

Dear Legislators:

As academics and social justice advocates, we oppose assisted suicide on the grounds of systemic inequality. All of us have studied and written in the field of disability studies, and have employed our scholarship in teaching, presentations at the Society of Disability Studies, and publications that identify a relationship between anti-disability discrimination (ableism), medical paternalism and assisted suicide. Indeed, some of us have written such pieces through a combination of academic training and personal experience. This combination of research and experience has determined our position that the people who will benefit from this law, are, one might argue, the 1%: people who are privileged by race, gender, sexual identity and ability status.

Our opposition is not based solely on intellectual theories, but in our practical interactions with oppressed and disempowered communities. As individuals who have experienced and studied systemic oppression, we are passionately engaged in efforts to advance social equality. In addition to our work in disability studies, queer studies, women's studies and bioethics, we have worked or volunteered in the fields of special education, end of life care, and the independent living, respectively. We have done activism on behalf of the rights of disabled people, women, people of color, and LGBT individuals; our individual activism spans from the National Gay and Lesbian Task Force, People Opposing Weightism; Transgender New Hampshire (TGNH); Philadelphia Trans Health Conference, ASAN, ADAPT, the National Women's Studies Association to Little People of America and the National Centers for Independent Living.

Our signatories span a range of generations. Like Brittany Maynard, many of us are members of the millennial generation. Since her story became public, bioethicist Arthur Caplan and Star-Ledger editor Tom Moran predicted that young adults would follow her in promoting legalization. But Caplan and Moran's speculation about millennials is undercut by the report of the prominent Pew Research Center, which found 54% of young adults opposed assisted suicide. Moreover, our research and activism has shown us that the latter is not in keeping with the basic tenets of equality that our generation was raised to protect and advance. Those of us who are Baby Boomers also consider such legislation as conflicting with the civil rights activism that characterized our generation: our generation individuals protested against the war in Vietnam because it saw the latter as a globally dominant society's violent subjugation of a globally powerless citizenry. We think you may be unaware that like the racial and women's justice movement, the disability justice movement gained significant momentum in the 1960s; when Ed Roberts successfully sued to gain accessible housing at the University of California, Berkley. This effort was pivotal in laying the groundwork for the empowerment of people with disabilities, but it did not alleviate it on a broader scale.

As those who have studied and lectured on the topic of how systemic oppression works, we view assisted suicide in light of the disabled community's cultural invisibility, which compounds social and political ignorance. We are disturbed by how Brittany Maynard's image has covered over the vast social inequalities in our society. In designing the law, legislators consider everyone, especially those people whose choices are already constrained by circumstance. The experience of autonomy that Maynard represented is simply not available to less privileged individuals.

For instance, we are concerned about how the phenomenon of medical apartheid might manifest itself in the practice of assisted suicide. While we realize that these fears are not born out in the Oregon statistics, we also note the state's lack of racial diversity, and we are concerned that Oregon's racial demographics make its statistics an inadequate indication of whether assisted suicide would exacerbate medical discrimination in other states.

Indeed, we note that Kevorkian's youngest victim, Roosevelt Dawson, was a disabled, African-American male who died in 1998, at age 21. Like Christopher Reeve, he had recently become a quadriplegic, but he did not have Reeve's access to economic privilege. In comparing media coverage of the two cases, Rosemarie Garland Thompson noted, "What makes life untenable for Dawson and life preferable for Reeve, I argue, is that the narrative emerging from Dawson's life imagined him as incurable, but Reeve, including his extensive support system and positive media image-focuses a great deal of cultural, economic and racial capital on creating an optimistic narrative of cure (Garland-Thompson, 778)." In validating suicide, society always uses discriminatory standards.

People in oppressed identity groups frequently lack access to healthcare, including pain control. Some individuals, such as those in the foster care system, do not have families to stand by them in the face of a serious illness. The same applies to those who have been abandoned by their families following the disclosure of sexual preference and identity. If such an individual were to become seriously ill, he, she or she would inevitably end up navigating their choices through a labyrinth of state bureaucracy, fiscal want, and social isolation. If doctors put a DNR on their charts without asking them, there would be no hovering loved ones to notice and inquire about their true wishes. Because such individuals are not socially conditioned to expect or demand equality, they would be less likely to know about all of the treatment options available to them. This compounds the universal problem of inaccurate diagnoses that have that potential to cut patient lives' short by months, years, or even decades.

Even if they did have this information, their choices would be constrained by whatever resources that the state is willing to put into their care. Their situations would be parallel to that of Oregon woman Barbara Wagner. They would be offered limited choices for treatment, one of which would be assisted suicide. Unlike people with a more stable background, they would not have the financial, familial or personal resources to "own," their bodies completely. Unlike the people whose stories are being used to push this bill, their bodies would always be partially owned by the state. Hence, any ostensive "choice" for assisted suicide on their part would be made in the context of their social subjugation.

We urge you to pass strong legislation mandating that medical schools provide rigorous training in pain management and social justice in the medical sphere. We urge you to pass legislation that advances LGBT employment and marriage rights, eliminates Section 14(c) of the Fair Employment Standards Act, legalizes the proposed Community Choice Act, requires medical schools to train their students in advanced pain control techniques, implements harsh penalties for police brutality, abolish the death penalty, raise special education standards and promote economic equality for all citizens. Please do not exacerbate these inequalities by passing legislation that our discriminatory society is not equipped or willing to oversee.

Sincerely,

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"How the Ideology of Pity is a Social Harm to People with Disabilities" *Social Philosophy Today* (2010)

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"My Two Moms: Disability, Queer Kinship and Maternal Subjectivity"

<http://onlinelibrary.wiley.com/doi/10.1111/hypa.12125/abstract>

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OTHER ACADEMIC ANALYSES OF ASSISTED SUICIDE

Rosemarie Garland Thompson, "The Cultural Logic of Euthanasia: "Sad Fancyings" in Herman Melville's 'Bartleby'" *American Literature*, 2004-PDF attached **

Bill Peace, "Comfort Care as Denial of Personhood" *The Hastings Report* 2011-PDF attached**

Patricia K. Jennings and Clarence R. Talley, "A Good Death? White Privilege and Public Opinion: Research on Euthanasia" *Race, Gender & Class*, 2002-PDF attached **

**denotes articles that address assisted suicide directly or that consider topics that are particularly relevant to that issue