Written Testimony of Bobby Schindler, M.S.
Opposing S.B. 579
Relating to Legal Forms of Suicide
April 5, 2019

Dear Chair and Members of the Committee:

My name is Bobby Schindler, and I serve as President of the Terri Schiavo Life & Hope Network. I submit this testimony on behalf of that organization as well as Americans United for Life, America's oldest and most active pro-life advocacy organization. My work as a disability rights advocate began with fighting for the life of my sister, Terri Schindler Schiavo. Advocating for Terri's life began in 2000, and lasted for five long years until she was was starved and dehydrated to death by court order at the demand of her husband in 2005. Terri was simply a disabled American; she had been neither actively dying nor near death, but death was intentionally caused by the denial of her basic care, food and water. I have spoken extensively throughout the United States and internationally about Terri, her case, and countless thousands of individuals facing the prospect of similar forms of denial of basic care.

For the past decade acting as a patient advocate, it has been become disturbingly evident that protections for medically vulnerable persons—elderly, disabled, chronically ill, and those with forms of depression or other treatable health issues—are being slowly eroded, thereby increasing the risk of patients facing an encouraged or imposed premature death by laws, policies, and healthcare systems. Consequently, I have deep concerns regarding the proposed bill that will expose more medically vulnerable persons to the expanding dangers of Oregon's current assisted suicide law.

While Oregon legalized "physician assisted suicide" in 1996, the bill now being considered would carry the state's toleration of suicide to new extremes. S.B. 579 eliminates the state's responsibility to act as an advocate for the vulnerable, in particular the elderly and the disabled. Indeed, the language under consideration will necessarily put many individuals in harm's way. This bill underscores the deep concerns opponents of suicide-tolerant laws have long expressed that the toleration of certain forms of suicide will naturally result in the expansion of the so-called "right to suicide." S.B. 579 pushs Oregon to adopt suicide as a right and will make it impossible for the state to legitimately regulate and thus to ensure individual protection from abuse.

Abuses and Coercion of Vulnerable Patients

Any language that incorporates vague or over-broad interpretations of the law will lead to abuse of the sort that will be impossible to prove. Persons who are made to feel unwanted or

unloved, particularly persons with disabilities and the elderly, will be at serious risk by the expanded suicide regime now under consideration.

In 2016 alone, nearly 4,000 Oregonians were victims of elder abuse.[1] Every similar case in the future will be exacerbated by the sort of suicide expansion being considered. Instead of diminishing protections, the state should prioritize protecting all vulnerable individuals. This is why I oppose suicide in all its forms, whether by physician or through other means.

The relative or subjective quality of one's daily experiences in life does not determine the objective and fundamental value of one's life. If Oregon wishes to enshrine suicide and death as a legitimate alternative to living with disability or a terminal disease, then the proposed legislation can and will further normalize suicide in Oregon

Leaders in the fields of bioethics, law and policy, and medicine share serious and fundamental concerns regarding abuses and failures in states like Oregon that have embraced forms of suicide as a legitimate social policy.[2] This would include a lack of reporting and accountability, as well as the failure to assure the competency of the requesting individual.[3] The bills under consideration would compound these deficiencies.

American Medical Association Opposes Suicide by Physician

Perhaps most noteworthy is that the American Medical Association (AMA) opposes suicide by physician, even in "end of life" scenarios. This is because the AMA believes that "permitting physicians to engage in assisted suicide would ultimately cause more harm than good." Furthermore, suicide by physician "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[4]

Waiting Periods Are an Important Safeguard

S.B. 579 would eliminates the waiting period for the second request for life-ending medication and the waiting period for the writing of the prescription for life-ending medication for patients when the physician has "medically confirmed" that the patient will, "within reasonable medical judgment" die before the waiting period elapses. If a patient is told "reasonable medical judgment" gives him less than 15 days to live, he would be able to make the request for life-ending medication and receive the prescription without having time to fully process this information.

It is not always medically possible to predict the course of serious diseases, as the Supreme Court recognized in *United States v. Rutherford*. Rejecting the notion that the "safety and efficacy" requirements of the Food, Drug and Cosmetic Act were inapplicable to the prescribing of laetrile for "terminal" cancer patients, the Court observed:

> The FDA's practice [of considering "effectiveness" of drugs used to treat terminal patients] also reflects the recognition, amply supported by expert medical testimony in this case, that with diseases such as cancer it is often impossible to identify a patient as

> terminally ill except in retrospect. Cancers vary considerably in behavior and in responsiveness to different forms of therapy. Even critically ill individuals may have unexpected remission and may respond to conventional treatment.

United States v. Rutherford, 442 U.S. 544, 556-57 (1979) (holding that there is no exception under the Federal Food, Drug, and Cosmetic Act for drugs used by the terminally ill). [6]

As the most recent Data Summary from Oregon shows, the median period of time between the first request for medication and death was 43 days in 2018, and 47 days from the first year of legalization. [5] Patients should be given this much-needed time to consider all the alternatives. In a recent article, a neuroscientist identified three reasons why patients often recover from what might be a seemingly hopeless prognosis: (1) their will to live, (2) support from family, and (3) love. Similar studies conclude that those contemplating forms of suicide almost always are suffering emotionally or psychologically, and often lose their will to live or lack family support. [7] Expanding assisted suicide will necessarily increase the vulnerability of already-vulnerable persons who are not genuinely terminal and who would benefit from authentic care and treatment.

Distinguishing Suicide and Care

Encouraging new forms of suicide does nothing to provide the sort of care and treatment that thousands of vulnerable Oregonians would benefit from each year. What is being considered in these bills is neither a medical nor healthcare issue.

What people who allegedly "want to die" need is encouraging life-affirming care, comfort, and compassion. Senate Bill 579 will only encourage vulnerable individuals to embrace suicide as an option. Therefore, I ask you to reject Senate Bill 579. Thank you.

Sincerely,

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[1] Zarkhin, & Terry, (2017) *Kept in the Dark: Oregon hides thousands of cases of shoddy senior care*, www.oregonlive.com/health/index.ssf/2017/04/senior_care_abuse_neglect_poor_care_hidden.html

[2] Washington State Death with Dignity Act Report (2018), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf

[3] Disability Rights Education & Defense Fund (DREDF), *Why Assisted Suicide Must Not Be Legalized*, https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#safeguards

[4] AMA Code of Medical Ethics Op. 5.7 (Physician–Assisted Suicide), https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf.

[5] Or. Health Auth. Pub. Health Div., Oregon Death With Dignity Act 2018 Data Summary (Feb. 15 2019) https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf (last visited Apr. 4, 2019).

[6] See also *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (quoting 42 Fed.Reg. 39768, 39805) (Statement of Dr. Peter Wiernik, Chief of the Clinical Oncology Branch of the National Cancer Institute's Baltimore Research Center which stated that, "no one can prospectively define the term 'terminal' with any accuracy .... Many patients who are critically ill respond to modern day management of cancer.").

[7] Owen, Adrian M OBE, Ph.D., *When a Vegetative-State Patient Returns to Tell the Tale*, https://www.psychologytoday.com/us/blog/the-gray-zone/201902/when-vegetative-state-patient-returns-tell-the-tale