

My name is Steve Brunk and I'm here representing the Family Policy Alliance of Kansas. We regularly communicate with thousands of individuals and families across our state. Additionally, Family Policy Alliance works in conjunction with over 40 policy councils across the country to promote a state and nation where God is honored, religious liberty flourishes, families thrive, and every life is cherished. To that end, **we strongly support HCR 5010.**

**Assisted suicide is currently prohibited by state statute** (often as a felony) or common law in **44** states, including Kansas. Assisted suicide is also opposed by most of the country's leading medical organizations, including: American Medical Association, American Medical Directors Association, National Hospice & Palliative Care Organization, National Spinal Cord Injury Association, American College of Medical Quality, American Nurses Association, Christian Medical and Dental Association, and Catholic Health Association. Sadly, an organization called Compassion and Choices (better known as the "Hemlock Society") has been pushing states to legalize assisted suicide and just experienced success in Colorado and Washington, D.C. **There has even been a bill introduction (HB2120, the so called "Kansas Death with Dignity Act) to this committee proposing physician assisted suicide. That brings this topic very close to home.**

**Assisted suicide policies rely upon legislators' judgment that the lives of some patients in Kansas are no longer worth living. Kansans need their elected officials to push forward HCR 5010 so they can be reassured that their elected officials still believe that ALL of our lives are worth fighting for.**

HCR 5010 reinforces that Kansas legislators believe our state has an unqualified interest in the preservation of human life, preventing suicide, identifying and treating the causes of suicide, and in interpreting and treating the suicidal impulses of Kansans who are elderly, or who have disabilities or serious illnesses, the same as anyone else's.

**Assisted suicide policies send mixed messages to society.** Some who express a desire for suicide will be given intervention and treatment. Others who express that same desire will be given a lethal prescription. The defining line between these two groups will almost always be based on health condition, socioeconomic status, and/or physical ability. HCR 5010 is needed to affirm that Kansas will not become a state where compassion and healthcare are reserved only for those in good health or above the poverty line.

**HCR 5010 further reinforces that suicide is not medical care.** Again, from the experience in Oregon, we know that nearly half of patients seeking assisted suicide change their minds when physicians intervene and appropriately address suicidal feelings by treating their pain, depression and other medical problems. Assisted suicide policies debase



February 23, 2017

ATTN: Bette Crigger, Administrator  
Council on Ethical and Judicial Affairs,  
American Medical Association

[SUBMITTED ELECTRONICALLY: [bette.crigger@ama-assn.org](mailto:bette.crigger@ama-assn.org)]

Dear Council on Ethical and Judicial Affairs:

Family Policy Alliance, Focus on the Family, and our network of 40 state-based family policy councils have been working to influence public policy, through grassroots advocacy and through our work at state legislatures and Congress, since the late 1980s. Our organizations submit this letter for consideration by your members during your March meeting regarding the American Medical Association's position on physician-assisted suicide.

Our organizations firmly believe that every life is worth fighting for, regardless of health condition, disability, socioeconomic status, or any other factor. We have long appreciated your strong opposition to the legalization of assisted suicide as "fundamentally incompatible with the physician's role as healer" and a harm to society—instead guiding your physicians nationwide to "aggressively respond to the needs of patients at the end of life."<sup>1</sup> Your position has been critical in affirming that physicians will believe that the lives of their patients are worth fighting for—even when they face a serious illness.

If the American Medical Association (AMA) were to soften its strong opposition to assisted suicide, this would represent a radical shift in the medical profession. We believe this shift would result in three main harmful consequences to families across the country—consequences that underscore the AMA's sound rationale in opposing assisted suicide in the first place: (1) A lethal prescription will become an acceptable (and more affordable) form of "healthcare," distorting the physician's role as healer; (2) Physicians will no longer need to aggressively respond to the needs of their patients near the end of life, especially when those patients lose hope; (3) Public policy and society will follow the lead of their trusted medical professionals, creating discrepancies in law and culture between who is worthy of receiving suicide intervention and who is not. We will briefly elaborate on each of these consequences in the remainder of this letter.

### **Lethal prescriptions distort the physician's role as healer**

First, when suicide is prescribed by respected professionals entrusted with the care of our own lives, a physician is no longer a healer. Rather, the physician is now complicit in an act that results in the taking of a life—an act that is currently prohibited by statute (often as a felony) or

---

<sup>1</sup> Am. Med. Ass'n, Code of Med. Ethics No. 5.7, available at <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf> (last visited Feb. 17, 2017).

common law in 44 states.<sup>2</sup> There are several obvious reasons that caution against a policy that debases the physician's proper role as healer.

**a. What constitutes a "terminal illness" is overly broad**

The first is a technical issue with assisted suicide laws in general. The definition of "terminal illness" in these laws is overly broad, usually defined similar to California's: "Terminal disease means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months."<sup>3</sup> We are certain you will immediately see as medical professionals that these overly broad definitions can include diseases such as diabetes, which could result in death within six months if left untreated. The overly broad definition would then include millions of Americans—not only those suffering from terminal illnesses that are seemingly inexorable even in the face of standard curative treatment or management, but also those suffering from a manageable but *potentially* fatal condition or disease. If the AMA were to soften their opposition to assisted suicide, the well-respected organization would be sending a message that even those with diseases like diabetes should have access to a lethal dose.

**b. Prognoses can be wrong**

Assisted suicide further debases a physician's role as healer and harms the ability of a physician to work with his or her patient (and the family) individually because, as your physicians will attest, prognoses can be wrong. Often unexplainably, patients will far outlive their six-month or other prognosis—much to the joy of their loved ones and even their physicians. Currently, physicians are typically the ones who know their patients best, besides loved ones. They are able to work with patients individually to make judgment calls and know best how a patient will respond to various treatments based on personal medical history. Assisted suicide removes individualization and requires that patients be offered the option of a lethal dose if "standard medical practice" and averages dictate that a patient should only live six more months maximum. Should the AMA be in the position of encouraging physicians to write lethal prescriptions for patients who are "likely to die within six months according to standard medical practice"? We argue they should not. Assisted suicide cuts short individualized care and the opportunity for unexpected months or even years of remaining life for patients and their loved ones. The medical profession is far too respectable for this and should remain healers in the eyes of the families who trust them.

**c. Assisted suicide policies implicate healthcare professionals in falsifying state records**

As if the above reasons were not enough, assisted suicide typically requires physicians to participate in falsifying official state records. In states where assisted suicide legislation has passed, the cause of death on death certificates and medical records is listed as the underlying disease that gave the patient access to the life-ending drug in the first place.<sup>4</sup> The impact of falsified death records is far-reaching—including inaccurate statistics for the particular disease from which the patient suffers, inaccurate census data, inaccurate genealogy, and hindered criminal or other investigations for officials attempting to uncover the cause and manner of death. The integrity of the medical community and the healers' interest in accurate records on their patients and health conditions should not be sullied by assisted suicide policies requiring physicians to engage in deceiving the very communities they serve.

---

<sup>2</sup> See, e.g., Minn. Stat. § 609.215 (2016); N.D. Cent. Code § 12.1-16-04; R.I. Gen. Laws § 11-60-3.

<sup>3</sup> See, e.g., Cal. Code § 443.1 (2015).

<sup>4</sup> See, e.g., Wash. Code § 70.245.040(2) (2016).

**d. The reasons patients choose assisted suicide reveal the need for a true healer, not a lethal prescription**

Finally, the very reasons given by patients for choosing assisted suicide reveal the harm these policies cause to physicians' role as healer. From the data available in Oregon, the state with the oldest assisted suicide law, the overwhelming top three reasons for a patient choosing assisted suicide do not include pain. Rather, the top three reasons were (1) loss of autonomy, (2) losing the ability to engage in activities that make life enjoyable, and (3) loss of dignity.<sup>5</sup> When patients determine that prematurely ending their lives by assisted suicide is the appropriate response to losing autonomy, losing the ability to engage in certain activities or losing dignity, those feelings represent a failure of the medical community and society as a whole to properly care for, support, and value that patient—not a case for assisted suicide. Assisted suicide policies limit physicians' ability to do the hard work of really valuing a patient and helping a patient sort through the inevitable physical, psychological, and psychosocial impact a terminal diagnosis brings by telling the physician instead to prescribe the lethal dose when the patient requests.

**Assisted suicide harms physicians' ability to aggressively respond to patient needs at the end of life**

Second, those patients facing the fear and unknown of a terminal diagnosis instantly become a member of one of our most vulnerable populations. More than ever, they need to know that they have the full support and care of their loved ones and healthcare professionals as they walk through a new chapter of life that each of us fears but never expects will come.

Desire for suicide is an extreme reaction to even a serious life challenge. Many individuals who contemplate suicide, including the terminally ill, suffer from treatable mental disorders (most commonly clinical depression) that can be overlooked when focusing on the immediate challenges of the terminal illness.<sup>6</sup> However, it is important to note that in Oregon, 46 percent of patients seeking assisted suicide changed their minds when their physicians intervened and appropriately addressed pain, depression, and/or other medical problems.<sup>7</sup> Patients and their families need to be able to trust that their physicians will work to address all medical complications arising from a terminal diagnosis—including mental health issues—not just provide a lethal dose when asked. Assisted suicide policies harm that trust.

Further, access to and quality of palliative care<sup>8</sup> continues to improve and is nearly always successful in relieving pain and allowing a person to die naturally, comfortably, and in a dignified manner—while providing support for the patient's family along the way.<sup>9</sup> Palliative care has even been shown to improve quality of care for patients, prolong life, and cut costs—potentially saving more than \$1 billion annually in healthcare costs.<sup>10</sup>

---

<sup>5</sup> Ore. Pub. Health Div., *Oregon Death with Dignity Act Annual Report (2016)*, available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf>.

<sup>6</sup> New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 77-82 (May 1994).

<sup>7</sup> Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 *NEW ENG. J. MED.* 557, 557 (2000).

<sup>8</sup> "Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice." National Hospice and Palliative Care Organization, available at <http://www.nhpco.org/palliative-care-4> (last accessed 6/10/16).

<sup>9</sup> Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 *MICH. L. REV.* 1612, 1634-35 (2008).

<sup>10</sup> *Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care*, *The Milbank Quarterly* (Sept. 2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3214714/>.

Unfortunately, the experiences in Oregon and the Netherlands explicitly demonstrate that palliative care options deteriorate with the legalization of assisted suicide.<sup>11</sup> As has always been the AMA's position, physicians should continue to aggressively respond to their patients' needs at the end of life through advancing palliative care or other means. Assisted suicide simply gets in the way.

**The medical community's approval of assisted suicide would have devastating impacts on law and society as a whole**

The third and final point we will address in this letter is of particular importance to our work. If the AMA were to soften its position on assisted suicide, the impact on families and society as a whole would be disastrous, and the ability of state governments to advance their interest in protecting every life—particularly vulnerable people groups—and in preventing suicide in general would be forever harmed.

**a. Medical community approval of assisted suicide will harm state efforts to protect life and advance quality care**

Every state “has an unqualified interest in the preservation of human life” and in “preventing suicide, and in studying, identifying, and treating its causes.”<sup>12</sup> Every state also has a particular interest in advancing policies affirming “that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives for the young and healthy, and that a seriously disabled [ , *terminally ill, or elderly*] person's suicidal impulses should be interpreted and treated the same as anyone else's.”<sup>13</sup> These state interests reflect the rationale behind the 44 states' prohibitions on assisted suicide.

If the AMA were to soften its opposition to assisted suicide, it would be taking a public position declaring that assisted suicide is acceptable “medical treatment” and that the overwhelming majority of states are wrong in protecting their most vulnerable populations. Already, assisted suicide legalization has produced a more than six percent increase in the overall suicide rate.<sup>14</sup> Further, as described above, a shift in the AMA's position on assisted suicide would harm state efforts to strengthen the quality of, and access to, palliative care, and would provide cover for states to legalize assisted suicide.

**b. Medical community approval of assisted suicide sends mixed messages to society**

A change in the AMA's position on assisted suicide would send mixed messages to society. Some who express a desire for suicide will be given intervention and treatment. Others who express that same desire will be given a lethal prescription. The defining line between these two groups will almost always be based on health condition, socioeconomic status, and/or physical ability.

When the medical community—or health insurance companies—begin to value some people's lives more than others because of their health condition, physical ability, socioeconomic status, or other factor, that sends a very clear warning signal of a regressive society—and alerts families across the country that the medical community can no longer be trusted with their care.

---

<sup>11</sup> Hendin at 1615-20 (noting that only 13 percent of patients received palliative care consultations after the Oregon assisted suicide law went into effect).

<sup>12</sup> *Washington v. Glucksberg*, 521 U.S. 702, 729-30 (1997).

<sup>13</sup> *Id.* at 731-32.

<sup>14</sup> David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 599-604 (2015).

## **Conclusion**

Assisted suicide policies rely upon a physician's judgment that a patient's life is not worth living—and that the physician should no longer act as healer. On behalf of our constituencies, millions of American families across the nation, we urge the American Medical Association to maintain its well-founded opposition to assisted suicide so that we may instead rely upon your physicians' judgments that all our lives are worth fighting for.

Sincerely,



Paul Weber, President & CEO  
Family Policy Alliance

Jim Minnery, President  
Alaska Family Action

Jonathan Keller, President  
California Family Council

Peter Wolfgang, Executive Director  
Family Institute of Connecticut

John Stemberger, President & General Counsel  
Florida Family Policy Council

James R. "Duke" Aiona, Jr.  
Hawaii Family Advocates

Julie Lynde, Executive Director  
Cornerstone Family Council (Idaho)

Bob Vander Plaats, President & CEO  
The FAMiLY LEADER (Iowa)

Kent Ostrander, Executive Director  
The Family Foundation (Kentucky)

Carroll Conley, President  
Christian Civic League of Maine

John Helmberger, President & CEO  
Minnesota Family Council

Jeff Laszloffy, President  
Montana Family Foundation

Shannon McGinley, Executive Director  
Cornerstone Action (New Hampshire)



Jim Daly, President & CEO  
Focus on the Family

Cathi Herrod, President  
Center for Arizona Policy

Debbie Chaves, Executive Director  
Colorado Family Action

Nicole Theis, President  
Delaware Family Policy Council

Cole Muzio, President & Executive Director  
Family Policy Alliance of Georgia

Eva Andrade, President  
Hawaii Family Forum

Curt Smith, President  
Indiana Family Institute

Eric Teetsel, President & Executive Director  
Family Policy Alliance of Kansas

Gene Mills, President  
Louisiana Family Forum

Andrew Beckwith, President  
Massachusetts Family Institute

Joe Ortwerth, Executive Director  
Missouri Family Policy Council

Karen Bowling, Executive Director  
Nebraska Family Alliance

Len Deo, President  
New Jersey Family Policy Council

Rev. Jason J. McGuire, Executive Director  
New Yorker's Family Research Foundation

Mark Jorritsma, President & Executive Director  
Family Policy Alliance of North Dakota

Dr. Oran P. Smith, President & CEO  
Palmetto Family Council (South Carolina)

David Fowler, President  
Family Action Council of Tennessee, Inc.

Victoria Cobb, President  
The Family Foundation of Virginia

Julaine K. Appling, President  
Wisconsin Family Action

John L. Rustin, President  
North Carolina Family Policy Council

Michael Geer, President  
Pennsylvania Family Institute

Dale Bartscher, Executive Director  
Family Heritage Alliance Action (South  
Dakota)

Jonathan Saenz, Esq., President  
Texas Values

Allen Whitt, President  
Family Policy Council of West Virginia