

The Pilot

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Ten reasons to oppose Question 2

There are many groups opposing the legalization of assisted suicide in the Commonwealth of Massachusetts and that are urging a “No on Question 2” vote this Nov. 6. In total, more than 100 reasons to oppose this ballot measure have been shared with me since we began our educational efforts on this issue. Some arguments are based on principle, others on prudence, and still others on process — and all of them are valid. Today, I want to share with you ten of the most compelling. In turn, I encourage you to share these reasons with all those you know between now and Election Day.



Cardinal Seán P. O'Malley, OFM Cap.

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(1) Question 2 would legalize assisted suicide; suicide is always a tragedy and never a dignified way to die. For many people, opposition to assisted suicide is based on respect for God's law, “Thou shalt not kill.” However, one does not need to be a person of faith to understand the tragedy of suicide. Our society admires suicide prevention organizations like the Samaritans that stand ready to

help people in the throes of depression and suicidal thoughts. Their hotlines are staffed with volunteers, always prepared to try to bring solace and help to those suffering from suicidal impulses. There are also heroic first responders who often risk their lives to help stop someone from taking one's own life. Yet, proponents of Question 2 are trying to convince us that assisted suicide at the end of life is not suicide — they strive to avoid the word suicide — and rather a compassionate response to the plight of people who have a terminal illness. It is not. Do not be misled by the seductive language of “dignity,” “mercy,” “compassion” or “aid in dying.” True compassion does not put a lethal weapon, in this case a prescription of 100 capsules of Seconal, into the hands of a person to help take his or her life.

(2) Suicide always impacts others beyond the individual that takes his or her life. Proponents of Question 2 assert that “dignity” requires a radical form of autonomy and control in which one should be able to determine the manner and time of one's death. They ignore the profound interconnectedness of our lives and the impact suicide has on family members, colleagues and society in general. Suicide researchers describe the “copycat syndrome” where the publicity of one suicide in a community leads others to contemplate or act on it. Suicide prevention organizations worry that suicides in the general population will increase if society legalizes assisted suicide because it creates the message that suicide is an acceptable and legal “choice” in some situations. As a society, we shouldn't sanction suicide as a response to hardship.

(3) Doctors strongly oppose assisted suicide and Question 2. Organizations of physicians, including the Massachusetts Medical Society (MMS) and American Medical Association (AMA), have argued that assisted suicide would bring about a massive change in the nature of medical care and the doctor-patient relationship. Not only will it violate the values and oaths of the medical profession, but it will destroy trust between patients and doctors because some patients will see doctors and

nurses as possible executioners, rather than as defenders of life. Doctors worry that cost-containment pressures in health care will make a prescription for assisted suicide seem attractive for certain conditions. They fear being coerced to write prescriptions or to make referrals to “specialists” who barely know the patient but will write an assisted-suicide prescription. They are also concerned that there is no requirement that the doctors who write the prescription will have particular training in terminal diseases or end-of-life care. Doctors from these organizations believe that the discussion should be about how we can improve care at the end of our lives, not to improve “options” to help patients end their lives.

(4) Advocates for the disabled strongly oppose assisted suicide and Question 2. They point to the lack of adequate safeguards, which could open the door to abuse, manipulation and coercion. They state that the lack of safeguards could lead to increased elder abuse, because it allows a witness to the patient's signed request for assisted suicide to be an heir, beneficiary or possibly exploitative caretaker. Question 2 even allows proxy requests that allow someone familiar with the mode of communication of a terminally-ill person to indicate that they are requesting suicide. Advocates for the disabled are concerned that Question 2 may eventually lead to “quality of life” standards in our society where those with a lower perceived quality of life receive fewer benefits or protections, or to situations like the Netherlands where there is “non-voluntary” and involuntary euthanasia. In short, they believe that assisted suicide will make the vulnerable more vulnerable.

(5) Terminal diagnoses are often wrong. Under Question 2, eligibility for assisted suicide is based on a terminal diagnosis of six-months or less. There is no specificity whether this six-month diagnosis is with or without medical treatment for the illness. Doctors know terminal diagnoses are simply their best estimate and that these predictions are often inaccurate. Patients often live months, even years, longer. Question 2 could lead people to make a life or death decision based on someone's guess, give up on treatment and lose good years of their lives.

(6) Question 2 is shockingly flawed. Even voters that might generally be in favor of assisted suicide have been shocked by some of the elements of Question 2 and have committed to vote no. Most people first think that “physician assisted suicide” consists of receiving one pill from their family physician to be ingested in the presence of a doctor. They are shocked to learn that, instead, a specialist (who likely doesn't know the person and who isn't required to have pain-management training) would provide a prescription for 100 pills to be dispensed at a neighborhood pharmacy and then ingested all at once with no doctor present. They are also shocked to learn that there is no oversight of the lethal drug once it is dispensed to the patient and that there need not be witnesses to the act of suicide to prevent abuse. They are astonished to learn that the death certificate won't indicate that they patient died of assisted suicide and that there are no enforcement provisions, investigative authority, oversight or data verification included in Question 2.

(7) Question 2 does not require a patient to consult with a psychiatrist or palliative care expert before receiving the lethal prescription. Many terminally ill

patients suffer from depression and there is no requirement that a psychiatrist determine that the person is of sound mind before the request is granted. Additionally, there is no requirement that the doctors who are consulted have expertise in palliative care to ensure that a fear or experience of pain, which can be managed, is leading to the request. Many attendees of our educational workshops have been surprised that these reasonable safeguards aren't included.

(8) Question 2 does not require family notification. There is no requirement that the patient notify family members. For example, a husband could receive a lethal prescription without his wife being required to be notified. A mother could feel a “duty” to not be a burden and to leave a large estate to her children without her children having a chance to state that they care more about her than her money. Out-of-state family members might not know that their loved one is contemplating suicide and have an opportunity to intervene. Compassionate care at the end of life should involve the loving support and involvement of family members.

(9) Assisted suicide would weaken efforts to expand and improve palliative care. Palliative and hospice care, and the loving support of family members, are better alternatives than suicide for the terminally ill. Palliative care is a person-centered approach that treats all of the different aspects of pain and suffering. Palliative care experts consider assisted suicide as a “lazy way out.” Rather than ending a life that is filled with pain and suffering, we should offer compassion, respect and dignity by providing the best in palliative care. That is where our efforts should be directed. However, the incentive to do so will be removed if assisted suicide becomes legal, because suicide will become a substitute for quality health care in some situations. It is also likely, palliative care leaders say, that investment in training for palliative care, effective pain management, and end-of-life communication will be undermined.

(10) Complex issues like assisted suicide should be decided in a legislative process rather than a ballot initiative. Some voters in Massachusetts oppose Question 2 because they believe that a ballot initiative process (dominated by 30-second commercials and sound bites) is not a good way to deal with a complex, ethical issue involving life and death. The legislature exists to review proposals, hold public hearings and build consensus on complicated issues.

When we grow old or sick and we are tempted to lose heart, we should be surrounded by people who ask “How can I help you?” We deserve to grow old in a society that views our cares and needs with a compassion grounded in respect, offering genuine support in our final days. The choices we make together now will decide whether this is the kind of caring society we will leave to future generations. Please join me on Election Day to stop assisted suicide by voting “No on Question 2.”

The Archdiocese of Boston has developed an educational website on the Church's teachings on end of life issues, www.SuicidelsAlwaysATragedy.org. The archdiocese is also part of a large coalition of groups from other faiths, from the medical community, and from disabilities rights groups that are advocating a no vote on Question 2. The coalition's website is www.StopAssistedSuicide.org.