Attachment G

TESTIMONY OF NATALIE L. DECKER
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Regarding House Bill 15-1135, Concerning a Terminally Ill Individual's Freedom To Make End-of Life Decisions ("Physician-Assisted Suicide")

February 6, 2015

My name is Natalie L. Decker. I am an attorney and legal counsel with Alliance Defending Freedom, an alliance-building non-profit legal organization. I have been licensed and actively practiced law in Colorado since 1997. I have extensive experience in a variety of areas of law, including criminal justice, elder law and probate law.

HB 15-1135 is fraught with danger. HB 15-1135 is not about "freedom," "choices" or "dignity." It is suicide, plain and simple—just with the government's stamp of approval. It is an effort to legislatively over-ride the historic tradition of Western civilization for *over 700 years* to preserve and protect human life and to reject physician-assisted suicide. The United States Supreme Court has repeatedly held that the preservation and protection of life is a legitimate and valuable state interest. While all lives are valuable and to be protected, it is paramount that society and our legal system protect its more vulnerable members—the elderly, the infirm, and the disabled. This bill makes the state an agent of death instead of a protector of life.

The problems with this bill are numerous—too numerous to address in this limited time, but we encourage you to review the policy brief we authored for the Centennial Institute (see attached). However, beyond these numerous sound public policy reasons to oppose physician-assisted suicide generally, we want to draw your attention to *just a few* of the egregious flaws in *this* bill:

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1. **No witnesses** are required at the time the lethal drugs are administered.
2. There are almost **no required qualifications** for who can be a witness to the "request" for lethal drugs. "Witnesses" may be an heir and the heir's best friend. The "witnesses" need not sign in the presence of anyone else, including each other, nor sign under oath. There is not even a notarization requirement for *any* of the signatures.
3. The **presence of the "attending" physician is not required.** Indeed, in Oregon and Washington, the "attending" physician is almost never present.
4. This bill **does not require the same legal capacity that is required to execute legal documents** and instead deliberately uses the term "capable." Decisions regarding whether someone is "capable" are left to persons who are not required to be trained or have any expertise in making such a determination.
5. There is ***no definition* of the term "self-administered,"** nor is there a requirement anywhere in the bill that a patient *actually* self-administer the lethal drugs to him/herself with no assistance.
6. **Another person is allowed to speak for the patient** to request the lethal drugs, and does not even require that the person be an agent or qualified fiduciary. There are virtually no requirements for that person; (s)he simply must be "familiar with the individual's manner of communicating." § 24-47-102 (3)
7. The **definition of "terminal" illness or disease is arbitrary** and includes people who may not even be dying. § 24-47-102 (14)
8. There is a complete **lack of transparency** and all records are private.
9. There are **inadequate safeguards** for rights of conscience.
10. There is **no oversight of the lethal drugs** once they are administered and no mechanism for accounting for the disposal of unused lethal drugs.
11. Physician-assisted suicide is always a **slippery slope**, and if passed, this legislation will be no exception.

It is neither a constitutional nor a civil right to commit suicide. It is certainly neither a constitutional nor civil right for someone who desires to commit suicide to enlist the assistance of others in doing so. The State should not encourage suicide nor become an accomplice to it.

We urge you to carefully consider the life-and-death issues this bill raises and affirm the State's interest in protecting all of its citizens.

Centennial Institute

POLICY BRIEF

Suicide By Doctor

What Colorado Would Risk on the Slippery Slope of Physician-Assisted Suicide

Centennial Institute Policy Brief No. 2015-1

By Michael J. Norton, Natalie L. Decker and Catherine Glenn Foster

Editor: Following the lead of four other states and several foreign countries, proponents in Colorado this year are seeking legislation to allow a physician to assist with a patient's suicide.

If such a measure became law, it would invert the doctor's time-honored role from the sacred duty of sustaining life to the ghoulish power of terminating it.

Centennial Institute asked three respected attorneys from our sister organization, Alliance Defending Freedom, for a legal and ethical analysis of what is at stake as the Colorado General Assembly confronts this issue. Here is their report.

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OVERVIEW: EUGENICS FOR THE INFIRM

From earliest times, physicians have been caregivers and healers for the elderly, the infirm, and the disabled. But today, prompted by the recent suicide of Brittany Maynard, a 29-year-old woman with terminal brain cancer, pressure is mounting from "progressives" to allow doctors to abandon their historic role as healers and instead help their patients commit suicide.

Last year, even as the suicide of Robin Williams, also diagnosed with a terminal illness, was being mourned by millions and condemned as a tragedy, radical assisted-suicide advocates twisted his death into an argument for their cause.

Blackstone called it "self-murder"

Indeed, in recent years, physician-assisted suicide has been repackaged and promoted to the American public as "Death with Dignity." However, physician-assisted suicide is anything but dignified and amounts to eugenics for the infirm, but with the government's stamp of approval.

Physician-assisted suicide is dangerous for a myriad of reasons and should be aggressively resisted.

DISTINCTION FROM EUTHANASIA OR REFUSAL OF TREATMENT

As with any examination of an issue, it is important to understand the various terms used when discussing "physician-assisted suicide"—what it is and what it is not.

Physician-assisted suicide requires the affirmative assistance of a doctor to facilitate the death by suicide of her patient. The doctor supplies death-inducing drugs to her patient;

then her patient, at least theoretically, performs the act that ultimately causes death (i.e., consumes the fatal drugs).[1] In Oregon, for example, the most commonly prescribed drugs for physician-assisted suicide are secobarbital and pentobartibal, bitter drugs in lethal doses that are mixed with juice in an attempt to make them more palatable.[2]

After the patient drinks this concoction, death may or may not come quickly.[3] Reportedly, the overwhelming majority of the time, the physician is not present at the time of the suicide or ingestion of the fatal prescription.[4]

Euthanasia, in contrast, is the term referring to a circumstance where the doctor, rather than the patient, performs the act that causes the death of the patient. Theoretically, this is done after the patient expresses the wish to end his or her life, although there is substantial and growing evidence that, in many instances, physicians have euthanized patients without an express request by the patient.[5]

Importantly, neither physician-assisted suicide nor euthanasia involves the situation where a patient, as patient has a right to do, ***refuses medical treatment*** or requests that it be withdrawn.[6]

Indeed, it is well-settled that competent adults have the ability to either receive or refuse medical care and treatment. In those instances, as opposed to physician-assisted suicide or euthanasia, death is from natural causes and is not a result of an act by either the patient or doctor.

HISTORY OF PHYSICIAN-ASSISTED SUICIDE AND THE RIGHT TO DIE

Throughout history, suicide—and assisting another person in committing suicide—has been condemned. For over 700 years, Anglo-American legal tradition has disapproved of, or even punished, suicide and assisting another in committing suicide, even going back to the pre-Norman era.[7]

In the 13th century, Henry de Bracton noted in a legal treatise that a man committed a felony by killing another person or himself. Indeed, the property of a person who killed himself was subject to forfeiture.

Sir William Blackstone, centuries later, referred to suicide as "self-murder" and ranked it among the highest of crimes. The American colonies followed this English common-law approach although they ultimately reduced or eliminated the harsh common-law penalties.

Notably, the historic prohibitions against suicide included the prohibition of assisting another in committing suicide, with no exceptions for those who were near death.[8]

Efforts to legalize physician-assisted suicide have consequently been met with tremendous resistance. This has necessitated messaging campaigns by those in the "right to die" movement as they have sought to engage contributors and increase popular support. (See further discussion in Appendix.)

Organization names have even been changed over the years in an effort to repackage their message and blur its implications, but the underlying purposes have remained essentially the same. Despite their efforts, assisted suicide remains unlawful and morally unacceptable throughout most of the world.

In the World

Of the world's 195 countries, only a miniscule fraction permit physician-assisted suicide. ***Switzerland*** has tolerated assisted suicide for many years, and even today physician-assisted suicide is not clearly regulated by law.[9]

In ***Nazi Germany***, Dr. Karl Brandt, Hitler's personal physician, was in charge of the Nazis' T-4 Euthanasia Program, which was instrumental in euthanizing thousands of people. Brandt later testified at his Nuremburg trial, "The underlying motive was the desire to help individuals who could not help themselves and were thus prolonging their lives of torment."[10]

The Netherlands was first exposed to assisted suicide in 1973 when a physician, Dr. Geertruida Postma, gave a lethal injection to her 78-year-old mother who was deaf and partially paralyzed. While Dr. Postma was later convicted of murder, the suspended sentence issued by the court effectively exonerated her, finding the act to be "compassionate".[11] Tolerated thereafter, physician-assisted suicide formally became legal in the Netherlands in 2002.

In 1997, ***Colombia's*** Supreme Court found a constitutional right to euthanasia for those terminally ill patients who requested it.[12]

In 1995 assisted suicide was legalized for a brief time in the Northern Territory of ***Australia***, though that was quickly repealed.[13]

Luxembourg legalized euthanasia and physician-assisted suicide in 2009.[14]

Hitler's doctor: Motive was to help

Belgium legalized euthanasia in 2002, and in 2014 the law was extended to permit euthanasia for children.[15]

In This Country

In the United States, only four states permit physician-assisted suicide.[16] The citizens of ***Oregon*** passed a physician assisted suicide referendum in 1994, promoted as "Death with Dignity." The Oregon referendum narrowly passed, receiving only 51 percent of the vote

while 49 percent of citizens voted against the referendum. After a long legal battle, physician-assisted suicide was implemented in Oregon in 1998.

Ten years later, in 2008, physician-assisted suicide was approved by a ballot measure in ***Washington State***, and went into effect in 2009.

In 2009, the ***Montana*** Supreme Court ruled that a consent defense was available for physicians who assisted their patients with suicide as there was nothing in Montana case law or statutes that indicated that "physician aid in dying is against public policy."

In 2013, ***Vermont's*** legislature legalized physician-assisted suicide.

The legality of physician-assisted suicide is currently being litigated in ***New Mexico*** state courts after a district court judge ruled that terminally ill patients have a right to assisted suicide under the state constitution.

Although the legality of physician-assisted suicide is currently limited to these states, there are active efforts to expand physician-assisted suicide to other parts of the country. Here in ***Colorado***—where Compassion and Choices, formerly the Hemlock Society, is based – a so-called Death with Dignity law is currently before the state legislature.

U.S. SUPREME COURT CASES REGARDING THE RIGHT TO DIE

While physician-assisted suicide has most often been dealt with at the state level, the United States Supreme Court has also weighed in on the issue. The Court has decided four cases involving the right to die, three of which involved physician-assisted suicide.

The Supreme Court first addressed the right to die, at least indirectly, in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). Nancy Cruzan had been severely injured in an automobile accident. When doctors opined that Cruzan, though not considered "terminally ill," would never recover from what they termed a "persistent vegetative state" nor regain cognitive functioning, her parents sought a court order to direct the removal of her food and hydration.[17]

Cruzan case opened the door

Cruzan's so-called "persistent vegetative state" left her incompetent and unable to make an "informed and voluntary" decision regarding whether to continue or refuse medical treatment. Missouri had established safeguards requiring that an incompetent patient's wishes regarding withdrawal of treatment be established by clear and convincing evidence. In the initial proceedings, her parents were unable to provide "clear and convincing evidence" of her expressed desire to withdraw life support before she had become incompetent.

The Court held that a competent person has a right under the Fourteenth Amendment's Due Process Clause to refuse unwanted medical treatment. *Id.* at 278 (citing *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905)). The Court confirmed that the protection and preservation of human life is a legitimate state interest.

"[I]ndeed, all civilized nations demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide," stated the majority opinion. "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." [18]

The Court acknowledged that in some circumstances, family members will not act to protect a patient,[19] and that an erroneous decision to withdraw life-sustaining treatment could not be corrected.[20]

Although the Cruzans technically lost at the U.S. Supreme Court with the Court ruling that the U.S. Constitution did not prevent the State of Missouri from requiring clear and convincing evidence of an incompetent patient's wishes to withdraw life-sustaining treatment, the Cruzans ultimately prevailed.

Shortly after the Supreme Court ruling, the Cruzans went back to state court with new "clear and convincing evidence," and were granted a court order to remove Nancy's food and hydration. Nancy Cruzan died twelve days later.

Glucksberg and Vacco cases deferred issue to states

A few years later, the U.S. Supreme Court specifically addressed the issue of physician-assisted suicide in two cases brought by pro-euthanasia advocates. The Court held that statutes criminalizing physician-assisted suicide violated neither the Due Process Clause nor the Equal Protection Clause of the Fourteenth Amendment. *Washington v. Glucksberg*, 521 U.S. 702 (1997), involved a constitutional challenge to a Washington statute criminalizing physician-assisted suicide,[21] alleging that the statute violated the Fourteenth Amendment.

The Court held that the Fourteenth Amendment Due Process Clause does not provide a "fundamental liberty interest" in physician-assisted suicide. [22] The Court found that the Washington statute was "reasonably related" to a compelling state interest, including protecting life, preventing suicide, preserving the integrity of the medical profession, protecting vulnerable groups, and avoiding the slippery slope from voluntary to involuntary euthanasia.[23]

In another case, decided the same day, *Vacco v. Quill*, 521 U.S. 793 (1997), the Supreme Court held that a New York statute criminalizing assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment.[24] The plaintiffs, three New York physicians and their terminally ill patients, had argued that physician-assisted suicide was essentially the same as allowing a mentally competent, terminally ill patient to refuse treatment and attempted to use the *Cruzan* decision in support of their position.

The Court flatly rejected this argument and stated that while "*[e]veryone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide."[25] The New York law was upheld as constitutional and reasonably related to essentially the same compelling state interests discussed in *Washington v. Glucksberg*.[26]

While neither *Glucksberg* nor *Vacco* recognized a constitutional right to physician-assisted suicide, neither case equated to a ban on the practice. Consequently, yet another case arose, *Gonzales v. Oregon*, 546 U.S. 243 (2006), wherein the Supreme Court again addressed physician-assisted suicide, this time in the context of the Oregon Death with Dignity Act.

Bush Administration's anti-suicide rule struck down

In 2001, the U.S. Attorney General under President George W. Bush, Alberto Gonzales, had issued an Interpretive Rule providing that "assisting suicide is not a 'legitimate medical purpose'...and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the Controlled Substances Act."[27]

The Court found in *Gonzales* that the Interpretive Rule did not actually "interpret" the relevant federal statute, but expanded upon it, and that the CSA did not authorize the Attorney General to prohibit doctors from prescribing federally regulated drugs to terminally ill patients to assist their suicides.[28]

The practical effect of this holding was that the Attorney General could not use the Controlled Substances Act to prohibit doctors from prescribing federally-regulated drugs under Oregon's Death with Dignity Act, and ultimately it advanced the legalization of physician-assisted suicide.

EIGHT REASONS TO REJECT PHYSICIAN-ASSISTED SUICIDE

There are a plethora of reasons why voters and legislators across the country, and in Colorado, should embrace the historic tradition of Western civilization to preserve and protect human life and reject physician-assisted suicide.

While there can be heart-wrenching cases that cause any compassionate person to question his or her position on this issue, those cases are rare given the current state of medical care and technology, and, as the stakes are huge, important public policy should not be based on a handful of exceptional cases, but rather on sound, rational reasoning that supports life.

One: All human life, including the lives of those who are elderly, infirm, or disabled, should be preserved and protected.

All human life is precious and deserves to be protected. The United States Supreme Court has repeatedly held that the preservation and protection of life is a legitimate and valuable state interest.[29] While all lives are valuable and to be protected, it is paramount that society protect its more vulnerable members—the elderly, the infirm, and the disabled. In addition to providing safeguards for their physical well-being, there must also be safeguards regarding decision-making by and for these vulnerable populations. This is particularly true in the context of physician-assisted suicide.

In states where physician-assisted suicide has been legalized, statistical reports are consistent with elder abuse.[30] Elder adults with a larger net worth are prime targets for abuse, often at the hands of family members.[31] The majority of physician-assisted suicides are elder, well-educated people, who are covered by insurance.[32] These people are more likely to have heirs, thus providing an incentive to promote suicide and preserve the wealth for the victims' heirs.

Dangerously, some of the physician-assisted suicide laws permit heirs and beneficiaries to be at least one of the witnesses to the "request" for physician-assisted suicide. While there is a façade of neutrality created by the requirement that one witness not be so interested, that façade is shattered when it is recognized that there are virtually no other requirements for the second witness. Consequently, the two "witnesses" could be the victim's heir and the heir's best friend – hardly an objective, disinterested pair.

Two: The integrity of the medical profession should be preserved and protected.

The Supreme Court has held that states have a legitimate interest in preserving the integrity and ethics of the medical profession.[33] The Court acknowledged that physician-assisted suicide could undermine the trust that is critical to the physician-patient relationship by "blurring the time-honored line between healing and harming."[34]

Throughout history, physicians have been the healers, not the harmers. Doctors provide care and treatment for their patients, as opposed to killing them. The Hippocratic Oath, the oldest and most popularly administered medical oath, essentially compels doctors to "do no harm." The traditional oath includes the provision: "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect."[35]

Don't blur the line between healing and harming

As Justice Scalia noted in his dissent in *Gonzalez v. Oregon*, "virtually every medical authority from Hippocrates to the current American Medical Association (AMA) confirms that assisting suicide has seldom or never been viewed as a form of 'prevention, cure, or alleviation of disease,' and (even more so) that assisting suicide is not a 'legitimate' branch of that 'science and art,'" and that physician-assisted

suicide is wholly incompatible with the physician's role as healer."[36] It would seem that proponents of physician-assisted suicide really want to include physicians in the suicide process in order to give legitimacy to a historically repugnant act.

The largest physician-based organization in Colorado, the Colorado Medical Society, opposes physician involvement in patient suicide. According to the CMS Policy Manual, adopted in September 2013: "The professional and societal risks of involving physicians in medical interventions intended to cause patients' deaths are too great to condone euthanasia or physician-assisted suicide. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care."[37]

Similarly, the American Medical Association, in an ethics opinion opposing physician-assisted suicide, stated:

> It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good.
>
> Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.
>
> Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.[38]

AMA: Patients shouldn't be abandoned

In the face of this, however, and ominously, some of the physician-assisted suicide legislative proposals require government officials to falsify information on death certificates by declaring that "actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide."[39] That is simply false; physician-assisted suicide, regardless of what it is called, is suicide by definition.

It is imperative that the rights of conscience for physicians and other healthcare providers be protected. While there are a plethora of secular reasons to oppose physician-assisted suicide, there are many faith-based reasons to do so, as well. The religious liberties of medical professionals must be protected in this context.

Three: Depression and mental health reasons, not pain relief, are significant motivators in requests for physician-assisted suicide.

One of the primary arguments proponents of physician-assisted suicide posit is that it is necessary to alleviate the pain and suffering of those who have been diagnosed with terminal illnesses. However, intolerable pain and suffering is not a requirement in any of the physician-assisted suicide laws in the United States.

Moreover, no studies support the assertion that pain is the primary motivation behind physician-assisted suicide requests.[40] Much of the research demonstrates that depression, hopelessness, and fear of loss of autonomy and control are the primary motivations behind physician-assisted suicide requests.[41] The statistics gathered in Oregon and Washington to date confirm this. In Oregon, from 1998 to 2009, only 22 percent of patients who died as a result of physician-assisted suicide reported being in pain or afraid of being in pain.[42] According to the 2013 Annual Report for Oregon, "inadequate pain control or concern about it" was next to the bottom of the list of patients' end of life concerns.[43]

Dutch euthanasia advocate: Trend "off the rails"

The top three concerns were losing autonomy, being less able to engage in activities making life enjoyable, and loss of "dignity." The statistics reported in the 2013 Annual Report for Washington are the same. It is important to note that these are just concerns or fears, and may not even be reality.

In the Netherlands, people who are not terminally ill but rather those who suffer from depression or who are in the early stages of dementia are now being euthanized or assisted to suicide. In 2012, the Life-Ending Clinic went into operation in order to "assist" those whose personal physicians refused to assist in their suicides or euthanize them.

Even a psychiatrist seen as a pioneer of the Dutch euthanasia movement has commented that the law has "gone off the rails."[44] There are countless tragic stories of healthy people suffering from depression being assisted with suicide—including a 35-year-old woman.

Significant advancements in palliative and medical care and treatment have made it such that it is only in extremely rare instances that physicians are unable to alleviate a patient's pain.

Four: Misdiagnoses or inaccurate prognoses can lead to faulty decisions to request physician-assisted suicide.

If physician-assisted suicide is legalized, those who have been diagnosed with terminal illnesses will make decisions based on the information they have been provided by their doctors. They will make the decision of whether to take their own lives based on a *guess* as to when they may die from their illnesses. Yet there are plenty of instances where diagnoses have been incorrect or the guess as to how much time a person has left has been just plain wrong. (Maryann Clayton's story, given in Appendix, is one dramatic example.)

The states that permit physician-assisted suicide require a diagnosis that death will result in six months or less. There is no legal guidance as to how to determine how long a person will live, and short of suicide or murder, there is simply no way to ascertain that with any degree of certainty. Indeed, many people who are terminally diagnosed and given six months to live survive beyond time period. Thus patients are making decisions in the context of physician-assisted suicide based on faulty information and guesswork.

Dr. Nicholas Christakis is a Harvard professor of sociology and medicine whose own mother was given only a 10% chance to live more than three weeks when Christakis was only six years old and *yet lived another 19 years*. He has researched when patients die in comparison with the prognosis they receive from their physicians. His finding: at least 17% of patients – about one person in six – outlive their prognosis.[45]

According to a paper published in the Journal of the American Medical Association, 70% of the 900 patients eligible for hospice care lived longer than six months.[46] That's more than two persons in three.

It seems that one area where people can agree is that the six-month prognosis often required for physician-assisted suicide is arbitrary, and it is difficult to ascertain what will really happen with a person six months into the future.[47]

Given the uncertainties and potential for misdiagnoses and inaccurate prognoses, it is important to consider that, just as the Supreme Court noted with decisions to withdraw life-sustaining treatment, an erroneous decision to commit suicide is not susceptible to correction.

Five: In the states where assisted suicide has been legalized, there is little oversight of the process and medications prescribed.

Amazingly, none of the states where physician-assisted suicide is legal require the presence of the prescribing physicians. The physician issues the prescription and it is filled by the patient or his or her agent. There is virtually no oversight once the drugs leave the pharmacy. The statistics from Oregon and Washington reveal that a disturbing number of lethal doses of these medications are unaccounted for.

In Oregon, according to the 2013 Death With Dignity Act Report, prescriptions were written for 122 people during 2013. Of those people, 63 ingested the medication and died, whereas 28 people did not ingest the mediations and died. Ingestion status is unknown for 31 patients. Consequently, the whereabouts of almost 50% of the highly lethal drug dosages are undocumented and likely unknown. And that is just for 2013.

Lax chain of custody for killer meds

In Washington, according to the 2013 Death With Dignity Act Report, medication was *dispensed* to 173 patients in 2013. 159 of those patients are known to have died. Of those, only 119 died after ingesting the medication, whereas 26 did not take the medication; the ingestion status of the remaining 14 is unknown. Thus of 173 fatal does, the whereabouts

of 54 highly lethal drug dosages are undocumented and likely unknown. Again, that is just for the year 2013.

None of these laws have any procedures for overseeing or accounting for these lethal drug prescriptions once issued. The laws merely direct that unused medications be disposed of according to medication take-back programs. The FDA information on disposal of unused medications is hardly sufficient to address drugs so powerful that they can kill within a minute of being ingested.[48] Essentially, once the lethal prescriptions leave the pharmacy, there is no telling where they will end up.

Perhaps even more troubling is the fact that these laws do not require the consent of the patient at the time the lethal drugs are administered, nor do they require the presence of the prescribing physician—or anyone else, for that matter.[49] Consequently, a terminally ill patient could obtain and fill a prescription to have as a "back up" plan just in case the drugs were later wanted, but then have the drugs administered to them by another person at a time when the patient was unable or unwilling to consent.

In Oregon, the prescribing physician was present when medication was ingested and death occurred in only 8 cases (out of 122 prescriptions issued) in 2013. The rest of the cases, over 90%, were unsupervised.

In Washington, the prescribing physician was present for ingestion of the drugs in only *two* instances in 2013. Essentially, a handful of doctors are issuing these fatal prescriptions and then failing to provide any oversight of the actual processes. Such is a process ripe for abuse.

Six: Cost savings are not a legitimate reason to permit suicide by doctor.

Derek Humphreys, founder of the Hemlock Society now known as Compassion and Choices, acknowledged that money was an "unspoken" argument in favor of physician-assisted suicide, noting that hastening the death of the infirm would "free resources for others."[50] He estimated the amount could run into the "hundreds of billions of dollars."[51]

While Compassion and Choices and other euthanasia advocates now conveniently, and wisely, leave this resource argument out of their physician-assisted suicide talking points, it is indeed a major motivating factor for some.[52] That money is an underlying motive behind the push for physician-assisted suicide is readily apparent in Oregon, as Barbara Wagner and Randy Stroup know all too well.

Oregon to cancer patients: Please die

Ms. Wagner and Mr. Stroup, each diagnosed with terminal cancer, received chemotherapy prescriptions that could extend their lives by slowing the cancer's progression and also make them more comfortable. Each applied for payment for their prescribed treatments through the Oregon Health Plan, the state's Medicaid program. However, rather than receiving coverage for these life-sustaining treatments, each received a letter from the State of Oregon informing them that the state would *not* pay for the prescribed drugs, but

would pay for physician-assisted suicide drugs.[53] One physician noted the financial incentive the state had to pay for death rather than life: the drug prescribed to Ms. Wagner, would cost the state $4,000 each month whereas the assisted-suicide drugs would cost less than $100, once.[54]

Nor were Ms. Wagner and Mr. Stroup the only two patients to receive such bleak news. A similar morbid letter was sent to terminally ill patients across the entire State of Oregon, stating that Oregon will not provide life-prolonging treatment unless there is a greater than 5% chance the treatment will assist the patient in living at least five more years; however, the State will pay for physician-assisted suicide, defining it as means of "comfort."[55]

Seven: The suggestion that suicide is the "dignified" way to die is offensive to the thousands of Americans who die naturally *and* with dignity each year, as well as to those who care for them.

Advocates of euthanasia and assisted suicide have taken care to package the patient's suicide as "death with dignity." Indeed, this is the formal title of Colorado's proposed legislative act. The suggestion is that committing suicide is the dignified way to die.

This is utterly false. Thousands of people with terminal illnesses die naturally in this country each year.

It is disgraceful and offensive to attribute "indignity" to those who fought valiantly until their natural deaths, as well as to those medical professionals and caretakers who dedicated their careers and lives to caring for the terminally ill.

It might be more fair to ask whether those who *choose* suicide as a result of their terminal illness have tragically fallen victim to their own fatalism.

Eight: The slope is indeed slippery.

Dr. Ezekiel J. Emanuel, an oncologist, former White House adviser, and brother of Chicago Mayor Rahm Emanuel, has asserted that assisted suicide is a slippery slope:

> Once legalized, physician-assisted suicide and euthanasia would become routine. Over time doctors would become comfortable giving injections to end life and...comfort would make us want to extend the option to others who, in society's view, are suffering and leading purposeless lives.[56]

This is most certainly true in other places where assisted suicide and euthanasia have been legalized. In Switzerland, there is the "suicide tourism" phenomenon. In Belgium, two healthy but deaf brothers, concerned with becoming blind and the potential resultant loss of independence, were euthanized.

Switzerland is seeing suicide tourism

An elderly Belgian couple, worried about loneliness in the event that the other would die first and that the cost of a good retirement home would be unaffordable, announced,

with the blessing of their children, their plan to commit suicide. Indeed, their son *assisted* them with physician-shopping, helping them locate a doctor willing to perform the euthanasia.[57]

What began in those countries as an alleged effort to help those suffering with unbearable pain and agony at the end of their lives has evolved into the legalization of the "murder" of those who are depressed, children with deformities or illnesses, and victims in all sorts of other tragic scenarios. There is absolutely nothing to prevent those same evils here.

In fact, as just described, Oregon residents with terminal illnesses who have not requested physician-assisted suicide are being told the State will pay for them to kill themselves but won't pay for life-prolonging treatment. That would cost the State too much money.

Moreover, once consideration of the victim's own resources enters the picture, the slope becomes all the more slippery as even the personal resources a terminally ill person spends on his or her own treatment are then unavailable for the younger, the healthy and the heirs.

CONCLUSIONS

Suicide is a final, irreversible act.

The doctor's essential obligation of sustaining life must be kept inviolate, not tainted with the license to play God by terminating life before that person's appointed time.

People of good will in Colorado and elsewhere must solidly stand against the evil of physician-assisted suicide.

APPENDIX

Strategems of the Suicide Movement: Further from Page 3

Perhaps the most well-known of the "right to die" organizations is the Hemlock Society. Derek Humphrey founded the Hemlock Society in 1980 as a euthanasia advocacy group. The group published a "suicide manual," and first, unsuccessfully proposed legalizing physician-assisted suicide in California in 1986.

Five years later the organization published "*Final Exit*," a "how, where and when to kill yourself or someone else" guide designed to provide instruction on orchestrating the "perfect death."

After determining that the Hemlock Society needed a name and image change due to its "baggage," the organization's name was changed to "End-of-Life-Choices." In 2004, it was merged with another organization and is now called "Compassion and Choices."

Under this bland, the group today aggressively pursues its pro-euthanasia, pro-eugenics agenda across the country. Indeed, it is behind the scenes in many of the attempts to push assisted suicide bills through state legislatures, showing up on scene with publicists, lobbyists, and large amounts of money to persuade lawmakers or voters.

It is important that the public understand, however, that it is really hearing from the same old Hemlock Society, just packaged with a new alias. *See* Rita Marker, *Assisted Suicide & Death with Dignity: Past, Present & Future – Part I*, InternationalTaskForce.Org, Jan. 2005, http://www.patientsrightscouncil.org/site/rpt2005-part1/

Prognoses Disproved: Further from Page 10

Maryann Clayton, at age 62, was diagnosed with Stage IV lung cancer and a metastasized tumor and given two to four months to live. Alive and well four years and many family vacations later, Ms. Clayton spoke out about her experience when Washington sought to legalize physician-assisted suicide. *See* Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, available at http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

In this same article other similar stories are recounted. One is by Dr. J. Randall Curtis, who describes a patient he treated who was suffering from septic shock and multiple organ failure; he kept her on life support "against his better judgment because her family insisted," despite his belief that she had only days or weeks to live. That woman improved, left the hospital, and subsequently returned to visit him. There are many, many more of these stories, and they make Brittany Maynard's decision to commit suicide all the more tragic.

ENDNOTES

[1]*See* Ezekiel Emanuel, *Whose Right to Die?*, The Atlantic Online, March 1997, available at http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/.

[2] Jennifer Fass, *et al.*, *Physician-Assisted Suicide: Ongoing Challenges for Pharmacists*, Am J. Health Syst. Pharm. (2011) 68(9):846-849, available at http://www.medscape.com/viewarticle/742070_3

[3] *See* Oregon Public Health Division, *Death With Dignity Act Report, 2013*, at 7. In 2013, the range of minutes between ingestion and death was 5 minutes to 336 minutes (5.6 hours).

[4] *Id.* at 6. Of the 71 known physician-assisted suicide deaths in 2013 in Oregon, the prescribing physician was present in only 8 of those deaths. Notably, there were 122 prescriptions written for the lethal prescription in 2013 in Oregon. *See also* Washington State Dept. of Health, *2013 Death With Dignity Act Report*, at 9. Of the 173 lethal prescriptions issued in Washington in 2013, 119 are known to have died after ingesting the drugs; the prescribing physician was present when the fatal drugs were ingested in just *two* of those instances.

[5] *See, e.g.,* Emanuel, *supra* note 1.

[6] *Id.*

[7] Chief Justice Rehnquist, in *Washington v. Glucksberg*, 521 U.S.702, 710-716 (1997), provides an excellent overview of the history of opposition to suicide and assisted suicide.

[8] *Id.*

[9] Saskia Gauthier et al., *Suicide Tourism: A Pilot Study on the Swiss Phenomenon*. J. Med. Ethics 2014.

[10] K. Green, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the "Slippery Slope."* 13 Ind. Int'l & Comp. L. Rev. 639, 649 (2003). *See also T4 Program*, Encyclopedia Britannica, available at http://www.britannica.com/print/topic/714411. In a directive issued by Hitler, Dr. Karl Brandt and Chancellery chief Philipp Bouhler were "charged with responsibility for expanding the authority of physicians…so that patients considered incurable, according to the best available human judgment of their state of health, can be granted a mercy killing." *Id.*

[11] Emanuel, *supra* note 1.

[12] Christian Medical & Dental Associations, *Standards 4 Life: Physician-Assisted Suicide*, available at http://www.ethicalhealthcare.org/CMDA/ResourcesServices2/Publications1/Standards_4_Life1/Standards_4_Life_Phy.aspx.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] Indeed, in the United States, thirty- nine states have laws that prohibit assisted suicide, and three prohibit it by common law. A state-by-state summary of physician-assisted suicide laws is available at http://euthanasia.procon.org/view.resource.php?resourceID=000132.

[17] A former deputy assigned to guard Nancy Cruzan's room in order to prevent anyone from providing assistance to her once her parents were finally granted court permission to remove her food and hydration has expressed doubt as to the PVS diagnosis. Dennis Graves, *Emotions Still Linger from Nancy Cruzan's Right-to-Die Case*, Free Republic, Oct. 22, 2003, available at http://www.freerepublic.com/focus/f-news/1371221/posts.

[18] *Id.*

[19] *Id.* at 281.

[20] *Id.* at 283.

[21] RCW § 9A.36.060(1).

[22] 521 U.S. at 728. The case was originally filed in the U.S. District Court for the Western District of Washington and was decided as *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994).

[23] *Id.* at 728-33.

[24] *521 U.S.* at 808-09.

[25] *Id.* at 800 (emphasis in original)

[26] *Id.* at 808-09.

[27] *Gonzales*, 546 U.S. at 253-54 (quoting Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001)).

[28] *Id.* at 274-75.

[29] *Glucksberg*, 521 U.S. at 710; *Cruzan*, at 280; see also *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833 (1992).

[30] Margaret Dore, *Death With Dignity: A Recipe for Elder Abuse & Homicide (Albeit Not By Name)*, 11 Marq. Elder Advisor 387, 396 (2010).

[31] *Id.*; *see also Broken Trust: Elders, Family and Finances*, MetLife Mature Mkt. Inst., (2009); *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders*, MetLife Mature Mkt. Inst. (June 2011).

[32] *See* Dore, *supra* note 30 at 397; Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, The New York Times, Oct. 27, 2012, available at http://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/; Oregon 2013 Death With Dignity Act Report, *supra* note 3, Washington 2013 Death With Dignity Act Report, *supra* note 3.

[33] *Glucksberg*, 521 U.S. at 731.

[34] *Id.*

[35]Peter Tyson, *The Hippocratic Oath Today*, March 27, 2001, available at http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html.

[36] *Gonzalez*, 546 U.S. at 285-286 (Scalia, J., dissenting).

[37] Colorado Medical Society, *Policy Manual*, September 2013, at 16.

[38] American Medical Association, *Opinion 2.211 – Physician-Assisted Suicide*, AMA Code of Medical Ethics, June 1994.

[39] See proposed § 25-47-118, C.R.S., in Colorado's draft bill. *See also* O.R.S. 127.880 §3.14.

[40] Emanuel, *supra* note 1

[41] *See* Emanuel, *supra* note 36; Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. 1613 (2008); Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 J. Am. Med. Ass'n 19 (2000).

[42] Emanuel, *supra* note 32.

[43] Oregon 2013 Death With Dignity Act Report, *supra* note 3.

[44] Nadette de Visser, *The Dutch Debate Doctor-Assisted Suicide for Depression*, Feb. 3, 2014, available at http://www.thedailybeast.com/articles/2014/02/03/the-dutch-debate-doctor-assisted-suicide-for-depression.html.

[45] *Id.* Interestingly, in a recent interview, Brittany Maynard's husband said that *he* picked up the drugs for Brittany while she was traveling and that he did so in May, six months prior to Brittany's death. Her original diagnosis was in January 2014, and apparently modified to six months in April 2014. There is no way to know for certain how long Brittany would have lived had she not committed suicide, but certainly she would have exceeded the six month prognosis. See http://www.today.com/video/today/56780613.

[46] Federal Medicaid will pay for hospice for patients with a prognosis of six months or less to live.

[47] *Id.*

[48] FDA, *Disposal of Unused Medicines: What You Should Know*, available at http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm.

[49] *See* Dore, *supra* note 30.

[50] *See* Neil Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequences: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments for Legal Change*, 2004 Wis. L. Rev. 1347, 1389 (2004).

[51] *Id.*

[52] *See* Dore, *supra* note 30. *See also* Simon Caldwell, *Elderly Couple to Die Together by Assisted Suicide Even Though They Are Not Ill*, Daily Mail, Sept. 25, 2014, available at http://www.dailymail.co.uk/news/article-2770249/Healthy-OAP-couple-die-assisted-suicide-Husband-wife-support-three-children.html; Michael F. Haverluck, *Belgian Media Exploits Elderly Couple, Pushes "Couples" Euthanasia*, Sept. 29, 2014, http://onenewsnow.com/pro-life/2014/09/29/belgian-media-exploits-elderly-couple-pushes-couple-euthanasia.

[53] Vermont Alliance for Ethical Healthcare, *Oregon's Physician-Assisted Suicide: Abused and Exploited*, available at www.vaeh.org.

[54] Susan Harding, *Letter Noting Assisted Suicide Raises Questions*, Oct. 30, 2013, available at http://www.katu.com/news/26119539.html.

[55] Dan Springer, *Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care*, July 28, 2008, available at http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care/.

[56] Emanuel, *supra* note 1.

[57] Caldwell, *supra* note 52; Haverluck, *supra* note 52.

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Suicide By Doctor: What Colorado Would Risk on the Slippery Slope of Physician-Assisted Suicide

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