SENATE JUDICIARY
Exhibit No. 38
Date 2/10/15
Bill No. SB202

To: Senate Judiciary Committee

From: Ted W. Friesen TWF

Subject: SB 202 VOTE NO

To: House Judiciary Committee

From: Ted W. Friesen TWF

Subject: HB 328 VOTE YES

Dr. Paul McHugh, former Psychiatrist-In-Chief at Johns Hopkins Hospital, wrote an Opinion piece on Physician-Assisted-Suicide in the Wall Street Journal (dated January 23, 2015) "Dr. Death Makes a Comeback".

In the article, Dr. McHugh points out the following dangers (among others) associated with Physician Assisted Suicide. "First: Once doctors agree to assist with a person's suicide, ultimately they find it difficult to reject anyone who seeks their services. The killing of patients by doctors spreads to encompass many treatable but mentally troubled individuals, as seen today in the Netherlands, Belgium

and Switzerland.

Second: When a "right to die" becomes settled law, soon the right translates into a duty. That was the message sent by Oregon, which legalized assisted suicide in 1994, when the state-sponsored health plan in 2008 denied recommended costly cancer treatments and offered instead to pay for the less-expensive suicide drugs.....Physician-assisted suicide is sentimental medicine. It's not the sentiments that are bad; it's the medicine-bad because when assisted suicide is legalized, the sick don't get more choices for their care; they get fewer.

Assisted suicide is the cheap and easy option for doctors, a simple, irrevocable, one- size-fits-all remedy that slights diagnostic thought, forsakes therapeutic options and crosses a time-honored barrier protecting patients from mischief.

Finally," the fundamental premise of medicine is the vocational commitment of doctors to care for all people without doubting whether any individual is worth the effort. That means doctors will not hold back their ingenuity and energies treating, rich or poor, young or old, prominent or socially insignificant-curable or incurable.

This is the heart and soul of medical practice. The confidence with which patients turn to their physicians depends on it, and it is what spurs doctors to find innovative ways of helping the sick."

PO Box 1258
Bigfork, MT.

OPINION

Dr. Death Makes a Comeback

By Paul McHugh

"I guess Jack's won," a pal of mine said, alluding to Jack Kevorkian, whose views on physician-assisted suicide are lately back in vogue. With backing from liberal financier George Soros—a longtime supporter of "right to die" legislation—proponents are intent on expanding beyond Oregon, Vermont and Washington the roster of states where the practice is legal. Legislation to allow assisted suicide is moving through New Jersey's statehouse, last month a New York legislator vowed to introduce a similar bill, and in California state Sens. Bill Monning and Lois Wolk are working to legalize the practice.

Legalizing physician-assisted suicide is receiving fresh support, but doctors should think twice before signing on.

My pal may have a point, but he perhaps has forgotten how often in fights for good ideas, the bad ones—even when crushingly defeated, as when Michigan sent Kevorkian to prison in 1999—sidle back into the ring and you have to thrash them again.

Since ancient Greece physicians have been tempted to help desperate patients kill themselves, and many of those Greek doctors must have done so. But even then the best rejected such actions as unworthy and, as the Hippocratic Oath insists, contrary to the physician's purpose of "benefiting the sick." For reasons not too different, doctors traditionally refuse to participate in capital punishment; and, when they are inducted into military service, do not bear arms.

Also, as Ian Dowbiggin showed in "A Merciful End: The Euthanasia Movement in Modern America" (2003), physician-assisted suicide was periodically championed in the 20th century yet rejected time after time by American voters when its practical harms were comprehended. As recently as 2012, Massachusetts voters defeated an initiative to legalize assisted suicide.

There are two essential harms from the practice. First: Once doctors agree to assist a person's suicide, ultimately they find it difficult to reject anyone who seeks their services. The killing of patients by doctors spreads to encompass many treatable but mentally troubled individuals, as seen today in the Netherlands, Belgium and Switzerland.

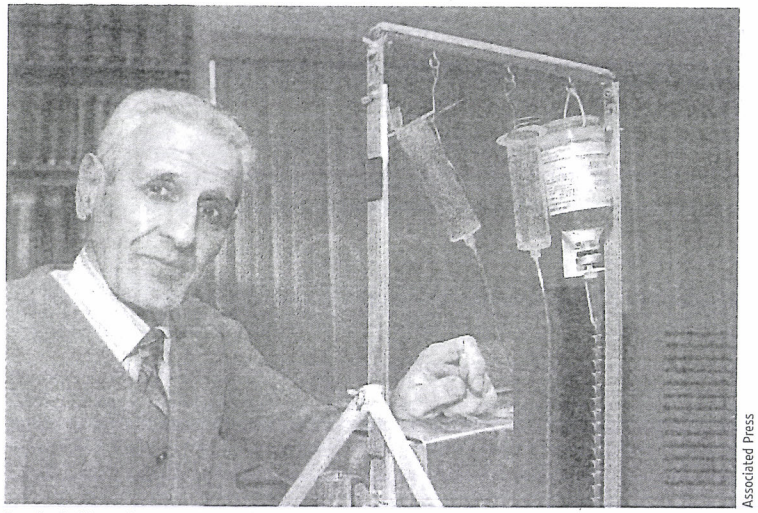
Second: When a "right to die" becomes settled law, soon the right translates into a duty. That was the message sent by Oregon, which legalized assisted suicide in 1994, when the state-sponsored health plan in 2008 denied recommended but costly cancer treatments and offered instead to pay for less-expensive suicide drugs.

These intractable, recurrent drawbacks are but one side of the problematic transaction involved with assisted suicide. The other, more telling side is the way assisting in patients' suicides hollows out the heart of the medical profession.

The fundamental premise of medicine is the vocational commitment of doctors to care for all people without doubting whether any individual is worth the effort. That means doctors will not hold back their ingenuity and energies in treating anyone, rich or poor, young or old, prominent or socially insignificant—or curable or incurable.

This is the heart and soul of medical practice. The confidence with which patients turn to their physicians depends on it, and it is what spurs doctors to find innovative ways of helping the sick.

So why do the arguments for physician-assisted suicide regularly recur? Primarily because of compelling stories about patients who despair when medical futility, burdensome treatments and an unavoidable, painful fate seem to combine. Such patients have never been rare.



Associated Press

Dr. Jack Kevorkian with his 'suicide machine' in 1991. He died at age 83 in 2011.

A recent high-profile case was that of Brittany Maynard, a 29-year-old woman diagnosed last year with a malignant brain tumor. She chose to publicize how, given her fears over what doctors were predicting, she would move from California to Oregon where a physician could—and did—prescribe medications for her to kill herself before many of the symptoms she feared had developed.

Since the time of Hippocrates, it has been the fellow-feelings evoked in all of us by patients' descriptions of their plight that have carried the argument for assisted suicide. All the counterarguments based on practical, factual or vocational matters tremble before these sentiments.

We'd be dour folk indeed if we did not respond in some way to the Brittany Maynards. But, surely one can ask, is poisoning her the best response on offer? And, since Hippocrates, most thoughtful doctors have said, "No."

Thinking about the place of sentiments in our actions might be helpful. G.K. Chesterton addressed this issue in a 1901 essay entitled "Sentimental Literature": "If sentimental literature is to be condemned," he wrote, "it must emphatically not be because it is sentimental, it must be because it is not literature." We all can immerse ourselves happily in tales of the loyal, courageous or romantic. The sentiments aren't bad; it's the literature—hackneyed, contrived, simplistic.

Physician-assisted suicide is sentimental medicine. It's not the sentiments that are bad; it's the medicine—bad because when assisted suicide is legalized, the sick don't get more choices for their care; they get fewer.

Assisted suicide is the cheap and easy option for doctors, a simple, irrevocable, one-size-fits-all remedy that slights diagnostic thought, forsakes therapeutic options and crosses a time-honored barrier protecting patients from mischief.

Proper medical end-of-life care—the kind that answers the sentiments by bringing thorough, supportive professional skills to the patient—is challenging and often complex. It depends on doctors recognizing that terminal illness is not a uniform death sentence—as Kevorkian claimed—but differs with each patient. Distressing symptoms such as pain, nausea, confusion or fear come in distinctive forms and from various sources, needing and responding to individual treatments.

For the terminally ill today, treatment of this sort is regularly supplied by palliative hospice care in ways detailed by Atul Gawande in his recent book "Being Mortal." Doctors and nurses have the tools to relieve much of the pain and suffering from terminal illnesses. With these tools—along with an interdisciplinary concern for the patient's emotional and spiritual state—hospice now can supply what Cicely Saunders, its British founder in the 1960s, promised when she declared, "Last days need not be lost days."

With physician-assisted suicide, many people—some not terminally ill, but instead demoralized, depressed and bewildered—die before their time. Hardly a surprise, that being the whole idea of suicide. All that's needed to stop this killing is for doctors, as they do with capital punishment, to refuse to participate. Hundreds of Oregon physicians already do so, and much honor to them.

Legislators and voters across the country should not let sentiment cloud their view of assisted suicide when proponents raise it for consideration yet again. Rather than legalizing physician-assisted suicide, better to advocate for palliative care by doctors and nurses who are ready to help.

Dr. McHugh, former psychiatrist in chief at Johns Hopkins Hospital, is the author of "Try to Remember: Psychiatry's Clash Over Meaning, Memory, and Mind" (Dana Press, 2008).