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NATIONAL CATHOLIC PARTNERSHIP ON DISABILITY

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February 24, 2016

The Honorable Robert A. Zirkin  
Chair, Senate Judicial Proceedings Committee  
Miller Senate Office Building, 2 East Wing  
11 Bladen St.  
Annapolis, MD 21401-1991

Re: S.B. 418, “Richard E. Israel and Roger ‘Pip’ Moyer End-of-Life Option Act”

Dear Senator Zirkin:

My name is Stephen L. Mikochik. I am Professor Emeritus of Constitutional Law at Temple University in Philadelphia and past Chair of the National Catholic Partnership on Disability (NCPD). NCPD was established four decades ago to implement the *Pastoral Statement on People with Disabilities* of the U.S. Catholic Bishops. On behalf of NCPD and the thousands of disabled Catholics it serves, I would urge you to reject Senate Bill 418 as a further step in the new eugenics that threatens the lives of people with disabilities.<sup>1</sup>

At present, four states permit assisted suicide by statute or ballot initiative.<sup>2</sup> Like S.B. 418,<sup>3</sup> they all require a terminal condition as a

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<sup>1</sup> Commenting on how mentally disabled people were treated during the eugenics movement in the first half of the last century, Justice Marshall (Marshall, J., joined by Brennan & Blackmun, JJ., concurring in part and dissenting in part) has observed that “A regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow.” *Cleburne v. Cleburne Living Center*, 473 U.S. 432, 463 (1985). But see *Buck v. Bell*, 274 U.S. 700, 707 (1927) (O.W. Holmes) justifying a state eugenics sterilization program on grounds that “[t]hree generations of imbeciles are enough.”

<sup>2</sup> See O.R.S. §127.800 *et seq.* (Oregon); Wash. Rev. Code Ann. §70.245.010 *et seq.* (West 2009) (Washington State); 18 V.S.A. §5281 *et seq.* (Vermont); A.B. 15, *Cal. Health & Safety Code*, § 443 *et seq.* (California). Additionally, the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state’s public policy. See *Baxter v. Montana*, 354 Mont. 234.

<sup>3</sup> See S.B. 418, §5-6A-01(p)(4).

prerequisite;<sup>4</sup> like S.B. 418,<sup>5</sup> three expressly forbid writing the lethal prescription “solely” based on disability.<sup>6</sup> Why then are persons with disabilities so concerned about the rise of such legislation? Simply put, people with disabilities are unwelcome guests in society and fear that, by sanctioning assisted suicide, society will send the unmistakable hint that they should leave.

Such threat has its origin in the abortion of fetuses with genetic anomalies. We know, for example, that up to 85% of fetuses diagnosed with Down syndrome are aborted;<sup>7</sup> and rates for fetuses diagnosed with other serious anomalies are doubtless similar.<sup>8</sup> As pre-natal testing advances,<sup>9</sup> we can expect comparable numbers for other genetic conditions. Laws declaring the equal dignity of a class of people<sup>10</sup> ring hollow when society makes it abundantly clear that they are not welcome in the first place.

Next, if a severely disabled child makes it through the birth canal, she will first face in the neo-natal unit the chance of infanticide by neglect<sup>11</sup> and then, should she survive, the continuing prospect of having needed treatment declared “futile.” That practice permits doctors to refuse life-sustaining treatment they consider inappropriate, over patient or family objections.<sup>12</sup> The danger is that doctors will refuse treatment, not because it is ineffective, but because they consider severely disabled patients’ lives not worth living.<sup>13</sup>

Finally, if all else fails, there is the offer of assistance in suicide. True, it is presently limited to patients with terminal conditions; but, as the practice takes hold, legislatures will doubtless extend the offer to people “solely” based on their disabilities. The incentive is simple: The primary reasons terminal patients give for requesting lethal drugs—loss of autonomy, loss of dignity, inability to participate in

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<sup>4</sup> See O.R.S. §127.805(1); Wash. Rev. Code Ann. §70.245.020(1) (West 2009); 18 V.S.A. §5283(a); A.B. 15, *Cal. Health & Safety Code*, §443.2(a).

<sup>5</sup> See S.B. 418, §5-6A-04(a)(2).

<sup>6</sup> See O.R.S. §127.805(2); Wash. Rev. Code Ann. §70.245.020(2) (West 2009); A.B. 15, *Cal. Health & Safety Code*, §443.2(b).

<sup>7</sup> See Erin Biba, “Early Warning System,” *Wired*: Vol. 21; Iss. 1 (Jan. 1, 2013).

<sup>8</sup> Simple blood tests early in pregnancy can screen for other chromosomal disorders besides Down syndrome, including Edwards, Patau, Turner, and Klinefelter Syndromes. See *id.*

<sup>9</sup> See *id.*

<sup>10</sup> See, e.g., 42 U.S.C. §12101(a)(1) (Americans with Disabilities Act).

<sup>11</sup> See David P. Mortimer, “The New Eugenics and the Newborn: The historical ‘Cousinage’ of Eugenics and Infanticide,” *Ethics & Med.* 155-169 (Oct. 1, 2003).

<sup>12</sup> See AMA Opinion 2.035-Futile Care, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page?>

<sup>13</sup> The most egregious example is a Texas law, see V.T.C.A. §166.046, allowing doctors to refuse life-sustaining treatment for patients incapable of caring for themselves or making medical decisions due to an “irreversible condition.” *Id.* at §166.002(9). See *id.* at §166.031(2) (Qualifying patients include those with terminal or irreversible conditions). If such refusal is affirmed by the hospital ethics committee—and there are no standards to ensure that the review is made on the quality of the treatment rather than the quality of the patient’s life—the patient has ten days to find another hospital willing to provide treatment before most life-support ends. See *id.* at §166.046. Given the high cost of care, the chance of finding a willing provider is slim.

activities that make life enjoyable<sup>14</sup>—are the same reasons disabled people seek suicide.<sup>15</sup> If people with only six months to live can end such distress, why not those who face it for a lifetime? As the Supreme Court observed in rejecting a constitutional right to assisted suicide, “[a]n insidious bias against the handicapped—... coupled with a cost-saving mentality—makes them especially in need of ... statutory protection’.”<sup>16</sup> Yet, the protection states have adopted, rather than safeguarding patients’ choice, instead provides a recipe for their abuse. Accordingly, as S.B. 418 tracks the provisions of the assisted suicide laws enacted by Oregon and Washington State, it shares in their major flaws as well.

Turning to the specifics of the proposed legislation, it is first worth noting that nothing in its terms requires the presence of or potential for insufferable pain as a qualifying condition. Though it imposes a waiting period before the prescription is written, patients can have a lethal drug in hand fifteen days after the terminal diagnosis is made,<sup>17</sup> clearly insufficient time to acclimate to a terminal prognosis.

Further, the bill allows persons with a financial interest in the patient’s death to be one of the two witnesses to the written request, attesting to the patient’s competence and the lack of coercion.<sup>18</sup> Though patients can revoke their request “in any manner [,]”<sup>19</sup> including “*communication through another individual familiar with the individual’s manner of communicating*,”<sup>20</sup> nothing prevents the interested witness to the patient’s written request from filling that role. That same person can be the only witness present when the lethal drug is taken since S.B. 418 fails to require an objective observer to the act. This is an open invitation to patient abuse<sup>21</sup> since no one will know if the patient resisted.<sup>22</sup>

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<sup>14</sup> As in prior years, the three most frequently mentioned end-of-life concerns reported by Oregon in 2014 were: “loss of autonomy” in 91.4% of cases, “decreasing ability to participate in activities that made life enjoyable” in 86.7% of cases, and “loss of dignity” in 71.4% of cases. See REP. OF ORE. PUBLIC HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT—2014, available at <https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year17.pdf>. Washington State reported similar findings for 2014. See WASH. DEPT. PUBLIC HEALTH, 2014 DEATH WITH DIGNITY ACT REPORT, available at <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf>. The three most frequently mentioned end-of-life concerns reported by Oregon in 2015 were: “loss of autonomy” in 92.4% of cases, “decreasing ability to participate in activities that made life enjoyable” in 96.2% of cases, and “loss of dignity” in 75.4% of cases. See REP. OF ORE. PUBLIC HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT—2015, available at <https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year18.pdf>. Washington State’s 2015 statistics are not yet available, nor are any annual reports from Vermont or California.

<sup>15</sup> Cf. Diane Coleman, Editorial, *State’s Rights Versus Civil Rights*, SEATTLE POST-INTELLIGENCER, Sept. 29, 2005, available at <http://www.seattlepi.com/local/opinion/article/States-rights-versus-civil-rights-1183888.php>.

<sup>16</sup> *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (quoting *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9<sup>th</sup> Cir. 1995) (panel decision)).

<sup>17</sup> See S.B. 418, §§5-6A-02(a) (requiring an initial oral request, a second such request at least 15 days after the first, and a written request at least 48 hours before the second). Cf. O.R.S. §§127.840 & 127.850; Wash. Rev. Code Ann. §§70.245.090 & 70.245.110(1-2) (West 2009).

<sup>18</sup> S.B. 418, §5-6A-03(b)(1)(ii) (“Only one of the witnesses ... may be[,] ... at the time the written request is signed by the individual, entitled to any benefit on the individual’s death.”). Cf. O.R.S. §127.810(2)(b); Wash. Rev. Code Ann. §70.245.030(2)(b) (West 2009).

<sup>19</sup> S.B. 418, §5-6A-07(a)(6). Cf. O.R.S. §127.815(1)(c)(H); Wash. Rev. Code Ann. §70.245.100 (West 2009).

<sup>20</sup> S.B. 418, §45-6A-01(d)(3). Cf. O.R.S. §127.800(3); Wash. Rev. Code Ann. §70.245.010(3) (West 2009).

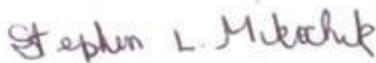
<sup>21</sup> See Margaret K. Dore, *Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice*, 36-WTR Vt. B.J. 53 (2011).

<sup>22</sup> Secobarbital (*Seconal*) and pentobarbital (*Nembutal*) are the drugs most prescribed in Oregon and Washington State for aid in suicide. See OREGON’S DEATH WITH DIGNITY ACT—2015, *supra* note 14; Washington’s 2014 DEATH WITH DIGNITY ACT REPORT, *supra* note 14. Both drugs are water-soluble and can be mixed with alcohol, for example, in a reluctant patient’s

In addition, no independent evaluation of the patient's competence at the time of ingestion is mandated, even though the patient may have the lethal drug in hand for months after the prescription is written.<sup>23</sup> Finally, since S.B. 418 requires all official records to list death from such lethal drugs as "death from **natural causes**,"<sup>24</sup> whoever completes the death certificate<sup>25</sup> must falsify it to list the underlying terminal condition, rather than the lethal drug, as the cause of death.<sup>26</sup> Consequently, other family members may never know their loved one died from assisted suicide.

Those who argue that such concerns will dissipate if safeguards are tightened fail to recognize the "real risk of subtle coercion and undue influence in end-of-life situations."<sup>27</sup> Those who argue that dignity is affirmed when disabled people are given the right to choose to make themselves dead underestimate how devalued they are in society; how internalized such attitudes can become; how attractive the hint to leave can then appear. Finally, those who argue that assisted suicide is no prelude to euthanasia forget that unwelcome guests who "can't take a hint" are eventually helped to leave. Since every law, like "[e]very principle[,] tends—to expand itself to the limit of its logic[.]"<sup>28</sup> I urge your Committee to reject S.B. 418 as a looming threat to the lives of persons with disabilities.

Respectfully submitted,



Stephen L. Mikochik

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drink. See *Seconal Sodium* (Secobarbital Sodium Capsules) Drug Information, available at <http://www.rxlist.com/seconal-sodium-drug.htm>; *Nembutal* (Pentobarbital) Drug Information, available at <http://www.rxlist.com/nembutal-drug.htm>.

<sup>23</sup> See S.B. 418, §5-6A-07(a)(1) ("[T]he attending physician shall ... inform the qualified individual that it is the decision of the qualified individual as to whether and when to self-administer the ... [lethal drug.]").

<sup>24</sup> *Id.* At §5-6A-11(a) ("**For all ... record-keeping purposes ... governed by the laws of the State, ... the death of a qualified individual by reason of the self-administration of ... [such lethal drug] shall be deemed to be a death from natural causes, specifically as a result of the terminal illness from which the qualified individual suffered.**"). *Cf.* Wash. Rev. Code Ann. §70.245.040(2)(West 2009).

<sup>25</sup> See S.B. 418, §5-6A-07(c) ("**If a qualified individual self-administers ... [such lethal drug] and dies, the attending physician may sign the qualified individual's death certificate.**").

<sup>26</sup> Either the lethal drug will accelerate the patient's death from the underlying terminal condition or it will kill the patient whose terminal prognosis is wrong. In any event, ingesting the lethal drug is a cause in fact and, as either the intervening or sole cause, the legal cause of death. See *Oxendine v. State*, 580 A.2d 870 (Del. 1987). See also Joshua Dressler, *Understanding Criminal Law* (4<sup>th</sup> ed.) 198-99 (2006).

<sup>27</sup> *Glucksberg*, 521 U.S. at 732 (citations omitted).

<sup>28</sup> Benjamin N. Cardozo, *The Nature of the Judicial Process* 51 (1921).