

# **Assisted Suicide: Death by “Choice”?**

By Rita L. Marker, Esq.

Across the country assisted suicide is being promoted as a “choice” that should be available. This promotion, however, is just the first step of a strategy developed by assisted-suicide advocates to achieve their goal of death on demand.

Assisted suicide means deliberately and intentionally providing an individual with the means to commit suicide. It means that doctors would provide lethal overdoses of drugs to patients so they can end their lives.

In 1994 Oregon voters approved the “Death with Dignity Act,” transforming the crime of assisted suicide into a “medical treatment.” In the years that followed, similar laws were proposed in more than twenty states. Each and every one failed until November 2008, when Washington State voters adopted a law virtually identical to that in Oregon.

Deceptively soothing phrases like “death with dignity” and “aid in dying” gave some people the impression that they were voting for compassionate care, for better pain control, and for the right to forego medical treatment that was overly burdensome and unwanted. Nothing could be further from the truth.

Today, a pharmacist in Oregon or Washington can dispense a lethal prescription, accompanied by instructions to take it with a light snack and alcohol to cause death. And health insurance can pay for that prescription.

Concerns about health care costs are currently reaching a boiling point. If assisted suicide is added to the cauldron, the final result can be doubly lethal. Making assisted suicide a medical treatment gives it the status of only one among many options for the treatment of certain conditions. It is extremely affordable and can always be covered by health insurance. The force of economic gravity can lead to increased pressure on patients to request, and doctors to prescribe, assisted suicide. Patients in Oregon have already encountered that reality.

In May 2008, 64-year-old retired school bus driver Barbara Wagner received bad news from her doctor. Her cancer had returned. Then she got some good news. Her doctor gave her a prescription for medication that he said would likely slow the cancer’s growth and extend her life. It didn’t take long for her hopes to be dashed.

She was notified by letter that the Oregon Health Plan (OHP) wouldn’t cover the prescribed cancer drug. It also informed her that, although it wouldn’t cover the prescription, it would cover all costs for her assisted suicide.

Wagner said she told the OHP, “Who do you guys think you are? You know, to say that you’ll pay for my dying, but you won’t pay to help me possibly live longer?”

Wagner's case was not isolated. Other patients received similar letters. An OHP spokesperson said the letters were a public relations blunder. In the future, insurance officials will "pick up the phone and have a conversation" to avoid putting the decision in writing.

Both the Oregon and Washington laws limit assisted suicide to terminally ill, competent adults who must self-administer the lethal drugs. Yet personal autonomy and ending suffering were the two chief reasons given for permitting assisted suicide in the first place. Those reasons, in and of themselves, logically demand that the practice not be limited to terminally ill, competent adults who happen to be physically able to self-administer the drugs. Consider:

- If personal autonomy is the basis for permitting assisted suicide, why would a person only have personal autonomy when diagnosed (or misdiagnosed) as having a terminal condition?
- If assisted suicide is proclaimed by force of law to be a good solution to the problem of human suffering, then isn't it both unreasonable and cruel to limit it to the dying?
- Once assisted suicide is changed from a bad thing to be prevented into a good thing to be facilitated, isn't it easy to see how the early "safeguards" will come to be seen as obstacles to be surmounted?
- On what basis could one deny a good and compassionate medical "treatment" to those who are suffering from chronic conditions? Or to children? Or to those who never have been or are no longer competent?
- If a lethal dose of drugs is considered a good medical treatment, isn't the requirement of self-administration both illogical and overly restrictive? What about the person who is physically disabled and unable to self-administer the lethal dose?

In fact, assisted-suicide leaders have acknowledged that laws like those in Oregon and Washington are only a "first step" in achieving their agenda of death, for persons of any age and for any reason.

Do we want to have a society where assisted suicide is common, where it is considered normal?

Do we want to go from a situation where, initially, people are horrified by assisted suicide, but then tolerate it and, finally, accept it? Do we want to see a time, in the not too distant future, when people feel guilty for *not* choosing assisted suicide?

Many people in Oregon and Washington, including those who voted for a "death with dignity" law, didn't have a clue about its implications. All of us need to help others know what legalized assisted suicide really means. That is the only way we can prevent its spread.

We must work to prevent assisted suicide from becoming the American way of death. Not only our lives but the lives of our children and grandchildren depend on it.

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