

**Submission re: Draft General Comment on Article 6**

**of the International Covenant on Civil and Political Rights – Right to Life**

October 6, 2017

**Executive Summary**

Not Dead Yet USA is a national, grassroots disability rights group that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people. Not Dead Yet USA helps organize and articulate opposition to these practices in the United States based on secular social justice arguments. Not Dead Yet also demands the equal protection of the law for the targets of so called “mercy killing” whose lives are seen as worth-less.

This submission concerns paragraph 10 of the Draft Comment, which reads as follows:

[While acknowledging the central importance to human dignity of personal autonomy, the Committee considers that States parties should recognize that individuals planning or attempting to commit suicide may be doing so because they are undergoing a momentary crisis which may affect their ability to make irreversible decisions, such as to terminate their life. Therefore,] States should take adequate measures, without violating their other Covenant obligations, to prevent suicides, especially among individuals in particularly vulnerable situations. At the same time, States parties [may allow] [should not prevent] medical professionals to provide medical treatment or the medical means in order to facilitate the termination of life of [catastrophically] afflicted adults, such as the mortally wounded or terminally ill, who experience severe physical or mental pain and suffering and wish to die with dignity. In such cases, States parties must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and, unambiguous decision of their patients, with a view to protecting patients from pressure and abuse.

We strongly oppose this draft language, which supports assisted suicide and euthanasia, thus proposing to carve older, ill and disabled people out of equal protection of the law. This submission will focus on the risks to individuals and society associated with assisted suicide and euthanasia. We will discuss the evidence from Oregon, the earliest of the five U.S. states and District of Columbia to legalize assisted suicide, and outline the concerns of the disability community.

Regardless of our abilities or disabilities, none of us should feel that we have to die to have dignity, that we have to die to be relieved of pain, or that we should die to stop burdening our families or society. The Draft Comment on this topic must be rejected.

**Introduction**

Not Dead Yet is a national, grassroots disability rights group that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people. Formed by disabled people in 1996, Not Dead Yet helps organize and articulate opposition to these practices in the United States based on secular social justice arguments. Not Dead Yet also demands the equal protection of the law for the targets of so called “mercy killing” whose lives are seen as worth-less. Since our founding, autonomous sister organizations have been formed in a number of other countries, including the United Kingdom and Canada.

In 1997, the U.S. Supreme Court ruled that a federal constitutional right to assisted suicide does NOT exist[[1]](#endnote-1), but noted that individual states might be able to experiment with laws pertaining to the practice. Since then, five of the 50 states and the District of Columbia have legalized the practice by statute, beginning with Oregon in 1997 by ballot referendum. In addition, the high court in the state of Montana declined to find a state constitutional right to assisted suicide, but ruled that physicians may raise the defense of a victim’s consent if they are prosecuted for homicide in an assisted suicide case[[2]](#endnote-2). While we disagree with much of the *Baxter* court’s decision, it’s approach has the benefit of denying to those involved in the death of an old, ill or disabled person the blanket legal immunity that is the core provision of the state statutes that have been enacted.

**An Analysis of Claims About Assisted Suicide in Oregon**

In view of the frequent claims by assisted suicide proponents that Oregon’s experience demonstrates that there have been no problems of mistake, coercion or abuse of the state’s assisted suicide law, our analysis begins there.

Assisted suicide proponents claim that the data from Oregon on implementation of its assisted suicide law demonstrate that there are no problems. The [Oregon “Death With Dignity Act” Reports](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx),[[3]](#endnote-3) and now the Washington Reports[[4]](#endnote-4) as well, provide the appearance of scientific data, but little substance. They leave the most significant questions unasked and unanswered, mostly providing an annual excuse to announce through the press that everything’s fine, no problems, nothing to see. Nevertheless, as the Reports repeatedly admitted, the state is unable to assess the extent of under-reporting and noncompliance with the law’s requirements.[[5]](#endnote-5)

Financial Pressures

A chapter called “The Unspoken Argument” in a book co-authored by Derek Humphry, co-founder of the Hemlock Society and long time leader within the World Federation of Right to Die Societies, stated:

*“Similar to other social issues, the right-to-die movement has not arisen separate and distinct from other concurrent developments of our time. In attempting to answer the question Why Now?, one must look at the realities of the increasing cost of health care in an aging society, because in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice.”* Humphry and Clement (2000) *Freedom to Die: people, politics, and the right-to-die movement*. (Emphasis added.)

More importantly, in terms of U.S. health care policy, the disability community has always been concerned about the fact that assisted suicide costs a lot less than ongoing health care. People with disabilities have long been denied many forms of needed health care for cost reasons (e.g. therapies that maintain rather than improve function are almost always denied coverage; adequate home and community based long term care is often denied). While most of Oregon’s reported assisted suicides involved people with public or private insurance coverage, that statistic alone does not say anything about the insurance deductibles and co-payments involved, nor does it address the problem of long term care services which are not covered by Medicare or most private insurance plans.

Eventually, with increasingly tight state Medicaid budgets, the [Barbara Wagner](http://abcnews.go.com/Health/story?id=5517492&page=1)[[6]](#endnote-6) case came to light, involving a letter from the State of Oregon denying cancer treatment but offering assisted suicide. While Oregon data show that most who reportedly die by assisted suicide had some type of health insurance, that does not say anything about whether they received timely and appropriate coverage of necessary medical treatments nor that the required out-of-pocket co-payments were affordable.

Moreover, it’s well established that at least some doctors are willing to deny life-sustaining health care under [futility policies](http://www.ama-assn.org/resources/doc/code-medical-ethics/2037a.pdf)[[7]](#endnote-7) and overrule an individual’s expressed decision to receive care based on subjective standards that amount to quality of life judgments.

Failure to Address Depression and Other Psycho-Social Factors

Among the issues that are revealed in the Oregon Reports is the low incidence and downward trend in requests for psychiatric consultations by doctors who issue lethal prescriptions with only 3.8% referred in 2016[[8]](#endnote-8). The [assisted suicide law](http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx)[[9]](#endnote-9) uses the word “counseling” but defines it, not as some type of supportive talk therapy, suicide prevention or other treatment, but as consultation “for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.” To clarify the legalistic language on this point: a person who has depression may still be eligible for assisted suicide if a physician or, upon the optional referral, a psychiatrist or psychologist says it does not cause impaired judgment.

This so-called psychological “safeguard” avoids the bigger questions: who actually judges whether judgment is impaired, and how? [In 95% of the Oregon cases](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/yr13-tbl-1.pdf) from 1997 through 2016, i.e. those with no psychological referral, the physician who issued the lethal prescription rendered the determination that judgment was not impaired, even if they diagnosed or suspected depression. [Studies show that most physicians aren’t able to diagnose depression](http://www.time.com/time/health/article/0,8599,1913312,00.htm).[[10]](#endnote-10) It appears to be anyone’s guess how they assess whether depression causes impaired judgment, and whether the desire for a lethal prescription is the product of rational or impaired judgment.[[11]](#endnote-11)

One might suspect that, for healthy people, the desire for a lethal prescription would be seen by many professionals, in and of itself, as proof of impaired judgment. In contrast, it appears that assisted suicide and euthanasia advocates have concluded that this would not be the case for people with significant health impairments or physical disabilities. From our perspective, this is a simple case of circular reasoning. In fact, there is no objective evidence to justify the conclusion that the suicidal impulses of ill and disabled people are any less the product of impaired judgment than those of physically healthy people. Specialists in the field of elder suicide prevention clearly believe that suicidal feelings in seniors who face illness and disability can be successfully addressed.[[12]](#endnote-12)

This whole line of “rational suicide” thinking in the psychology profession has been promoted by James Werth[[13]](#endnote-13), a prominent pro-assisted suicide psychologist. He waves a professional wand over understandable human fears and feelings about aging, illness and disability so that these emotions can be classified as “rational” without addressing their roots in social conditioning, social stigma and societal neglect of people with expensive health and disability-related needs.

In addition, the individual who requests assisted suicide must supposedly not be coerced, but the Oregon statute offers no real protection. The law requires four people to certify that the person is not being coerced to sign the assisted suicide request form: the prescribing doctor, second opinion doctor, and two witnesses.

The Oregon state reports say that the median duration of the physician patient relationship is only 13 weeks.[[14]](#endnote-14) In most cases, the prescribing doctor is a doctor referred by assisted suicide proponent organizations.[[15]](#endnote-15) The witnesses on the assisted suicide request form[[16]](#endnote-16) need not know the person either. The form says that if the person is not known to the witness, then the witness can confirm identity by checking the person’s ID.

So neither the doctors nor witnesses need to actually know the person well enough to “certify” that they are not being coerced, such as by the threat of nursing home placement.

The third year Oregon case of Kate Cheney, reported in detail in the Oregonian newspaper (Barnett, E.H.“Is Mom Capable of Choosing to Die?”10/17/99), provides an important example of disability concerns. Mrs. Cheney's physician was concerned that she had early dementia and that her daughter might be pressuring her toward assisted suicide, so he referred her for a psychological consultation.  The first consultant found that Mrs. Cheney's assisted suicide would not be voluntary because of pressure from her daughter, but a second referral concluded that her suicide would be voluntary in spite of pressure from her daughter. The lethal prescription was issued, but Mrs. Cheney didn't take it until after her family put her in a nursing home for a week so they could have respite from care-giving. So Mrs. Cheney was presented with the following so called "choice": be a burden on family, go to a nursing home, or accept physician assisted suicide. 

Doctor-Shopping for Pro-Assisted Suicide Physicians

It’s been reported that Compassion in Dying (which later merged with the Hemlock Society/End-of-Life Choices to become Compassion and Choices) initially claimed that 75% of the doctors issuing lethal prescriptions were affiliated with their organization[[17]](#endnote-17). According to Dr. Elizabeth Goy of Oregon Health and Science University, Compassion in Dying (since renamed Compassion & Choices) sees “almost 90 percent of requesting Oregonians…”[[18]](#endnote-18)

The public relations image that one’s own physician who has cared for you throughout a serious illness is not the predominant reality. As noted above, the median duration of the patient’s relationship with the Oregon physicians who provide a lethal prescription is 13 weeks. But the significant extent to which “doctor shopping” for an assisted suicide prescription leads to Compassion and Choices’ doorstep is another issue not covered in the official state reports.

Non-Terminal People Receive Lethal Prescriptions

However, the reports do highlight some key disability issues. First, they document for each year the minimum and maximum number of days that lapsed between the date of an individual’s first request for assisted suicide and his or her death, from a low of 14 days to a high of 1009[[19]](#endnote-19). In 2016, at least one person lived 539 days. In every year except the first year, the upper end of the range is significantly longer than six months or 180 days. The Oregon Reports thus demonstrate that some people who received prescriptions were not terminal (i.e. lived longer than the required six-month or 180 day prognosis). How many prognoses were incorrect? Inexplicably, the *number* of people who did not die within six months of their request for assisted suicide is not in the Oregon Reports, and the underlying data is destroyed annually. Moreover, there will never be a way to know how many people would not have died within six months if they had not taken the lethal prescription. In the related area of hospice care where a six-month prognosis is needed to support government health care funding, about 15% of people outlive their prognosis. In any case, there is no indication that the dispensing of lethal prescriptions to people who proved not to be “terminal” under the law’s six-month requirement has been the subject of investigation or remedial action in any form.

In addition, the doctor need not consider the likely impact of medical treatment in terms of survival. Many conditions will or may become terminal if certain medications or routine treatments are discontinued. The state report lists conditions found eligible for assisted suicide to include:

*“. . . benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, cerebrovascular disease, other vascular diseases, diabetes mellitus, gastrointestinal diseases, and liver disease.”[[20]](#endnote-20)*

It should also be noted that the primary attending physician who determines terminal status is not required to be an expert in the disease condition involved.

As slippery as a “terminal” definition based on a six-month prognosis may be, one state has repeatedly proposed (but not passed) assisted suicide bills with a more expansive definition. Bills in [New Hampshire have defined “terminal”](http://notdeadyetnewscommentary.blogspot.com/2009/01/new-hampshire-poised-to-redefine.html) [[21]](#endnote-21) to mean “*an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.”* That would make a lot of us with disabilities “terminal” no matter how many years of life a doctor predicts we have left.

Disability Issues Are Central to Assisted Suicide Requests, But Remain Unaddressed

But the most significant disability issues revealed in the Oregon and Washington Reports are the reasons physicians check off on the [multiple choice reporting form](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/mdintdat.pdf) for why a lethal prescription was requested, deemed appropriate and granted. Five of the seven reasons listed are disability issues, which appear to be accepted as appropriate without any need for definition, examination, question or required steps to address and alleviate them:

*A concern about…*

(42.2%)…the physical or emotional burden on family, friends, or caregivers.

(91.4%)…his or her terminal condition representing a steady loss of autonomy.

(89.7%)…the decreasing ability to participate in activities that made life enjoyable.

(46.8%) …the loss of control of bodily functions, such as incontinence and vomiting.

(77.0%)…a loss of dignity.

The indicated percentages are the percent of persons dying under the law for whom doctors reported that reason for the assisted suicide request across all years from 1997-2016.[[22]](#endnote-22) Concerns about financial cost and pain are the least frequently selected reasons. The top five reasons all relate to disability concerns rather than terminality. From a disability rights perspective, nothing more clearly demonstrates the emptiness of the purported safeguards in the assisted suicide law. What the reporting form and physician responses show is that the law’s rather privileged proponents are determined to have doctors fully immunized for giving them an easy and aesthetic escape from disability. In fact, they are so determined that they have no problem with the certainty, based on the reports themselves, that non-terminal people have died from lethal prescriptions. They are so determined that they have no problem with the certainty that people have died without any evidence that an attempt was made to address their reasons for requesting the prescription by any means other than a lethal prescription (e.g. providing home care to someone who felt like a burden on family members).

The Risks of Elder Abuse and Homicide

Finally, as attorney [Margaret Dore has pointed out](http://www.choiceillusion.org/p/legal-analysis.html),[[23]](#endnote-23) the Oregon law contains no standards that apply at the time the lethal dose is ingested, and the reports contain nothing to address the concern that a third party, such as an heir or caregiver, could administer the drugs without the individual’s consent. Federal authorities estimate that one in ten elders are abused, most often by family and caregivers.[[24]](#endnote-24) Given the documented prevalence in society of elder abuse by family members (see [1998[[25]](#endnote-25)](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf) and [2009](http://www.lifespan-roch.org/documents/UndertheRadar051211.pdf)[[26]](#endnote-26) studies), and the [under-investigation of elder homicide](http://canhr.org/newsroom/canhrnewsarchive/2011/NPR20110205.html),[[27]](#endnote-27) the reports leave a gaping hole in our knowledge of what happened to each individual.

**Why Disability Activists Oppose Assisted Suicide As A Deadly Form of Discrimination**

In the U.S., a major struggle in the disability community is to expose the façade that assisted suicide is only for the terminally ill and not about disability. Supposedly, people with disabilities are not eligible in the U.S. states that have legalized assisted suicide. Proponents refuse to recognize or acknowledge that virtually all of the people dying under these laws are disabled, some terminal and some not. Not Dead Yet (USA) has consistently asserted that assisted suicide laws violate the Americans With Disabilities Act[[28]](#endnote-28) by establishing a system of unlawful discrimination whereby most suicidal people, those who reveal their intentions, receive suicide prevention services, while old, ill and disabled people receive suicide assistance instead. Indeed, we have filed amicus briefs in cases brought in the U.S. Supreme Court and several states making this discrimination argument.[[29]](#endnote-29)

In addition to the issues discussed above, the following is a summary of other issues and concerns that Not Dead Yet has raised.

Lessons From Disability History: Prior to the formation of Not Dead Yet, disability activists opposed a number of so-called “right to die” court cases involving ventilator users who sought freedom from nursing homes, essentially arguing “give me liberty or give me death.” Society’s response, denying them the home care needed to give them freedom from nursing homes but granting them death, was a wake up call to the disability rights movement. (Herr, S.S., Bostrom, B.A, & Barton, R.S. (1992). No place to go: Refusal of life-sustaining treatment by competent persons with physical disabilities. Issues in Law & Medicine, 8 (1), 3-36.)

Suicide v. Assisted Suicide: It should be noted that suicide, as a solitary act, is not illegal in any state. Disability concerns are focused on the systemic implications of adding *assisted* suicide to the list of “medical treatment options” available to seriously ill and disabled people.

Physicians Are Assisted Suicide Gatekeepers: Anyone could ask for assisted suicide, but physicians decide who gets it. Physicians must predict, however unreliably, whether a person will die within six months. Physicians judge whether or not a particular request for assisted suicide is rational or results from impaired judgment, but the basis for such a judgment is undefined and, thus, overly subjective and influenced by biased “quality of life” assessments.

We Don’t Need To Die to Have Dignity: In a society that prizes physical ability and stigmatizes impairments, it's no surprise that previously able-bodied people may tend to equate disability with loss of dignity. This reflects the prevalent but insulting societal judgment that people who deal with incontinence and other losses in bodily function are lacking dignity. People with disabilities are concerned that these psycho-social disability-related factors have become widely accepted as sufficient justification for assisted suicide.

Physicians Misjudge Quality of Life: In judging that an assisted suicide request is rational, essentially, doctors are concluding that a person’s physical disabilities and dependence on others for everyday needs are sufficient grounds to treat them completely differently than they would treat a physically able-bodied suicidal person. There's an established body of research demonstrating that physicians underrate the quality of life of people with disabilities compared with our own assessments (Gerhart, K. A., Kozoil-McLain, J., Lowenstein, S.R., & Whiteneck, G.G. (1994). Quality of life following spinal cord injury: knowledge and attitudes of emergency care providers. Annals of Emergency Medicine, 23, 807-812; Cushman, L.A & Dijkers, M.P. (1990). Depressed mood in spinal cord injured patients: staff perceptions and patient realities, *Archives of Physical Medicine and Rehabilitation*, 1990, vol. 71, 191-196). Nevertheless, the physician’s ability to render these judgments accurately remains unquestioned. Steps that could address the person’s concerns, such as home care services to relieve feelings of burdening family, need not be explored under Oregon’s law. In this flawed worldview, suicide prevention is irrelevant.

Door Open for Involuntary Euthanasia: Assisted suicide’s so-called “safeguards” apply when the lethal prescription is requested, but not when it is administered. Oregon’s law contains no requirement that the patient be capable or give consent when the lethal dose is administered. Nothing in the Oregon law prevents an abusive heir or caregiver from giving the drug, with or without the person’s consent -- no witnesses are required at the death, so who would know?

Health Care Cuts Severe: For seniors and people with disabilities who depend on publicly funded health care, federal and state budget cuts pose a very large threat. Many people with significant disabilities, including seniors, are being cut from Medicaid programs that provide basic help to get out of bed, use the toilet and bathe.

Involuntary Denial of Care: Most people are shocked to learn that futility policies and statutes allow health care providers to overrule the patient, their chosen surrogate or their advance directive and withhold desired life-sustaining treatment.[[30]](#endnote-30) With the cause of death listed as the individual’s medical conditions, these practices are occurring without meaningful data collection, under the public radar.

Window Dressing Safeguards, Immunity Law for Physicians: The Oregon law grants civil and criminal immunity to physicians providing lethal prescriptions based on a stated claim of “good faith” belief that the person was terminal and acting voluntarily. This is the lowest culpability standard possible, even below that of “negligence,” which is the minimum standard legally governing other physician duties.

ADA Discrimination: Legalized assisted suicide sets up a double standard: some people get suicide prevention while others get suicide assistance, and the difference between the two groups is the health status of the individual. This is blatant discrimination and a violation of the Americans with Disabilities Act (ADA).

National Disability Rights Organizations: A number of established national disability organizations have joined Not Dead Yet to adopt positions against assisted suicide, including ADAPT, the Autistic Self Advocacy Network, the National Council on Independent Living, the Disability Rights Education and Defense Fund, the National Council on Disability, United Spinal Association and others.[[31]](#endnote-31)

Unacceptable Losses: Disability is at the heart of the assisted suicide debate. Some people fear disability as a fate worse than death. Proponents of legalized assisted suicide are willing to treat lives ended through assisted suicide coercion and abuse as “acceptable losses” when balanced against their unwillingness to accept disability or responsibility for their own suicide.

**National Council on Disability**

Approximately a year after the founding of Not Dead Yet in April 1996, the National Council on Disability, a quasi-governmental body formed to advise the President, Congress and federal agencies on matters of disability policy, issued a lengthy position paper opposing legalization of assisted suicide. The Council compellingly summarized its concerns as follows:

*The dangers of permitting physician-assisted suicide are immense. The pressures upon people with disabilities to choose to end their lives, and the insidious appropriation by others of the right to make that choice for them are already prevalent and will continue to increase as managed health care and limitations upon health care resources precipitate increased "rationing" of health care services and health care financing.*

*People with disabilities are among society's most likely candidates for ending their lives, as society has frequently made it clear that it believes they would be better off dead, or better that they had not been born. The experience in the Netherlands demonstrates that legalizing assisted suicide generates strong pressures upon individuals and families to utilize that option, and leads very quickly to coercion and involuntary euthanasia. If assisted suicide were to become legal, the lives of people with any disability deemed too difficult to live with would be at risk, and persons with disabilities who are poor or members of racial minorities would likely be in the most jeopardy of all.*

*If assisted suicide were to be legalized, the only way to ward off the most dire ramifications for people with disabilities would be to create stringent procedural prerequisites. But, to be effective, such procedural safeguards would necessarily sacrifice individual autonomy to the supervision of medical and legal overlords to an unacceptable degree -- the cure being as bad as the disease.*

*For many people with disabilities, it is more often the discrimination, prejudice, and barriers that they encounter, and the restrictions and lack of options that this society has imposed, rather than their disabilities or their physical pain, that cause people with disabilities' lives to be unsatisfactory and painful. The notion that a decision to choose assisted suicide must be preceded by a full explanation of the programs, resources, and options available to assist the patient if he or she does not decide to pursue suicide strikes many people with disabilities as a very shallow promise when they know that all too often the programs are too few, the resources are too limited, and the options are nonexistent. Society should not be ready to give up on the lives of its citizens with disabilities until it has made real and persistent efforts to give these citizens a fair and equal chance to achieve a meaningful life.*

*For these reasons, the Council has decided that at this time in the history of American society it opposes the legalization of assisted suicide. Current evidence indicates clearly that the interests of the few people who would benefit from legalizing physician-assisted suicide are heavily outweighed by the probability that any law, procedures, and standards that can be imposed to regulate physician-assisted suicide will be misapplied to unnecessarily end the lives of people with disabilities and entail an intolerable degree of intervention by legal and medical officials in such decisions. On balance, the current illegality of physician-assisted suicide is preferable to the limited benefits to be gained by its legalization. At least until such time as our society provides a comprehensive, fully-funded, and operational system of assistive living services for people with disabilities, this is the only position that the National Council on Disability can, in good conscience, support.*[[32]](#endnote-32)

NCD affirmed this position in a letter to certain members of Congress concerning a proposed Congressional Resolution[[33]](#endnote-33) opposing legalization of assisted suicide introduced on October 26, 2017. NCD stated, in part:

*NCD has always stood up for the right of people with disabilities to exercise self-determination and personal autonomy, but the dignity of people with disabilities should be affirmed not in the manner of their death, but in the value placed on their lives. The appropriate response from society to the needs of people with disabilities is to provide supports that enable them to live independently in the community and to ensure that the services, supports and treatments they need to enhance their quality of life are available and within the control of the recipient so that they can lead fulfilling lives even as they face serious health challenges. This non-binding resolution details the inherent shortcomings of physician assisted suicide laws. Not only do they fail to provide sufficient protections against coercion and other abuses that rob individuals of the ability to make informed end-of-life decisions, they often require doctors to make impossible prognostications regarding both the length and likely quality of a patient’s life. These decisions are also often lacking in transparency.*

*NCD welcomes this sense of Congress which fundamentally concurs with the position taken by NCD for decades, that policies or practices that support, encourage, or facilitate assisted suicide undermine the healthcare system by asking physicians to be willing to violate their Hippocratic Oath, to “Do No Harm” and poses a higher risk of deadly harm to individuals with disabilities.[[34]](#endnote-34)*

**U.S. Congressional Resolution Against Legalizing Assisted Suicide (Proposed)**

As noted above, on September 26, 2017, a Resolution[[35]](#endnote-35) expressing opposition to legalization of assisted suicide was introduced in the U.S. Congress by a bipartisan group of ten legislators, five Democrats and five Republicans. The Resolution language includes twenty-two “Whereas” clauses detailing concerns about legislation and public policy authorizing the practice of assisted suicide, including but not limited to the following:

* Whereas society has a longstanding policy of supporting suicide prevention such as through the efforts of many public and private suicide prevention programs, the benefits of which could be denied under a public policy of assisted suicide;
* Whereas assisted suicide most directly threatens the lives of people who are elderly, experience depression, have a disability, or are subject to emotional or financial pressure to end their lives;
* Whereas the United States Supreme Court has ruled twice (in Washington v. Glucksberg and Vacco v. Quill) that there is no constitutional right to assisted suicide, that the Government has a legitimate interest in prohibiting assisted suicide, and that such prohibitions rationally relate to “protecting the vulnerable from coercion” and “protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and ‘societal indifference;’”
* Whereas a handful of States have authorized assisted suicide, but over 30 States have rejected over 200 attempts at legalization since 1994;
* Whereas States that authorize assisted suicide for terminally ill patients do not require that such patients receive psychological screening or treatment, though studies show that the overwhelming majority of patients contemplating suicide experience depression;
* Whereas such State laws contain no requirement that a qualified monitor be present to assure that the patient is knowingly and voluntarily taking, using, ingesting, or administering the lethal dose;
* Whereas such State laws do not prevent family members, heirs, or health care providers from pressuring patients to request assisted suicide;
* Whereas such States qualify some patients for assisted suicide by using a broad definition of “terminal disease” and “going to die in six months or less” that includes diseases (such as diabetes or HIV) that, if appropriately treated, would not otherwise result in death within six months;
* Whereas reporting requirements vary by State, but when required, rely on prescribing physicians or dispensing pharmacists to self-report;
* Whereas there is an astounding lack of transparency in the practice of assisted suicide to the extent that State health departments and other authorities admittedly have no method of knowing if it is being practiced within the bounds of State laws and have no funding or authority to make such a determination;
* Whereas some State laws actively conceal assisted suicide by directing the physician to list the cause of death as the underlying condition without reference to death by suicide;
* Whereas the cost of lethal medication is far less costly than many life-saving treatments, which threatens to restrict treatment options, especially for disadvantaged and vulnerable persons, as has happened in several known cases and presumably many more unknown in which insurers have denied and/or delayed coverage for life-saving care while offering to cover assisted suicide; . ..

The concerns expressed are applicable to all countries that have allowed the practice of assisted suicide and euthanasia. In fact, though beyond the scope of this submission but documented in others, in some countries euthanasia is practiced without consent in a significant number of cases.

**Elder Suicide**

While the rates of elder suicide are rising nationally, it should be noted that Oregon has one of the highest suicide rates in the country.[[36]](#endnote-36) Perhaps one of the most important questions raised by the Oregon experience is whether legalizing these individual assisted suicides has a broader social impact. Does it matter that a society accepts the disability-related reasons that people give for assisted suicide, the supposed loss of dignity or feelings of being a burden, then declares the suicide rational and provides the lethal means to complete it neatly? Does it harm people who are not deemed eligible for assisted suicide under the current version of the law but still experience the same sense of stress from illness? In the face of constant social messages that needing help in everyday living robs one of dignity and autonomy, makes one a burden and justifies state sponsored suicide, maybe Oregon residents have taken this disgusting and prejudicial message to heart.

A recently published statistical study[[37]](#endnote-37) comparing suicide rates in states that have legalized assisted suicide found that, controlling for various socioeconomic factors, unobservable state and year effects, and state-specific linear trends, legalizing assisted suicide was associated with a 6.3% increase in total suicides (including assisted suicides). This effect was larger in the individuals older than 65 years.

**Conclusion**

Disability concerns are focused on the systemic implications of adding assisted suicide to the list of “medical treatment options” offered to seriously ill and disabled people.  The disability rights movement has a long history of healthy skepticism toward medical professionals who are assisted suicide’s statutory gatekeepers.  Our skepticism has grown to outright distrust since the cost-cutting orientation of managed care has dominated the health care scene.  Anyone who asserts that money will not influence the treatment options offered to people, or that the impact of uncovered out-of-pocket costs of illness and disability on an individual’s family will not influence the individual’s feelings of being a burden, is at best unrealistic and at worst dishonest.    
  
Pro-assisted suicide advocates call it “choice” but, with or without the purported safeguards, the so-called “autonomy” of assisted suicide is not being offered to healthy, non-disabled people. According to the U.S. Surgeon General, 16 of every 17 suicide attempts fail, and most don’t try again.[[38]](#endnote-38) Assisted suicide is not about parity in the opportunity for suicide.  It’s about a government and a health care system guaranteeing that certain suicides don’t fail. That’s discrimination. What looks to some like a choice to die begins to look more like a duty to die to many disability activists.     
  
The wish for an easy and certain method of suicide under some circumstances is understandable. But that wish must be weighed against the certainty of increasingly routine medical killing of older and disabled people. Whether or not any one of us worries about inevitable medical abuses affecting us personally, the lives of those who will be lost due to mistake, coercion, abuse and outright homicide are not an acceptable price for legalizing this practice.  
  
Regardless of our abilities or disabilities, none of us should feel that we have to die to have dignity, that we have to die to be relieved of pain, or that we should die to stop burdening our families or society.

1. *Vacco v. Quill,* 521 U.S. 793 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997). [↑](#endnote-ref-1)
2. *Baxter v. Montana*, Mont. Sup. Ct., 2009 MT 449, 354 Mont. 234, 224 P.3d 1211 (2009) [↑](#endnote-ref-2)
3. Oregon Death With Dignity Act Reports: <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> [↑](#endnote-ref-3)
4. Washington Reports: <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct.aspx> [↑](#endnote-ref-4)
5. See, e.g., Second Year Oregon Death With Dignity Act Report, page 12, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year2.pdf> [↑](#endnote-ref-5)
6. ABC News story on Barbara Wagner: <http://abcnews.go.com/Health/story?id=5517492&page=1> [↑](#endnote-ref-6)
7. Medical Futility in End-of-Life Care, *Journal of the American Medical Assn*., Vol. 281, No. 10, page 937, March 10, 1999, <http://www.thaddeuspope.com/images/CEJA_AMA_-_JAMA_-_1999.pdf> [↑](#endnote-ref-7)
8. Oregon Death With Dignity Act Report 2016, page 9: http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf [↑](#endnote-ref-8)
9. Oregon Death With Dignity Act: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx> [↑](#endnote-ref-9)
10. Study: Doctors Don’t Always Spot Depression: <http://www.time.com/time/health/article/0,8599,1913312,00.htm> [↑](#endnote-ref-10)
11. Martyn, Susan R. and Bourguignon, Henry J., Physician's Decisions About Patient Capacity: The Trojan Horse of Physician-Assisted Suicide (2000). Psychology, Public Policy and Law, Vol. 6, 2000. Available at SSRN: http://ssrn.com/abstract=1158077 [↑](#endnote-ref-11)
12. # See, e.g. Center for Elderly Suicide Prevention, <http://www.ioaging.org/services/all-inclusive-health-care/psychological-services/center-for-elderly-suicide-prevention/> ; Promoting Emotional Health and Preventing Suicide, A Toolkit for Senior Centers

    <https://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA15-4416> [↑](#endnote-ref-12)
13. James Werth and “rational suicide”: <http://books.google.com/books/about/Rational_Suicide.html?id=gMZU0cKqarAC> [↑](#endnote-ref-13)
14. Oregon Death With Dignity Act Report 2016, page 11: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf> [↑](#endnote-ref-14)
15. See, M. Golden, [Why Assisted Suicide Must Not Be Legalized](https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/), section on “Doctor Shopping” and related citations. <https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/> [↑](#endnote-ref-15)
16. REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

    <http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/pt-req.pdf> [↑](#endnote-ref-16)
17. See Hendin and Foley, [**Physician-Assisted Suicide in Oregon: A Medical Perspective**](http://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf), Michigan Law Review (2008): <http://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf>, page 1628. [↑](#endnote-ref-17)
18. For more details and citations on the role of Compassion and Choices in Oregon assisted suicides, see M. Golden, Why Assisted Suicide Must Not Be Legalized, Section C. 1., entitled “Doctor Shopping: All Roads Lead to Rome”, <http://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#marker46> [↑](#endnote-ref-18)
19. Oregon Death With Dignity Act Report 2016, page 11: <http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year19.pdf> [↑](#endnote-ref-19)
20. *Id.* [↑](#endnote-ref-20)
21. Death With Dignity Act, HB 1325, Chapter 137-L, Section L:2 XIII, <http://www.gencourt.state.nh.us/legislation/2014/HB1325.html>; Not Dead Yet blog on the New Hampshire bill: <http://www.notdeadyet.org/2009/01/new-hampshire-poised-to-redefine.html> [↑](#endnote-ref-21)
22. Oregon Death With Dignity Report 2016, *Id*. at page 10. [↑](#endnote-ref-22)
23. Margaret Dore’s analysis of Oregon and Washington assisted suicide laws: <http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html> [↑](#endnote-ref-23)
24. U.S. Official: Elder Abuse is ‘Broad and Widespread,’ Healthline News, Jan. 27, 2014, <http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714> [↑](#endnote-ref-24)
25. National Elder Abuse Incidence Study 1998: <https://www.acl.gov/sites/default/files/programs/2016-09/ABuseReport_Full.pdf> [↑](#endnote-ref-25)
26. Under the Radar: New York State Elder Abuse Prevalence Study 2009: <http://www.ocfs.state.ny.us/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf> [↑](#endnote-ref-26)
27. Autopsy Cutbacks Reveal “Gray Homicides”: <http://canhr.org/newsroom/canhrnewsarchive/2011/NPR20110205.html> [↑](#endnote-ref-27)
28. 42 U.S.C. § 12101, *et seq.* [↑](#endnote-ref-28)
29. See e.g., Not Dead Yet et al. brief in Gonzales v. Oregon (<http://www.notdeadyet.org/wp-content/uploads/2013/09/gonzales.html>) and Myers v. Schneiderman (<http://notdeadyet.org/wp-content/uploads/2017/05/NY-COA-Amicus-Feb-14-2017.pdf>) [↑](#endnote-ref-29)
30. Medical Futility in End-of-Life Care*, Id.* [↑](#endnote-ref-30)
31. See <http://notdeadyet.org/disability-groups-opposed-to-assisted-suicide-laws> [↑](#endnote-ref-31)
32. Assisted Suicide: A Disability Perspective, Position Paper, National Council on Disability, March 24, 1997, Marca Bristo, Chairperson, Written for the National Council on Disability by Professor Robert L. Burgdorf Jr., University of the District of Columbia School of Law <http://www.ncd.gov/publications/1997/03241997> [↑](#endnote-ref-32)
33. # H.Con.Res.80 - Expressing the sense of the Congress that assisted suicide (sometimes referred to as death with dignity, end-of-life options, aid-in-dying, or similar phrases) puts everyone, including those most vulnerable, at risk of deadly harm and undermines the integrity of the health care system. <https://www.congress.gov/bill/115th-congress/house-concurrent-resolution/80/text?q=%7B%22search%22%3A%5B%22H.con.res.80%22%5D%7D&r=1>

    [↑](#endnote-ref-33)
34. # NCD Letter to Congressman Wenstrup Regarding Sense of Congress on Assisted Suicide, September 29, 2017, <https://ncd.gov/publications/2017/ncd-letter-sense-congress-assisted-suicide>

    [↑](#endnote-ref-34)
35. See endnote 33. [↑](#endnote-ref-35)
36. # Age-Adjusted\* Suicide† Rates, by State§ — United States, 2012, <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6345a10.htm>

    [↑](#endnote-ref-36)
37. Jones D and Paton D, “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?”, Southern Medical Journal & Volume 108, Number 10, page 599-604, October 2015. [↑](#endnote-ref-37)
38. U.S. Public Health Service, “The Surgeon General’s Call to Action to Prevent Suicide,” Washington, D.C.: U.S. Government Printing Office, 1999, <http://www.sprc.org/sites/sprc.org/files/library/surgeoncall.pdf>. [↑](#endnote-ref-38)