

SENATE BILL NO. 47
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The following testimony is from Dr. William L. Toffler MD, Professor of Family Medicine:

There has been a profound shift in attitude in my state since the voters of Oregon narrowly embraced assisted suicide 17 years ago. A shift that, I believe, has been detrimental to our patients, degraded the quality of medical care, and compromised the integrity of my profession.

Since assisted suicide became an option, I have had more than a dozen patients discuss this option with me in my practice. Most of the patients who have broached this issue weren't even terminal.

One of my first encounters with this kind of request came from a patient with a progressive form of multiple sclerosis. He was in a wheelchair yet lived a very active life. In fact, he was a general contractor and quite productive. While I was seeing him, I asked him about how it affected his life. He acknowledged that multiple sclerosis was a major challenge and told me that if he got too much worse, he might want to "just end it." "It sounds like you are telling me this because you might ultimately want assistance with your own assisted suicide- if things got a worse," I said. He nodded affirmatively, and seemed relieved that I seemed to really understand.

I told him that I could readily understand his fear and his frustration and even his belief that assisted suicide might be a good option for him. At the same time, I told him that should he become sicker or weaker, I would work to give him the best care and support available. I told him that no matter how debilitated he might become, that, at least to me, his life was, and would always be, inherently valuable. As such, I would not recommend, nor could I participate in his assisted-suicide. He simply said, "Thank you."

The truth is that we are not islands. How physicians respond to the patient's request has a profound effect, not only on a patient's choices, but also on their view of themselves and their inherent worth.

- When a patient says, "I want to die"; it may simply mean, "I feel useless."
- When a patient says, "I don't want to be a burden"; it may really be a question, "Am I a burden?"
- When a patient says, "I've lived a long life already"; they may really be saying, "I'm tired. I'm afraid I can't keep going."
- And, finally, when a patient says, "I might as well be dead"; they may really be saying, "No one cares about me."

Many studies show that assisted suicide requests are almost always for psychological or social reasons. In Oregon there has never been any documented case of assisted suicide used because there was actual untreatable pain. As such, assisted suicide has been totally unnecessary in Oregon.

Sadly, the legislation passed in Oregon does not require that the patient have unbearable suffering, or any suffering for that matter. The actual Oregon experience has been a far

cry from the televised images and advertisements that seduced the public to embrace assisted suicide. In statewide television ads in 1994, a woman named Patty Rosen claimed to have killed her daughter with an overdose of barbiturates because of intractable cancer pain. This claim was later challenged and shown to be false. Yet, even if it had been true, it would be an indication of inadequate medical care- not an indication for assisted suicide.

Astonishingly, there is not even inquiry about the potential gain to family members of the so-called "suicide" of a "loved one." This could be in the form of an inheritance, a life insurance policy, or, perhaps even simple freedom from previous care responsibilities.

Most problematic for me has been the change in attitude within the healthcare system itself. People with serious illnesses are sometimes fearful of the motives of doctors or consultants. Last year, a patient with bladder cancer contacted me. She was concerned that an oncologist might be one of the "death doctors." She questioned his motives—particularly when she obtained a second opinion from another oncologist that was more sanguine about her prognosis and treatment options. Whether one or the other consultant is correct or not, such fears were never an issue before assisted suicide was legalized.

In Oregon, I regularly receive notices that many important services and drugs for my patients—even some pain medications—won't be paid for by the State Health Plan. At the same time, assisted suicide is fully covered and sanctioned by the State of Oregon and by our collective tax dollars. Substitution of assisted suicide for medical care is not a theoretical risk. In 2007 the Oregon Health Plan denied treatment for Barbara Wagner and other patients with cancer. If the state judged that their statistical likelihood of being alive in 5 years to be less than 5% curative therapy is denied. Yet, in the same denial letter Barbara and others received, they were offered full coverage for assisted suicide.

I urge Montana's leaders to reject the seductive siren of assisted suicide. Oregon has tasted the bitter pill of barbiturate overdoses and many now know that our legislation is hopelessly flawed. Montana has been a leader ensuring access to care for its citizens; I urge every legislator to continue to promote care—not killing.

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