

Why vulnerable patients need care and legal protections—not pressure for lethal "solutions" ⁱ

Eleven members of the District of Columbia Council decided in November 2016 to legalize assisted suicide, paving the way to providing DC citizens with lethal pills to kill themselves. Because assisted suicide represents a deadly danger to vulnerable patients, to the medical profession and to society, Congress is moving to overturn the DC law through a disapproval measure—a seldom-exercised authority but an imperative action with lives at risk.

The following ten reasons, based upon medical research and the testimony of vulnerable patients, illustrate why governments must focus on compassionate care rather than lethal "solutions."

1. Patients already have the ability to decline extraordinary measures that only prolong death, and to receive aggressive pain relief and palliative care.

The law and medical practice have long provided for the ceasing of extraordinary measures for patients that simply prolong death. Much progress has been made in pain control technology and in recognizing the value of aggressive pain control—including when it has the secondary, unintended effect of hastening death. Palliative care offers compassionate and effective comfort to patients in their last days, as well as the support of loved ones.

In fact, such progress in recognizing the time for natural death, in aggressively treating pain and in providing compassionate palliative care is strong evidence that make legalizing assisted suicide even less reasonable. Yet still more progress can be made in the legal arena regarding aggressive pain control; this was in part the impetus for the bipartisan bill introduced in 1999 by Senators Nickles and Lieberman, the Pain Relief Promotion Act.

As the American College of Physicians and American Society of Internal Medicine have observed, “We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide. A broad right to physician-assisted suicide could undermine efforts to marshal the needed resources, and the will, to ensure humane and dignified care for all persons facing terminal illness or severe disability.”ⁱⁱ

2. Doctors cannot accurately predict life expectancy.

The DC assisted suicide measure criteria hinges on a physician's prediction of life expectancy:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within 6 months.

Yet research has shown that when it comes to predicting life expectancy, "reasonable medical judgment" is usually *wrong*.

A 2012 study of such predictions related to prostate cancer patients found, "Overall, respondents were within 1 year of actual life expectancy only 15.9% of the time; on average, respondents were 67.4% inaccurate in relation to actual survival."ⁱⁱⁱ

Such dismal prediction rates led researchers to conclude, "Physicians do poorly at predicting life expectancy and tend to underestimate how long patients have left to live. This overall inaccuracy raises the question of whether physicians should refine screening and treatment criteria, find a better proxy or dispose of the criteria altogether."

3. Doctors all too frequently misdiagnose illnesses.

The DC assisted suicide measure does not require an autopsy, so exactly how many patients choose assisted suicide as a result of a misdiagnosis or inaccurate prediction of how long they have to live will remain uncertain. But research suggests the number will be significant.

A research study published in April 2014 found that doctors' "diagnostic errors affect at least 1 in 20 US adults."^{iv}

4. Assisted suicide encourages judgment of the disabled as "life unworthy of life."

Members of the disability-rights group Not Dead Yet strongly opposes legalizing assisted suicide because it encourages and facilitates the devaluing of their lives:

[I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.^v

The idea of ridding society of the vulnerable, including the disabled, has a long and sordid history. One reason why the school of Hippocrates gained ascendancy in ancient times is that before Hippocratic protections, physicians possessed the fearful power of poisoning their patients. Undergirding this poisonous power was the notion, expressed by Plato, that "Mentally and physically ill persons should be left to death; they do not have the right to live."

Centuries later, the Nazis revived this deadly outlook on the disabled, dismissing the values of such individuals as "life unworthy of life" ("Lebensunwertes Leben"). Today this lethal, utilitarian judgment of life as unworthy of life seeks new roots in the capital of the United States, in the process sending a chilling message to the disabled and other vulnerable patient communities. As a national capital that is viewed as a symbol of American values, assisted suicide sends this chilling message worldwide.

5. Empowering doctors to kill disempowers patients.

Once policy makers in the Netherlands and Belgium discarded the Hippocratic ethic in favor of assisted suicide and euthanasia, the dike of patient protections broke and a sea of medical killing swept in.

A report published in a 2011 edition of the journal *Current Oncology*,^{vi} entitled, “Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls,” revealed that in the Netherlands, “For every five people euthanized, one is euthanized without having given explicit consent.” The report also noted, “In Belgium, the rate of involuntary and non-voluntary euthanasia deaths (that is, without explicit consent) is three times higher than it is in the Netherlands.”

Testimony before the US Senate Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Property Rights included personal stories from the Netherlands that illustrate how doctors can become determined to carry out medical killing regardless of patients' wishes.

The testimony relates how an old Dutch sailor, as a doctor administered a sedative to prepare for his euthanasia, sat up in bed exclaiming, "I don't want to die!" The doctor coolly proceeded with the second lethal shot that took his life away.^{vii}

6. Financial and personal pressures create a "duty to die."

The dangerous power of judging lives as unworthy does not come into effect only when physicians or politicians inflict on victims their power to kill with impunity; it can also insidiously infect patients' self-perception and lead to voluntary deaths. "Maybe my life really is not worth living. Maybe I really am a burden to my loved ones and to society. Maybe I owe it to everyone to kill myself."

The DC assisted suicide measure turns the movie, "It's a Wonderful Life," on its head, by actually facilitating suicide—voluntary or coerced—as a way to cash in on life insurance funds:

The sale, procurement, or issuance of any life, health, accident insurance ... may not be conditioned upon or affected by the making or rescinding of a qualified patient's request for a covered medication.

Former US Surgeon General Dr. C. Everett Koop personally observed many, especially elderly, patients who felt a sense of what Dr. Koop came to identify as a "duty to die."

In 1985, Dr. Koop prophetically noted regarding assisted suicide, "Two other forces are now at the crossroads: the decline of medical ethics and the push for health cost containment."^{viii}

When cash-strapped governments condone and legalize suicide, it is hard for patients to escape the sense that as far as the government is concerned, suicide is a cost-saving preferred option. Media have reported on instances of government payers favoring assisted suicide over paying for patient care. One such patient, Randy Stroup, found out that Oregon's assisted suicide law provides a powerful incentive for government and other payers to save on end-of-life care:

Since the spread of his prostate cancer, 53-year-old Randy Stroup of Dexter, Ore., has been in a fight for his life. Uninsured and unable to pay for expensive chemotherapy, he applied to Oregon's state-run health plan for help. Lane Individual Practice Association (LIPA), which administers the Oregon Health Plan in Lane County, responded to Stroup's request with a letter saying the state would not cover Stroup's pricey treatment, but would pay for the cost of physician-assisted suicide.^{ix}

Financial factors contributing to a vulnerable patient's sense of a "duty to die" include insurers and government entities that balk at paying for lifesaving drugs, the prospect of depleting resources that otherwise would pass on to loved ones as an inheritance and even subtle pressure from heirs to accelerate the dying process under a guise of compassion. Even the way a careless or uncaring physician negatively presents a prognosis can influence patients to choose early death.

7. Distrust inhibits minority healthcare access.

Distrust of physicians who discard patient protections such as the Hippocratic oath adds to distrust long rooted in some minority communities. In research published in the February 2009 *Archives of Pediatric and Adolescent Medicine*,^x a cross-sectional survey of parents who accompanied children to a primary care clinic found that 67 percent—over two in three--of African-Americans distrusted the medical establishment. Even after controlling for education, race remained an independent predictor of distrust.

Such distrust traces its roots back to a long history of segregation and abuse, painfully illustrated by the infamous Tuskegee Syphilis Study in which treatment known to be effective was withheld from black patients. Adding a fear of physician as killer to the existing distrust already embedded in minority communities can only further decrease access to healthcare in minority-rich centers such as Washington, DC.

8. Undiagnosed depressed but treatable patients will choose suicide.

Research shows that nine out of ten people who die by suicide suffer from clinical depression or another diagnosable mental disorder.^{xi} The sense of hopelessness that severely depressed patients experience can deter them from seeking the help they desperately need.

Yet the DC assisted suicide measure simply notes that doctors should merely

"Inform the patient of the availability of supportive counseling to address the range of possible psychological and emotional stress involved with the end stages of life."

Instead of making sure that severely depressed patients experiencing hopelessness receive a psychological examination or treatment for depression, the DC measure requires merely a suggestion of help before handing the patient a bottle of lethal pills.

Normally, and especially given the rising epidemic of teen suicides, government and social organizations seek to provide messages and resources to discourage suicide and to maximize interventions and treatment of depressed individuals in order to prevent suicides. The DC government's measure turns that approach on its head, instead facilitating the suicide choice and sending a message, "Depressed and despairing of life? Here's an easy way out."

Consider the impact of such a message on a despairing teenager—a very real scenario under the DC assisted suicide measure, which applies even to 18-year-olds:

"Patient" means a person who has attained 18 years of age...

John Norton, now aged 74, recalls, "When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. I was told that I would get progressively worse (be paralyzed) and die in three to five years. The diagnosis was devastating to me. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity." ^{xii}

9. A rise in non-assisted suicides follows legalization of assisted suicide.

What impact does the government's message in legalizing assisted suicide send? What happens to the rate of other suicides after assisted suicide is made legal?

A 2015 study used regression analysis to test the change in rates of non-assisted suicides and total suicides (including assisted suicides). The study found that after legalizing assisted suicide, other suicides increased:

Controlling for various socioeconomic factors, unobservable state and year effects, and state-specific linear trends, we found that legalizing PAS [physician-assisted suicide] was associated with a 6.3% (95% confidence interval 2.70%–9.9%) increase in total suicides (including assisted suicides). This effect was larger in the individuals older than 65 years (14.5%, CI 6.4%–22.7%).^{xiii}

10. Home-stored lethal chemicals are unlocked loaded guns.

The DC assisted suicide measure provides for patients to obtain lethal chemicals and then simply store them in their own homes. Storing lethal prescriptions in the home is the equivalent of storing unlocked loaded guns around the house.

A 2016 survey published online in *JAMA Internal Medicine* found that nearly 60 percent of Americans have leftover narcotics in their homes, 20 percent have shared those with another person and fewer than nine percent kept medications in a location that could be locked.^{xiv} Given this pattern, the likelihood of lethal prescriptions falling into the hands of individuals, including children, other than the patient, is dangerously high.

For these reasons and many more, the DC assisted suicide measure represents a severe threat to patients, to the medical profession and to society. Congress must act quickly to protect the lives of vulnerable patients and to restore the integrity of the medical profession as trusted healers.

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^{vii} Testimony of Jonathan Imbody, Christian Medical Association, U.S. Senate Committee on the Judiciary Subcommittee on the Constitution, Civil Rights and Property Rights, May 25, 2006. Available online at <http://www.judiciary.senate.gov/imo/media/doc/Imbody%20Testimony%20052506.pdf>.

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^{ix} "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care," Fox News, July 28, 2008. Available online at <http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html>.

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^{xiii} Affidavit of John Norton in opposition to assisted suicide and euthanasia," March 2012, Judiciary Committee of the Massachusetts Legislature. Available online at <http://www.massagainstassistedsuicide.org/2012/09/john-norton-cautionary-tale.html>.

^{xiii} David Albert Jones, DPhil, David Paton, PhD, "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" Volume: 108 Issue: 10 October, 2015. Available online at <http://sma.org/southern-medical-journal/article/how-does-legalization-of-physician-assisted-suicide-affect-rates-of-suicide/>.

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