and was transferred to the university hospital due to shortness of breath. He received diagnostic evaluation and attempt to remove cancerous fluid from around his lung. Unfortunately, we had reached the limits of our disease-directed interventions, and he was ready to return to his local hospital for ongoing care, likely with a hospice focus. While on private rounds to see him, he asked me to give him medicine to take his life. With caution and caring, I explained to him that I could not and would not do that, but I would do whatever I could to treat his symptoms and make him comfortable. The next day, he decided he wanted to stay in our hospital under my care. I found out later that his primary reason for requesting hastened death is that his wife also had lung cancer, and he did not want her to see him suffer and fear the same fate for herself. The patient requested physician-assisted death, but I believe what he really wanted was compassionate, competent care for the sake of his wife, and he was very grateful.

Secondly, PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity. Without question, people suffer. Suffering knows no boundaries – it is not a respecter of person, race, gender, socioeconomic status or even ostensible good health. Suffering is personal and can be experienced in many domains – physical, emotional, spiritual, relational and many others, and it can strike any time. When suffering is present, it cries for a human response, and when it is in the context of illness it often pleads for a physician's response. Therefore, the first job is one of listening. I must sit, spend time, and listen intently to know the source of suffering. When it is physical suffering, for example severe pain, it is almost always remediable.

¹ Commentary on Hippocratic Oath from Dr. John Patrick, www.johnpatrick.ca.

When the suffering is non-physical, such as existential anguish, it is far more difficult, but even in such situations there is frequently some way to help. The term palliate is from the Latin root *pallium*, which means to cloak or to cover, in that even if the core problem cannot be cured or corrected it can be addressed with efforts to relieve symptoms and other burdens. In the setting of terminal illness, which is the context for Senate Bill 151, interdisciplinary palliative care and hospice teams provide the most expert response to suffering. We are not perfect, and I never promise *perfect* relief of problems; that would be foolish. What I do promise is our best efforts at addressing the problems, and the expertise and efforts of the team is almost invariably helpful to patient and family. As mentioned, existential distress is most difficult, and though it sometimes cannot be relieved it is arguably not a strictly medical issue and appropriately involves people and resources in various parts of the community. Suicide may seem like a simple solution to the problems or suffering, but it may itself be a source of suffering to others. Thus, I submit that the proper response to suffering is not PAS but listening and responding to the person's needs, which in the context of terminal illness should include expert palliative care.

I would like to illustrate my second point with two patients whose stories convey hope for relief of suffering. First is the story of a man, 50 to 60 years old, whom I was asked to see because he wanted to stop kidney dialysis and die. To the referring doctor, it was pretty straightforward – stop dialysis, explain the expected course of decline, and keep him comfortable. However, when I met with him I wanted to discern what was driving his decision. He said, “The pain, . . . the pain. If I didn't have the pain, I would love to keep on living.” So, I treated his pain successfully, and he happily continued his dialysis-dependent life. The second story of pain, though, is far more complicated but thankfully also one of relief. She was a middle-aged woman professional with an abdominal cancer, experiencing severe pain and evident anxiety. Her pain was brought under adequate control initially, but it was progressive and increasingly difficult to control. Despite having home hospice, pain management required admission to an acute hospital palliative care unit. Pain improved but persisted. Then, one day, in the course of two and one-half hours of physician at bedside with patient and family member, a source of emotional and spiritual suffering was revealed from her past, and with counseling and prayer she achieved reconciliation and healing. Her physical pain resolved completely, and she later died peacefully. Two patients; two sources of suffering; and in these cases relief was realized with expert palliative care rather than hastening death.

Thirdly, PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia. I understand that one of the most strongly stated reasons for PAS is autonomy – the ability to self-govern or control one's own life. However, there is no place in medicine for absolute autonomy. A patient cannot demand tests and treatments and expect to always receive them, because they might not be indicated, they might not be affordable (individually or societal), and in the case of certain requests they may be against the conscience of the practitioner. *Respect* for autonomy should always be practiced, but it doesn't necessitate rote compliance with the patient's wish. But, in the case of PAS, even if it were legalized and requests granted,

I believe it would lead to *less* respect for autonomy as a society – with serious risk of involuntary euthanasia.

In delineating my rationale for PAS leading to euthanasia, I will quote a legal opinion and give an historical reference. The legal opinion is from attorney Walter Weber: “Under the equal-protection clause of the Fourteenth Amendment to the U.S. Constitution, legislative classifications that restrict constitutional rights are subject to strict scrutiny and will be struck down unless narrowly tailored to further a compelling governmental interest. ... A right to choose death for oneself would also probably extend to incompetent individuals. ... [A] number of lower courts have held that an incompetent patient does not lose his or her right to consent to termination of life-supporting care by virtue of his or her incompetency... [T]he [“substituted judgment”] doctrine authorizes – indeed requires – a substitute decision maker, whether the court or a designated third party, to decide what the incompetent person would choose, if that person were competent. ... Therefore infants, those with mental illness, retarded people, confused or senile elderly individuals, and other incompetent people would be entitled to have someone else enforce their right to die.”² Thus, though Senate Bill 151 is expressly intended for competent individuals, it might not stay that way.

The historical reference alluded to above is from pre-Nazi Germany, and I use this not for fear of intended “cleansing” but of cost control. We are all aware of the looming crisis of how health care and custodial care will be provided for our aging society. I have heard it said, and believe it, that if we want to continue to care for our people the same way we do now, we could never build enough hospitals and nursing homes to care for all those who will need them. Please bear that in mind as you listen to quotes from physician Alfred Hoche and lawyer Karl Binding, both Germans, writing in reference to “life devoid of value” – i.e., mentally disabled, “ballast persons:”

- The question of whether we should spend all of this money on ballast type persons of no value was not important in previous years because the state had sufficient money. Now, conditions are different...
- Opposed to our task is the modern effort to keep alive all sorts of weaklings and to care for all those who are perhaps not mentally retarded but are still large burdens...
- ... The granting of death with dignity to life devoid of value to affect the release of the burden will for a long time be met with resistance for mostly sentimental reasons...
- In order to attain the necessary results, we must investigate... the possibility and conditions for euthanasia.³

We know the results of the years to follow, and may we heed the warnings of history.

Illustrating my third point is a story of request for assisted death by an individual on behalf of another person. I was caring for a pleasant, married woman of about 70 years

² Walter Weber, “What right to die?” *Suicide and Life-Threatening Behavior* 1988;18:181-184, quoted in O’ Steen DN and Balch BJ, “What’s wrong with making assisted suicide legal?” www.cmda.org.

³ Quoted in, Baker R and McCullough L, “Medical ethics’ appropriation of moral philosophy: the case of the sympathetic and the unsympathetic physician. *Kennedy Institute of Ethics Journal* 2007;17:3-22.

old. She had multiple myeloma with a tumor mass causing paralysis of her legs. In the course of care, she became delirious, suspected to be caused by medications and/or urinary tract infection. While she was delirious, a common source of suffering for family members watching the ill person, her husband asked one day if there were, "Anything [I] could do" [to take her life so she wouldn't suffer]. I explained to him, as I did in the first case I shared with you, that I could not and would not do that, but that we would continue to care for her and try to relieve her suffering with means available to us. Her delirium was corrected after adjustment of medications, addition of antibiotics, and some hydration. Upon becoming coherent again, the patient was directed to a friend of hers who provided specific spiritual counseling, after which she had renewed joy and peace. She seemed like a new person, and she later stated (of course never knowing of her husband's request for her hastened death), "I'm sure glad I didn't die, because I would have never known this peace." I conclude this section on respect for autonomy by communicating my hope that intentionally hastening death is never a legal option, despite the striving for absolute autonomy.

My fourth point is that Senate Bill 151, as written, is pragmatically untenable even if it were acceptable in principle, due to the procedural requirements of terminal illness, voluntariness, and competency. With regard to terminal illness, it is commonly known that even the best clinicians are poor at survival prognosis, and it is cogently argued elsewhere⁴ that strategies to clearly define the "terminally ill" are so problematic that it precludes restricting PAS to that category of people. An Institute of Medicine report⁵ on end-of-life issues addresses the next two issues:

- "The criterion of voluntariness also presents problems in determining patient status and articulating boundaries (e.g., what constitutes undue influence by another party). Further, the question can be raised whether serious socioeconomic disadvantage nullifies voluntariness."
- "Similarly, requiring that patients be mentally competent raises questions about what standards will be used, what threshold will be set, how fluctuating capacities will be handled, and what will be done about directions in advance."

To reiterate, even if PAS were acceptable in principle, the procedural requirements of the bill make it untenable in practice.

In conclusion, I restate my strong personal and professional opposition to Senate Bill 151 that is intended to legalize PAS. I hope I have conveyed to you my rationale and experience that PAS is inconsistent with a physician's responsibility to heal and care, is not a compassionate response to suffering, does not represent a true respect for autonomy, and is procedurally untenable. Woe to us if we choose to proceed down the path of legalizing and medicalizing elective death, for it would be a path of terrible and unnecessary consequences.

Thank you very much for your time and attention to this important matter.

⁴ Lynn J, Harrell FE, Cohn F, Hamel MB, Dawson N, Wu AW. Defining the "terminally ill:" Insights from SUPPORT. *Duquesne Law Review*. 1996;35:311-336.

⁵ Field MJ and Cassel CK, eds. *Approaching death: improving care at the end of life*. Institute of Medicine. Washington: National Academy Press, 1997.



Submitted testimony of **Michael T. Claessens, M.D.**, Palliative Medicine physician,
M320 Galvin Avenue, Marshfield, WI, 54449,

in opposition to

Senate Bill 151, "Death with Dignity,"

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

January 23, 2008.

Ladies and gentlemen, thank you for allowing me to submit written testimony in opposition to Senate Bill 151 that proposes the legalization of physician-assisted suicide (PAS). I just heard about this bill less than five days ago, and my patient care responsibilities preclude my being present with you in Madison. The views herein expressed are my own views and are not intended to represent my employer.

Allow me first to outline my background as one familiar with the issues outlined in this bill. I am a physician specialist in Palliative Medicine, the subspecialty focused on identifying, addressing, and treating areas of suffering for patients seriously ill or dying, and their loved ones. Importantly, I have had requests made to me for PAS or euthanasia. I am certified by the American Board of Internal Medicine and the American Board of Hospice and Palliative Medicine. My training has been at Dartmouth College in religion and philosophy, the University of Minnesota Medical School, Dartmouth-Hitchcock Medical Center in internal medicine, and with palliative care pioneers at McGill University and the University of Ottawa Institute of Palliative Care. I have co-authored scientific papers on the care of the suffering and dying. Since 1999, I have practiced full time Palliative Medicine in Marshfield, Wisconsin. However, I believe my most important qualification to speak to this bill is that I spend my days, and at times my nights, at the bedside of the suffering and dying, where my most important skill is listening to my patients.

The purpose of my testimony today is to oppose Senate Bill 151 based on the following:

- (1) PAS is inconsistent with the physician's responsibility to heal and care for his or her patients;
- (2) PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity;
- (3) PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia; and
- (4) The bill, as written, is pragmatically untenable even if it were acceptable in principle.

I will include for each of my first three points stories of real persons for whom I have personally cared.

First, PAS is inconsistent with the physician's role as healer, not only violating the oaths most of us have taken as professionals but effectively abrogating the special trust patients and society may have had in us. The Hippocratic Oath states that its adherents, "Will give no deadly medicine to any one if asked, nor suggest any such counsel..."

Hippocrates was a Greek physician, circa 400BC, who objected to the medical culture of his day, in which euthanasia was commonplace, and wrote his oath that affirms the sacredness of life and the doctor's duty to protect it. Essential elements of the oath include the following: transcendence – the recognition of the need for a power over and above mankind; teaching within a moral ethos; a high value of human life; the importance of trust between practitioner and patient; collegiality in support of not pressuring practitioners to act against their consciences; and integrity, supporting that purity of motive and beneficence would guide practice.¹ These issues of trust and integrity are particularly important at a time of great vulnerability for the patient. When a patient is sick, suffering, and perhaps dying, his family and he often are looking for guidance from a health care team that is familiar with the issues they face (present and future), will listen to them, and will advise them in a trustworthy manner. They want to believe what is succinctly stated in a 15th century French proverb, that the practitioner will, "cure sometimes, heal often, and comfort always."

I would like to illustrate my first point with a story that I believe demonstrates integrity, caring and patient trust. The patient was a middle-aged man for whom I cared while still a resident in internal medicine. He had lung cancer and was transferred to the university hospital due to shortness of breath. He received diagnostic evaluation and attempt to remove cancerous fluid from around his lung. Unfortunately, we had reached the limits of our disease-directed interventions, and he was ready to return to his local hospital for ongoing care, likely with a hospice focus. While on private rounds to see him, he asked me to give him medicine to take his life. With caution and caring, I explained to him that I could not and would not do that, but I would do whatever I could to treat his symptoms and make him comfortable. The next day, he decided he wanted to stay in our hospital under my care. I found out later that his primary reason for requesting hastened death is that his wife also had lung cancer, and he did not want her to see him suffer and fear the same fate for herself. The patient requested physician-assisted death, but I believe what he really wanted was compassionate, competent care for the sake of his wife, and he was very grateful.

Secondly, PAS is *not* a compassionate response to suffering and thus is the wrong focus of efforts toward death with dignity. Without question, people suffer. Suffering knows no boundaries – it is not a respecter of person, race, gender, socioeconomic status or even ostensible good health. Suffering is personal and can be experienced in many domains – physical, emotional, spiritual, relational and many others, and it can strike any time. When suffering is present, it cries for a human response, and when it is in the context of illness it often pleads for a physician's response. Therefore, the first job is one of listening. I must sit, spend time, and listen intently to know the source of suffering. When it is physical suffering, for example severe pain, it is almost always remediable.

¹ Commentary on Hippocratic Oath from Dr. John Patrick, www.johnpatrick.ca.

When the suffering is non-physical, such as existential anguish, it is far more difficult, but even in such situations there is frequently some way to help. The term palliate is from the Latin root *pallium*, which means to cloak or to cover, in that even if the core problem cannot be cured or corrected it can be addressed with efforts to relieve symptoms and other burdens. In the setting of terminal illness, which is the context for Senate Bill 151, interdisciplinary palliative care and hospice teams provide the most expert response to suffering. We are not perfect, and I never promise *perfect* relief of problems; that would be foolish. What I do promise is our best efforts at addressing the problems, and the expertise and efforts of the team is almost invariably helpful to patient and family. As mentioned, existential distress is most difficult, and though it sometimes cannot be relieved it is arguably not a strictly medical issue and appropriately involves people and resources in various parts of the community. Suicide may seem like a simple solution to the problems or suffering, but it may itself be a source of suffering to others. Thus, I submit that the proper response to suffering is not PAS but listening and responding to the person's needs, which in the context of terminal illness should include expert palliative care.

I would like to illustrate my second point with two patients whose stories convey hope for relief of suffering. First is the story of a man, 50 to 60 years old, whom I was asked to see because he wanted to stop kidney dialysis and die. To the referring doctor, it was pretty straightforward – stop dialysis, explain the expected course of decline, and keep him comfortable. However, when I met with him I wanted to discern what was driving his decision. He said, “The pain,... the pain. If I didn't have the pain, I would love to keep on living.” So, I treated his pain successfully, and he happily continued his dialysis-dependent life. The second story of pain, though, is far more complicated but thankfully also one of relief. She was a middle-aged woman professional with an abdominal cancer, experiencing severe pain and evident anxiety. Her pain was brought under adequate control initially, but it was progressive and increasingly difficult to control. Despite having home hospice, pain management required admission to an acute hospital palliative care unit. Pain improved but persisted. Then, one day, in the course of two and one-half hours of physician at bedside with patient and family member, a source of emotional and spiritual suffering was revealed from her past, and with counseling and prayer she achieved reconciliation and healing. Her physical pain resolved completely, and she later died peacefully. Two patients; two sources of suffering; and in these cases relief was realized with expert palliative care rather than hastening death.

Thirdly, PAS does *not* represent a respect for autonomy but puts us precariously on the slippery slope leading toward involuntary euthanasia. I understand that one of the most strongly stated reasons for PAS is autonomy – the ability to self-govern or control one's own life. However, there is no place in medicine for absolute autonomy. A patient cannot demand tests and treatments and expect to always receive them, because they might not be indicated, they might not be affordable (individually or societal), and in the case of certain requests they may be against the conscience of the practitioner. *Respect* for autonomy should always be practiced, but it doesn't necessitate rote compliance with the patient's wish. But, in the case of PAS, even if it were legalized and requests granted,

I believe it would lead to *less* respect for autonomy as a society – with serious risk of involuntary euthanasia.

In delineating my rationale for PAS leading to euthanasia, I will quote a legal opinion and give an historical reference. The legal opinion is from attorney Walter Weber: “Under the equal-protection clause of the Fourteenth Amendment to the U.S. Constitution, legislative classifications that restrict constitutional rights are subject to strict scrutiny and will be struck down unless narrowly tailored to further a compelling governmental interest. ... A right to choose death for oneself would also probably extend to incompetent individuals. ... [A] number of lower courts have held that an incompetent patient does not lose his or her right to consent to termination of life-supporting care by virtue of his or her incompetency... [T]he [“substituted judgment”] doctrine authorizes – indeed requires – a substitute decision maker, whether the court or a designated third party, to decide what the incompetent person would choose, if that person were competent. ... Therefore infants, those with mental illness, retarded people, confused or senile elderly individuals, and other incompetent people would be entitled to have someone else enforce their right to die.”² Thus, though Senate Bill 151 is expressly intended for competent individuals, it might not stay that way.

The historical reference alluded to above is from pre-Nazi Germany, and I use this not for fear of intended “cleansing” but of cost control. We are all aware of the looming crisis of how health care and custodial care will be provided for our aging society. I have heard it said, and believe it, that if we want to continue to care for our people the same way we do now, we could never build enough hospitals and nursing homes to care for all those who will need them. Please bear that in mind as you listen to quotes from physician Alfred Hoche and lawyer Karl Binding, both Germans, writing in reference to “life devoid of value” – i.e., mentally disabled, “ballast persons:”

- The question of whether we should spend all of this money on ballast type persons of no value was not important in previous years because the state had sufficient money. Now, conditions are different...
- Opposed to our task is the modern effort to keep alive all sorts of weaklings and to care for all those who are perhaps not mentally retarded but are still large burdens...
- ... The granting of death with dignity to life devoid of value to affect the release of the burden will for a long time be met with resistance for mostly sentimental reasons...
- In order to attain the necessary results, we must investigate... the possibility and conditions for euthanasia.³

We know the results of the years to follow, and may we heed the warnings of history.

Illustrating my third point is a story of request for assisted death by an individual on behalf of another person. I was caring for a pleasant, married woman of about 70 years

² Walter Weber, “What right to die?” *Suicide and Life-Threatening Behavior* 1988;18:181-184, quoted in O’ Steen DN and Balch BJ, “What’s wrong with making assisted suicide legal?” www.cmda.org.

³ Quoted in, Baker R and McCullough L, “Medical ethics’ appropriation of moral philosophy: the case of the sympathetic and the unsympathetic physician. *Kennedy Institute of Ethics Journal* 2007;17:3-22.

old. She had multiple myeloma with a tumor mass causing paralysis of her legs. In the course of care, she became delirious, suspected to be caused by medications and/or urinary tract infection. While she was delirious, a common source of suffering for family members watching the ill person, her husband asked one day if there were, "Anything [I] could do" [to take her life so she wouldn't suffer]. I explained to him, as I did in the first case I shared with you, that I could not and would not do that, but that we would continue to care for her and try to relieve her suffering with means available to us. Her delirium was corrected after adjustment of medications, addition of antibiotics, and some hydration. Upon becoming coherent again, the patient was directed to a friend of hers who provided specific spiritual counseling, after which she had renewed joy and peace. She seemed like a new person, and she later stated (of course never knowing of her husband's request for her hastened death), "I'm sure glad I didn't die, because I would have never known this peace." I conclude this section on respect for autonomy by communicating my hope that intentionally hastening death is never a legal option, despite the striving for absolute autonomy.

My fourth point is that Senate Bill 151, as written, is pragmatically untenable even if it were acceptable in principle, due to the procedural requirements of terminal illness, voluntariness, and competency. With regard to terminal illness, it is commonly known that even the best clinicians are poor at survival prognosis, and it is cogently argued elsewhere⁴ that strategies to clearly define the "terminally ill" are so problematic that it precludes restricting PAS to that category of people. An Institute of Medicine report⁵ on end-of-life issues addresses the next two issues:

- "The criterion of voluntariness also presents problems in determining patient status and articulating boundaries (e.g., what constitutes undue influence by another party). Further, the question can be raised whether serious socioeconomic disadvantage nullifies voluntariness."
- "Similarly, requiring that patients be mentally competent raises questions about what standards will be used, what threshold will be set, how fluctuating capacities will be handled, and what will be done about directions in advance."

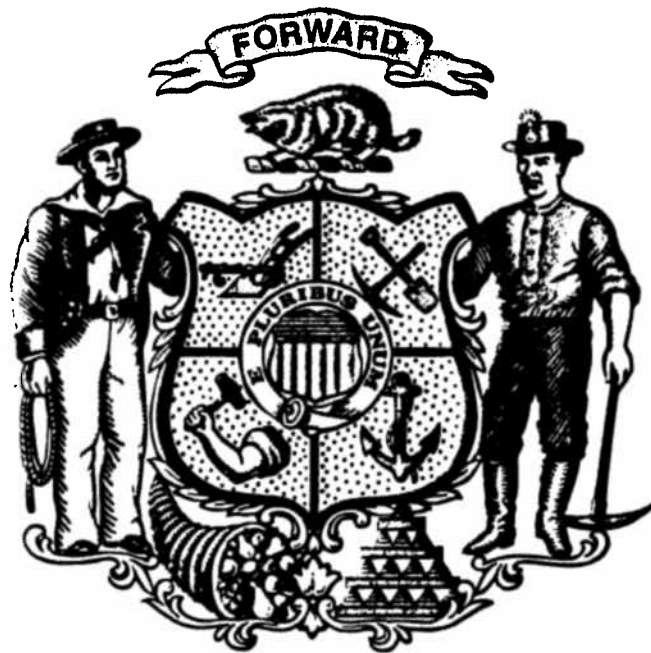
To reiterate, even if PAS were acceptable in principle, the procedural requirements of the bill make it untenable in practice.

In conclusion, I restate my strong personal and professional opposition to Senate Bill 151 that is intended to legalize PAS. I hope I have conveyed to you my rationale and experience that PAS is inconsistent with a physician's responsibility to heal and care, is not a compassionate response to suffering, does not represent a true respect for autonomy, and is procedurally untenable. Woe to us if we choose to proceed down the path of legalizing and medicalizing elective death, for it would be a path of terrible and unnecessary consequences.

Thank you very much for your time and attention to this important matter.

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⁵ Field MJ and Cassel CK, eds. *Approaching death: improving care at the end of life*. Institute of Medicine. Washington: National Academy Press, 1997.





WISCONSIN CATHOLIC CONFERENCE

TESTIMONY IN OPPOSITION TO SB 151: ASSISTED SUICIDE
Presented to the Senate Committee on Public Health, Senior Issues,
Long Term Care and Privacy
January 23, 2008

Thank you for the opportunity to testify on Senate Bill 151. My name is Barbara Sella and I'm the Associate Director for Respect Life and Social Concerns at the Wisconsin Catholic Conference.

The Wisconsin Catholic Conference is strongly opposed to this proposed legislation. Not only does it involve the taking of human life, but it also weakens rather than strengthens the bonds of human solidarity.

Assisted suicide raises questions that are profoundly personal and heart wrenching. Yet, it is in these very moments that we are most in need of principles to guide our choices and to define the limits of our actions.

The first of these principles is that human life is sacred, a gift with which we are endowed by God. Hence, it is inalienable.

This is not merely a "Catholic" proposition, nor a uniquely Christian one. It is, rather, a "self-evident" proposition, recognized as such by the Founders and reaffirmed by Lincoln at Gettysburg when he dedicated the nation to a new birth of freedom, but a freedom under God's providence.

The second principle is that human life is social. We humans, by our nature, are bound to each other. Any decision that violates basic rights or that devalues life affects other types of behavior and other choices. Such decisions are never a purely private matter or choice.

Because human life is both sacred and social, we regularly exhort our fellow citizens to embrace a consistent life ethic that calls us to evaluate all decisions in the light of their impact on human life and dignity. Physician-assisted suicide is a rejection of this ethic because it involves a direct attack on human life.

Supporters of assisted suicide stress that personal freedom means that one should be able to choose the time, place, and manner of one's own death in order to die with dignity.

If choice is what matters most, then it is difficult to justify imposing any limit on that choice. Why must death be expected in six months, as the bill provides? Why have any time limit at all?

Why limit the right to die to the terminally ill? Many chronically ill persons may be experiencing greater suffering, for a more extended period, and at greater cost to themselves, their families, and society.

If the goal of assisted suicide is to avoid pain and suffering, why limit this bill only to those who patients who are capable of making an informed choice? What about non-competent patients who are suffering and who are not capable of expressing their desire to die? What about infants?

We simply cannot go in this direction.

These concerns are not merely academic. If we look to the Netherlands, where assisted suicide and euthanasia is widely practiced, it is clear that all the scenarios outlined above have come to pass. Doctors have assisted not just the terminally ill to die, but those who are completely symptom free, those who are severely depressed, and those who have not voluntarily consented to ending their lives.

Furthermore, since the publication of the Netherlands' Groningen Protocol in 2004, the Dutch permit doctors to euthanize newborns born with serious disabilities, like severe spina bifida.

In other words, the justifications used to allow a competent person to kill himself have led to doctors killing incompetent persons.

Human freedom and personal choice are not absolute values or rights. We limit individual action when one person's unfettered choice can easily lead to the degradation or destruction, not just of her life, but of others as well. In short, the law places some limits on freedom and choice in the interest of protecting human life and dignity.

If our law does not recognize a person's choice to become a prostitute or a slave, how can it permit her to use the argument of freedom in order to be killed? Personal freedom and choice cannot trump the inalienable right to life.

It does not follow, however, that a terminally ill patient is obligated to accept or employ every means of treatment just to stay alive. Catholic moral teaching makes a clear distinction between ordinary and extraordinary means of care, between accepting death and choosing to cause it. If a patient chooses to forego aggressive (i.e. extraordinary) treatment for advanced cancer, she is not choosing death. Rather, she is choosing life without the burden of extraordinary medical intervention.

On the question of pain and suffering, there is a distinction to be made between the two.

Pain is physical and very real for the dying person. Everything possible should be done to reduce and alleviate it, and indeed, enormous strides are being made in the area of palliative care. Catholic medical ethics permits the use of powerful painkillers even when they may have the unintended side effect of shortening a patient's life.

Suffering, though very real, is not solely a matter of physical discomfort. Suffering is also a matter of emotional and psychological anguish. Persons near death anguish for their families and care-givers. Loved ones often suffer for those dying.

We can never remove all suffering without taking away our human nature. But we can ease most suffering. As individuals and as a society, we can and must comfort dying persons and reassure them that we value their continued presence. We can and must tell them that their dependency does not diminish their inherent dignity. We can and must affirm that their lives still matter.

One final concern with Senate Bill 151 is the requirement that the attending physician either fulfill the patient's request for medication to end her life or "make a good faith attempt to transfer" the patient to another physician who will provide the medication. A physician who refuses or fails to make a good faith effort to transfer shall be guilty of unprofessional conduct.

To force anyone to become complicit in a suicide is morally wrong.

For all these reasons, the Wisconsin Catholic Conference urges you to oppose this legislation.

Thank you.



Senate Bill 151 (Wisconsin's assisted-suicide bill)

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

January 23, 2008

Rita L. Marker, J.D.

Good morning. My name is Rita Marker. I am an author, patient advocate, attorney and executive director of the International Task Force on Euthanasia and Assisted Suicide.

For more than twenty-three years, I have been deeply engaged in the debate about assisted-suicide and euthanasia from a public policy perspective.

I am here today to discuss the implications of Wisconsin's assisted-suicide proposal and the flaws in Oregon's assisted-suicide law upon which the Wisconsin bill is patterned.

Physician-assisted suicide would be carried out in today's dysfunctional health care system and culture.

Its proponents virtually always depict legalized assisted suicide as something that would take place within the context of a loving family, facilitated by a caring doctor who, after lengthy discussions with the patient, would write a prescription for lethal drugs to be used as a last resort.

But I ask you to consider the following:

According to the Wisconsin Department of Health & Family Services, 1 out of 11 people in the state are without health insurance at any given time. That, by definition, means that they may not have access to quality medical treatment, let alone have the luxury of lengthy, personal discussions with a physician. Maybe that is why we don't see poor people demanding the "right" to assisted suicide.

To make matters worse, even for those who have health insurance, time with a physician is greatly limited. Because physicians are forced to work within an economic system dominated by managed care and HMOs, their interaction with patients may be limited to 10 or 12 minutes a visit. Furthermore, even for people who have medical insurance, authorization often depends on cost effectiveness.

The cost of drugs for assisted suicide is under \$100. If assisted suicide becomes a legally accepted medical treatment, the economic force of gravity is obvious. What could be more cost effective than a prescription for assisted suicide?

Meanwhile, many families are under tremendous strain. At a time of rising gas prices, home foreclosures and general economic uncertainty, it would be foolhardy to ignore the role that finances would play when making life and death decisions. Furthermore, while we would all

like to believe that family means warmth, love and protection, we need to face the reality that dysfunctional families are not rare and elder abuse – much of it at the hands of a family member – is a fact of life.

Nonetheless, in Oregon, assisted suicide has been a medical treatment for ten years. That state's experience is touted as a model by assisted-suicide advocates who claim that the law's safeguards protect patients and that the annual official reports prove that there have been no problems or abuses.

However, statements made by individuals who have been involved in assisted suicide in Oregon – those who implement it, compile official reports about it, or prescribe the lethal drugs – clearly show that the law's safeguards are not protective and that effective monitoring is close to non-existent.

Assisted suicide in Oregon is carried out behind a shroud of secrecy with non-enforceable guidelines and non-verifiable reports.

Annual reports unreliable

- ◆ **All information in official reports is provided by those who carry out assisted suicide. There is no independent state oversight. If a doctor violates the law, he or she is unlikely to report the violation to the state.**

Under Oregon's law, doctors participating in assisted suicide must file reports with the state. The doctor first helps the person commit suicide and, afterwards, reports that his or her actions complied with the law. Then, that information is used to formulate annual reports. But, from the time the law went into effect, Oregon officials in charge of formulating annual reports have conceded that "there's no way to know if additional deaths went unreported."¹ A lead author of several official reports said that information received from doctors "is a self-report, if you will, of the physician involved."²

- ◆ **There are no penalties for non-reporting or for inaccurate or incomplete reporting.**
- ◆ **Complications or other problems associated with assisted suicide are almost impossible to determine.**

When asked if there is a systematic way of finding out and recording complications, a state official said, "Not other than asking physicians."³ According to the last official report, physicians who prescribed the drugs for assisted suicide were present at only 21.5% of reported deaths.⁴ Any information the absentee doctors provide might come from secondhand accounts⁵ or may be based on guesswork.

- ◆ **The state does not have any authority to verify if reports made by assisted-suicide providers are accurate or complete. It also does not have the authority or the funding to track complications or abuse.**

A state official who was the lead author of most of Oregon's official reports said, "Not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."⁶

- ◆ **Records used in annual reports are destroyed.**

According to one state official, "After we issue the annual report, we destroy the records."⁷ Thus, there is no way to reexamine information if questions or concerns about an assisted-suicide death arise later.

Safeguards are based on political calculations, not patient protection

- ◆ **The waiting period between requests for assisted suicide and provision of the lethal prescription was based on political strategy.**

Oregon's law requires a fifteen-day waiting period between the first request and the provision of drugs for suicide. Kathryn Tucker, legal counsel of Compassion & Choices (the organization spearheading attempts to pass Oregon-type laws in other states), admitted that the waiting period was included to assure passage of the law. Referring to the waiting period, she explained that, after failing in several states, their strategy evolved:

"In my view, the Oregon measure, in some sense, became overly restrictive. It has a fifteen-day waiting period. And my own view of the federal constitutional claim is that *a fifteen-day waiting period would be struck down immediately* as unduly burdensome. As we've seen in the reproductive rights context, you can't have a waiting period of that kind of duration. But in the legislative forum, to pass, you need to have measures that *convince people* that it's suitably protective so you see a fifteen day waiting period."⁸

- ◆ **The required life expectancy of six months or less is both disingenuous and disregarded.**

Oregon's law requires that patients be diagnosed with a life expectancy of six months or less before they are eligible for assisted suicide. However, a physician who has been involved in Oregon assisted-suicide deaths numbering in double digits said that such life expectancy predictions are inaccurate. Dr. Peter Rasmussen, an advisory board member for Compassion & Choices of Oregon, dismissed the need for an accurate prognosis of life expectancy, saying:

"Admittedly, we are inaccurate in prognosticating the time of death under those circumstances. *We can easily be 100 percent off, but I do not think that is a problem.* If we say a patient has six months to live and we are off by 100 percent and it is really three months or even twelve months, I do not think the patient is harmed in any way...."⁹

- ◆ **Oregon's law permits doctors to help mentally ill or depressed patients commit suicide.**

A referral for counseling is only necessary if, in the opinion of the attending or consulting physician, the patient requesting assisted suicide may be suffering from a psychiatric or psychological disorder or depression *causing impaired judgment*.¹⁰ If the counselor determines that the patient's judgment is not impaired from the mental illness or depression, the prescription for assisted suicide may be issued. In the last year for which reports are available, physicians reported referring only 4% of assisted-suicide patients for psychological or psychiatric evaluation to determine if they had impaired judgment.¹¹

- ◆ **Widely reported abuses do not find their way into official reports.**

Kate Cheney died from assisted suicide even though her own physician and a psychiatrist determined that she was incapable of understanding what she was requesting and that her daughter was "somewhat coercive." Nonetheless, the drugs were finally prescribed after a managed care ethicist determined that she was qualified for assisted suicide.¹²

Michael Freeland, whose case was described in a paper presented at the American Psychiatric Association,¹³ received lethal drugs for assisted suicide almost 2 years before he died a natural death – meaning that he did not meet the requirement of a 6 months life expectancy. After receiving the drugs, he was hospitalized because he had become delusional but he was permitted to keep the prescription for assisted suicide.

- ◆ **There are no "safeguards" after the prescription is written. Physicians aren't required to keep track of patients who have received assisted-suicide prescriptions.**

According to one Oregon official, "Our job is to make sure that all the steps happened *up to the point the prescription was written*."¹⁴ She said that the "law itself only provides for writing the prescription, *not what happens afterwards*."¹⁵

The rationale for transforming assisted suicide from a crime into a medical treatment requires that the practice not be confined to self-administration by a terminally ill, competent adult.

If assisted suicide is proclaimed by the force of law to be a good solution to the problem of human suffering then it is both unreasonable and cruel to limit it to the dying. Once we have changed assisted suicide from a bad thing to be prevented to, at least in some cases, a good thing to be facilitated, then it is easy to see how the early "safeguards" come to be seen as obstacles to be surmounted.

On what basis could one deny a good and compassionate medical treatment to those who are suffering from chronic conditions? Or from children? Or from those who never have been or are no longer competent?

How long would it be before the requirement of "self-administration" was deemed illogical and overly restrictive? What about the person who is physically unable to self-administer the lethal dose? After all, is there any other medical treatment that a physician can prescribe for but not administer to a patient?

One could legitimately ask why such expansion has not taken place in Oregon where assisted suicide has been practiced for ten years. The answer, in a word, is "expediency." Assisted-suicide proponents are admittedly well-meaning and committed. They are also well aware that moving too far, too fast will be counterproductive to achieving their goals.

This strategy was described recently in a *New York Times Magazine* cover story. Former Governor Booth Gardner, the spokesperson for a current campaign to legalize assisted suicide in Washington, said the restrictive assisted-suicide proposal (virtually identical to Oregon's law) is a compromise. According to the article:

"Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide.... Gardner's campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation's resistance will subside, the culture will shift and laws with more latitude will be passed..."¹⁶

The current Wisconsin proposal is based on Oregon's assisted-suicide law. That "model law" is deeply flawed as a number of states have found when considering similar proposals. Since the passage of Oregon's law, 22 states (including Wisconsin) have considered proposals that are virtually identical to it. All have failed.¹⁷

I would ask that Wisconsin consider following their lead.

Endnotes:

- ¹ Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News*, Sept. 7, 1998.
- ² Testimony of Dr. Melvin Kohn before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*. Apr. 4, 2005, p. 263, question 598. (Hereafter referred to as *HL*.) Available at: <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf> (last accessed Jan. 17, 2008).
- ³ Testimony of Dr. Katrina Hedberg, *HL*, p. 263, question 597.
- ⁴ DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (<http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf>) The annual report states that the presence of the attending physician in 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.
- ⁵ DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods." (<http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf>)
- ⁶ Testimony of Dr. Katrina Hedberg, *HL*, p. 266, question 615.
- ⁷ *Ibid.*, p. 262, question 592.
- ⁸ Kathryn Tucker, speaking at Discovery Institute Conference, Seattle Pacific University, July 12, 1997. Transcript of videotaped presentation.
- ⁹ Testimony of Peter Rasmussen *HL*, p. 312, question 842. (Emphasis added.)
- ¹⁰ ORS 127.825 §3.03. (Emphasis added.)
- ¹¹ DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (<http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf>)
- ¹² Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
- ¹³ N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., "Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report," presented at the American Psychiatric Association Annual Meeting, New York, New York, May 6, 2004. Available at: <http://www.pccf.oorg/articles/art28.htm> (last accessed Jan. 17, 2008).
- ¹⁴ Testimony of Dr. Katrina Hedberg, *HL*, p. 259, question 566. (Emphasis added.)
- ¹⁵ *Ibid.*, p. 259, question 567. (Emphasis added.)
- ¹⁶ Daniel Bergner, "Death in the Family," *The New York Times Magazine*, Dec. 2, 2007.
- ¹⁷ For a listing of failed assisted-suicide proposals see: <http://www.internationaltaskforce.org/usa.htm>.

For additional information, see: <http://www.internationaltaskforce.org> or contact:
Rita L. Marker, J.D.
rmarker@internationaltaskforce.org
800-958-5678