

## INTRODUCTION

Good morning, Members of the Public Health Committee. Thank you for the opportunity to present my opposition to Proposed Bill No. 48 “An Act concerning Physician Assisted Suicide.”

My name is Lisa Honkanen, M.D. I am a physician of Geriatric Medicine from the State of New York, with an active practice caring for the frailest old in a house call model for homebound patients. All my patients are facing the end of life, although we do not know how near that end is. I am here today to explain from a medical doctor’s perspective why you should not support this bill or any measures that promote physician assisted suicide.

Physician assisted suicide (PAS) or the euphemistic term “aid in dying” used by its supporters to soften the unpalatable truth of the former term, is defined by the American Medical Association (AMA), as that in which “[a] physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g. , the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.)”<sup>1</sup> It should be noted that some understand this to mean merely that the patient swallows the pills, thereby effecting his suicide, even if the pills are administered by another person.<sup>2</sup>

The Declaration of Independence tells us that we are endowed by our Creator with certain unalienable rights, including the right to Life. It is true that we have an unavoidable expectation that we will die, but not a right to plan and execute the taking of a life through either homicide or suicide. In fact in 1997, the Supreme Court rejected the claim that there is a constitutional right to assisted suicide and cautioned about the prospect of unintended and unwanted consequences that might ensue from the recognition of a Constitutional right to assisted suicide.<sup>3</sup> Furthermore, the AMA, supported by the American College of Physicians, opposes PAS because it contradicts the fundamental tenet of the medical profession: “Primum nocere.” First do no harm. The traditional Hippocratic Oath declares, “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” **The AMA further states “permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult to control, and would pose serious societal risks.”**<sup>1</sup>

We should remember, too, that words have meaning. The Death with Dignity Act, as it is called in Oregon, and any policy that endorses physician assisted suicide, is strongly promoted by Compassion and Choices, a euthanasia advocacy group. I would like to bring attention to the root of the word “compassion” which is to “suffer with” – to walk the journey with him who suffers. It is *never* an acceptable choice to end the suffering by ending the sufferer. It is the ultimate abandonment to assist in causing the death of another, even if guided by a false sense of altruism. It *should not* become a physician’s duty to do so because it profanes the art of medicine. It *cannot* become a physician’s duty without grave consequences to patients and society. PAS is not compassion and its legalization takes away choice. PAS does not embrace dignity -- it undermines it.

We live in a time and place where evidence-based medicine is considered the “gold standard” – using the facts, the data, based on clinical experience, to make decisions. Rather than debate on heart-wrenching anecdotes, because both sides can do that to great emotional effect, let us look at what physician assisted suicide is, what it does, and how its legalization leads to abuses. Even President Obama instructed: “Part of what we want to do is to make sure that those decisions are being made by doctors and medical experts based on evidence.....”<sup>4</sup>

So what is the experience of PAS and why is the evidence strongly against it?

## CAUSES FOR REQUESTS FOR PAS

First let us begin with the reasons individuals request PAS. Intractable pain is often cited as a primary and compelling motivation to desire PAS. However, Dr. Ezekiel Emanuel has published in the *Lancet* that, “Patients with pain do not seem to view euthanasia or PAS as the appropriate response to poor pain management....Indeed, oncology patients in pain may be suspicious that if euthanasia or PAS are legalized, the medical care system may not focus sufficient resources on provision of pain relief and palliative care.”<sup>5</sup> Indeed, we see in Oregon that from 1996-7 compared with 1999-2002, patients and their families reported a 50% *increase* (30.8% to 48%) in the incidence of moderate or severe pain or distress in dying patients.<sup>6</sup> Moreover, advancements in pharmacology and technology allow most physical pain to be managed quite effectively so that incapacitating or intolerable pain is very uncommon and therefore a rare motive to request PAS. Patients’ concerns that PAS directs resources away from advances in end of life care, was supported in arguments presented to the Supreme Court in 1997: at that time, The Netherlands, where PAS is legal, had only 3 hospices, but Great Britain, where PAS was illegal, had 185 hospices. When PAS is an option, there is no incentive to improve or expand alternative treatments.<sup>7</sup>

In fact, those seeking PAS more often *fear* the loss of autonomy (84%), a diminished ability to participate in enjoyable activities (84%) and becoming dependent on others (47%).<sup>8</sup> However, a disabling condition does not diminish the inherent value of one’s life, but rather environmental barriers and social prejudices reduce one’s *perceived* status. We need to fix those flawed aspects of our culture by uplifting and accompanying those who suffer, not by eliminating the burdens they are *to us*.

Dr. Leon Kass, a hospice doctor has stated, “Only because I knew that I could not and would not kill my patients was I able to enter most fully into caring for them as they lay dying.”<sup>9</sup>

## UNTREATED DEPRESSION – CREATING A DISCRIMINATED CLASS

Untreated depression in individuals described as “terminal,” leads to a discriminated class of citizens. While physical symptoms are often cited as a primary reason patients request PAS, psychosocial and existential factors appear more directly related to the desire for a controlled death.<sup>10</sup>

In one study of terminally ill cancer patients receiving aggressive palliative care, depressed patients were 4 times more likely to desire hastened death.<sup>11</sup>

We also know that in the general population, hopelessness is a better predictor of completed suicide than depression alone, but if patients are not depressed or hopeless, they do not wish for hastened death.<sup>12</sup> Is not offering the option of death by PAS a hopeless pathway for a patient who may already be feeling hopeless or depressed? Is this not a conflict of interest, an unfair inducement to consider, accept and accomplish the PAS option while in a mental state that favors an irreversible decision one might not otherwise choose? It cannot be emphasized enough that many people who request PAS withdraw that request if their depression and pain (physical or mental) are treated. We also know that as a disease or condition progresses, people acclimate and adjust – *they change their minds about what is tolerable or acceptable*.<sup>13</sup> Should we take this opportunity away from them because they fear an uncertain future -- a future which could just as easily be much greater than expected? We underestimate that human resilience when we offer PAS as a treatment “option” – it is essentially, a dead end street with no options.

One further point is the prejudice experienced by the sick and dying in Oregon. There is universal depression screening for adults in the general population, but such screening is not required for those seeking PAS even though they are at highest risk of incidence and exploitation from depression.<sup>14</sup>

Indeed, there is no requirement for a psychiatric evaluation of individuals seeking PAS, even though we know that a terminal diagnosis may lead to depression and if untreated, may be the singular reason an individual wishes a hastened death. In fact, Oregon’s guidebook states that “the presence of depression does not necessarily mean that the patient is incompetent” to make a decision about PAS. However, most clinical and forensic psychiatrists agree that “the presence of major depressive disorder should result in an automatic finding of incompetence” to make decisions about PAS.<sup>2</sup>

## **PAS INCREASES OVERALL SUICIDE RISKS – UNINTENDED CONSEQUENCES**

Introducing PAS has the unintended and undesirable consequence of increasing the incidence of suicide in the general population. Note that in Oregon, deaths from PAS are not listed as suicides on the death certificate and therefore are not reflected in suicide statistics of the general population. The World Health Organization recognizes that promotion of suicide can lead to imitative suicidal behaviors, warning against normalizing suicide or presenting it as a solution to problems.<sup>15</sup> However,

the strategy of Compassion and Choices is to normalize PAS and offer it as a solution to suffering. The ramifications, though, are not unnoticed. Since PAS took effect in Oregon, suicide has become the leading cause of injury death; it is the 2<sup>nd</sup> leading cause of death in Oregonians 15-34 years old, and the rate of suicide has been rising rapidly since 2000. In 2007, *the rate of suicide in Oregon was 35% higher than the national average* (and that excludes PAS cases).<sup>14</sup>

## A PARTIAL ENUMERATION OF ABUSES

Abuses are rampant but largely unmonitored. Drs. Hendin and Foley, experts in psychiatry and hospice palliative care, outline some of the abuses observed from the Oregon experience.<sup>16</sup> The evidence indicates that the intended safeguards delineated at the outset of legalized PAS have been circumvented to patient detriment. Let us review a few of them.

There is insufficient monitoring to ensure that when an individual requests PAS he is properly informed about alternatives or referred to those with expertise in the area with which he has unendurable suffering.

I already mentioned the omission of appropriate psychiatric screenings, but to further the example, Oregon's Public Health Division confirmed that from 1998 to 2009 only 8.4% of patients who died by PAS were referred for counseling. By 2010 and 2011, this percentage had declined to 1.5% or less – despite the knowledge that depression and other psychological factors strongly influence the desire for PAS.<sup>8</sup>

The voluntary nature of the PAS request is also unchecked. Subtle or overt coercion to “take the lethal prescription” by those with conflicts of interest in a patient's circle of caregivers are not monitored and family need not be apprised of a patient's request.

The reporting system, in order to protect physician liability, has shielded PAS in a cloud of secrecy that obscures the details necessary to ensure compliance with standards of care and regulations designed to protect patients. Dr. Katrina Hedbery of Oregon's Dept of Human Services has said, “We are not given the resources to investigate PAS cases and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves.”<sup>17</sup>

Sometimes PAS does not go as planned. In Oregon, physician presence during the suicide was previously about 20%, but more recently, the doctor is present in only 9% of cases at the time of lethal ingestion. Otherwise there is no supervision to address complications from vomiting, incorrect self-administration or resistance resulting in an unsuccessful fatality and perhaps leaving the patient worse off than before.<sup>8</sup> Maybe even more disturbing for those who draw a moral distinction between PAS and active euthanasia, one Dutch study indicates that complications from ineffective attempts at self-administration of the lethal prescription have led to active euthanasia by the physician to achieve the intended outcome.<sup>18</sup>

Admittedly, PAS saves money so it is attractive to insurance companies, a society with economic pressures, and even families facing financial difficulties. A “cheap option” like PAS may create an undue pressure to spare substantial end of life health care costs, introducing a “duty to die”.

Barbara Wagner. The most likely victims of this abuse would be the poor, uneducated, dying patients who generally pose a greater burden to their relatives.<sup>3,19-20</sup> A leading hospice physician in the Netherlands has written that “Regulation has proved to be difficult if not impossible and is fraught with danger. It also serves to stifle creativity in palliative care and even to make proper care impossible to achieve.”<sup>21</sup> Patients may think they have acquired a new right with PAS, but they don’t know that effectively, legalization of PAS provides fewer options, diminished care, compromised protections, and less transparency of standards. Is this what you want for CT?

## IS A “TERMINAL ILLNESS” TERMINAL?

We traditionally consider a “terminal” condition one in which there is an estimated six months to live, but none of us can predict what tomorrow holds. Doctors make mistakes in diagnoses, cures arise, and people “beat the odds,” but when a patient opts for PAS, the opportunity to see tomorrow’s blessings dies with him. It is unfathomable that with all these abuses documented from Oregon and Europe, that Compassion and Choices views PAS as an appealing option for a broad class of patients, beyond what we traditionally think of as “terminal.” “Terminally ill adult patient” as proposed by Compassion & Choices, and by which I suspect Bill No. 48 intends, is one “who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will in the opinion of his or her attending physician, result in death within a relatively short time.” With this definition, young people with chronic conditions such as insulin dependent diabetes could be classified as terminally ill.<sup>22</sup>

## THE SLIPPERY SLOPE

We may start with the best intentions and the most laudable goals, but human nature, economic pressures, etc. inevitably prove us to repeat history. These examples of abuses are not exceptional. They are reproducible in their own forms of legalized killing between Oregon, The Netherlands, Belgium, etc. They are inescapable.

If we stand here and claim that patient autonomy is justification for PAS, than why should it be limited to the “terminally” ill? It will not. You will recall the recent case in Belgium of twin brothers, born deaf, who learned they were going blind and feared not seeing each other again. Neither was in pain or terminally ill but on December 2012 they were killed at the hands of a physician by lethal injection.<sup>23</sup> While the mode of death is slightly different than that in PAS, i.e. they did not self-administer a lethal prescription, the case is horrifying because the guidelines to qualify are the same, and these two men would have just as easily qualified as candidates for PAS in

Oregon. In 2002, when Belgium legalized euthanasia it was intended only for terminally ill patients. Compassion and Choices has already re-defined “terminal.”

Then, too, if PAS is a good and acceptable medical treatment to end suffering whether it is terminal or not, why should it be limited to adults or only those with decision making capacity? It will not. Almost ten years after Holland set up very strict guidelines for euthanasia, over 1000 people a year were actively killed by physicians without patients’ knowledge or consent – even when the doctors thought there were other options available. In fact, 32% of deaths in Belgium were done without explicit request and sometimes, even the physician was not consulted by the nurse administering the lethal medication.<sup>17</sup>

## CONCLUSION

Our society will one day be judged by how we cared for the infirm and vulnerable among us. Setting up a system that ultimately leads to exploitation and dispensability is not an answer or a solution to unaddressed suffering. We need to focus our resources on real caring and support, suffering with our frail and dying brothers and sisters, not abandoning them with a system that uses a false sense of “dignity” to undermine their medical care and trust in humanity. PAS is wrong for patients, families, doctors and our medical system. I implore you to oppose Bill No. 48, because otherwise, one day it may be you who wishes we heeded the evidence.

Thank you for this opportunity.

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