

NCPD Board Statement on the Washington State “Death with Dignity Act”

The National Catholic Partnership on Disability (NCPD) represents more than 14 million Catholics with disabilities in the United States. On their behalf, we urge the citizens of Washington State to VOTE “NO” on Initiative 1000. **We oppose the initiative because it is cynically misleading.** We oppose the initiative because it substitutes lethal prescriptions and illusory safeguards for compassionate care. We oppose the initiative because it does not mandate family involvement. Finally, we oppose Initiative 1000 because its supporters aim to include people with disabilities and we **emphatically** reject assisted suicide as a response to disability.

We oppose the initiative because it is cynically misleading.

Although labeled the “Death with Dignity Act,” Initiative 1000 actually authorizes physicians to prescribe lethal doses of narcotics so their terminal patients can kill themselves. It attempts to change the clear meaning of words by stating that “self-administering life-ending medication” is not suicide or assisted suicide. It requires physicians to falsify the patient’s death certificate, listing the underlying terminal disease rather than lethal medication, as the cause of death. Initiative 1000 does not authorize active euthanasia on its face; but its backers can argue, as happened in Oregon,¹ that patients unable to self-administer lethal medication may be entitled to direct assistance as an accommodation legally required by their disabling conditions.

We oppose the initiative because it substitutes lethal prescriptions and illusory safeguards for compassionate care.

Initiative 1000 does little to ensure that physicians have their patients’ best interest in mind. Experts point out that, when patients are treated by physicians “who can hear their desperation, understand the ambivalence that most feel about their request, treat their depression, and relieve their suffering, their wish to die usually disappears.”² Initiative 1000 is not concerned with carefully tending to these needs but rather with carefully protecting physicians from legal liability and professional sanctions for helping their patients to die.

The safeguards Initiative 1000 provides patients are largely illusory. Physicians, for instance, are to inform their patients of available alternatives to suicide, including palliative care for the effective management of pain and other symptoms. Few physicians are expert in such care, however; and this expertise is not required in order for them to write a lethal prescription. Without a good knowledge of pain-management, these doctors are not able to fully inform patients of their options. Good palliative care, along with psychotherapy and antidepressant medication, is “instrumental in providing relief from distress and making it possible for patients to appreciate and even enjoy whatever time they have left to live.”³

¹ See Letter from Oreg. Deputy A.G. David Schumann to State Sen. Neil Bryant, Chair, Senate Judiciary Committee (Mar. 15, 1999).

² Hendin, Herbert & Foley, Cathleen, “Physician-Assisted Suicide in Oregon: A Medical Perspective,” 106 *Mich. L. Rev.* 1613, 1623 (June 2008).

³ *Id.* at 1631.

The fact is that, in Oregon, inadequately treated pain is a bigger problem for terminal patients since that state's assisted suicide program began.⁴ Pain control was a concern raised by more Oregon patients requesting lethal prescriptions in 2007 than in any previous year.⁵ Ironically, the Oregon Health Plan now considers physician assisted suicide a form of palliative care; so the state will pay for assisted suicide instead of paying for certain expensive chemotherapy for advanced cancer treatment.⁶

Supporters contend that there is a safeguard for depressed patients within the Initiative since doctors are required to refer such patients whose judgment they consider impaired for psychiatric or psychological counseling before giving them a lethal prescription. Yet, just as in the case of doctors lacking specialized knowledge about palliative care, neither the attending nor consulting physicians need to have specialized training to identify such depression. Notably, of the 49 patients who died last year from lethal medication under Oregon's nearly identical law, none had been referred by their physicians for psychiatric evaluation.⁷ Since patients under Initiative 1000 can have lethal drugs in hand less than three weeks after receiving a terminal diagnosis, when depression is surely at its greatest, its failure to mandate counseling in all cases is a major flaw and a reason to reject the Initiative.

We oppose the initiative because it does not mandate family involvement.

Caring families who may be able to offer additional support and express their affection in ways that change the minds of loved ones to end their lives, are not ensured that opportunity. And because Initiative 1000 requires that the death certificate falsely list the underlying terminal condition as the cause of death, they may never know that their loved ones committed suicide with their physicians' assistance.

We oppose Initiative 1000 because its supporters aim to include people with disabilities and we emphatically reject assisted suicide as a response to disability.

Booth Gardner, a major supporter of the Initiative, explained his views in an interview with the New York Times Magazine (Dec. 2, 2007): “‘This will be my last campaign....’ He has Parkinson’s.... [A]nd his last campaign is driven by his desire to kill himself. ‘I can’t see where anybody benefits by my hanging around....’” Mr. Gardner has a disability, and he clearly supports Initiative 1000 because he hopes it will eventually allow people with disabilities, not just those with terminal conditions, to kill themselves.

Once assisted suicide is accepted by a society, extending its use to other than terminally ill persons is but a short step. In the Netherlands, the procedure has progressed from the terminal patient to those chronically ill, from physical illness to psychological distress, from voluntary euthanasia to non-voluntary and involuntary euthanasia. There is no reason to assume that this will not happen here.

As compassionate forms of care become less available and deemed too expensive by health care providers, terminally ill and disabled patients will feel more marginalized, with no other

⁴ See *id.* at 1619.

⁵ See Oreg. Dept. of Human Services, “Summary of Oregon’s Death with Dignity Act - 2007.”

⁶ See Christie, Tim, “A Gift of Treatment,” *The Register-Guard* (June 3, 2008).

⁷ See Oreg. Dept. of Human Services, “OR_PAS_yr10-tbl-1” (2007).

alternative than assisted suicide. This is neither compassionate care nor real choice and is beneath the dignity of any civilized society.

Conclusion

Legalizing assisted suicide is abandoning the higher goal of truly compassionate care for the dying. Assisted suicide eliminates the patient, not the pain. As representatives of more than 14 million people who live with challenges but love life, we urge the voters of Washington to discard Initiative 1000, not the lives of terminally ill patients and, as its backers hope, the lives of people with disabilities as well. We urge you to vote “NO” on Initiative 1000 because, rather than providing patients death with dignity, it presumes that they are only dignified when dead.

Distributed by



415 Michigan Avenue, NE Suite 95
Washington, DC 20017

202-529-2933; 202-529-2934 (tty); 202-529-4678 (fax)

www.ncpd.org