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Testimony in strong opposition to SF 1880
Minnesota Compassionate Care Act of 2015
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Senator Sheran and members of the Health, Human Services, and Housing Committee:

I am an autistic adult and one of the leaders of Second Thoughts Connecticut, a coalition of people with disabilities opposed to the legalization of assisted suicide. Our organization works together with national disability rights organizations including Not Dead Yet and the Disability Rights Education and Defense Fund to oppose such legislation.

You may wonder why a disability rights advocate over 1200 miles away in Connecticut cares so much about legislation in Minnesota. To paraphrase the Reverend Dr. Martin Luther King, Jr.'s "Letter from a Birmingham Jail," I cannot stand by idly in Connecticut and not care about what happens in Minnesota. Injustice anywhere truly is a threat to justice everywhere.

Over 175 attempts to pass similar legislation have been rejected by legislatures across the nation. So far this year, New Jersey, Maryland, Iowa, Colorado, Utah, Arizona, and Hawai'i have all rejected "aid in dying" or "death with dignity" legislation. When legislators look at the details of these bills, they understand that legalizing doctor-prescribed suicide diminishes rather than enhances choice. It also poses unacceptable risks to people who have no intention of dying, or who could have lived productive lives with treatment. They have second thoughts and oppose such legislation.

The ostensible safeguards in SF 1880 are hollow. The witnesses to the requests for the lethal prescription can be an heir and a close friend of that heir seeking to pressure someone into ending his or her life. There is no requirement that either of the two requests be made in the presence of the physician who will prescribe the lethal dose. The heir could pressure the victim to sign the two requests at home and mail them to the physician, who may have no clue that the requests were coerced. Moreover, the bill does not require any witnesses at the time the lethal prescription is consumed. Did Grandpa take the 100 Seconal pills voluntarily, or did he change his mind only to have his heir compel him to do it? SF 1880 has no investigational authority and gives legal immunity to prescribing doctors who act in "good faith." Furthermore, in Subd. 10 (B) (b), doctors are **required** to falsify death certificates, listing the cause of death as the underlying illness and not the lethal prescription, further covering up potential foul play. The possibilities for elder abuse are enormous.

For people with communication disabilities, there an additional danger. SF 1880 defines "competent" in a manner that allows someone else to claim to communicate for the patient, referring to "communicating through a person familiar with a patient's manner of communicating." Back in December 2014, I testified in opposition to an assisted suicide bill in

New Jersey. Dawn Parkot, who has multiple disabilities including a severe speech disability, testified that a similar provision in that bill endangered her life and would allow someone else to murder her. Subsequently she wrote a letter to the New Jersey Senate, published on the website of Second Thoughts Massachusetts, detailing this danger: http://www.second-thoughts.org/main.legislative_efforts.dawn_parkot_letter_to_nj_senate

> At the time the patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request. However, the bill defines "capable" as having the capacity to make health care decisions and to communicate them to a health care professional, including communication through persons familiar with the patient's manner of communicating if those persons are available.
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> Simply, legislation makes it possible for someone to speak for the person if they are familiar with the person's manner of communicating. As someone who is disabled and unable to speak without communication aids, this makes this bill extremely frightening to somebody with a significant speech disability. Legalizing this bill raises the potential for a profoundly dangerous situation.
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> Abuse of the elderly and disabled is a growing problem, making coercion virtually impossible to prove or stop. Who can confirm that the assisted suicide choice was freely made when the only witness is dead? With the lack of witnesses present, someone else can administer the lethal drug without the patient's consent. Someone could use an alternate method, such as suffocation. Who would know? The mere presence of a lethal drug request would provide an alibi. Without witnesses, the patient's control over the "time, place and manner" of his or her death, isn't guaranteed.

The definition of "self-administer" is also problematic and may not necessarily mean what the term means in plain English. SF 1880 defines self-administer as mere ingestion. If someone else puts the pills in your mouth, or jams them down your throat, you have ingested them. Last year, my close friend Cathy Ludlum, who has a severe neuromuscular disability, testified against the assisted suicide bill in Connecticut, and was asked about this same definition of "self-administer" in Connecticut HB 7015. She responded that under this definition, someone could pour a liquid version of the lethal barbiturates into her feeding tube while she is sleeping and that also could qualify under this loose definition of "self-administer"—even as she is physically incapable of administering medication to herself in the plain English sense of the term. Her testimony is online on CT-N (start video near beginning at roughly clip position 12:00): http://www.ctn.state.ct.us/ctnplayer.asp?odID=11321

Contrary to claims of proponents, there have been a number of documented abuses in Oregon, in addition to all the ones we will never know about because of the lack of investigational authority. The case of Tami Saywer and Thomas Middleton is instructive. Middleton had ALS and moved into Sawyer's home, where he died a month later under Oregon's assisted suicide law. Two days after the death, Sawyer sold Middleton's house and deposited the proceeds into her account. Sawyer pleaded guilty to fraud and money laundering in a Ponzi scheme. A second case involving Middleton's estate was dropped only because she was already serving jail time. We will never know whether this was merely fraud or murder for profit. Indeed, this story came to light only because of suspicious real estate transactions and in spite of the concealment entailed by Oregon's assisted suicide law.

Oregon also demonstrates the deadly mix between assisted suicide and medical cost-containment. Barbara Wagner and Randy Stroup were denied chemotherapy for their cancers under the Oregon Health Plan (Medicaid) yet offered suicide drugs instead. Chillingly the president of Compassion & Choices, former HMO executive Barbara Coombs Lee, wrote an op-ed in *The Oregonian* defending Oregon's denial of Tarceva to Barbara Wagner, suggesting that government steer people away from curative care and toward less aggressive treatment or suicide.

Another problem in Oregon is suicide contagion. According to the Centers for Disease Control, Oregon's already high suicide rate has increased much more than the national average; from 1999 (shortly after the Oregon Death with Dignity Act took effect) until 2010, the rate of increase for people age 35-64 was 49% in Oregon versus 28% nationally. Given the motto of Compassion & Choices and other "right-to-die" organizations is "My Life. My Death. My Choice." this should come as no surprise.

Mercilessly bullied autistic and LGBT youth can pick up this message that "my death" is "my choice"—a message which Compassion & Choices has displayed on its green stickers and Facebook pages—and act on it. Those of us on the autism spectrum can take messages like this quite literally. Nikki Bacharach, the autistic daughter of Burt Bacharach and Angie Dickinson, committed suicide eight years ago. Her parents issued the following statement, according to Lisa Jo Rudy of About.com: "She quietly and peacefully committed suicide to escape the ravages to her brain brought on by Asperger's." This strange and creepy announcement is the logical product of Compassion & Choices' assisted suicide advocacy, where "peaceful suicide" is glorified and disability is viewed as "ravaging" our minds and bodies. This is disability discrimination and is unacceptable.

About one year ago, Connecticut became the first state to officially recognize the wrongfulness of this discrimination in its state suicide prevention plan. Here is the relevant excerpt from the *State of Connecticut Suicide Prevention Plan 2020*, which explicitly cites legalized assisted suicide as a contributing factor (pp. 43-44):

> People with Chronic Health Conditions and Disabilities
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> Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system, traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.
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> In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality. Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.
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> Until recently, the CTSAB [Connecticut Suicide Advisory Board] was considering assisted suicide of the terminally ill as a separate issue from suicide prevention. The active disability community in Connecticut, however, has been vocal on the need for suicide prevention services for people with disabilities. There may be unintended

consequences of assisted suicide legislation on people with disabilities. Peace (2012) writes that "Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live."

People with disabilities have a right to responsive suicide prevention services. The CTSAB intends to continue to explore the needs of the disability community for such services.

Targeted Recommendations:

- Develop greater scrutiny of someone's intentions to die.
- Identify and train practitioners to develop expertise in the work with disabled people who are suicidal.
- Do not "assume" suicide is a "rational" response to disability.
- Treat mental health conditions as aggressively as with a person without disability.
- CTSAB should encourage and increase participation from the disability community and encourage educational presentations.

I would strongly urge Minnesota to follow Connecticut's lead and fully include disabled people in your state's suicide prevention plan, officially recognizing the discrimination of legalized assisted suicide.

Misdiagnosis and incorrect prognosis are also serious concerns when assisted suicide is legalized. SF 1880 allows for a prognosis of six months to live, but does not take into account the effects of treatment. Many people with severe disabilities who need breathing support, or people with diabetes controlled by insulin, would be eligible for suicide under this bill. Even if the bill were to include the effects of treatment, many people have dramatically outlived doctors' expectations. Senator Ted Kennedy was diagnosed with brain cancer and given 2-4 months to live, yet lived 15 very productive months. Actress Valerie Harper was diagnosed with a different form of brain cancer and given 3 months to live; she is alive and fighting her disease 39 months later. Jeanette Hall, diagnosed with cancer and given six months to a year to live, sought to die under Oregon's assisted suicide law. Her doctor persuaded her to accept treatment, and she is alive and well nearly 15 years later. John Norton was diagnosed with ALS at age 18 and given 3-5 years to live. The diagnosis was confirmed by the prestigious Mayo Clinic. Six years later, the progression of his disease suddenly stopped and he is alive at age 78, with a wife, children, and retired from a successful career. He writes that if assisted suicide had been legal at the time, "I would have taken that opportunity."

Rahamim Melamed-Cohen, sometimes called "Israel's most famous terminally ill patient," was diagnosed with ALS over 20 years ago and was also given 3-5 years to live. In spite of the fact that he can only think and blink his eyes, he has said that "if they [the doctors] had let me die, I would have missed out on the best, most beautiful years of my life." He has written 12 books and created beautiful artwork using Microsoft's eye-tracking technology. What makes Dr. Melamed-Cohen a role model for the rest of us is his attitude, which is the complete opposite

of the "death with dignity" movement: "Don't despair. Be optimistic and work on joy in your heart. No matter what you're lacking think of what's possible to do in your present situation."

Dr. Melamed-Cohen's attitude reminds us of the importance of our social interconnectedness, that "my death" is not a private, individualistic choice, but affects all around us. In the immortal words of Reverend Dr. Martin Luther King, Jr., "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly." Yet under SF 1880, family notification is merely recommended, not required. What if one of your relatives took the lethal prescription and you had no idea this was coming? Death is too important to be reduced to six word slogans claiming it is merely a matter of "my choice."

Finally, there is the issue of expansion. Leaders of Compassion & Choices and other "right-to-die" organizations have publicly stated their intent to come back later to expand beyond "six months," "terminally ill," and "mentally competent." At a gathering in Hartford, Connecticut in October 2014, Compassion & Choices president Barbara Coombs Lee declared her support for assisted suicide for people with dementia and cognitive disabilities unable to consent. *CT News Junkie* quoted her saying, "It is an issue for another day but is no less compelling." Dr. Marcia Angell, leading proponent of the defeated 2012 Massachusetts' assisted suicide ballot question, wrote in *The New York Review of Books* that she now favors euthanasia as well as assisted suicide. Last year, Oregon debated legislation (HB 3337) with six co-sponsors that would have extended eligibility for assisted suicide from a six month prognosis to one year.

If SF 1880 were enacted, expansion will move into the hands of judges. While we in the disability-rights community view legalizing assisted suicide as a violation of the Americans with Disabilities Act and the equal protection clause of the Minnesota Constitution—people with certain disabilities are thus denied the benefit of suicide prevention services—judges could easily use both of these provisions to require extending the "benefit" of "aid in dying" to other disabled people. The limitations of "self-administer," "six months," "terminally ill," and "mentally competent" in SF 1880 all discriminate on the basis of disability. Indeed, back in 1999, former Deputy Attorney General of Oregon wrote this response to state senator Neil Bryant regarding the issue of self-administration:

> "The Death with Dignity Act does not, on its face and in so many words, discriminate against persons who are unable to self-administer medication. Nonetheless, it would have that effect....It therefore seems logical to conclude that persons who are unable to self-medicate will be denied access to a 'death with dignity' in disproportionate numbers. Thus, the Act would be treated by courts as though it explicitly denied the 'benefit' of a 'death with dignity' to disabled people...."

So what about the person with ALS who has a six month prognosis, but has lost the ability to (literally) self-administer—the justification behind Oregon HB 3337? What about the person with Parkinson's disease, who will have tremors for years before dying? What about people with communication disabilities who may not be able to make the request on their own? What about Grandma with dementia, or the person with a severe psychiatric disability? Once the door to assisted suicide is pried open in enough states, Compassion & Choices will seek to open it further through the courts, going from six months terminal to one year, to perhaps five years; from assisted suicide to euthanasia; and from euthanasia for terminal illness, to chronic

illness, to mental suffering. This is how we go down the same road as Belgium and the Netherlands, where we see euthanasia for deaf twins who fear going blind, or for someone unhappy with gender reassignment surgery, and where euthanasia is the cause of 1 out of every 50 deaths. This is how we go down the same road as Canada, whose radical Supreme Court decision requiring the legalization of active euthanasia for mental suffering was heartily praised by Barbara Coombs Lee. For Compassion & Choices, these are merely issues for another day, and for them, no less compelling.

For those of us in the disability community, opposition to assisted suicide is an issue of justice and civil rights. Reject SF 1880, which enshrines lethal disability discrimination into law. Instead, let us recall Dr. King's dream, in which we all—regardless of race, religion, gender, sexual orientation, or disability—have inherent dignity, and we do not have to die to get it.

We Shall Overcome!

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John Wayne Cockfield
USMC Retired.

Dear members of the committee:

I am a medically retired Marine Sergeant who was wounded in the Vietnam War. I am 100% disabled and have spent the last 46 years in a wheelchair. I am writing to oppose SF 1880, the bill promoting Doctor Prescribed Suicide.

First, let me say that people have always had the right to refuse unwanted medical treatment, but there is a huge difference between refusing medical treatment and institutionalizing the killing of vulnerable and unwanted human beings.

This bill uses deceptive, public relation terms in order to give a false sense of respectability to killing the unwanted. Giving someone poison is not "aid in dying." It is Doctor Prescribed Suicide. It is killing them. "End of Life Care" is not about the end of life. It is, in reality, about ENDING A LIFE.

Suicide Proponents say people should have the right to end their lives; that this country is all about freedom and choosing when to die. But if this is a freedom, why will almost all citizens of Minnesota be prohibited from this freedom? Why is it only available to a small segment of society - The old, the ill, and the disabled? Why is it not available to everyone?

The answer is: Because it is not about freedom. It is about supposed quality of life and making death a "medical choice" for those that do not measure up.

This bill claims to provide a "dignified and humane death." "Death with Dignity" is always at the heart of the Doctor Prescribed Suicide debate. Death with dignity is a slur against disabled and devalued people. It is saying to people like me that my life has no dignity unless I'm dead. It is the ultimate form of discrimination.

Many equate disability with loss of dignity. Problems common to living as a disabled person, such as assistance with dressing and toiletry needs are promoted as reasons for suicide. It is dangerous to disabled people when **society at large begins to include "death" as a therapeutic treatment**.

Doctors and medical professionals are neither "value-free or opinion free. If I am depressed and go to a doctor for a so-called humane and dignified death, I would receive suicide assistance because I am disabled. Many doctors themselves have a fear of disability and they would look at me and say, of course you want suicide. Who would want to be like you? I would not want to live like you. Therefore, you should not want to

live. Let me help you, here - take this poison. This is not compassion! This is medical abandonment and medical abandonment is not compassion.

Moreover, terminal illness has varying definitions today. This bill does not define whether terminal means WITH treatment being provided or WITHOUT treatment being provided. A person could live many years with treatment and still be classified as terminal under modern definitions.

A Minnesota Bill that transforms doctors into suicide enablers is not about end of life care; it is about killing the unwanted. Doctor Prescribed Suicide is the final solution for people with disabilities.

If one reads the literature supporting the "humane killing" of devalued people, it quickly becomes apparent that physical disabilities and dependence on others for everyday needs are sufficient grounds to treat the disabled completely differently than an able-bodied suicidal person. There's an established body of research demonstrating that physicians underrate the quality of life of people with disabilities

For example, an article in the Journal of the South Carolina Medical Association highlights a physician who says that Doctor Prescribed Suicide "is most rationally chosen by the disabled." This preposterous claim demonstrates that the biases of many medical professionals are dangerous to people with disabilities. This same article also says that life saving treatment should be avoided for not only those in pain, but also for those suffering with loss of independence, depression, and anxiety.

As society's abhorrence for Doctor Prescribed Suicide lessens, it is likely that pressure to amend the eligibility requirements to include the criteria of loss of independence, depression, and anxiety will only increase. This has already happened in other places.

Another warning flag waving over the push for Doctor Prescribed Suicide is the fluidity of definitions. Victims of Doctor Prescribed Suicide are often described as needing poison because their medical care has become futile. Unfortunately, the term, "futile care" is not what it used to be. Futile care used to mean that one would die *even with medical care*. Today, it is defined as someone who may be saved with treatment, but his or her "quality of life" does not rise to the perceived level justifying the treatment. In other words, *the patient can be saved, but is just not worth saving.* It is no longer futile care being talked about, but a futile life.

A criterion for therapeutic killing by Doctor Prescribed Suicide is a terminal illness with no more than 6 months to live. Can this be an accurate medical diagnosis? In states where suicide laws are on the books, such as Oregon, numerous people have changed their

minds about taking the poison drugs and have lived many months, even years past their "terminal date." The fact is that doctors cannot accurately predict how long someone may live.

Another problem with terminal illness is the term itself. There are varying definitions of just what the term means. Terminal definitions today include dying WITHOUT medical treatment. People so diagnosed **may live years WITH treatment**. According to the Department of Veterans Affairs, "terminal" is defined as – *"Terminal illness refers to a debilitating condition which is medically incurable or not treatable in terms of available technology, and which can be expected to cause death. In situations involving terminal illness, as defined herein, it can be concluded that the provision of life-sustaining treatment would be of limited or no benefit to the patient since the institution or continuation of such treatment would only postpone the moment of death. Terminal illness, as defined herein, includes but is not limited to, conditions where death is imminent, **as well as chronic and debilitating conditions from which there is no reasonable hope for recovery**."*

According to this definition, as a 100% disabled Marine who has a chronic and debilitating condition from which there is no reasonable hope for recovery, I am terminally ill. This demonstrates just how fluid and dangerous medical terminology is. *It also shows just how dangerous terminal designations are to people with disabilities.*

I am one of those in the bulls-eye of this proposed new freedom; a freedom that is only available to sick, devalued, and disabled people. Describing conditions that I live with everyday as a reason to yearn for the freedom of suicide is deeply devaluing.

I am the target. I do not want to be the victim. Please oppose this dangerous and deceptive bill.

Some Oregon and Washington State Assisted Suicide Abuses and Complications

"We are not given the resources to investigate [assisted-suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."[1]

Dr. Katrina Hedberg, Oregon Department of Human Services

Under Oregon and Washington State's lax oversight, these are some of the documented abuses and complications that have come to light. This list includes abuses and medical complications, as well as other incidents showing some of the harms and dangers that accompany assisted suicide laws.

Doctor Shopping Gets Around Any "Safeguards"

- **Kate Cheney,**[1] 85, died by assisted suicide under Oregon's law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

- **The first known assisted suicide death**[2] under the Oregon law was that of a woman in her mid-eighties who had been battling breast cancer for twenty-two years. Initially, two doctors, including her own physician who believed that her request was due to depression, refused to prescribe lethal drugs. Compassion & Choices—then operating under the name Compassion in Dying, although originally called The Hemlock Society—became involved in the case and referred the woman to a doctor willing to write the prescription.

  Dr. Peter Goodwin, the group's former Medical Director, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's assistance.[3] In one example year, during 2003, the organization was involved in 79 percent of reported assisted suicide deaths.[4] According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying sees "almost 90 percent of requesting Oregonians..."[5] "In 2008 the proportion of C&C PAS deaths significantly increased to 88 percent (53/60) of all reported deaths."[6] And in 2009, 57 of the 59 assisted suicide deaths were Compassion & Choices clients. But then they ceased to provide further information.[7]

Depression and Psychiatric Disability

- **Michael Freeland,**[8] age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn't think that a psychiatric consultation was "necessary." But the law's supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years post-diagnosis. Oregon's statistics for the years 2011 - 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs.[9]

- **Absence of psychiatric consultation:** This case is about what can happen when competent psychiatric consultation is not provided. [A] woman in her mid-fifties with severe heart disease . . . requested assisted suicide from her cardiologist, despite having little discomfort and good mobility. She was referred to another doctor, who in turn referred her to a physician willing to provide assisted suicide. That doctor determined that the woman had more than six months to live, according to his best estimate. She was eventually dismissed as ineligible. Rather than inquire further into possible causes of [her] suicidal despair [or refer her for psychiatric treatment], the physician apparently considered ... his responsibility ended. ... [H]e told her to go back and make yet another appointment with her original physician and dismissed her. She killed her self the next day.[10]

Economic Pressures and Coercion

- **Linda Fleming**, the first to use the WA state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death.[11] But we are told by proponents that financial pressures have never played a role.

- **Thomas Middleton** was diagnosed with Lou Gehrig's disease, was moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited $90,000 into her own account.[12] It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.

Self-Administration

- **Patrick Matheny**[13] received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services said that "we do not know exactly how he helped this person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted ..." The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.

- **Another anonymous patient:** Dr. David Jeffrey wrote, "The question of administration is a delicate one, a patient even had a PEG feeding tube inserted solely to allow him to have PAS [physician assisted suicide]."[14] Concern about the fate of unused lethal barbiturates is compounded by the fact that the Oregon law does not necessarily require that the drugs be ingested by mouth. Barbara Glidewell, Patient Advocate at Oregon Health & Science University, said that patients who cannot swallow would "need to have an NG tube or G tube placement ... [Then, they could] express the medication through a large bore syringe that would go into their G tube."[15] Kenneth R. Stevens, Jr. MD, former Chairman of Radiation Oncology at Oregon Health & Science University, observed that since the lethal agent can be administered to a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once injectable pentobarbital leaves the pharmacy, there is nothing to prevent it from being used through an intravenous (IV) line, or as a lethal injection. If a patient or someone assisting appears to have used a feeding tube or an injection, abuse is far more difficult to detect and prove.[16] Yet, supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually swallow the lethal agents.

Deadly Mix Between Our Broken Health Care System & Assisted Suicide

- **Barbara Wagner** & **Randy Stroup:** What happened to these patients underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. **Wagner**, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients' one-year survival rate increased by more than 45 percent. But the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment "but ... it would cover ... [among other things,] physician-assisted suicide." **Stroup** was prescribed Mitoxantrone as chemotherapy for his prostate cancer. His oncologist said the medication's benefit has been shown to be "not huge, but measurable"; while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain.[17] Yet Stroup also received a letter saying that the state would not cover his treatment, but would pay for the cost of, among other things, his physician-assisted suicide.[18]

  These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than a five-percent expectation of five-year survival. H. Rex Greene, M.D., retired, former Medical Director of the Dorothy E. Schneider Cancer Center at Mills Health Center in San Mateo, CA and formerly a member of the AMA Ethics Council, called this rule "an extreme measure that would exclude most treatments for cancers such as lung, stomach, esophagus, and pancreas. Many important non-curative treatments would fail the five-percent/five-year criteria."[19] Though called free choice, when insurers won't pay, assisted suicide is a phony form of freedom.

Breakdown in Rules Attendant to Changing the Law

The following cases were caused be **legal erosion and the breakdown in rules and codes of conduct** associated with assisted suicide laws, rules and codes that elsewhere protect health care patients.

- **Wendy Melcher**[20] died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge,

in clear violation of Oregon's law. No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."[21]

- **Annie O. Jones, John Avery, and three other patients** were killed by illegal overdoses of medication given to them by a nurse, and none of these cases have been prosecuted in Oregon.[22]

Medical Complications

Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick and simple death. The body sometimes expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as assisted suicide advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15 percent to 25 percent.[23]

- **Peaceful death?** Speaking at Portland Community College, pro-assisted-suicide attorney Cynthia Barrett[24] described one botched assisted suicide. "The man was at home. There was no doctor there" ... . "After he took it [the lethal dose], he began to have ... physical symptoms ... that were hard for his wife to handle. Well, she called 911." He was taken to a local Portland hospital and revived, then to a local nursing facility. "I don't know if he went back home. He died shortly – some ... period of time after that ... ."

  Commenting on this botched assisted suicide case, The Oregonian editorial columnist David Reinhard observed, "The Health Division knows nothing [about this case], ... through no fault of its own. Why? Because the doctor who wrote the prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law] reporting requirements are a sham."

- **David Prueitt**[25] took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon DHS issued a release saying it "has no authority to investigate individual Death with Dignity cases."[26]

Impacts by Doctors and Their Quality of Care

- **Kathryn Judson** wrote of bringing her seriously ill husband to the doctor in Oregon. "I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought)," she wrote. "To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher."[27] According to prescribing doctors, 40% of people who died by assisted suicide reported feeling like a burden on family and caregivers as a reason for requesting lethal drugs.[28]

- **By contrast: Jeanette Hall** of Oregon was diagnosed with cancer in 2000 and told she had six months to a year to live. She knew about the assisted suicide law, and asked her doctor about it, because she didn't want to suffer. Her doctor encouraged her not to give up, and she decided to fight the disease. She underwent chemotherapy and radiation. Eleven years later, she wrote, "I am so happy to be alive! If my doctor had believed in assisted suicide, I would be dead. ...

Assisted suicide should not be legal."[29] Unfortunately, not all doctors are like Jeanette Hall's.

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DISABILITY RIGHTS OREGON

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February 10, 2016

Roland L. Halpern, MNM
Cultivation Manager
Compassion & Choices
4155 E Jewell Avenue
Denver, CO 80222

Dear Roland:

Thank you for your letter of January 22 asking if anything has occurred that would change my former position on the matter.

The answer is no. DRO has still not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act.

Thanks for you inquiry.

Sincerely,

Bob Joondeph
Executive Director

610 SW Broadway, Suite 200 / Portland, OR 97205
Voice: 503-243-2081 or 1-800-452-1694 / Fax: 503-243-1738 / **www.droregon.org**
Disability Rights Oregon is the Protection and Advocacy System for Oregon