

Killing us softly: the dangers of legalizing assisted suicide

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Abstract

This article is an overview of the problems with the legalization of assisted suicide as public policy. The disability community's opposition to assisted suicide stems in part from factors that directly impact the disability community as well as all of society. These factors include the secrecy in which assisted suicide operates today, in states where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangerous potential of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms. Legalizing assisted suicide would augment real dangers that negate genuine choice and self-determination. In view of this reality, we explore many of the disability-related effects of assisted suicide, while also addressing the larger social context that inseparably impacts people with disabilities and the broader public. First, after addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. Third and finally, we explore the ways that so-called "narrow" assisted suicide proposals threaten inevitable expansion. © 2010 Elsevier Inc. All rights reserved.

Keywords: Assisted suicide; Physician assisted suicide; Doctor assisted suicide; Death with dignity; Aid in dying; People with disabilities; Disability; Disability rights; Terminal illness; Chronic illness; Chronic conditions

The legalization of assisted suicide¹ strikes many people, initially, as a cause to support. But upon closer inspection, there are many reasons why legalization is a serious mistake. Supporters focus on superficial issues of choice and self-determination. It is crucial to look deeper. Legalizing assisted suicide would not increase choice and self-determination, despite the assertions of its proponents.

It would actually augment real dangers that negate genuine choice and control.

Because of these dangers, approximately half the states in the United States have either defeated bills to legalize assisted suicide or have passed laws explicitly banning it [1]. In many cases, the bills or referenda were defeated by an opposition coalition spanning the political spectrum from left to right.²

Financial disclosure: Our employer, the Disability Rights Education and Defense Fund (DREDF), received a grant from the Milbank Foundation for Rehabilitation for public policy work associated with preventing the legalization of assisted suicide. We have received no funds from this foundation directly, nor any other funds besides our salaries.

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¹ A note about terminology: The words used in this policy debate are controversial. We use the term "assisted suicide" because it is understood by the public and is used in the legal and medical literature. A clear, specific term is needed. "Aid in dying" could mean anything done to help a dying person, while "death with dignity" has many meanings. The politicization of this terminology is discussed below.

² Coalitions opposing the legalization of assisted suicide typically represent disability rights organizations, physicians and other health care workers, hospice organizations, and Catholics and other right-to-life organizations. In some cases, they also include organizations representing the Latino community, poor people, and workers. Notable opponents include the World Health Organization, American Medical Association and its state affiliates, American College of Physicians—American Society of Internal Medicine, National Hospice and Palliative Care Organization, American Cancer Society, American Geriatrics Society, many other medical organizations, and League of United Latin American Citizens (LULAC). Many prominent Democrats and liberals also oppose legalization, including Bill Clinton, Ralph Nader, and noted civil liberties journalist Nat Hentoff.

Throughout the world, disability rights advocates and organizations are important voices in the opposition to assisted suicide.³ The disability community's opposition is based on the dangers to people with disabilities and the devaluation of disabled peoples' lives that results from assisted suicide. Further, this opposition stems from factors that directly impact the disability community as well as all of society. These factors include the secrecy in which assisted suicide operates today, in states where it is legal; the lack of robust oversight and the absence of investigation of abuse; the reality of who uses it; the dangerous potential of legalization to further erode the quality of the U.S. health care system; and its potential for other significant harms.

In view of this reality, we address many of the disability-related effects of assisted suicide, while also encompassing the larger social context of assisted suicide that inseparably impacts people with disabilities as well as the broader public. First, after addressing common misunderstandings, we examine fear and bias toward disability, and the deadly interaction of assisted suicide and our profit-driven health care system. Second, we review the practice of assisted suicide in Oregon, the first U.S. state to legalize it, and debunk the merits of the so-called Oregon model. We examine Oregon because its law is copied in proposals through the country, including Washington State, which legalized assisted suicide last year. By detailing significant problems with Oregon's supposed safeguards, we raise some of the dangers of assisted suicide, particularly for people with depression and other psychiatric disabilities. Finally, we explore the ways that so-called "narrow" assisted suicide proposals threaten easy expansion. This article focuses primarily on conditions in the United States, although much of it also applies in other countries.

³ The opposition to the legalization of assisted suicide is often mischaracterized as driven exclusively by religious conservatives, but most current opposition coalitions include many persons and organizations whose opposition is based on their progressive politics. Among those are disability rights groups. These 12 nationally prominent disability organizations have stated their opposition to the legalization of assisted suicide: American Disabled for Attendant Programs Today (ADAPT); American Association of People with Disabilities (AAPD); Association of Programs for Rural Independent Living (APRIL); Disability Rights Education and Defense Fund (DREDF); Justice For All (JFA); National Council on Disability (NCD); National Council on Independent Living (NCIL); National Spinal Cord Injury Association; Not Dead Yet (NDY); TASH; the World Association of Persons with Disabilities (WAPD); and the World Institute on Disability (WID) (updates from NDY staff in personal interview, March 26, 2003) [2]. The Disability Section of the American Public Health Association has also declared its opposition. Many state and local disability community leaders and organizations have further declared their opposition in states where assisted suicide proposals have been introduced. For example, the list for Washington State is available at http://dredf.org/assisted_suicide/Washington_Orgs_Indivs_List.pdf.

Few helped, many harmed: disability prejudice and the damage to society

Legal alternatives available today

The movement for the legalization of assisted suicide is driven by anecdotes of people who suffer greatly in the period before they die. But the overwhelming majority of these anecdotes describe either situations for which legal alternatives exist today or situations in which the individual would not be legally eligible for assisted suicide.

It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn. It is legal to receive sufficient painkillers to be comfortable, and we now know this will not hasten death [3].⁴ And perhaps least understood, for anyone who is dying in discomfort, it is legal in any U.S. state to receive palliative sedation, wherein the dying person is sedated so discomfort is relieved during the dying process. Thus, there is already recourse for painful deaths. These alternatives do not raise the serious difficulties of legalizing assisted suicide.

Moreover, anyone with a chronic but nonterminal illness is not eligible for assisted suicide in either Oregon or Washington State. Anyone with depression that affects his or her judgment is also ineligible. Thus, the number of people whose situations would actually be eligible for assisted suicide is extremely low, yet its harmful consequences would be significant.

Fear, bias, and prejudice against disability

Fear, bias, and prejudice against disability play a significant role in assisted suicide. Who ends up using assisted suicide? Supporters advocate its legalization by suggesting that it is needed for unrelievable pain and discomfort at the end of life. But the overwhelming majority of the people in Oregon who have reportedly used that state's assisted suicide law wanted to die not because of pain, but for reasons associated with disability, including the loss of dignity and the loss of

⁴ According to Herbert Hendin and Kathleen Foley, "We now know that that proper use of pain medications in patients with chronic pain, as well as patients at the end of life, does not hasten death. Studies have demonstrated that dying patients who received morphine lived longer than those who did not receive morphine." Herbert Hendin is chief executive officer and medical director, Suicide Prevention International, and *Professor of Psychiatry*, New York Medical College. Kathleen Foley is *Attending Neurologist*, Memorial Sloan-Kettering Cancer Center; *Professor of Neurology, Neuroscience, and Clinical Pharmacology*, Weill Medical College of Cornell University; and *Medical Director*, International Palliative Care Initiative of the Open Society Institute.

control of bodily functions [4]. Similar reasons are reported in the Netherlands [5].⁵

This fear of disability typically underlies assisted suicide. Janet Good, an assisted suicide advocate who worked with Jack Kevorkian, was clear about this: “Pain is not the main reason we want to die. It’s the indignity. It’s the inability to get out of bed or get onto the toilet. . . [People]. . . say, ‘I can’t stand my mother—my husband—wiping my butt” [6]. But as many thousands of people with disabilities who rely on personal assistance have learned, needing help is not undignified, and death is not better than reliance on assistance. Have we gotten to the point that we will abet suicides because people need help using the toilet [7]?

The legalization of assisted suicide would occur “within the context of a health care system and a society pervaded with prejudice and discrimination against people with disabilities” [8]. Already, this prejudice and discrimination play out in life-threatening ways, including pressure by hospital staff on people with disabilities who are nowhere near death to sign Do Not Resuscitate orders and reject life-sustaining treatment [8].⁶ Because of public images that disability is “a fate worse than death,” legalized assisted suicide threatens to create a “two-tiered system”: nondisabled individuals who express suicidal wishes will receive suicide prevention services, while individuals with disabilities will receive lethal prescriptions, resulting “in death to the socially devalued group” [10].

A deadly mix: managed health care and assisted suicide

An ailing system made worse

A significant problem with legalization is the deadly interaction between assisted suicide and profit-driven managed health care. Health maintenance organizations (HMOs) and managed care bureaucracies have often overruled physicians’ treatment decisions because of the cost of care, sometimes hastening patients’ deaths.⁷

⁵ In Oregon, individuals cited concerns “including the loss of autonomy (89.9%), the loss of the ability to engage in activities that make life enjoyable (87.4%), the loss of dignity (83.8%), and the loss of control of bodily functions (58.7%)” [4]. In the Netherlands, the majority of physicians surveyed say the primary reason that patients seek death is “loss of dignity” [5].

⁶ These near-fatal encounters with antidisability prejudice in the health care system are not limited to the United States [9].

⁷ See, for example, the story of Dr. Linda Peeno [11,12]. In 1996, before the U.S. House of Representatives Commerce Committee, she testified, “In the spring of 1987, as a physician [and managed-care executive for the HMO Humana], I caused the death of a man [by denying coverage of a heart transplant] . . . I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was ‘rewarded’ for this. It brought me an improved reputation in my job, and contributed to my advancement afterwards.”

Financial considerations can have similar results in nonprofit health plans and government-sponsored health programs such as Medicare and Medicaid, which are often underfunded. Cost-cutting pressures also shape physicians’ choices. A 1998 study from Georgetown University’s Center for Clinical Bioethics found a strong link between cost-cutting pressure on physicians and their willingness to prescribe lethal drugs to patients, were it legal to do so [13].

The cost of the lethal medication generally used for assisted suicide is about \$300, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment already poses a significant danger. This danger is far greater where assisted suicide is legal. Direct coercion is not necessary. If patients are denied necessary life-sustaining health care treatment, or even if the treatment they need is delayed, many will, in effect, be steered toward assisted suicide.

The deadly impact of legalizing assisted suicide would fall hardest, whether directly or indirectly, on socially and economically disadvantaged people who have less access to medical resources and who already find themselves discriminated against by the health care system. Particularly at risk are individuals in poverty, people of color, older adults, people with progressive or chronic conditions, and terminally ill individuals [8]. As the New York State Task Force on Life and the Law noted, assisted suicide, despite supposed safeguards:

will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those . . . most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered [14].

Deteriorating health care in Oregon

Oregon’s adoption of assisted suicide must be critically examined in relation to its curtailment of Medicaid spending. As Paul Longmore, professor of history at San Francisco State University and a foremost disability advocate on this subject, explained, Oregon instituted “health care rationing for the poor” in the same year that the state’s assisted suicide initiative became law in 1994 [8]. That year, the Oregon Medical Assistance Program (OMAP) ranked over 700 health services and terminated funding for 167 of them. Four years later, when the assisted suicide law went into effect, OMAP directors put lethal prescriptions on the list of “treatments,” categorized as “comfort care.” At the same time, OMAP slashed Medicaid funding for more than 150 services crucial for people with disabilities, people with terminal illnesses, and older adults, while trimming already limited funding for in-home support. In the same year, OMAP attempted, but failed, to limit the funded doses of a powerful pain medication and

successfully put barriers in the way of funding for a path-breaking antidepressant.⁸

The impact of the Oregon Health Plan's drastic limitations became very real to Medicaid recipients Barbara Wagner and Randy Stroup. 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% increased survival rate for patients with advanced lung cancer, and patients' 1-year survival rate increased by more than 45%. But the Oregon Health Plan sent Wagner a letter saying the plan would not cover the beneficial chemotherapy treatment "but . . . it would cover . . . doctor-assisted suicide." Stroup was prescribed mitoxantrone as chemotherapy for his prostate cancer. His oncologist said that while the drug may not extend a patient's life by very long, it helps make those last months more bearable by decreasing pain [15]. Yet Stroup also received a letter saying that the state would not cover his treatment but would pay for the cost of assisted suicide [16].

These treatment denials were based on an Oregon Medicaid rule that denies surgery, radiotherapy, and chemotherapy for patients with a less than 5% expectation of 5-year survival. In a July 5, 2009, letter, H. Rex Greene, M.D., former medical director of the Dorothy E. Schneider Cancer Center at Mills Health Center and currently 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."

It is often alleged that legalized assisted suicide has improved end-of-life care in Oregon. While it is true that Oregon has shown some improvements, similar improvements have occurred in other states that have not legalized assisted suicide.⁹ And research strongly suggests that Oregon has seen a reduction in the quality of end-of-life palliative care since the Oregon law went into effect. Dying patients in Oregon are nearly twice as likely to experience moderate or severe pain during the last week of life, as reported by surviving relatives, compared with patients before the law

took effect [18]. And several recent studies show inadequate palliative and end-of-life care in Oregon [3].

Broad indirect impacts on health care

Addressing the negative impact of the legalization of assisted suicide on the practice of medicine, the two professional associations representing oncologists in California wrote in 2007 that legalization "strikes at the heart of what we do as physicians and adds ambiguity to the physician-patient relationship." Legalization, they concluded, undermines the "physician's primary directive . . . to *first, do no harm*"; "destroys the trust between the patient and doctor"; and, "[u]nder the pretense of providing compassion," relieves a physician "of his or her primary responsibility . . . to safeguard [patients' lives] and to provide comfort to the suffering. It is the ultimate patient abandonment" [19].

The death of Wendy Melcher in August 2005 illustrates the indirect impact of legalization on medical practice and law enforcement. Two nurses, Rebecca Cain and Diana Corson, gave Melcher large overdoses of morphine and phenobarbital. They claimed that she had requested assisted suicide, but they administered the drugs without her physician's knowledge, in clear violation of the law. Yet no criminal charges have been filed against the two nurses. Proponents of assisted suicide argue that this case has no connection to the Oregon law. But it is a strong indication of the legal erosion of public protections due to assisted suicide. 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" [20].

Supporters of assisted suicide frequently assert, without evidence, that the underground practice of assisted suicide disappears where it is legal. But Melcher's death suggests the opposite, that underground assisted suicide probably does occur, and may in fact be thriving in Oregon in the wake of assisted suicide's legalization, due to the breakdown in legal rules and codes of conduct that elsewhere protect patients.

The failure of safeguards and the case of Oregon

Oregon's Death with Dignity Act initiative, known as Measure 16, narrowly passed in November 1994, but court proceedings delayed its implementation. Then the Oregon legislature, concerned with the dangerous flows of Measure 16, referred it back to the voters for reconsideration in a November 1997 special election. After a campaign in which initiative proponents succeeded in keeping the public's attention away from the proposal's actual problems, Oregon voters legalized assisted suicide [21].

One of the myths about assisted suicide in Oregon is that it is highly regulated and has strong safeguards. As a result of this myth, Oregon's law has been duplicated in bills and referenda proposed in many other states. None have passed except in Washington State, where Initiative 1000 passed in November 2008 and went into effect in March 2009. Although

⁸ One leading proponent of assisted suicide, Barbara Coombs Lee, the author of Oregon's assisted suicide legislation, was very involved in developing the state's current health plan. And former Oregon governor John Kitzhaber, a leading proponent of the plan, openly admitted "only three states spend less per person on health care for the poor" [8].

⁹ Kenneth R. Stevens, Jr., M.D., and William L. Toffler, M.D., noted in 2008 in *The Oregonian* that many states do better than Oregon [17]. For example, the latest data rank Oregon ninth (not first) in Medicare-age use of hospice; four of the top five are states that have criminalized assisted suicide. Stevens is professor emeritus and former chairman of radiation oncology at Oregon Health & Science University (OHSU) and vice-president, Physicians for Compassionate Care Education Foundation (PCCEF). Toffler is professor of family medicine at OHSU and the national director of PCCEF.

Washington's law follows the Oregon model, the discussion that follows focuses largely on Oregon because assisted suicide has been legal in Washington for less than a year.

The myth of Oregon's effective safeguards claims that the law ensures that patients are competent to make the decision to end their lives, limits assisted suicide to people who are terminally ill, ensures that each request is voluntary, requires that a second opinion be obtained, requires a 15-day waiting period, and requires physicians to inform the state of any lethal prescriptions they write. The safeguards myth further purports that physicians must present patients with the option for palliative care [3]. However, each and every one of these reportedly strong rules is either fundamentally flawed or has been rendered an empty ritual.

Exploring the practice of assisted suicide in Oregon is a means to examine the significant problems with the legalization of assisted suicide. These problems include the myth of free choice and self-determination, the fundamental loophole of terminal illness prognosis, the safeguards in name only, the danger to people with depression and psychiatric disabilities, Oregon's minimal data and fatally flawed oversight, and the questionable circumstances of Oregon deaths.

The myth of free choice and self-determination

Assisted suicide proponents frequently appeal to free choice and self-determination. But in reality, legalized assisted suicide actually diminishes individual choice and control.

Margaret Dore, an elder law specialist, has shown how the Oregon and Washington State assisted suicide laws dramatically undermine patient control:

During the [Washington assisted suicide campaign], proponents touted [assisted suicide] as providing "choice" for end-of-life decisions. A glossy brochure declared, "Only the patient—and no one else—may administer the [lethal dose]." The Act, however, does not say this—anywhere. The Act also contains coercive provisions. . . . It allows an heir who will benefit from the patient's death to help the patient sign up for the lethal dose. . . . [It] also allows someone else to talk for the patient during the lethal-dose request process, for example, the patient's heir. This . . . invites coercion.

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons. Indeed, no one is required to be present. The Act does not state that "only" the patient may administer the lethal dose; it provides that the patient "self-administer" the dose. . . . Someone else putting the lethal dose in the patient's mouth qualifies as "self-administration." Someone else putting the lethal dose in a feeding tube or IV nutrition bag also would qualify. . . . Someone

could use an alternate method, such as suffocation. Even if the patient struggled, who would know? The lethal dose request would provide an alibi. . .

By signing the form, the client is taking an official position that if he dies suddenly, no questions should be asked. The client will be unprotected . . . in the event he changes his mind after the lethal prescription is filled and decides that he wants to live [22].

Moreover, there is danger that many people would choose assisted suicide due to external pressure. Elderly individuals who do not want to be a financial or caretaking burden on their families might take this escape. In fact, the percentage of reported Oregon cases attributed to patients' reluctance to burden their families has risen shockingly. It totaled 12% in 1998, but increased to 26% in 1999, then 42% in 2005, and 45% in 2007 [23–26]. Nothing in the Oregon law will protect patients when family pressures, whether financial or emotional, distort patient choice.

Also troubling is widespread elder abuse in the United States. The perpetrators are often family members.¹⁰ Such abuse could easily lead to pressures to "choose" assisted suicide.

Still others may undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. A case in point, Oregon resident Kate Cheney (discussed later) was apparently motivated to take her life by fear of the nursing home where she had just spent an unhappy week. The Oregon law has no "requirement that sufficient home and community-based long-term care services be provided to relieve the demands on family members and ease the individual's feelings of being a 'burden'" [10].

While the proponents of legalization argue that it would guarantee choice, assisted suicide would actually result in deaths due to a *lack* of choice. Real choice would require adequate home and community-based long-term care, universal health insurance, and housing that is available, accessible, and affordable—a full range of social supports largely unavailable today. In a perverse twist, widespread acceptance of assisted suicide could *reduce* pressure on society to provide these very services, thus reducing genuine options further.

The fundamental loophole of terminal illness prognosis

The Oregon and Washington laws are based on the faulty assumption that it is possible to make a clear

¹⁰ The National Elder Abuse Incidence Study (NEAIS) was conducted by the National Center on Elder Abuse at the American Public Human Services Association. It showed that, in 1996, 450,000 elders aged 60 and over were abused, according to a study of observed cases. In almost 90% of the elder abuse and neglect incidents with a known perpetrator, the perpetrator was a family member, and two-thirds of the perpetrators were adult children or spouses [27].

distinction between those who are terminally ill with 6 months to live and everyone else. Everyone else is supposedly protected and not eligible for assisted suicide.

But it is extremely common for medical prognoses of a short life expectancy to be wrong. Studies indicate that only cancer patients show a predictable decline, and even then, it is only in the last few weeks of life. With every disease other than cancer, prediction is unreliable [28-31].¹¹ Prognoses are based on statistical averages, which are nearly useless in determining what will happen to an individual patient. Thus, the potential reach of assisted suicide is extremely broad and could include many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead.

This poses considerable danger to people with new or progressive disabilities or diseases, who may often be misdiagnosed as terminally ill but who, in many cases, outlive these prognoses by years or even decades. People with new disabilities frequently go through initial despondency and suicidal feelings but later adapt well and find great satisfaction in their lives [33-39]. However, the adaptation usually takes longer than the mere 15-day waiting period required by the Oregon and Washington assisted suicide laws. People with diagnoses of terminal illness appear to go through similar stages [14]. In that early period before one learns the truth about how good one's quality of life can be, it would be all too easy, if assisted suicide is legal, to make an irrevocable choice.¹²

Safeguards in name only

Doctor shopping: all roads lead to Rome

There are many other significant weaknesses in Oregon's safeguards. For example, physicians are not permitted

¹¹ "17% of patients [outlived their prognosis] in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13% of hospice patients around the country outlived their six-month prognoses. . . . When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70% of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*" [32].

¹² Dr. Richard Radtke, a well-known retired academic oceanographer in Hawaii, provides one such example [40]. Dr. Radtke has had a very disabling form of muscular sclerosis for over 25 years. In the period after his diagnosis, physicians often classified him as terminally ill. He experienced severe depression for 2 years. Had assisted suicide been legal, he acknowledges that he would have chosen it and died long ago. Today, still with an extremely limiting disability, he has retired from a successful academic career, is a happily married father, remains the president of a charitable foundation, and is grateful for the length and varied experiences of his life. How many such individuals is our society prepared to sacrifice as the collateral damage from the legalization of assisted suicide?

to write a lethal prescription under a set of inappropriate conditions defined in the law, such as when a patient is incompetent or when a request is involuntary. But in many instances, patients have engaged in "doctor shopping," which can circumvent these supposed protections. When the first physician a patient approached refused to comply with the request for lethal drugs, possibly because the patient did not meet the conditions of the law, the patient sought out a second physician, and in some cases, a third and fourth, until someone finally agreed. In fact, in the first three years assisted suicide was legal in Oregon, patients had to ask at least two physicians before receiving lethal drugs in 59% of cases; with the fourth year, officials dropped these disturbing data from the annual reports [41].

To understand how easily the approval-by-two-physicians "safeguard" can also be circumvented, it is important to know that the lead organization advocating for assisted suicide, Compassion & Choices, facilitates most of Oregon's reported assisted suicides, often by referring individuals to assisted-suicide-friendly physicians. In addition, the organization's officers "are the authors [of the law] . . . and [are its] self-proclaim[ed] . . . stewards . . .," as Kenneth R. Stevens, Jr., M.D., reports. Stevens is professor emeritus and former chairman of radiation oncology at Oregon Health & Science University, and vice-president, Physicians for Compassionate Care Education Foundation [42]. Dr. Peter Goodwin, Compassion & Choices former medical director, said that about 75% of reported Oregon assisted suicide deaths through 2002 did so with the organization's assistance [43]. In one example year, during 2003, the group was involved in 79% of these deaths [44]. According to Dr. Elizabeth Goy of Oregon Health & Science University, Compassion in Dying (since renamed Compassion & Choices) saw "almost 90% of requesting Oregonians. . ." [45].¹³ And "in 2008 the proportion of C&C PAS deaths significantly increased to 88% (53/60) of all [OPHD] reported deaths" [42].

The first person reported to die under Oregon law, whose name was not revealed, represents an example of doctor shopping. Her physician and a second physician refused her a lethal prescription. The latter diagnosed her as "depressed." Nonetheless, a physician affiliated with Compassion in Dying wrote the prescription after knowing her only briefly [46].

Another example is Kate Cheney, an 85-year-old woman [47]. She saw two physicians. Her daughter thought the first physician was "dismissive" and requested another opinion.

¹³ Dr. Elizabeth Goy testified before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill. In 2004, members of the British House of Lords traveled to Oregon seeking information regarding Oregon's assisted suicide law for use in their deliberations about a similar proposal that was under consideration in Parliament. They held closed-door hearings on December 9 and 10, 2004, and published the proceedings on April 4, 2005.

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 then 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.

Alternatives: presented but not provided

In the Oregon law, physicians are required to present alternatives to assisted suicide as another safeguard. However, there is no requirement that these alternatives actually be made available to patients, or even that the professional who discusses them fully understands them. Kate Cheney’s case exemplifies this. Further, her case demonstrates the shocking laxness with which safeguards in Oregon are followed. Cheney decided to take the lethal drugs immediately after spending a week in a nursing home to give her family a break from caregiving. The chronology shows that Cheney felt she had only three choices: burdening her family, the hell of a nursing home, or death [10].

After reading about Kate Cheney, Diane Coleman, president and founder of Not Dead Yet, a grassroots disability organization opposed to legalizing assisted suicide, sent a letter to Dr. Robert Richardson, who authorized Cheney’s request for lethal drugs. It stated, in part:

As a long-term care advocate, I have heard for years of Oregon’s claim to operate the most progressive long-term care programs in the country, model programs that emphasize in-home and community-based services, even for the most frail elderly. What in-home services was Ms. Cheney receiving? How is it that Ms. Cheney had to spend a week in a nursing home to give her family respite from caregiving? Did Ms. Cheney and her family know of other respite options? If not, who failed to tell them? How can their actions have been based on the informed consent promised in Oregon’s law? Or did the family choose the nursing home respite option with the knowledge of other alternatives (an even more disturbing possibility)? . . .

There are many ways to resolve the feeling of being a burden on family, and the family’s feelings of being burdened. In what depth were these issues explored? In this context, family relationships are complex, and the emotional dynamics could not realistically be uncovered in a brief consultation [10].

Dr. Richardson did not reply.

Good faith: a safeguard for physicians, not patients

There is one foolproof safeguard in the Oregon and Washington laws. Unfortunately, it is for physicians and other health care providers rather than for patients—the good faith standard. This provision holds that no person will be subject to any form of legal liability, whether civil or criminal, if they act in good faith [48]. However, a claim of a good faith effort to meet the requirements of the law is virtually impossible to disprove. As a result, this provision renders all other alleged safeguards effectively unenforceable.

Even more alarming, for all other medical procedures, physicians are liable under a much stronger legal standard, that of negligence. Yet even negligent practitioners of assisted suicide will not be found to have violated the law as long as they practice in good faith. In an ironic twist, assisted suicide physicians are safer from liability if they cause a patient’s death than if they provide his or her medical treatment.

Herbert Hendin, M.D., and Kathleen Foley, M.D., suicide prevention and end-of-life care experts, offered this analysis.¹⁴

[T]he physician is immunized from civil and criminal liability for actions taken in “good faith” in assisting a suicide . . . even when the physician acts negligently.

Good faith is a troublesome, subjective standard. . . . In professional practices a negligence standard based on objective, established medical guidelines is customary. If the intent of the assisted suicide law is to protect physicians from accountability for violating the statute’s provision, the good faith standard is ideal. But if the intent of the law is to provide protection for patients, a negligence standard would be more appropriate [3].

The danger to people with depression and psychiatric disabilities

Depression and the wish to die

The drive to legalize assisted suicide comes from anecdotes of painful, uncomfortable deaths. Yet available data show that when assisted suicide is legal, those who use it are not typically acting based on

¹⁴ Herbert Hendin is chief executive officer and medical director, Suicide Prevention International and professor of psychiatry, New York Medical College. Kathleen Foley is Attending Neurologist, Memorial Sloan-Kettering Cancer Center; professor of neurology, neuroscience, and clinical pharmacology, Weill Medical College of Cornell University; and medical director, International Palliative Care Initiative of the Open Society Institute.

current pain or other discomfort. As H. Rex Greene, M.D., explained:

Demoralization Syndrome . . . is very common in chronic, . . . life threatening illness, the features of which (hopelessness, helplessness, and despair) fit the profile of the victims of Oregon’s law, who are consistently reported NOT to be in pain or disabled by their allegedly terminal illness but request [assisted suicide] because of fears of . . . the future: helplessness, dependency, becoming a burden. Oregon in fact has proven that the only symptom driving requests for [assisted suicide] is psychological distress. Clearly the standard of care for depression and demoralization is not a lethal overdose of barbiturates [49].

Greene further noted:

The wish for death is a “cry for help,” a reliable sign of depression. How absurd that it would be met with a lethal prescription . . . Advances in palliative medicine have made it possible to relieve . . . symptoms in virtually all dying patients. . . . [49].

Other research supports Greene’s conclusion that most patients requesting death do so not based on physical symptoms such as pain but rather based on depression and other forms of psychological distress.¹⁵

¹⁵ The two professional associations representing oncologists in California wrote:

It is critical to recognize that, contrary to belief, most patients requesting physician-assisted suicide or euthanasia do *not* do so because of physical symptoms such as pain or nausea. Rather, depression, psychological distress, and fear of loss of control are identified as the key end of life issues. This has been borne out in numerous studies and reports. For example, . . . a survey of 100 terminally ill cancer patients in a palliative care program in Edmonton, Canada, . . . showed no correlation between physical symptoms of pain, nausea, or loss of appetite and the patient’s expressed desire or support for euthanasia/PAS. Moreover, in the same study, patients demonstrating suicidal ideation were much more likely to be suffering from depression or anxiety, but not somatic symptoms such as pain.

An important study from the Netherlands of a cohort of 138 cancer patients with a life expectancy of 3 months or less demonstrated similar findings. In this study, the authors had hypothesized that patients requesting euthanasia would be unlikely to have depressed mood or affect, since it would be expected that such a request would be a well-thought-out decision, particularly since euthanasia has been legal in the Netherlands since 2002. The authors expected that these patients would be more accepting of their terminal diagnosis and therefore better adjusted. What they found surprised them—depressed patients were more than 4 times as likely to request euthanasia as were patients who were not depressed. Over 40% of depressed patients requested euthanasia. Of those who requested euthanasia, about half were depressed [19].

Ignoring what lies beneath: the abandonment of the patient

Addressing the situation of the individual patient, Hendin stated in congressional testimony:

A request for assisted suicide is . . . usually made with as much ambivalence as are most suicide attempts. If the physician does not recognize that ambivalence as well as the anxiety and depression that underlie the patient’s request for death, the patient may become trapped by that request and die in a state of unrecognized terror [50].

As Hendin and Foley also pointed out, when patients requesting a physician’s assistance to die “are treated by a physician who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears” [3].¹⁶ Yet primary care physicians are generally not experts in diagnosing depression. Where assisted suicide is legal, the depression remains undiagnosed, and the only treatment consists of a lethal prescription.

N. Gregory Hamilton, M.D., distinguished fellow of the American Psychiatric Association and co-founder of Physicians for Compassionate Care, has demonstrated how Oregon’s flimsy safeguards do not protect people with psychiatric and other mental health disabilities. In his 2004 testimony to a British delegation considering a law similar to Oregon’s, Hamilton documented the case of Michael Freeland, a man with “a long history of serious depression and previous suicide attempts” who nonetheless received lethal drugs under the Oregon law [52,45]. A recent study confirmed that that some of the reported Oregon cases were patients who were, in fact, depressed [53].

People with depression can receive lethal drugs in Oregon and Washington legally, because they are still technically eligible as long as they are deemed legally competent, that is, “competent and not suffering from a psychiatric or psychological disorder or depression *causing impaired judgment*” [emphasis added] [54,55]. Yet the notion that patients with depression may be considered legally competent to decide to end their lives, merely because the depression does not impair their legal competency—Orwellian at best—is also at variance with the majority of clinical and forensic psychiatrists who believe “that the presence of major depressive disorder should result in an automatic finding of incompetence” to make decisions about assisted suicide [56]. And as Hendin and Foley pointed out, “Reducing the psychiatric consultation to the issue of competency ignores all the

¹⁶ Also: “Contrary to much popular and professional opinion, depression is a treatable condition, even in patients who are terminally ill” [51].

other psychological factors that go into the request for assisted suicide” [3].

One visit, rarely: the impact on the individual

Regarding the supposed safeguard of psychiatric evaluations, the following example indicates how psychological evaluations are misused in Oregon.

In discussing Joan Lucas, an Oregon woman whose evaluating psychologist decided she was competent “on the basis of a single questionnaire administered by her family,” Hendin and Foley explained that when a psychiatric evaluation occurs, it tends to be used to protect clinicians rather than patients:

[The Oregon Public Health Division’s] monitoring procedures do not make it possible for OPHD to evaluate the care Joan Lucas received. To do so OPHD would have to interview Joan’s primary care physician who had refused to assist in her suicide and to assess the quality of her psychological evaluation. Using psychologists or psychiatrists as gatekeepers only to establish a patient’s capacity to make a decision for assisted suicide contributes to *pro forma*, meaningless consultations.

In the Lucas case, we have no way of knowing if Joan Lucas was seriously depressed or if the physician or psychologist was disposed to proceed even if she were. Even more troubling is that OPHD does not seem to want to know about the psychiatric status of patients requesting assisted suicide. Under the current monitoring system, OPHD collects no information from psychiatrists who did not find patients to be competent and has no direct communication with psychiatrists or psychologists who did. Its monitoring reflects a lack of concern with the welfare of depressed patients [3].

Moreover, the Oregon and Washington laws do not require psychiatric evaluations except when physicians determine a patient’s judgment is impaired. This determination is rarely made. Psychiatric evaluation of individuals who are reported to die from assisted suicide dropped from 31% in 1998 to a mere 5% in 2003–2004 [57–59]. In the 2007 Oregon report, *no* Oregon patients underwent a psychiatric evaluation [60,61]. And “over the [following] two years in Oregon, less than 2% of patients committing assisted suicide were referred for psychiatric evaluation” [62].

However, even when it occurs, the psychiatric evaluation is often unreliable or insufficient. Only 6% of Oregon psychiatrists are confident they can diagnose depression after one visit [63], yet the Oregon and Washington definitions of a psychiatric consultation permit one visit only [54,55]. Moreover, as N. Gregory Hamilton, M.D., pointed out, physicians who support

assisted suicide will refer patients to psychiatrists or psychologists who agree with that view, and “the evaluations tend to be *pro forma*,” or else alternative opinions that favor assisted suicide are found, providing no protection for people with depression and psychiatric disabilities [52].

Hendin and Foley illustrated what can happen when effective psychiatric consultation is not provided, in this Oregon example showing how assisted suicide undermines standards of care. A woman in her mid-50s with heart disease, but otherwise with no significant pain or mobility limitations, requested a lethal prescription from her cardiologist. The cardiologist, in turn, referred her to another physician who was willing to write lethal prescriptions. This physician determined she was not terminally ill. But rather than ask about the origins of her suicidal wishes and give her a psychiatric referral, the physician simply told her to see her cardiologist again. Her cry for help unanswered, she committed suicide the following day [3].

Minimal data and fatally flawed oversight

The State of Oregon’s minimal data collection and gross lack of strong oversight of assisted suicide undermine any pretense of rigorous monitoring or strict regulation. A series of problems renders any conclusions based on the data to be critically flawed. Washington’s law contains similarly limited, deeply flawed provisions.

Oregon’s annual reports tell us very little. In reality, we do not know what is happening under the Oregon law due to these problems:

1. **The reporting requirement lacks teeth.** On paper, the law requires physicians to report all lethal drug prescriptions, but sets no penalties if physicians fail to report. Thus, this requirement is not enforced [3].
2. **Noncompliance is not monitored.** The law requires annual statistical reports from the Oregon Public Health Division (OPHD), but OPHD does not monitor underreporting, noncompliance, or violations. Many of Oregon’s reports acknowledge that the state cannot confirm compliance with the law. For example, OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside the law’s framework, stating “[W]e cannot detect or collect data on issues of noncompliance with any accuracy” [24,64].
3. **Important questions go unasked.** Most information in OPHD reports comes from physicians who wrote lethal prescriptions [60,65,66]. However, OPHD does not gather information from important parties other than prescribing physicians—for example, not asking why physicians refused to assist patients in suicide. Physicians who said “no” may have concluded that a patient did not meet legal requirements—essential

information if one truly intends to evaluate the law's outcomes. Nor does OPHD interview family members, friends, nurses, or social workers to learn about the physical and emotional status of those who died, and it does not collect any information from patients prior to their deaths [3,60]. Without these data, no one can know how many requests for assisted suicide are made, why some physicians declined while others agreed, and what transpired in individual cases [3].

4. **There is no investigation of abuse.** The state has no resources or even authority to investigate violations, cases of expansion, and complications reported in the media or documented by others.¹⁷ There is no method for the public to report abuse.

The Oregon Department of Human Services (DHS, of which OPHD is a part) acknowledged in a press release that DHS “has no authority to investigate individual Death with Dignity cases. . .” [67]. As Kenneth R. Stevens, Jr., M.D., added in a July 10, 2009, letter, DHS further lacks the time and desire to investigate. As the years go by, it makes public less and less information.

5. **Secrecy pervades the operation of assisted suicide.** There is an unnecessarily high level of secrecy about assisted suicide that undermines the public's right to know, as well as any independent, in-depth research. Oregon's law states “the information collected [for the annual reports] shall not be a public record and may not be made available for inspection by the public” (Or. Rev. Stat. § 127.860 3.11.2). Moreover, as Hendin and Foley explained, the statute includes “no provision for an independent researcher or evaluator to study whatever data are available,” and the lack of available data violates medical standards that “require openness about facts, research data, and records to assess the appropriateness of treatment” [3].

The level of secrecy is even more draconian in Washington. An article by John Ruhl, president of the King County (Seattle) Bar Association in 2006, and

William Watts, M.D., president of the King County Medical Society in 2007, discussed the Washington law's extraordinary requirement that on the death certificate, a patient's underlying disease must be listed as the cause of death—even if he or she died from lethal drugs at a time when that disease manifested no symptoms [68].

6. **The underlying data are destroyed annually.** Alarming, officials have acknowledged that OPHD destroys each year's records after it issues the report [69].

Assisted suicide is practiced in secret and without genuine oversight. In this lax context, the examples that come to light in the media and through other means are likely to be only the tip of the iceberg. These problems, in aggregate, belie any allegation by assisted suicide's backers that it is safely regulated.

In a final blow to transparency, rather than correcting any of these fundamental limitations, OPHD responded to pressure from pro-assisted suicide advocates not to use the term “assisted suicide.” OPHD had used this term each year on its website and in its annual reports. But Compassion & Choices, based on polling data that public support for assisted suicide decreases if the word “suicide” appears, successfully pressured OPHD in 2006 to switch to more nebulous terms such as “persons who use the Oregon Death with Dignity Act” [70].

The questionable circumstances of Oregon deaths

Another troubling aspect of how assisted suicide is practiced in Oregon is that there is no monitoring or control once the prescription for lethal drugs is written. Physicians are not required to be present when the drugs are taken. In 2005, for example, physicians were present a mere 23% of the time [19]. No one knows what happens to lethal agents that are not used by patients who originally request them, though Oregon's reports make it clear that some patients died of other causes [71]. The drugs could be stored over time in private homes or workplaces, with no oversight to protect public safety.

As if to underscore this point, Dr. Katrina Hedberg, a lead author of most of Oregon's official reports, testified in 2004:

Our job is to make sure that all the steps happened up to the point the prescription was written. . . . We do not have a way to track if there was a big bottle [of lethal drugs] sitting in somebody's medicine cabinet and they died whether or not somebody else chose to use it [69].

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 &

¹⁷ Although OPHD has no investigative authority, assisted suicide's defenders have occasionally responded to this critique by pointing out that the annual reports detail 20 referrals made to the Oregon Board of Medicine and 1 referral to the Board of Pharmacy. But no reports suggest that any disciplinary action was ever taken. Such referrals are made when physician-completed questionnaires or interviews involve minor paperwork irregularities such as “incorrectly completed report forms” or “an incomplete written consent.” Yet even these referrals do not constitute a meaningful investigation or a true safeguard, as they depend entirely on self-reporting, they address very minor irregularities, and there has not been disciplinary action. Oregon's second report acknowledges this problem, noting, “Under reporting and non-compliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division” [25].

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” [72]. 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 [assisted suicide]” [73]. Moreover, Oregon’s 2008 *The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals* states, “The Oregon [law] does not provide guidance on the degree of assistance with self-administration that may be given by another person” [61]. According to Sue Davidson of the Oregon Nurses Association, a 2002 survey found that nurses are very actively involved in the process and that “some indicated that they had assisted [patients] in the taking of [the lethal dose]” [45].

There is at least one documented example in Oregon in which assistance by others in the dying process has been acknowledged. Discussing a case in which a man said he helped his brother-in-law take the prescribed drugs, Dr. Katrina Hedberg said, “[W]e 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” [69].

Supporters of the Oregon law allege that assisted suicide is totally voluntary by virtue of the fact that the individual alone must actually ingest the lethal agents, and do so quickly, before the drugs’ effects stall the process. Yet, again contrary to the impressions created by assisted suicide supporters, the lethal drugs are not at all simple to take quickly.

As Kenneth R. Stevens, Jr., M.D., explained in conversations on July 8 and August 6, 2009, assisted suicides in Oregon have generally used one of two agents, secobarbital or pentobarbital (Nembutal). Use of secobarbital, a powder, requires a person to take the contents of 90 to 100 large capsules. These capsules cannot feasibly be swallowed, because the individual would fall asleep before ingesting enough to achieve the intended purpose. So the capsules must be emptied into applesauce or pudding, which cannot disguise the very strong and exceptionally bitter, distasteful flavor. Taking a substance to numb the mouth is not necessarily a good way to make the drug more palatable, because it could interfere with swallowing. The other agent, pentobarbital, is only available as an injectable liquid. Four bottles, or approximately 7 ounces of liquid, must be taken to reach the needed dose of 10 grams, and this potion is also exceptionally distasteful.

In at least one known Oregon case, a feeding tube was used.¹⁸ Since the lethal agent can be administered to

¹⁸ On March 11, 2007, a *Los Angeles Times* story described David Bradley, a man with esophageal cancer, who moved to Oregon from New Mexico, and underwent assisted suicide in summer 2005 [74]. The lethal substance was poured into his feeding tube.

a willing person through a feeding tube, it is equally possible to administer it to an unwilling person by the same means. Moreover, once the injectable pentobarbital leaves the pharmacy, there is absolutely nothing to prevent it from being used through an intravenous 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.

This slide away from self-administration is a cause of considerable concern to the disability community, which has known a long history of involuntary euthanasia at the hands of others, whether governments, medical establishments, or families [75-77]. With no controls on the drug after the prescription is filled, and with the possibility of administration through a nasogastric tube or gastrostomy feeding tube, or even through injection by third parties—⊕ how does this scheme protect vulnerable people from abuse, particularly at home?

The official data are ominous. H. Rex Greene, M.D., noted in a March 11, 2009, letter that the Oregon data consistently report 5-minute deaths—and only one victim has survived. He explained that nobody dies within 5 minutes—or even 20 minutes—following oral ingestion of a lethal dose of barbiturates. “About 15% of the Dutch overdoses survive and need to be euthanized,” Greene concluded. “If true, the Oregon numbers suggest they are asphyxiating the patients . . . in violation of the Oregon law.”¹⁹

So-called “narrow” proposals can easily expand

Most supporters claim that assisted suicide will be narrowly limited to people with terminal illness, but these so-called “narrow” proposals, if enacted, can easily expand. As the New York State Task Force on Life and the Law wrote, “Individuals who are not [able to make the choice for themselves], who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of assisted suicide, and no principled basis will exist to deny [it]” [78].

The example of the Netherlands demonstrates clearly that assisted suicide cannot be limited to a small, targeted group once Pandora’s box is open. Although it remained technically illegal until 2002, the Netherlands first began to legally tolerate assisted suicide in the early 1970s,

¹⁹ Other physicians specializing in end-of-life care have also questioned the circumstances of Oregon deaths [19]. Doctors at Physicians for Compassionate Care wrote [62], “The range of time between ingestion and death ranged from 2 minutes to 25 hours. Both of those times are problematic. It is very unlikely that someone would die within 2 minutes of taking an overdose of sleeping medication. Likewise, the major effect of the short-acting sleeping medication would have worn off by 25 hours. So what was the cause of death in these circumstances?”

providing the longest experience with assisted suicide in any country [79–83].²⁰ Today, active euthanasia—physicians giving lethal injections—has almost completely replaced assisted suicide [84].²¹

Frighteningly, assisted suicide and euthanasia have become not the rare exception but the rule for people with terminal illness in the Netherlands. As Herbert Hendin, M.D., explained in congressional testimony, Dutch policies have gradually expanded from assisted suicide to euthanasia for the terminally ill; to euthanasia for the chronically ill; to euthanasia for “psychological distress”; and from voluntary euthanasia to involuntary euthanasia, which “has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves” [50].

Government-sanctioned studies suggest an erosion of medical standards in the care of terminally ill patients in the Netherlands: 50% of Dutch cases of assisted suicide and euthanasia are not reported, more than 50% of Dutch physicians feel free to suggest euthanasia to their patients, and 25% of these physicians admit to ending patients’ lives

without their consent (more than 1000 people each year) [85,86].²²

U.S. assisted suicide advocates, attempting to distinguish the Oregon experience from that of the Netherlands, argue that the numbers of reported users of assisted suicide in Oregon are low. But in fact, the number of people requesting lethal drugs has steadily increased (see Table 1). In the beginning, the numbers were low in the Netherlands as well, but use grew along with social acceptance of the practice, which could happen in the United States.²³

Some of assisted suicide’s supporters, like former Washington governor Booth Gardner, are open about their expansive goals. Gardner hopes his state’s assisted suicide legislation will pave the way for a broader cultural shift and “laws with more latitude” [89]. Thus, the danger of expansion is another reason why it is important to maintain the legal barriers prohibiting assisted suicide.

In light of expansion and other dangers, leading disability rights organizations and advocates in the United States and in many countries, as well as health care providers and many others, will continue to oppose the legalization of assisted suicide and euthanasia. Instead of legalization, we will call for adequate home and community-based long-term care, universal health coverage, and a range of social supports that provide true self-determination for everyone. As Paul Longmore wrote, “Given the absence of any real choice, death by assisted suicide becomes not an act of personal autonomy, but an act of desperation. It is fictional freedom; it is phony autonomy” [8].

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²⁰ Both euthanasia and assisted suicide have been widely practiced in the Netherlands since 1973, although they were against the law until 2002. The Dutch situation between 1973 and 2002 was an outgrowth of a series of court decisions and medical association guidelines, beginning with a 1973 District Court case in which Geertruida Postma, a Dutch physician, was convicted of the crime of euthanasia after she ended the life of her seriously ill mother (*Nederlandse Jurisprudentie* 1973, No. 183, District Court of Leeuwarden, 21, February 21, 1973). Her admission that she had given her mother a lethal injection seemed calculated to force public and legal reconsideration of the laws against assisted suicide and euthanasia. While finding Dr. Postma guilty of the crime of mercy killing that was punishable by imprisonment for a maximum of 12 years, the court imposed a 1-week suspended sentence and 1 week’s probation. The Dutch court relied heavily on expert testimony by the district’s medical inspector who set forth certain conditions “under which the average physician thought euthanasia should be considered acceptable.” Inclusion of those conditions formed the basis for subsequent acceptance of euthanasia and assisted suicide in the Netherlands. The guidelines required that the patient must be considered incurable and experiencing subjectively unbearable suffering; the request for termination of life should be in writing; and there should be adequate consultation with other physicians before death could be induced [80]. Other cases followed, each widening the boundaries and further liberalizing the conditions under which euthanasia and assisted suicide, although remaining illegal, would not be punished. Among the cases was the *Alkmaar* case (*Nederlandse Jurisprudentie* 1985, No. 106) in which a woman died after requesting death because “her advancing age and physical condition caused her to be dependent on others, thus leading to psychological suffering.” The case gave rise to the 1986 decision by the Hague Court of Appeals that recognized “psychic suffering” and “potential disfigurement of personality” as grounds for induced death. The courts have also exonerated physicians who assisted in the suicides of a young woman with anorexia nervosa (Amelo, *Tijdschrift voor Gezondheidsrecht*, 1992, No. 19) and a woman who was depressed over the death of her two children and the failure of her marriage (Assen, *Nederlandse Jurisprudentie* 1994, No. 656).

²¹ “Doctors had reported that a total of 2,146 people were euthanised and 152 died in assisted suicides in 2008, while in 33 cases there was a combination of the two practices” [84].

²² Hendin wrote, “The most alarming concern has been the documentation of several thousand cases a year in which patients who have not given their consent have their lives ended by physicians. A quarter of physicians stated that they ‘terminated the lives of patients without an explicit request’ from the patient. Another third of the physicians could conceive of doing so.”

²³ Once assisted suicide is legal, problems with the ingestion of lethal drugs may create pressure for the legalization of euthanasia. Assisted suicide proponents and medical personnel alike have established that taking lethal drugs by mouth is often ineffective in causing a quick, simple death. The body expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly. Such ineffective suicide attempts happen in a substantial percentage of cases—estimates range from 15% to 25% [87,88]. The way to prevent these “problems,” in the view of euthanasia advocates, is by legalizing lethal injections. They could also increase underground euthanasia in the guise of assisted suicide.

Table 1

Eleven-year Breakdown of Reported Requests for Lethal Prescriptions and Reported Assisted Suicide Deaths from Oregon's Annual Reports

Year	Reported Lethal Prescription Recipients	Reported Deaths after Lethal Medication Administration*	Reported Deaths from Underlying Terminal Illness	Reported Alive at Year's End
1 (1998)	24	16	6	2
2 (1999)	33	27	5	2
3 (2000)	39	27	8	5
4 (2001)	44	21	14	11
5 (2002)	58	38	16	6
6 (2003)	67	42	18	10
7 (2004)	60	37	13	12
8 (2005)	64	38	15	17
9 (2006)	65	46	19	11
10 (2007)	85	49	26	13
11 (2008)	88	60	22	12

Total reported lethal prescription recipients: 627.

Total reported deaths after lethal medication administration: 401.

Total reported deaths from terminal illness within 1 year of receiving prescription: 162.

Total reported alive within year of receiving prescription: 101.

* Annual reports note that death total includes patients who received prescriptions in previous years.

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