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Physician-Assisted Suicide: Threat to Improved Palliative Care

Advocates for assisted suicide claim that the practice can simply be added to the “palliative care” options available to patients, and allowing it will improve end-of-life care. There is ample evidence that the opposite is true: Legalizing assisted suicide undermines efforts to maintain and improve good care for patients nearing the end of life, including patients who never wanted assisted suicide.

“We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide. A broad right to physician-assisted suicide could undermine efforts to marshal the needed resources, and the will, to ensure humane and dignified care for all persons facing terminal illness or severe disability.”

L. Snyder and D. Sulmasy, “Physician-Assisted Suicide” (Position Paper of the American College of Physicians and American Society of Internal Medicine), 135 *Annals of Internal Medicine* (2001) 209-16 at 214.

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Vermont legalized physician-assisted suicide in 2013. In 2015, the state’s Visiting Nurse Association announced it is conducting a study to discover why the state has “the third lowest hospice utilization rate in the nation.”

“Vermont VNA Seeking to Identify Causes of State’s Low Hospice Utilization Rates,” *Hospice and Palliative Care News*, April 29, 2015, at <http://healthrespubs.com/hospice-and-palliative-care-news/2015/04/29/vermont-vna-seeking-to-identify-low-hospice-utilization-rates/>.

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Oregon was a leader in promoting hospice care *before* it legalized assisted suicide. After legalization, its percentage improvement in utilization of hospice fell *below the national average*. The state opened only five new hospices from 2000 to 2014, at a time when 1,832 opened in other states. Washington, which legalized assisted suicide in 2008, also has a hospice utilization rate below the national average.

J. Ballentine et al., “Physician-Assisted Death Does Not Improve End-of-Life Care,” *Journal of Palliative Medicine* 19 (2016): 1-2.

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From one study of severe pain and distress in dying patients in Oregon, comparing the period before the assisted suicide law took effect (1996-1997) to a period after it took effect (1999-2002): “The frequency of family reports of moderate or severe pain or distress in Oregon decedents increased—from 30.8% in 1996-1997 to 48% in 1999-2002... An increase from 30.8% to 48% represents the increased suffering of over 5,000 additional decedents and families. Higher levels of pain have profound effects on seriously ill patients and are associated with greater functional impairment, greater depression, anxiety and suicidal ideation, and worsening cognition... In Oregon, there is evidence that...resources [for end-of-life care] have been stretched more thinly. Medicare patients in Oregon have among the lowest reimbursement in the

United States during the last 6 months of life and have fallen significantly during the study period.”

E. Fromme et al., “Increased Family Reports of Pain or Distress in Dying Oregonians: 1996 to 2002,” 7 *Journal of Palliative Medicine* (2004): 431-42 at 437, 439.

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While supporters of the Oregon assisted suicide law say it has helped the state maintain and improve its status as a leader in end-of-life care, this was not borne out by a nationwide study by the respected Last Acts coalition in 2002. The study “graded” the 50 states on various elements of such care, and found that a number of states where assisted suicide is illegal outpaced Oregon in key areas. According to the Last Acts report card: On median number of days in hospice, Oregon received a “D” (6 states had a better grade); on percentage of hospitals reporting a pain management program, a C (5 states and the District of Columbia); on percentage of hospitals reporting a hospice program, a D (three states); on percentage of hospitals reporting a palliative care program, an E (11 states and the District of Columbia); on percentage of nursing home residents with persistent pain, a C (one state, Hawaii, had a better grade; only 11 states had a worse one); on strength of the state’s pain policies, a C (16 states better); on percentage of primary care physicians who are certified in palliative medicine, a C (14 states); on percentage of nurses certified in palliative care, a B (5 states). As a sign of hope, the study noted that 30 states had statewide coalitions or partnerships to improve care of the dying; Oregon was not among them.

Last Acts, *Means to a Better End: A Report on Dying in America Today* (November 2002), www.rwjf.org/files/publications/other/meansbetterend.pdf, at 19, 23, 24, 25, 32, 36, 41, 42, 55.

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By contrast, palliative care has improved markedly when states pass laws that *prohibit* assisted suicide but explicitly allow use of powerful and effective drugs like morphine to control pain. According to a palliative care expert at Johns Hopkins University School of Medicine, “in Maryland as well as in every state that had passed such legislation, there was an increase in the legitimate prescription of opioids and other strong medications used for pain control. Indeed, physicians universally expressed a mixture of relief and elation on knowing that, for the first time, such protective legislation existed.”

F. Gloth, *Handbook of Pain Relief in Older Adults: An Evidence-Based Approach* (Humana Press 2004): 193. For data on increased use of morphine for pain control in 12 states after they passed such laws, see Brief Amicus Curiae of the U.S. Conference of Catholic Bishops, *et al.*, in *Gonzales v. State of Oregon* (May 9, 2005): 18-22, at <http://www.usccb.org/about/general-counsel/amicus-briefs/upload/amicus-sct-gonzales-v-oregon-2005-05.pdf>.

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In his concurring opinion in the U.S. Supreme Court’s 1997 rulings against a constitutional right to assisted suicide, Justice Breyer noted that a study by the British House of Lords found that “the number of palliative care centers in the United Kingdom, where physician assisted suicide is illegal, significantly exceeds that in the Netherlands, where such practices are legal.” The study found 185 such centers in the UK, but only 3 in the Netherlands.

Washington v. Glucksberg, 521 U.S. 702 (1997) at 792 (Breyer, J., concurring in the judgment), citing 2 House of Lords, Session 1993-1994 Report of Select Committee on Medical Ethics 113 (1994).

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A leading hospice physician in the Netherlands writes: “Accepting euthanasia or assisted suicide as a normal medical practice for some cases of unacceptable suffering assumes that the process will be controllable... Regulation has proved to be difficult if not impossible and is fraught with danger. It also serves to stifle creativity in palliative care and even to make proper care impossible to achieve.”

The physician recounts that he once had to explain to a colleague how to relieve a bowel obstruction that was causing great distress for a cancer patient. “Usually I solve this kind of problem by euthanasia,” the colleague explained, but in this case the patient did not accept euthanasia. The author comments: “The physician’s remark that he usually solves such problems with euthanasia is disturbing. It illustrates how euthanasia becomes a substitute for learning how to relieve the suffering of dying patients. Ordinarily physicians learn more from their patients than from books. By endangering this process, euthanasia has consequences not only for a particular patient, but also for the quality of care in general.”

Z. Zylicz, “Palliative Care and Euthanasia in the Netherlands: Observations of a Dutch Physician,” in K. Foley and H. Hendin, *The Case Against Assisted Suicide: For the Right to End-of-Life Care* (Johns Hopkins University Press 2002), 122-43 at 140-41, 142.

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