

'Right to die' can become a 'duty to die'



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Imagine that you have lung cancer. It has been in remission, but tests show the cancer has returned and is likely to be terminal. Still, there is some hope. Chemotherapy could extend your life, if not save it. You ask to begin treatment. But you soon receive more devastating news. A letter from the government informs you that the cost of chemotherapy is deemed an unjustified expense for the limited extra time it would provide. However, the government is not without compassion. You are informed that whenever you are ready, it will gladly pay for your assisted suicide.

Think that's an alarmist scenario to scare you away from supporting "death with dignity"? Wrong. That is exactly what happened last year to two cancer patients in Oregon, where assisted suicide is legal.

Barbara Wagner had recurrent lung cancer and Randy Stroup had prostate cancer. Both were on Medicaid, the state's health insurance plan for the poor that, like some NHS services, is rationed. The state denied both treatment, but told them it would pay for their assisted suicide. "It dropped my chin to the floor," Stroup told the media. "[How could they] not pay for medication that would help my life, and yet offer to pay to end my life?" (Wagner eventually received free medication from the drug manufacturer. She has since died. The denial of chemotherapy to Stroup was reversed on appeal after his story hit the media.)

Despite Wagner and Stroup's cases, advocates continue to insist that Oregon proves assisted suicide can be legalised with no abuses. But the more one learns about the ac-

tual experience, the shakier such assurances become.

At a meeting in the House of Commons on Monday night hosted by the anti-euthanasia charity Alert and Labour MP Brian Iddon, I hope to bring home to MPs and the British public just how dangerous it would be to legalise euthanasia. The Oregon experiment shows how easily the "right to die" can become a "duty to die" for vulnerable and depressed people fearful of becoming a burden on the state or their relatives. I know that a powerful and emotive campaign is being waged in the UK media – using heart-rending cases such as multiple sclerosis sufferer Debbie Purdy – to inveigle Parliament into changing the law.

Miss Purdy, who lost in the Appeal Court on Thursday, wants to secure a legal guarantee that her husband would not be prosecuted if he accompanied her to the Dignitas clinic in Switzerland – one of the few places where euthanasia is legal. Much as I sympathise with her plight, such a guarantee would lure us on to the slippery slope where the old and the sick come under pressure to end their lives.

A study published in the *Journal of Internal Medicine* last year, for example, found that doctors in Oregon write lethal prescriptions for patients who are not experiencing significant symptoms and that assisted suicide practice has had little to do with any inability to alleviate pain – the fear of which is a chief selling point for legalisation.

The report said that family members described loved ones who pursue "physician-assisted death" as individuals for whom being in control is important, who anticipate the negative aspects of dying and who believe the impending

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loss of self and quality of life will be intolerable. They fear becoming a burden to others, yet want to die at home. Concerns about what may be experienced in the future were substantially more powerful reasons than what they experienced at that point in time.

When a scared and depressed patient asks for poison pills and their doctor's response is to pull out the lethal prescription pad, it confirms the patient's worst fears – that they are a burden, that they are less worth loving. Hospices are geared to address such concerns. But effective hospice care is undermined when a badly needed mental health intervention is easily avoided via a state-sanctioned, physician-prescribed overdose of lethal pills.

Do the guidelines protect depressed people in Oregon? Hardly. The law does not require treatment when depression is suspected, and very few terminal patients who ask for assisted suicide are referred for psychiatric consultations. In 2008 not one patient who received a lethal prescription was referred by the prescribing doctor for a mental health evaluation.

As palliative care physician Dr Kathleen Foley and psychiatrist Herbert Hendin, an expert on suicide prevention, wrote in a scathing exposé of Oregon assisted suicide, physicians are able to "assist in suicide without inquiring into the source of the medical, psychological, social and existential concerns that usually underlie requests ... even though this type of inquiring produces the kind of discussion that often leads to relief for patients and makes assisted suicide seem unnecessary."

Oregon has become the model for how assisted suicide is supposed to work. But for those who dig beneath the sloganeering and feel-good propaganda, it becomes clear that legalising assisted suicide leads to abandonment, bad medical practice and a disregard for the importance of patients' lives.

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