Top 10 Reasons to Oppose Physician Assisted Suicide in Colorado

1) <u>There are better more compassionate policies addressing the needs of the terminally ill</u>.

The terminally ill understandably fear the dying process. They fear loss of autonomy and the dependence on others to perform activities of daily living. They fear losing control of bodily functions. They fear uncontrolled pain and suffering. They fear becoming a burden on their loved ones. *How we respond to these fears determines how our society will be judged.*

Rather than address these fears in a meaningful way, we can tacitly encourage suicide. This may be the simpler, more expedient, and possibly less costly approach, but it does not represent true compassion. A truly compassionate society would encourage end of life discussions so that individuals could better formulate and articulate their wishes pertaining to the limits of burdensome medical interventions and technologies. It would more aggressively look for and treat depression in those who suffer from chronic diseases. It would allocate more resources to enhance palliative care and hospice services for the terminally ill. It would devote more attention, not less, to those who face the most vulnerable times in their lives, recognizing that each of them has inherent dignity and worth whatever their mental/physical limitations.

2) <u>Approving assisted suicide provides legitimacy to the practice which will fuel its growth.</u>

What starts out as an option of last resort that very few individuals would choose will become a widespread practice that will transform the norms of society.

In Oregon in 1998, only 24 individuals sought life ending prescriptions. By 2015 this had grown to 218 which represented a 908% increase in just 17 years.[1] In Washington lethal prescriptions have been written 65 times in 2009 increasing to 213 in 2015.[2] This represents a 327% increase in 6 years. There have been similar increases in Switzerland (700% from 1998 to 2009 or 300 cases[3]) and Belgium (482% from 2003 to 2013 or 1807 cases[4-5]).

While assisted suicide currently still only represents a fraction of the total deaths in Oregon (0.37% of deaths) and Washington (0.33% of deaths), there is reason to believe this will inexorably change over time. Assisted suicide and euthanasia have been prevalent in the Netherlands since the 1970s. In 2014 assisted suicide/euthanasia accounted for 5306 deaths which was a 10% year over year increase and represented a

276% increase in just 8 years.[6] Utilizing data from the last comprehensive Netherlands death assessment in 2010, 3.2% of the Dutch died from euthanasia, assisted suicide, and "hastened deaths without an explicit request".[7] When corrected for documented under-reporting, this translates to a 4% rate.[8] (Another source suggests that unreported cases of euthanasia may be as high as 50%)[9]. However, if you exclude sudden and/or unexpected deaths (in which there is no opportunity to make an end of life decision and be euthanized), the more accurate rate is 5% of Dutch deaths. Finally, if you include "terminal sedation" (in which an individual is sedated to unconsciousness till death), more than *20% of the Dutch non-accidental/sudden deaths are at the hands of physicians*.

This is not a slippery slope; it is a slippery cliff. Are we prepared to see more than 1300 Coloradoans annually end their own life (if rates approach those of the Netherlands)?

3) <u>The circumstances in which assisted suicide is pursued will evolve from the terminally ill to those with non-terminal conditions</u>

Most individuals who pursue assisted suicide or euthanasia in countries or states where it has been legally sanctioned are cancer patients. Patients with malignancy have a more defined, albeit still not entirely predictable, prognosis. However, as assisted suicide and euthanasia programs evolve, inevitably, the individuals who are "treated" change.

In Oregon in 2015, only 72% of patients had a malignancy compared to the previous 77.1% 16 year running average.[1] Over the last three years, an increasing portion had chronic respiratory illness (3.8-9.9%) and "other" conditions (8.6-16.6%). "Other" conditions included benign neoplasms, other respiratory conditions, diseases of the nervous system, musculoskeletal/connective tissue diseases, viral hepatitis, diabetes, and alcoholic liver disease. These are inherently less predictable and less terminal disease categories. Furthermore, the fact that some patients have lived as long as 2.75 years from the time of their request until death by ingestion suggests that physician assisted suicide patients are not always as "terminal" as the guidelines suggest they should be.[1]

Switzerland reported that only 44% of cases in 2009 were prompted by cancer.[3] Non-terminal diseases included 6% musculoskeletal disorders and 3% depression. "Other" categories included euthanasia for diabetes, blindness, pain syndromes, and dementia.

In the Netherlands where assisted suicide and euthanasia have been practiced the longest, an even more disturbing trend is emerging. In 2014, 41 patients were euthanized with psychiatric disorders including depression, and 81 patients were euthanized for dementia.[6] Another 257 were euthanized for "multiple diseases of age". A more recent detailed analysis from a large Netherlands "End of Life Clinic" documented that 6.8% of those who successfully obtained Euthanasia/PAS were categorized as "tired of living" and 3.7% only had psychological suffering.[10] The ethicist, Theo Boer, who sits on the Regional Review Committee for euthanasia in the Netherlands and has reviewed almost 4000 euthanasia deaths, stated that "cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted of being aged, lonely or bereaved" and that "some of these patients could have lived for years or decades".[11]

The psychiatric nurse/writer, Hermina Kykxhoorn aptly described the inexorable progression of the PAS/euthanasia movement in Holland. "In 30 years Holland has moved from assisted suicide to euthanasia, from euthanasia of people who are terminally ill to euthanasia of those who are chronically ill, from euthanasia for physical illness to euthanasia for mental illness, from euthanasia for mental illness to euthanasia for psychological distress or mental suffering, and from voluntary euthanasia to involuntary euthanasia or as the Dutch prefer to call it "termination of the patient without explicit request".[12]

4) <u>The most vulnerable members of our society may become victims of the policy.</u>

As assisted suicide grows in acceptance it becomes less an act of self-determination as the "better off dead" philosophy begins to pervade society.[13] The "better off dead" philosophy can have a pernicious effect on the vulnerable disability and elderly communities. What starts out as a "right" becomes an obligation nurtured by the medical community and changing public attitudes.

Studies earlier in the history of assisted suicide/euthanasia did not find evidence for targeting of vulnerable populations based on extreme age, gender, educational status, income, race, or ethnic minorities although the conclusions are partially based on inferential data.[14] Oregon and Washington state do not collect patient data other than demographics and principal diagnosis. *Neither Oregon nor Dutch studies adequately evaluated whether physician assisted suicide or euthanasia are equally distributed in vulnerable and non-vulnerable groups with chronic physical or mental disability.*

The highest quality studies in the Netherlands and Oregon suggest that between 8-47% of patients requesting physician assisted suicide and euthanasia have depressive symptoms and somewhere between 2-17% of individuals who completed physician assisted suicide or euthanasia had depressive symptoms.[15] A cross-sectional survey from Oregon suggested that depression is missed or overlooked in patients pursuing physician assisted suicide.[16] Referral rates to mental health for those who chose physician assisted suicide were only 3.8% and 4% in Oregon (2015) and Washington (2014) respectively.[1-2] Consequently, the adoption of physician assisted suicide, ala Oregon and Washington, "may fail to protect some patients whose choices are influenced by depression".[16]

Disability advocates make the cogent argument that individuals with a terminal illness by definition have a disability, and by pursuing suicide prevention only in those who do not have a terminal illness (and tacitly approving suicide in those with terminal illness), the government is discriminating on the basis of disability.[17] This could be in violation of the Americans with Disabilities Act.

5) <u>Promoting suicide as a rationale response to pain and suffering may promote suicide throughout Colorado in unintended populations.</u>

The rate of suicide in Oregon has steadily increased since 2000.[18] (PAS was legalized in 1998). Suicide rates among adults ages 45-64 rose 50% from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increase was more dramatic among women than men. In 2010 the age adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.

A larger study using logistic regressions comparing suicide rates in states where PAS is legal to those where it remains illegal suggests that PAS was associated with a 6.3% increase in suicides.[19]

In 2013, 1004 Colorado residents committed suicide.[20] The rate "illustrates a continued upward trend in suicide deaths from 2009-2013". The number of suicide deaths exceeded the deaths from homicide, MVAs, breast cancer, influenza/pneumonia and diabetes. Among youth and young adults ages 10-24, suicide was the second leading cause of death. Colorado has the dubious distinction of consistently being ranked among the top ten states in suicide deaths.

Between 19.8-24% of adolescents have thought about suicide at some point in their lives.[21] Media coverage can significantly influence suicide behavior.[22] Furthermore, research has demonstrated that "inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim" and increase suicide rates.[23] This has been referred to as the "Werther effect". Recent stories, such as Britney Maynard's, portray physician assisted suicide as a heroic act. There is reason to be concerned that as physician suicide is promoted, it could be a factor contributing to suicide in unintended populations.

Coloradoans are sophisticated enough to discern that the Orwellian language used to market assisted suicide ("aid in dying" or "hastening death") does not change the reality of state sanctioned suicide. *Acceptance of physician assisted suicide sends the message that autonomy trumps all other societal values and that when an individual has significant pain/suffering, suicide is a reasonable, if not preferred, approach.*

6) Physicians who prescribe life ending drugs frequently have limited knowledge of the patient.

In Oregon the duration of the median patient-physician relationship in physician assisted suicide patients is 9 weeks and in Washington the majority know their patients for < 25 weeks.[1-2] Some physicians never met the patient prior to the request for assisted suicide. This does not inspire confidence that the physician understands and addresses the legitimate concerns the patient has before acquiescing to the suicide.

It is likely that physicians will promote themselves as "specialists" in assisting patients with their suicides in a manner similar to our recent experience with medical marijuana. It will be easy to find two physicians to agree to the suicide request and neither may know the patient or the circumstances provoking the request. The Netherlands have taken this concept to a new level with mobile euthanasia units and "traveling euthanasia doctors".[10]

7) Assisted suicide is the ultimate abandonment of care by physicians and will irreversibly compromise their role.

The Hippocratic Oath established the standard by which physicians have practiced for centuries. The principle of "primum non nocere", first do no harm, has been accepted wisdom.

It was not until the latter part of the 20th century that the "right to death" movement grew in Europe and spawned the current state of physician assisted suicide and voluntary/involuntary euthanasia.

Assisting suicide and euthanasia are antithetical to the role of the physician. Rather than addressing the mental and physical suffering of their patients, assisted suicide means that the physician must abandon those efforts in favor of an absolutist interpretation of patient autonomy and premature death.

Pressure from family who have ulterior motives can unduly influence the physician to acquiesce to an otherwise repugnant request when physician assisted suicide is sanctioned by the state. Similarly, it will be impossible to be confident that financial considerations (such as risk sharing) may place the physician in conflict with what may otherwise be in the best interest of the patient.

8) Hospice services become perverted when their goals shift from comfort/counseling to supporting assisted suicide.

Hospice is dedicated to the relief of suffering. It neither hastens nor impedes death. Studies have shown that patients in hospice have improved quality of life and not infrequently live as long or longer than patients with similar diseases who forego hospice care for more aggressive curative treatments.[24-25] Physician assisted suicide would fundamentally be in conflict with this decades long hospice goal of ameliorating suffering and improving the quality of life.

Anecdotally, patients frequently cite their fear that hospice staff will hasten their death as a reason to not enroll in hospice care. This threshold will be even greater if patients perceive hospice as a place where assisted suicide is practiced. This disturbing trend is already seen in Washington and Oregon where hospices are incorporating physician assisted suicide into their care algorithms and 81-92% of physician assisted suicide patients are enrolled in hospice programs.[1-2]

9) Nobody can stop an individual from committing suicide if that is their choice.

Suicide is always a tragedy. However, if someone is intent on taking their own life for whatever reason, there are many ways and opportunities for them to execute their death wish. Googling "how to commit suicide" leads to a plethora of resources and consultation services to assist the determined individual.

Compassion and Choices tellingly states on their website: "If I live in a state with no law protecting aid in dying, should I move to a state that does? No; there are many options

available to people across the nation, which an end-of-life consultant can explain to you. Compassion and Choices wants everyone with a terminal illness to have a peaceful death no matter which state they live in"[26].

This means that the push to approve the "death with dignity" legislation is not really about access to the tools of suicide but rather all about gaining acceptance for assisted suicide and euthanasia throughout the state and nation.

10) <u>The proposed ballot initiative is poorly written and would invite abuse.</u>

There are many criticisms that can be leveled at the ballot measure as written. The language of the measure does not adequately safeguard vulnerable patients.

Physicians are not equipped to identify depression in those with terminal disease. Physicians are also not trained to recognize end-of-life decisions made under duress or unduly influenced by family (who may have ulterior motivations). "Informed decisions" and mental capacity in the context of suicide requests are extraordinarily hard to assess.[27]

There is virtually no oversight. The physician won't be present for the majority of ingestions. The physician or other medical professionals are not obligated to describe the circumstances of the death. There is no way to be sure there is not coercion during ingestions that occur alone or that are only witnessed by family/friends with potential ulterior motives.

The law also invites abuse by government/insurance industry bureaucrats. In Oregon, Medicaid famously refused a patient's request for an expensive third line chemotherapy drug but would cover the patient's PAS drug regimen.

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