**Responses to the Negative Points in
Dr. Andrew Mullally’s Press Release of 9/25/2016
Concerning the Debate over Indiana State Medical Association
Resolutions on Medical Assistance in Dying**

Corrected Final Version: December 7, 2016; rev. 2/15/17

*Medical professionals should focus on providing care and comfort to patients – NOT becoming a source of lethal drugs.  Patients would not want their doctor to have this power and suggest suicide to them as an “option.”*

**Every state that has passed legislation allowing medical aid in dying specifically excludes it from the legal definition of suicide. Relief from suffering should be a physician’s primary concern, and it is only the patient who can truly determine that. Medical aid in dying would be a last resort to unbearable pain and the loss of dignity in the final days of life. In that sense, it is providing care and comfort to patients.**

*Doctors will be put in a conflict of interest with challenging patients. If a physician does not wish to continue treating a patient, this would be a safe harbor for physicians to help kill their difficult patients.*

**Given the safeguards in the proposed law, the possibility of physicians inappropriately influencing decisions regarding medical aid in dying seems quite small.  The same argument could be made about physicians' recommendations to withdraw life support.  In the experience of a retired physician on our Board, the opposite is true. He feels that continued life support is inappropriately recommended or continued by default. He suspects that physicians might more often avoid or fail to offer medical aid in dying in states where it is legal. After all, only about 1% of Oregon physicians write prescriptions for aid-in-dying medication each year. Indiana’s POST law provisions also could be abused, but it was passed in 2013 with overwhelming support from our legislators.**

*Will the government and insurance companies do the right thing – pay for treatment costing thousands of dollars – or the cheap thing – pay for lethal drugs costing hundreds of dollars?*

*Patients in Oregon have received letters from insurance companies refusing to pay for chemo but suggesting PAS.*

**These reported incidents have nothing to do with the Oregon Death with Dignity Act. Two patients who had incurable cancers received a letter from the state health insurance plan advising them that the state does not cover experimental treatments when there is less than a five percent chance the person will still be alive five years later. The drug their doctors recommended, Tarceva, may extend the life of some patients. Clinical trials found that patients taking Tarceva had a median overall survival rate of 6.7 months versus 4.7 months with a placebo.**

*Everyone knows someone who has been misdiagnosed or outlived a terminal diagnosis.*

**Two physicians must concur that the individual has a probable life expectancy of six months or less, and it is up to the patient to decide when and if to take the medication. If the person lives longer than predicted, that is good news.**

*Diabetes is considered a “terminal disease” that would qualify for PAS in Oregon.*

**This is true only if the disease has entered a terminal phase where the probable life expectancy is six months of less. Medical professionals who treat end-stage diabetes know that there are often several other complications arising at the end-stage of the disease, and diabetes itself is rarely the sole cause of the shortened life expectancy.**

*Wanting to die because of depression is treatable.  Millions of people are living proof.*

**The proposed law specifically excludes providing the medication to people who are depressed. Instead, if the person is diagnosed as depressed, the physician must refer the person to a mental health professional.**

*Everyone agrees that dying in pain is unacceptable, however nearly all pain is now treatable. A patient in pain should find a new doctor.*

**A terminally ill person may not physically be able to seek out a new doctor, or finding one could take weeks, during which time the person continues to suffer. Pain control is only the third most common reason for requesting the life-ending medication in Oregon. Loss of autonomy and serious diminution of the quality of life are the top two reasons. There is ample support in the medical literature that there are many patients for whom the pain associated with their condition is intractable. (1)**

*Oregon is proof that general suicides rise dramatically once assisted suicide is promoted as a “good.”*

**The number of suicides in Oregon was 761 in 2015 and 781 in 2014, a decrease of 2.6%. The latest official data for Indiana covers 2006-2010, during which time 4,115 people committed suicide (867 of those in 2010). The overall suicide rate in Indiana was higher than the Midwest and US rates. It is true that the percentage of people who have utilized the medication to end their own lives in Oregon has risen in the last two years for which data are available (132 in 2015 versus 105 in 2014 or a 25.7% increase), but the state is not reporting those deaths as suicides. Since the Oregon law took effect in 1997 through 2015, only 1,545 people obtained the prescription, and of those, less than 2/3 (991) died from taking the prescription. (2)**

*One could have a family member die from taking lethal drugs and would not know about it until he/she is dead because no family notification is required in advance.*

**This is true. It is a personal decision of the one who makes the request for the medication. Liberty of patient choice is the goal of the law. If a patient chooses to die alone without advising family members, he or she may do so.**

*Assisted suicide is a recipe for elder and disability abuse because it can put lethal drugs in the hands of abusers.*

*A relative who is an heir to the patient’s estate or an abusive caregiver can pick up the lethal drugs and administer them without the patient’s knowledge or consent.  There is no oversight and no witnesses are required once the lethal drugs leave the pharmacy.*

**The same could be argued for hospice care, where the dying person is usually left with a kit that contains enough morphine to end the person’s life if used all at once.**

**With medical aid in dying, the terminally ill person has been judged by two physicians to be actively dying, and only that person can initiate a request for the medication.**

**There are severe penalties (Level 1 felony) included in the draft law if another person abuses the medication. Under Indiana law a Level 1 felony carries a penalty upon conviction of a fixed term between twenty (20) and forty (40) years in prison and a fine of up to $10,000.00. This is a strong deterrent to abusing the law. Data from Oregon, Washington, Vermont and Montana collectively represent 36 years of experience with medical aid in dying without a single proven case of abuse or misuse.**

*PAS is against the Muslim faith as well as the Jewish, Christian, and Hindu faith as well as many other faith traditions.*

**A 2013 Pew Research Center poll on end of life decisions found that a majority of white mainline Protestants (61%) and about half of white Catholics (55%) approve of laws that allow physician-assisted suicide, as do two-thirds of religiously unaffiliated adults. (4)
Should we not also respect separation of church and state on these issues? There is nothing in the law that prohibits a patient from choosing not to proceed with medical aid in dying for any reason, including religious beliefs of the patient.**

*For 2500 years, physicians have professed the “Hippocratic Oath” which explicitly forbade PAS, and continue to hold as the first tenant (*sic*) of medical ethics, “primum non nocere” (first, do no harm).*

**An extensive review of the Hippocratic Oath by Dr. Steven Miles, M.D., notes “In fact, the history of the euthanasia debate and descriptions of the care of dying persons in ancient Greece make it unlikely that ‘I will not give a drug that is deadly’ refers to anything like our concepts of physician-assisted suicide, voluntary or non-voluntary euthanasia, or discontinuing life-sustaining treatment.” (5) The advances of modern medicine have largely contributed to the expansion of life spans in the last 100 years. One of the adverse consequences of these advancements is increased suffering due to longer life expectancies. What if the only “experiences” of a patient are continued pain and suffering that cannot be alleviated? Is the Hippocratic Oath better fulfilled when physicians are alleviating pain and suffering when “healing” is no longer an option? (5)**

*This would send the message to disabled and aged patients that their lives are not worth living.*

**Of course, that is not the message. The message is one of compassion and providing patients with a choice. Physicians and others supporting medical aid in dying have argued that competent, terminally ill patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering, but not dependent on life support such as respirators or dialysis, refusing treatment will not suffice to hasten death. Thus, to treat these patients equitably, we should allow assisted death as it is their only option to hasten death. (6)**

*Any safeguards set up to protect vulnerable patients from coercion to submit to PAS will erode as seen in the countries where this has been practiced for 30 years. Half of PAS nurses in those countries admit to euthanizing a patient without consent.*

**Although no source is cited for the claim about PAS nurses, an article that is sometimes referred to by opponents of medical aid in dying is: J. Pereira. "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls." *Current Oncology* v. 18, no. 2 (2011), pp. e38-e45. Pereira makes the following statements: "In a recent study in Flanders, 120 nurses reported having cared for a patient who received life-ending drugs without explicit request.  Nurses performed the euthanasia in 12% of the cases and in 45% of the cases without explicit consent."  The author makes no statement that this is half of all nurses who are involved in the process even in Flanders, and, he provides no evidence that this is a widespread phenomenon.  In fact, in the abstract for the paper he notes that in Europe all countries where it is allowed except Switzerland require the administration only by physicians.**

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**Notes**

1. *Intractable Pain.*

**“Among hospitalized patients, 25% to 40% experience uncontrolled pain at the end of life, even 3 days before death. Pain is experienced by most patients with advanced cancer, and is associated with unnecessary suffering and decreased quality of life.”
S. Dalal, E. Bruera. “Assessment and Management of Pain in the Terminally Ill.” *Primary Care* v. 38 no. 2 (June 2011), pp. 195-223.**

 **“Over half of all cancer patients will experience severe, uncontrollable pain during the course of their disease, and the management of pain is a primary challenge for the cancer patient and the treating oncologist.”
Brian L. Schmidt, Darryl T. Hamamoto, Donald A. Simone, and George L. Wilcox. “Mechanism of Cancer Pain.” *Molecular Interventions* v. 10 no. 3 (June 2010), pp. 164-178.**

**“Despite skilled palliative care, some dying patients experience distressing symptoms that cannot be adequately relieved.”
Bernard Lo, Gordon Rubenfeld. “Palliative Sedation in Dying Patients.” *JAMA* v. 294 No. 14 (October 12, 2005) pp. 1810-1816.**

**“It is unquestionable that a large minority of patients receiving PS [palliative sedation] continue to experience pain, dysphoria, or nausea or otherwise suffer in spite of optimal care, and that this suffering often continues unbeknownst to clinicians and family members.”
Alexander A. Kon. “Palliative Sedation: It’s Not a Panacea.” *The American Journal of Bioethics*, v. 11 no. 6 (2011), pp. 41-66.**

**“Palliative care is a discipline that provides satisfactory symptom relief to most patients with advanced life threatening disease. There remain circumstances, however, in which patients experience distressing symptoms and unbearable suffering that cannot be adequately relieved. In these situations, palliative sedation may be valuable as a last resort.”**

**Jorge H. Eisenchlas. “Palliative Sedation.” *Current Opinion in Supportive & Palliative Care* v. 1 no. 3 (October 2007), pp. 207-212.**

**“Awareness can occur in up to 17% of those undergoing conscious sedation. Seventeen percent of individuals who undergo palliative sedation fail to have symptoms relieved by sedation.”
Mellar P. Davis. “Does Palliative Sedation Always Relieve Symptoms?” *Journal of Palliative Medicine* v. 12, no. 10 (2009), pp. 875-877.**

1. *Rise in Suicide in Oregon and Other States*

**“Some estimates suggested that PAS also was associated with a significant increase in the rate of non-assisted suicides. When we included state-specific trends, however, the estimated association, although positive, was smaller and no longer statistically significant.”
David Albert, David Paton. “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” *SMJ; Southern Medical Journal* v. 108, no. 10 (October 2015), pp. 599-604 (603).**

**Oregon Death with Dignity Act: 2016 Data Summary (**[**http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf**](http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf)**)**

**Oregon Health Authority. Vital Statistics Annual Reports, v. 2. Mortality.**

**(**[**http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume2/Documents/2015/Table602.pdf**](http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume2/Documents/2015/Table602.pdf) **and** [**http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume2/Documents/2014/table602.pdf**](http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/Volume2/Documents/2014/table602.pdf)**)**

**Indiana State Department of Health. Suicide in Indiana Report 2006-2011. September 2013. (**[**http://www.in.gov/isdh/files/Suicide\_Report\_2013\_final(1).pdf**](http://www.in.gov/isdh/files/Suicide_Report_2013_final%281%29.pdf)**)**

1. *Possibility of Abuse by Others.*

**Indiana General Assembly. House Bill 1561 and Senate Bill 273.***.*

(<http://iga.in.gov/legislative/2017/bills/house/1561>)

(<http://iga.in.gov/legislative/2017/bills/senate/273>)

1. *Religious Objections*

**Pew Research Center. Views on End of Life Medical Treatments. November 21, 2013. (**[**http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/**](http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/)**)**

**Catholic Priest & Theologian Hans Küng has stated: “No person is obligated to suffer the unbearable as something sent from God.” “Such a freely chosen death (medical aid in dying) is not a murder, but a ‘surrendering of life’ or a ‘return of life’ to the hands of the Creator.”
Heneghan, Tom. “Catholic rebel Kueng, 85, considers assisted suicide.” Reuters. October 3, 2013.
(**[**http://www.reuters.com/article/us-religion-kueng-suicide-idUSBRE9920HX20131003**](http://www.reuters.com/article/us-religion-kueng-suicide-idUSBRE9920HX20131003)**)**

**Desmond Tutu, Archbishop of Cape Town recently stated: “Dying people should have the right to choose how and when they leave Mother Earth. I believe that, alongside the wonderful palliative care that exists, their choices should include a dignified assisted death.”
*The Washington Post*, October 6, 2016.
(**[**https://www.washingtonpost.com/opinions/global-opinions/archbishop-desmond-tutu-when-my-time-comes-i-want-the-option-of-an-assisted-death/2016/10/06/97c804f2-8a81-11e6-b24f-a7f89eb68887\_story.html?utm\_term=.8cc381524a7a**](https://www.washingtonpost.com/opinions/global-opinions/archbishop-desmond-tutu-when-my-time-comes-i-want-the-option-of-an-assisted-death/2016/10/06/97c804f2-8a81-11e6-b24f-a7f89eb68887_story.html?utm_term=.8cc381524a7a)**)**

1. The Hippocratic Oath

**“The Hippocratic Oath and the Ethics of Medicine” chapter 6, page 67, by Steven H. Miles, Oxford University Press, 2004.**

1. Disabled and Aged Persons.

**The option of medical aid in dying is supported by the American Medical Student Association, the American Medical Women’s Association, the American College of Legal Medicine and the American Public Health Association.**

**The California Medical Society, representing the largest society of physicians in the country, dropped its decades-long opposition to medical aid in dying stating “As physicians, we want to provide the best care possible for our patients. However, despite the remarkable medical breakthroughs we’ve made and the world-class hospice or palliative care we can provide, it isn’t always enough. The decision to participate in the End of Life Option Act is a very personal one between a doctor and their patient, which is why CMA has removed policy that outright objects to physicians aiding terminally ill patients in end of life options. We believe it is up to the individual physician and their patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage. Protecting that physician-patient relationship is essential.”**

**The Colorado Medical Society similarly dropped its long-held opposition stating: “The board of directors of the Colorado Medical Society, out of respect for the strongly held divergent, principled views of our colleagues regarding end-of-life assistance as proposed in Proposition 106, voted to take a neutral public stance. Our position was derived from extensive deliberation and consultation with the state’s leading clinical experts on palliative care, our appointed Council on Ethical and Judicial Affairs and a statewide survey of our members. Ultimately, Proposition 106 represents the most personal of decisions that must be left to our patients to determine in November. Should this measure pass we will continue to do our utmost to assure the highest standards and safeguards for our patients.” 64% of Coloradans who voted in November 2016 favored the proposition, so it is now legal in Colorado for a physician to provide aid in dying.**

Suggested reading:

Byron Chell. Aid in Dying: The Ultimate Argument; The Clear Ethical Case for Physician Assisted Death. 81 pp. (2014). [ISBN-13:9781497374935]