

To: Senate Judiciary Committee

Re: HB-505

I am writing from the perspective of a practicing internist and hospitalist with 27 years of experience treating patients with all ranges of advanced, chronic and terminal illnesses. I am opposed to assisted suicide on the following grounds:

1. It is unnecessary. In my practice lifetime I have never encountered a situation in which the aggressive use of narcotic analgesic ("pain alleviating") sedating medication failed to control a patient's terminal suffering. This "need" category is grossly exaggerated by proponents. Furthermore, it is currently legal to obtain and consume or administer such medications in quantities needed to achieve comfort, with the acknowledged risk that such doses may hasten death.
2. The potential for abuse/misuse is significant. Erroneous diagnoses and prognoses, which occur with regularity, are just one concern. Elder abuse and assisted suicide decisions made on the ground of "not wanting to be a burden" are legitimate worries, and not something that the language of the bill could ever prevent. Coercion, financially-motivated decision making, doctor shopping and discriminatory thinking and behavior toward the elderly and the disabled are documented risks when these laws are approved.
3. It's a distraction from what IS needed. Widely available and comprehensive patient centered palliative care consultations through a patient's primary provider or expert consultative services, would make assisted suicide unnecessary. Patients who are referred to such services for advice, counseling and treatment rarely if ever request assistance with suicide.
4. The Slippery Slope. While mentioned in point 2 above, it is worth reiterating this from Herbert Hendin M.D., in his testimony to the U.S. House of Representatives Committee on the Judiciary, regarding the Dutch Experience

"Over the past two decades," Hendin continued, "the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical (assistance to die), i.e. euthanasia, to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not [medically] competent to choose for themselves" (Hendin, 1996). Hendin describes how, for a substantial number of people in the Netherlands, physicians have ended their patients' lives without consultation with the patients.

Which brings one to an obvious question when we contemplate such legislation in our country: if one of the "selling points" or driving ethics of the promotion of such laws is patient autonomy and self-direction, then who are we to deny assistance with suicide to virtually any person deemed "capable"? How does one, morally and with logical consistency, limit it to the "terminally ill"?

Assisted suicide is dangerous and unneeded and only serves to distract us from a real commitment to and support of palliative care.

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