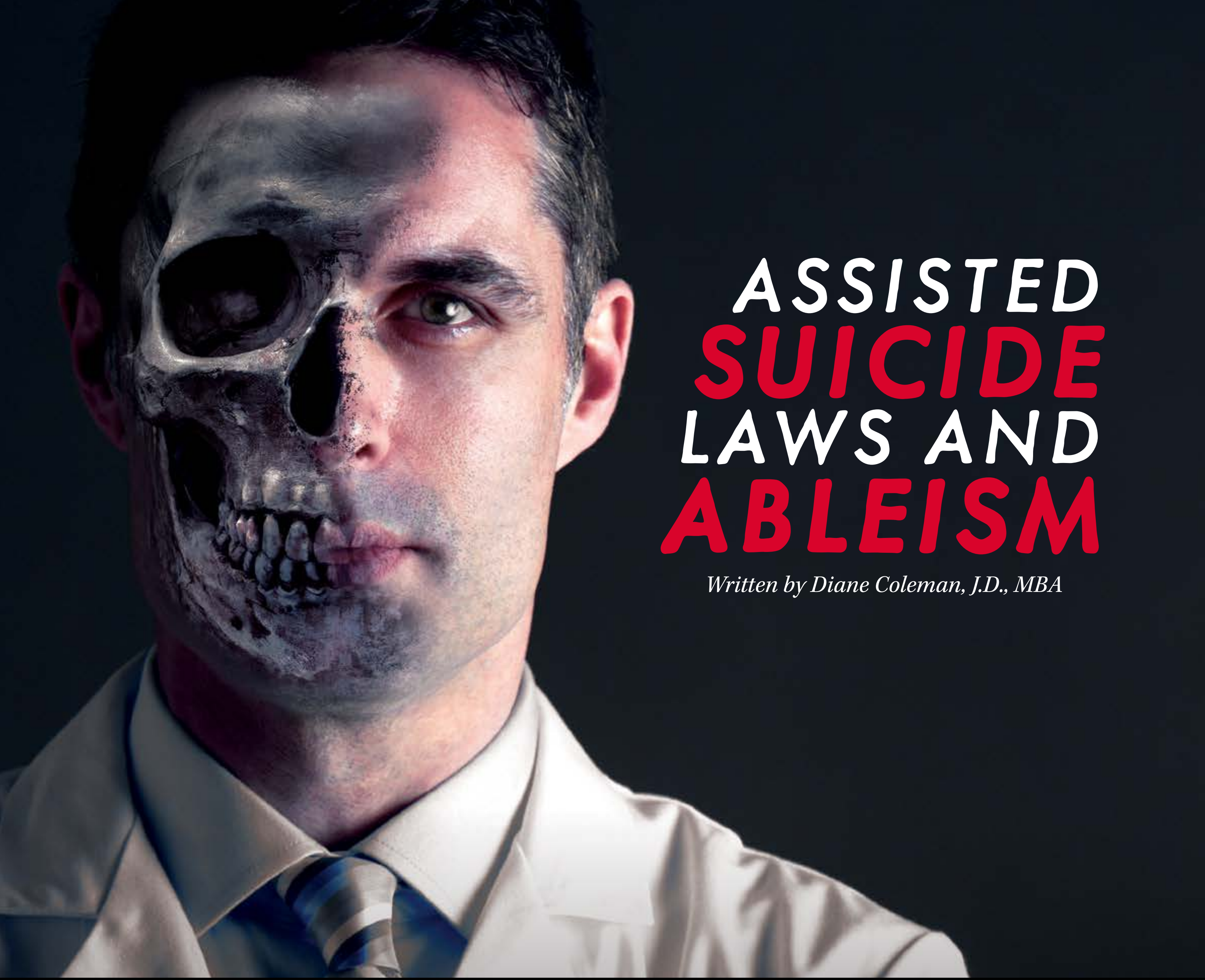

ASSISTED SUICIDE LAWS AND ABLEISM

Written by Diane Coleman, J.D., MBA

I have an advanced neuromuscular disability. Six years ago, I went into respiratory failure. I now use a ventilator with a CPAP mask about 22 hours a day, without which I would die in a short time.

As a disabled person who depends on life-sustaining treatment, I could qualify for assisted suicide if I lived where it is legal. If I became despondent, if I lost my husband or my job, and decided that I wanted to die, I would not be treated like a healthy nondisabled person who despaired over divorce or job loss.

Throughout my adult life, I have worked full time, first as an attorney and then directing small nonprofit disability organizations. I have also run a group I founded in 1996, Not Dead Yet,[1] which now has three staff, a few contractors, and volunteer advocates across the country. I have spoken at conferences, lectured at universities, published articles, submitted legislative testimony, and provided the day-to-day management an organization requires. I am not saying this to be "inspirational," but to make it clear that people like me have good lives and ***should not be written off.***

ECONOMIC PRESSURES TOWARD ASSISTED SUICIDE

If anyone doubted that someone like me would qualify for assisted suicide in a state like Oregon, those doubts were laid to rest in 2017 when an Oregon official clarified in writing:

> Patients suffering from any disease (not just those that typically qualify one for the DWDA [Death with Dignity Act]) may not be able to afford some treatments or medication, and may choose not to pursue some treatments or take some medication for personal reasons. . . If the patient does not receive treatment or medication (for whatever reason) and is left with a terminal illness, then s/he would qualify for the DWDA.[2]

If I could not afford insurance copays, I would be eligible for assisted suicide in Oregon. For over a year, I had a $500 monthly copay for my breathing support until my employer changed health plans. It was not easy. As assisted suicide gains traction, people of color, seniors, and other economically disadvantaged communities will increasingly find that other options slip away.

With managed care companies running most public and private health care, where providing expensive care generally reduces profits, we should at least question whether there is an inherent conflict of interest in having health care providers administrate a state-sanctioned assisted suicide program.

PUBLIC RELATIONS MESSAGING

In the decade leading up to the 1997 passage of Oregon's assisted suicide referendum, proponents often revealed their view that people with disabilities should be eligible. Two-thirds of "Dr. Death" Jack Kevorkian's body count were not terminally ill. The Hemlock Society contributed to his legal defense fund.

But when the Hemlock Society later morphed into "Compassion and Choices," expensive public relations efforts shifted messaging, employing an incremental strategy. Assisted suicide is only for people expected to die within six months, they said. The person must self-administer the lethal drugs, so no one else could kill them, they said.

DISABILITY DISCRIMINATION IS ABLEISM

All along, disability groups have pointed out the inherent discrimination and flimsy safeguards in assisted suicide bills. Why does everyone else get suicide prevention, while older, ill, and disabled people get suicide assistance? The discrimination of state-licensed health professionals denying equal suicide prevention and instead providing suicide assistance based on health and disability status is a fundamental violation of the Americans with Disabilities Act.

Anyone could ask for assisted suicide, but doctors decide who is eligible. Over the past year, the COVID-19 pandemic has revealed that people with disabilities have been denied treatment for the virus due to their disabilities and pervasive medical bias about our "quality of life."[3] According to a Harvard researcher, "In our survey of 714 practicing US physicians nationwide, 82.4 percent reported that people with significant disability have worse quality of life than nondisabled people."[4] This is only the most recent academic confirmation of experiences shared by many disabled people. Such bias is among the many factors that led the National Council on Disability in 2019 to issue a formal report entitled "The Danger of Assisted Suicide Laws."[5]

Reported reasons for requesting assisted suicide pertain to disability, chronic or acquired, due to illness. Oregon data lists "loss of autonomy" (91%), "less able to engage in activities" (90%), "loss of dignity" (74%), "burden on others" (47%), and "losing control of bodily functions" (43%).[6] Some of these reasons could be addressed by consumer-directed in-home personal care services, but neither disclosure nor provision of such services is required. The law operates as though the reasons do not matter and nothing needs to be done to address them. People who need home care are treated as disposable.

EMPTY "SAFEGUARDS"

Assisted suicide proponents claim that there has not been a single documented case of abuse or misuse of these laws. These claims are demonstrably false. For example, cases have been documented by Drs. Herbert Hendin and Kathleen Foley in "Physician-Assisted Suicide in Oregon: A Medical Perspective"[7] and the Disability Rights Education and Defense Fund compilation of "Oregon and Washington State Abuses and Complications."[8]

Moreover, the Oregon Public Health Division data[9] are based on forms filed by the prescribing physicians, with the early state reports admitting: "Under reporting and noncompliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division."[10]

Further emphasizing the serious limits on state oversight under the assisted suicide law, Oregon authorities also issued a release in 2005 clarifying that they have no authority to investigate Death with Dignity cases.[11] »

NON-TERMINAL PEOPLE GET LETHAL PRESCRIPTIONS

The Oregon reports show that non-terminal people received lethal prescriptions. The 2019 annual report[12] shows that at least one person lived 1,503 days, significantly longer than the 180-day prognosis the law requires. The 2020 report states that over the years, 4% of individuals who died by assisted suicide outlived their six-month prognosis.[13] This does not take into account the individuals who took the drugs quickly but may have survived if they waited.

Oregon also reports that non-cancer conditions found to qualify for assisted suicide include "neurological disease, respiratory disease, heart/circulatory disease, infectious disease, gastrointestinal disease, endocrine/metabolic disease (*e.g.* diabetes)" and, in the category labeled "other," arthritis, arteritis, blood disease, complications from a fall, kidney failure, musculoskeletal system disorders, sclerosis, and stenosis.[14]

COERCION AND ABUSE

Four people are required to certify that the person is not being coerced to sign the assisted suicide request form and appears to have decisional capacity: the prescribing doctor, second-opinion doctor, and two witnesses to the person's signature. Yet none are required to actually know the person. The typical Oregon doctor has known them for an average of 12 weeks,[15] so how could the doctor know if the person is being pressured or abused at home? This is significant in light of well-documented elder abuse identification and reporting problems in a society where an estimated 1 in 10 elders is abused, mostly by family and caregivers.[16]

Assisted suicide proponents are fond of saying that many people do not go through with it, but the lethal drugs give them peace of mind. What if some of those who change their mind about taking the lethal drugs have family members who wish otherwise? If the only other person present at the end is an impatient heir or tired caregiver, how will anyone know whether the person self-administered the lethal drugs or was cajoled, tricked, or forced?

Although "self-administration" is supposedly a key "safeguard" in all cases, in about half the reported Oregon assisted suicide deaths, there was no independent witness to consent or self-administration at the time of ingestion of the lethal drugs.[17] If the drugs were, in some cases, administered by others without consent, no one would know.

Finally, the definition of "capacity" in most assisted suicide laws and bills provides for the patient to communicate through a person "familiar with a patient's manner of communicating."[18] Doctors often speak with caregivers rather than disabled individuals, such as people with speech impairments, but this is especially dangerous in the assisted suicide context.

CONCLUSION

Proponents of legalizing assisted suicide have taken a legal immunity statute, which shields third parties, and marketed it deceptively as a personal rights statute. Only suicide assistors are protected, not patients.

Lawmakers should reject the ableism inherent in a public policy of assisted suicide and look behind the public relations images to the actual bill language to see the real dangers to the many older, ill, and disabled people who are not safe from mistake, coercion, and abuse.

Resources:

[1] *https://notdeadyet.org/*

[2] *https://drive.google.com/file/d/1xOZfLFrvuQcazZfFudEncpzp2b18NrUo/view; https://www.washingtontimes.com/news/2018/jan/11/diabetics-eligible-physician-assisted-suicide-oreg/*

[3] *https://www.centerforpublicrep.org/covid-19-medical-rationing/*

[4] *https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01452*

[5] *https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf*

[6] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf*

[7] *https://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf*

[8] *https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf*

[9] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf*

[10] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year2.pdf (page 12).*

[11] *https://dredf.org/wp-content/uploads/2012/08/Oregon-DHS.pdf*

[12] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf (page 13)*

[13] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf (page 11)*

[14] *Pages 11 & 13*

[15] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf (page 12)*

[16] *http://www.nejm.org/doi/full/10.1056/NEJMra1404688*

[17] *23rd year report, page 12*

[18] *https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx (127.800 s.1.01.(3))*

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