

Why Assisted Suicide Must Not Be Legalized

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LOOK DEEPER

Assisted suicide seems, at first, blush, like a good thing to have available. But on closer inspection, there are many reasons that legalizing assisted suicide is a terrible idea.

HOW MANY WOULD BE HELPED AND HOW MANY WOULD BE HARMED

While an extremely small number of people may benefit, they will tend to be at the upper end of the income scale, white, and have good health insurance coverage. At the same time, large numbers of people, particularly among those less privileged in society, would be at significant risk of substantial harm. We must separate our private wishes for what we each may hope to have available for ourselves some day and, rather, focus on the significant dangers of legalizing assisted suicide as public policy in this society as it is today. Assisted suicide would have many unintended consequences.

MANAGED CARE AND ASSISTED SUICIDE ARE A DEADLY MIX

Perhaps the most significant problem is the deadly mix between assisted suicide and profit-driven managed health care. Health maintenance organizations (HMO's) and managed care bureaucrats are already overruling doctors' treatment decisions, sometimes hastening patients' deaths. The cost of the lethal medication generally used for assisted suicide is about \$35 - \$50, far cheaper than the cost of treatment for most long-term medical conditions. The incentive to save money by denying treatment is already a significant danger; it would be far greater if assisted suicide is legal. It's not coincidental that the author of Oregon's assisted suicide law, Barbara Coombs Lee, was an HMO executive when she drafted it. Assisted suicide will accelerate the decline in quality of our health care system.

A 1998 study from Georgetown University's Center for Clinical Bioethics underscored the link between profit-driven managed health care and assisted suicide. [*1] The research found a strong link between cost-cutting pressure on doctors and their willingness to prescribe lethal drugs to patients, were it legal to do so. The study warns there must be "a sobering degree of caution in legalizing [physician-assisted suicide] in a medical care environment that is characterized by increasing pressure on physicians to control the cost of care."

The deadly impact would come down the hardest on socially and economically disadvantaged groups who have less access to medical resources and who already find themselves discriminated against by the health care system: poor people, people of color, elderly people, people with chronic or progressive conditions or disabilities, and anyone who is, in fact, terminally ill will be put at serious risk.

Dr. Rex Greene, a cancer specialist in Los Angeles for 23 years and a leader in his field, underscored the heightened danger to the poor. He said, "The most powerful predictor of

ill health is [people's] income. [Legalization of assisted suicide] plays right into the hands of managed care."

Supporters of assisted suicide frequently say that HMO's will not use assisted suicide as a way to deal with costly patients. They cite a 1998 study in the New England Journal of Medicine that found the savings of allowing people to die before their last month of life would be \$627 billion, which is only .07% of the nation's total health care costs per year. But this study has several significant problems that make it an unsuitable basis for claims about assisted suicide's potential impact. The researchers based their findings on the average cost to Medicare of patients with only four weeks or less to live. But assisted suicide proposals (as well as the law in Oregon, the only state where assisted suicide is legal) define terminal illness as having six months to live. The researchers also assumed that about 2.7% of the total number of people who die in the U.S. would opt for physician assisted suicide, based on reported physician-assisted suicide and euthanasia deaths in the Netherlands. But Dutch doctors are not required to report such deaths, which casts considerable doubt on this figure. And how can you compare the U.S. to a country that has universal health care? All these considerations would skew the costs much higher.

FEAR, BIAS, AND PREJUDICE AGAINST DISABILITY

Another major problem with assisted suicide is who ends up using it, both in Oregon and in the only other place on earth where it is legally tolerated, the Netherlands. The point of assisted suicide is purported to be relief from untreatable pain at the end of life. However, all but one of the people in Oregon who were reported to have used that state's assisted suicide law during its first year wanted suicide not because of pain, but for fear of losing functional ability, autonomy, or control of bodily functions. [*2] Oregon's second year report has similar results. Further, in the Netherlands, more than half the doctors surveyed say the main reason given by patients for seeking death is "loss of dignity." [*3]

This fear of disability typically underlies assisted suicide. Said one assisted suicide advocate, "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 behind.' It's about dignity." [*4] But needing help is not undignified, and death is not better than dependency. Have we gotten to the point that we will abet suicides because people need help using the toilet?

SUPPOSED SAFEGUARDS

Assisted suicide proposals are based on the faulty assumption that you can make a clear distinction between who is 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 predictions of a short life expectancy to be wrong. Studies show that only cancer patients show a predictable decline, and even then, it's only in the last few weeks of life. And with every disease other than cancer, there is no predictability. [*5] Prognoses are based on statistical averages, which are nearly useless in predicting what will happen to an individual patient. Moreover, doctors and the courts frequently classify people with long-term disabilities as "terminally ill." Thus, the

potential effect of assisted suicide is extremely broad, far beyond the supposedly narrow group the proponents claim.

This poses considerable danger to people with new or increasing disabilities or diseases. Research overwhelmingly shows that people with new disabilities frequently go through initial despondency and suicidal feelings, but later adapt well and find great satisfaction in their lives. [*6] However, the adaptation usually takes considerably longer than the mere two week waiting period required by assisted suicide proposals and Oregon's law. People with new diagnoses of terminal illness appear to go through similar stages. [*7] 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 to make the final choice one that is irrevocable, if assisted suicide is legal.

OTHER SUPPOSED SAFEGUARDS

In Oregon's law and similar proposals, doctors are not supposed to write a lethal prescription under inappropriate conditions that are defined in the law. This is seen as a supposed safeguard. But what's happened in several cases in Oregon is "doctor shopping" - if one physician refuses assisted suicide because the patient doesn't meet the conditions in the law, another physician is sought who will approve it, often one who's an assisted suicide advocate. Such was the case of Kate Cheney, age 85, whose case was described in *The Oregonian* in October 1999. Her doctor refused to prescribe the lethal medication, because he thought the request was actually the result of pressure by an assertive daughter who was stuck with caregiving, rather than the free choice of the mother. So the family found another doctor, and Ms. Cheney is now dead.

There is one safeguard in most assisted suicide proposals - for HMO's and doctors: the "good faith" standard. This "safeguard" provides that no person will be subject to any form of legal liability if they claim that they acted in "good faith." A claimed "good faith" belief that the requirements of the law are satisfied is virtually impossible to disprove, rendering all other proposed "safeguards" effectively unenforceable.

SO-CALLED "NARROW" PROPOSALS WILL INEVITABLY EXPAND

As the New York State Task Force on Life and the Law wrote, "Once society authorizes assisted suicide for...terminally ill patients experiencing unrelievable suffering, it will be difficult if not impossible to contain the option to such a limited group. 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)." [*8]

The longest experience we have with assisted suicide is in the Netherlands, where not only assisted suicide but also active euthanasia is practiced. The Netherlands is a very frightening laboratory experiment where, because of assisted suicide and euthanasia, "pressure for improved palliative care appears to have evaporated," [*9] according to Dr. Herbert Hendin in Congressional testimony in 1996. Assisted suicide and euthanasia have become not just the exception, but the rule for people with terminal illness.

"Over the past two decades," Hendin continued, "the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical (assistance to die), i.e. euthanasia, to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not competent to choose for themselves." [*10] In other words, for a substantial number of people in the Netherlands, doctors have decided patients should die without consultation with the patients.

Furthermore, assisted suicide proponents and medical personnel alike have documented how taking lethal drugs by mouth is often ineffective in fulfilling its intended purpose. The body expels the drugs through vomiting, or the person falls into a lengthy state of unconsciousness rather than dying promptly, as so-called "death with dignity" advocates wish. Such ineffective suicide attempts happen in a substantial percentage of cases -- estimates range from 15% to 25%. [*11] The way to prevent these "problems," in the view of euthanasia advocates, is by legalizing lethal injections by doctors, which is active euthanasia. This is an inevitable next step if society first accepts assisted suicide as a legitimate legal option.

We are told by assisted suicide proponents that these things will not happen. But why not? How can the proponents, or anyone, stop it? The courts have already completely blurred these categories. If the next step is wrong, then taking this step is tantamount to taking the next step.

NOT TRULY FREE CHOICE

Assisted suicide purports to be about free choice. But there are significant dangers that many people would take this "out" due to pressure, such as elderly individuals who don't want to be a financial or caretaking burden on their families. There's a significant amount of well-documented elder abuse in this country, and it's very often by family members, [*12] which could easily lead to such pressures. Also, leaders and researchers in the black and Latino communities have stated their fears that pressures to choose death would be applied disproportionately to their communities. [*13] Other people would undergo assisted suicide because they lack good health care, or in-home support, and are terrified about going to a nursing home. Assisted suicide would actually result in deaths due to a lack of choices for many people. 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.

FOOTNOTES:

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10. Herbert Hendin, M.D., "Suicide, Assisted Suicide and Euthanasia: Lessons From the Dutch Experience," U.S. House of Representatives, Committee on the Judiciary, Oversight Hearing, April 29, 1996.

11. Journal of the American Medical Association, August 12, 1998, Volume 280, No. 6, page 512.

New York Times, December 3, 1994: Letter to the Editor from Derek Humphrey, founder of the Hemlock Society and author of Final Exit

12. 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 age 60 and over were abused, according to a study of observed cases. In almost 90 percent 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.

13. Clarence Page, Chicago Tribune, February 24, 1999

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