

<p>Assisted Suicide Proponents claim:</p>	<p style="text-align: center;"><i>But the truth is:</i></p>
<p><i>Oregon has had a safe, peaceful and painless experience with physician-assisted suicide</i></p>	<p>Oregon's law gives the state no resources or authority to investigate violations or abuses. It does not penalize doctors who fail to report assisting suicides and the state destroys the records and its paperwork after each annual report, making it impossible to verify those reports' conclusions independently.</p> <p>California's proposed law is written the same way and remains unchanged. While prominent Democratic legislators have asked for amendments to help address these problems – their requests go unanswered.</p> <p>In Oregon, the public must rely on independent investigations and the news media to report complications. For example, the British House of Lords report on assisted suicide in Oregon quoted numerous complications have been reported through the media. According to a report pro-assisted-suicide attorney Cynthia Barrett described a botched assisted-suicide death in Oregon. “The man was at home. There was no doctor there,” she said. “After he took it [the lethal dose], he began to have some physical symptoms. The symptoms were hard for his wife to handle. Well, she called 911. The guy ended up being taken by 911 to a local Portland hospital. Revived. In the middle of it. And taken to a local nursing facility. I don't know if he went back home. He died shortly – some...period of time after that....”</p> <p>Commenting on this botched assisted-suicide case, The Oregonian editorial columnist David Reinhard observed, “The Health Division knows nothing [about this case], though through no fault of its own. Why? Because the doctor who wrote the [assisted-suicide] prescription, the emergency medical technicians and the hospital reported nothing. Why? Because [the assisted-suicide law] reporting requirements are a sham.”</p>
<p><i>Oregon data proves patients are of sound mind and given a psychological evaluation.</i></p>	<p>According to Physicians for Compassionate Care, citing the recent Oregon report: <i>Only two of the 46 patients dying from assisted suicide in 2006 were referred for psychiatric evaluation, yet depression is the most common cause of suicidal ideation.</i> Putting 2006 Oregon data in context with previous years indicates a clear pattern. In the three years previous only two patients each year were referred for a psychological evaluation—less than five percent of patients committing assisted suicide were ever referred by the prescribing doctor.</p> <p>And what can a patient expect if they are referred to a mental health professional? <i>One session.</i> The proposed California law, just as in Oregon, only calls for one psychological session to determine a patient's mental capacity to request assisted suicide – IF referred by their attending physician.</p>

<p>This law would strengthen the doctor patient bond and open up discussions about end of life care.</p>	<p>In the April 4, 2005 issue of AmedNews.com, Peter Rasmussen, M.D seems to have found a niche market in prescribing lethal assisted suicide drugs. “He [Rasmussen] says he has written several lethal prescriptions, but said he had decided a long time ago not to talk about absolute numbers.” He said “75% of the patients who come to him regarding assisted suicide are people he has never seen before...” More disturbingly, he admits that some of these consultations have occurred via “telephone conversation.”</p> <p>But doctors’ unfamiliarity with patients requesting assisted suicide is not isolated. A 2002 memo from an Oregon Kaiser Permanente health administrator asked doctors, “Are you willing to act as the <i>Attending Physician</i> under the law for members that <i>are not</i> your patients. (AMNews, September 9, 2002)</p> <p>As defined in AB 374, “Attending Physician” means: the physician who has primary responsibility for the care of the patient and for treatment of the patient’s terminal disease. As demonstrated above, physicians can become “attending” for patients they have never treated before, solely for the purpose of prescribing lethal drugs.</p>
<p>Legalized assisted suicide only applies to terminally ill patients.</p>	<p>Many individuals with chronic illnesses or disability have been given incorrect initial prognosis or have been misdiagnosed as terminal. In addition, terminal can be a relative term as indicated by some pro-assisted suicide proponents. When testifying before the House of Lords, Ann Jackson of the Oregon Hospice Association described a woman with severe arthritis who had decided to stop eating and drinking in order to hasten her death. The woman’s daughter thought she would be ineligible for hospice care because she was not terminally ill. Ms. Jackson said, “I pointed out that if she was not eating or drinking, she was terminally ill and, yes, she should be eligible for hospice care.”</p> <p>Assisted-suicide activists now soft-pedal their movement’s earlier vigorous advocacy of voluntary euthanasia for people with disabilities. The Hemlock Society (now part of Compassion & Choices) used to define mercy-killing as “the killing of a terminally or incurably ill person to put him or her out of perceived misery.” (F. J. Girsh, “Physician Aid in Dying – What Physicians Say, What Patients Say, What Politicians Say,” <i>Western Journal of Medicine</i> 157 (August 1992): 188-89.) Hemlock’s founder Derek Humphry devoted an entire chapter of his book <i>Final Exit</i> to the need for legalized assisted suicide for people with significant disabilities. (Derek Humphry, <i>Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying</i> “The Dilemma of Quadriplegics,” 58-62)</p> <p>Once the principle of assisted suicide is established as a legal right, it will be extremely difficult or impossible to argue that the application of that right should be limited to a relatively small group of terminal patients and not allow this option for the chronically ill and disabled that have “unbearable suffering.”</p>

<p><i>If I am diagnosed with a “terminal” illness, it is my choice to control my own form of death.</i></p>	<p>According to the California Hospice and Palliative Care Association’s letter to the Senate Judiciary Committee dated June 22, 2006:</p> <p><i>Diagnosing a terminal illness is not an exact science. Studies have confirmed that prognostic error in the case of terminal illness occurs frequently. In a study of 365 doctors and 504 hospice patients conducted by Nicholas Christakis at the University of Chicago, only 20% of prognoses were accurate. Data available from the Office of Statewide Health Planning and Development (OSHPD) shows that in 2004, 700 hospice patients were discharged “live” because they no longer met the hospice eligibility criteria of having less than six months to live.</i></p> <p>Far from upholding choice, legalization fosters an environment that denies desperate people community support and encourages their suicide and statistics from the Center for Disease control show that suicide is consistently a higher cause of death in Oregon than it is in California. (Source: Center for Disease Control, National Institute of Health Statistics.)</p>
<p><i>There is no such thing as a “slippery slope”</i></p>	<p>According to Oregon’s yearly reports on assisted suicide, most Oregonians who died under that state’s law feared becoming “dependent.” If that is a justifiable reason to assist someone’s suicide, there will be no way to restrict it to people with terminal illnesses. It will inevitably be expanded to cover the perceived “unbearable suffering” of chronically ill and disabled people. The Netherlands experience with Euthanasia and assisted suicide provides some instruction on the legal evolution of these laws.</p>
<p><i>This law would not result in any cost savings to HMO’s or health care providers</i></p>	<p>“If the power of money were to weigh in on this issue next year, five years from now, 10 years from now, would we be able to hold this simply to the terminally ill and suffering?” (Fmr. Senator Joe Dunn D-Santa Ana, Associated Press 6/27/2007)</p> <p>According to hospice and healthcare data, the majority of expense in patient care is during the last year of life. In a state where healthcare under-serves traditional minority groups, legalizing state-sanctioned assisted suicide is a frightening proposition. When you consider this legislation, remember that hundreds of people die daily because they do not have access to quality health care. Underserved groups too often receive second class health services and are vulnerable to a healthcare system that steers them toward an economical and less burdensome death.</p>
<p><i>Doctors are already hastening death through a practice known as “terminal sedation.”</i></p>	<p>In palliative medicine the distressing symptoms of dying patients may occasionally require inducing unconsciousness with sedative medications. The label “terminal sedation” has generally been abandoned in favor of “palliative sedation” to clarify that the intent is to relieve symptoms, not to shorten life. Its use remains uncommon, involving a few percent of dying patients. It is done when other treatments have failed and may be or may not be accompanied by withdrawal of hydration/feeding. It is only done with the informed consent of the patient or the patient’s proxy. Most commonly it is done for severe delirium, intractable pain or breathlessness.</p> <p>The intent is to relieve terrible symptoms—not to end life. In fact, a few such patients recover from their symptom crisis and do not die. Furthermore, no studies have shown that palliative sedation shortens life, although survival under these circumstances rarely exceeds a few days with or without sedation.</p>