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Assisted Suicide and Euthanasia: Beyond Terminal Illness

Advocates for physician-assisted suicide and euthanasia often claim these practices will only affect a narrow class of terminally ill patients who are expected to die soon in any case. But there is ample evidence of a “slippery slope” toward ending the lives of patients with chronic illnesses or disabilities, or even those who are vulnerable or marginalized in other ways.

Swiss Group Will Euthanize Those Who ‘Feel Old’

“In Switzerland, the association Exit (which has 70,000 members and is one of the biggest euthanasia organisations in the world) has voted to include ‘suicide because of old age’ on its statute.... Swiss law allows organisations that provide euthanasia services to establish their own internal rules, which may vary from clinic to clinic. The decision of Exit’s board has been criticised by the Swiss medical association, which fears that such a move could encourage suicide among the elderly.”

I. Abbadess, “Euthanasia Group Votes to Extend Suicide Choice to Those Who ‘Feel Old’,” *West*, June 2, 2014, <http://www.west-info.eu/euthanasia-group-votes-to-extend-suicide-choice-to-those-who-feel-old/>

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The Dutch Slippery Slope

Since the 1970s a series of court decisions has established that Dutch doctors need not fear punishment for taking their patients’ lives or assisting their suicides if they follow certain guidelines. The guidelines state, among other things, that these must be cases of intolerable pain for which there seems to be no other solution. But Dutch practice has become much broader.

On a landmark court ruling in 1986: “The patient in this case was not terminal, nor was she in acute physical pain. The court ruled, nevertheless, that ‘psychic suffering’ or the ‘potential disfigurement of personality’ could be acceptable grounds for requesting euthanasia.”

C. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (The Free Press 1991) at 39.

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By 2005 the Royal Dutch Medical Association had concluded that doctors should be allowed to perform euthanasia on patients who are not ill but are “suffering through living.”

News, 330 *British Medical Journal* 61 (8 January 2005).

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According to judicial guidance in the 1990s, later formalized at the University Medical Center in Groningen (“Groningen protocol”), physicians may sometimes give lethal injections to newborn infants with disabilities (most commonly spina bifida). Of 22 such cases analyzed by Groningen physicians, 59% of the infants had a “long life expectancy” – and this was counted *in favor* of euthanasia, as it meant a longer period of suffering and being dependent on medical care.

See E. Verhagen et al., “The Groningen Protocol – Euthanasia in Severely Ill Newborns,” 352.10 *New England Journal of Medicine* 959-62 (March 10, 2005) at 960, Table 1.

The Difficulties of a “Terminal” Prognosis

From the authors of the United States’ most extensive study of prognosis and treatment in terminal illness: “Deciding who should be counted ‘terminally ill’ will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide.”

J. Lynn et al., “Defining the ‘Terminally Ill’: Insights from SUPPORT,” 35.1 *Duquesne Law Review* 311-336 (Fall 1996) at 334.

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Under Oregon law, a request for physician-assisted suicide is not valid unless two physicians confirm that the patient has a “terminal disease” that is “incurable and irreversible” and “will, within reasonable medical judgment, produce death within six months.” Ore. Rev. Stat. § 127.800 (12). Yet the actual time from request to ingesting the lethal prescription has ranged from 15 days to 1,009 days (over two-and-a-half years).

See Oregon Public Health Division, “Oregon’s Death with Dignity Act – 2010,” at <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year13.pdf>, Table 1.

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Among those predicted to have less than six months to live, who do *not* hasten their deaths by lethal overdose, a significant percentage may live for years. In one study, among 900 patients found eligible for hospice care because they were expected to die in less than six months, 70% lived longer.

See N. Shapiro, “Terminal Uncertainty,” in *Seattle Weekly*, January 14, 2009, www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

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Broadening the Agenda to Chronic Illness and Disability in the United States

The *New York Times* reports on former Washington governor Booth Gardner, Parkinson’s disease patient and head of that state’s campaign to legalize physician-assisted suicide:

“Yet the proposed law in Washington wouldn’t go far enough for Gardner. It wouldn’t include him. Parkinson’s isn’t terminal... Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in

dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide. . . . Gardner’s campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation’s resistance will subside, the culture will shift and laws with more latitude will be passed. . . .”

D. Bergner, “Death in the Family,” *The New York Times Magazine*, December 2, 2007, pp. 38-45, 60, 76, 78, 80, and 82, at 40.

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Filing suit in Montana to urge recognition of a state constitutional right to physician-assisted suicide for “terminally ill adult patients,” the organization Compassion & Choices told the court this includes patients with chronic conditions who could live a long time if they simply receive medical treatment:

“The term ‘terminally ill adult patient,’ as used in the complaint, means a person 18 years of age or older 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. This definition is not limited to any specific set of illnesses, conditions or diseases.”

Plaintiffs’ Responses to State of Montana’s First Discovery Requests, Answer No. 4, *Baxter v. Montana*, No 2007-787 (Mont. 1st Dist., May 16, 2008), at www.margaretdore.com/pdf/C&C_Defines_Terminality.pdf.

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In 2009, assisted suicide advocates proposed a bill in New Hampshire (HB 304) allowing doctors to prescribe a lethal dose for patients with a “terminal condition.” The bill defined “terminal condition” as “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” (Sec. 137-L:2 (XIII)). Commented disability rights advocate Stephen Drake: “[T]erminality is defined as having a condition that is irreversible and will result in a premature death. Many people I work with. . . fit the definition. None of them are dying.”

S. Drake, “New Hampshire Poised to Redefine ‘Terminally Ill’ to PWDs and Others for Assisted Suicide Eligibility,” *Not Dead Yet News Commentary*, Jan. 30, 2009, <http://notdeadyetnewscommentary.blogspot.com/2009/01/new-hampshire-poised-to-redefine.html>.

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On the people “assisted” by Jack Kevorkian, who took part in an estimated 130 deaths:

“The first reported patient to seek him out and receive his aid was a 54-year-old woman with Alzheimer’s disease. His first eight such patients were women, and half of them had no terminal condition. Of the reported 75 suicides Kevorkian assisted through 1997, according to research by Silvia Canetto, a psychology professor specializing in the study of suicide at Colorado State

University, 72 percent were women, and more than three-quarters of those women were not terminally ill. (Multiple sclerosis affected about 30 percent of them.)”

D. Bergner, op. cit., at 41. Also see L. Roscoe et al., “Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998,” 343.23 *New England Journal of Medicine* 1735-6 (December 7, 2000) (reporting that “only 25 percent” of Kevorkian’s clients were terminally ill).

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Hemlock Society founder Derek Humphry on seniors in nursing homes: “Surveys have consistently found that most people would rather continue living at home rather than in a nursing home. What has not been known until recently, however, is that the aversion to ‘such a facility is so strong that 30% of those surveyed said they would rather *die* than live permanently in a nursing home.’ This information begs the question: Why do we, as a nation, not allow these people to die, if they have no alternative to a nursing home existence and this is what they want? Their lives would conclude with dignity and self-respect, and one measure of cost containment would be in place.”

D. Humphry and M. Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (St. Martin’s Press 1998) at 319 (emphasis in original).

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Collateral Damage? Assisted Suicide’s Impact on Suicides Generally

Publicity about suicide and assisted suicide, especially when it presents these favorably, leads to more suicides. This is the “collateral damage” of the assisted suicide agenda.

The World Health Organization warns that certain kinds of media coverage of suicide can lead to “imitative suicidal behaviours,” especially among young or depressed people. The WHO warns: “Avoid language which sensationalizes or normalizes suicide, or presents it as a solution to problems”; “Avoid explicit description of the method used in a completed or attempted suicide.”

World Health Organization, *Preventing Suicide: A Resource for Media Professionals* (WHO: Geneva 2008) at 6, 7, 8;

www.who.int/mental_health/prevention/suicide/resource_media.pdf.

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Unfortunately, proponents of assisted suicide engage in exactly this kind of publicity. In the year after the Hemlock Society published Derek Humphry’s book *Final Exit*, recommending a particular method for “rational suicide” in cases of terminal illness, the number of suicides by this method in New York City increased by a factor of four (from 8 to 33). During that period there was direct evidence that “at least 15 of the 144 people who committed suicide by asphyxiation or poisoning had probably been exposed to the book. . . . We found that most persons exposed to *Final Exit* were not terminally ill and had used it as a suicide manual.”

P. Marzuk et al., "Increase in Suicide by Asphyxiation in New York City After the Publication of *Final Exit*," 329.20 *New England Journal of Medicine* 1508-10 (Nov. 11, 1993) at 1509, 1510. Also see P. Chappell et al., "Final Exit and the Risk of Suicide," 267.22 *Journal of the American Medical Association* 3027 (June 10, 1992).

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A decade after Oregon's law allowing physician-assisted suicide took effect, suicide had become "the leading cause of injury death" in Oregon, and "the second leading cause of death among Oregonians ages 15-34." The suicide rate in Oregon has been rising since 2000, and in 2010 was "41 percent higher than the national average" – without counting physician-assisted suicides of seriously ill patients, which Oregon law does not allow to be counted as suicides. State public health officials have recommended special efforts to prevent suicide among young people, seniors, and veterans (who tend to have more physical health problems than others), and to "promote universal depression screening and care for adults, particularly seniors by healthcare providers" -- screening that Oregon law does not require, and Oregon doctors usually do not provide, for those requesting physician-assisted suicide.

X. Shen and L. Millet, *Suicides in Oregon: Trends and Risk Factors* (Oregon Department of Human Services, Nov. 2012) at 1.

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