



February 23, 2016

Senator Les Seiler
Chair, Judiciary Committee
Room #1103; Nebraska Legislative Office Building
P.O. Box 94604
Lincoln, NE 68509
Phone: (402) 471-2712
Email: lseiler@leg.ne.gov

Re: LB 1056 – “Patient Choice at End of Life Act”- OPPOSE

Dear Chairman Seiler:

On behalf of both the National Catholic Partnership on Disability (NCPD), whose Ethics and Public Policy Committee I chair, as well as the National Catholic Bioethics Center (NCBC), as Director of Bioethics and Public Policy, I am writing to request that your Committee refuse to endorse LB 1056: *Patient Choice at End of Life Act*.

NCPD was established to implement the 1978 *Pastoral Statement on People with Disabilities* of the U.S. Catholic bishops. The NCBC was established in 1972 to address the ethical issues arising in health care and the life sciences, as technological advances were out-pacing the ethical analysis needed to assure the protection of vulnerable populations. On behalf of both NCBC and

NCPD, and the thousands of Nebraska Catholics with disabilities and their caregivers whom we serve, from the children seeking societal inclusion to the frail elderly, I am testifying in opposition to this proposal which precedent has shown only leads to further discrimination, and yes, coercion and non-consensual death to persons whom society is abandoning through such proposals.

For over seven hundred years, Anglo-American law has condemned suicide.¹ Self-murder was a felony at common law; but, since the deceased was beyond penalty, his property was forfeited as a deterrent to others.² Recognizing the harm this caused innocent families, English and American law gradually decriminalized suicide.³ This development, however, did not mark the moral acceptance of suicide, since aiding its commission remained a common law offense.⁴ At the close of the Civil War, most states criminalized assisting a suicide.⁵ Many states subsequently reaffirmed this ban. By 1997, when the Supreme Court rejected the claim that physician-assisted suicide was a constitutional right,⁶ the vast majority of states made it a criminal act.⁷

Nevertheless, assisted suicide has recently become controversial and, spearheaded by Compassion and Choices, the successor to the Hemlock Society, has a foothold in American law. By ballot initiative in 1994, Oregon became the first state to allow physician-assisted suicide.⁸ Its so-called “Death with Dignity Act” set the pattern for the successful 2008 ballot initiative in Washington State.⁹ The Vermont legislature adopted its own version in 2013,¹⁰ while the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state’s public policy.¹¹ In October 2015 the Governor of California signed into law the legislative act legalizing physician assisted suicide in that state.¹² All other attempts to legalize assisted suicide, either by ballot initiative or legislative enactment, have failed.

¹ See *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997).

² See *id.* at 711-13.

³ See *id.* at 713.

⁴ See *id.* at 713-14.

⁵ See *id.* at 715.

⁶ See *id.* at 735.

⁷ See *id.* at 718.

⁸ See O.R.S. § 127.800 *et seq.*

⁹ See Wash. Rev. Code Ann. § 70.245.010 *et seq.* (West 2009).

¹⁰ See 18 V.S.A. § 5281 *et seq.*

¹¹ See *Baxter v. Montana*, 354 Mont. 234. Additionally, An Albuquerque district judge in January, 2014, barred prosecution of physicians for assisting the suicide of terminal patients. See James Monteleone, *Death Aid Case Appeal Possible*, ALBUQUERQUE JOURNAL, Jan. 24, 2014, available at <http://www.abqjournal.com/342190/news/attorney-general-might-appeal-ruling-on-assisted-suicide.html>. The New Mexico Attorney General, however, successfully appealed that ruling decided in the State’s favor on August 11, 2015. The New Mexico case is now under appeal at the New Mexico Supreme Court. See Patients Rights Council, available at <http://www.patientsrightscouncil.org/site/new-mexico/>.

¹² See California Legislative Information, SB2x-15, available at https://leginfo.ca.gov/faces/billStatusClient.xhtml?bill_id=201520162AB15.

Before turning to the specifics of LB 1056, I will address two threshold questions. First, how can laws that require consent constitute government decisions about who should live and who should die? Americans hold as self-evident that all men are “endowed by their Creator with certain unalienable rights; that among these [is the right to] life ...; [and] that, to secure these rights, governments are instituted among men[.]”¹³ As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.¹⁴ When government secures such rights for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying this class deserves less protection against homicide, its members deserve less safeguards of their unalienable rights, in other words, they deserve less respect because in some way they are less human.

Second, why should the disabled community in particular concern itself with laws legalizing assisted suicide that, on their face, are limited to terminal patients? As physical impairments that substantially limit life activities,¹⁵ terminal conditions are disabilities. Thus, to provide, as does LB 1056, that a patient is not qualified for assistance in suicide “solely” because of a disability¹⁶ is simply incoherent. Moreover, predictions of death within six months required for aid in dying¹⁷ are notoriously fallible. Thus, even if terminal and disabling conditions are different, the separating line is porous. Further, the primary reasons terminal patients give for requesting aid in dying—loss of autonomy, loss of dignity, inability to participate in activities that make life enjoyable¹⁸—are the same reasons disabled people seek suicide.¹⁹ If people with only six months to live can end such distress, why not those who face it for a lifetime?²⁰ As the

¹³ THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

¹⁴ John Locke, THE SECOND TREATISE OF GOVERNMENT, Ch. IV, §23, available at <http://www.constitution.org/jl/2ndtr04.htm> (“For a man, not having the power of his own life, cannot, by compact, or his own consent, enslave himself to any one, nor put himself under the absolute, arbitrary power of another, to take away his life, when he pleases. No body [sic] can give more power than he has himself; and he that cannot take away his own life, cannot give another power over it.”).

¹⁵ See, e.g., 42 U.S.C. §§12102(1)(A) (*Americans with Disabilities Act*).

¹⁶ See LB. 1056, § 3 (2).

¹⁷ See *id.* at § 2 (14).

¹⁸ See REP. OF ORE. PUBLIC HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT--2016, available at <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>. This report states that “[l]osing autonomy” was given as an end of life concern in 91.6% of cases; “[l]oss of dignity” in 78.7% of cases; and, “[l]ess able to engage in activities making life enjoyable” in 89.7% of cases. Surprisingly, financial concerns and fear of protracted pain are the least frequent reasons for requesting a lethal prescription, with “[i]nadequate pain control or concern about it” given as an end of life worry in only 25.2% of total cases, and “financial implications of treatment” given by only 3.1% of the total cases.

¹⁹ 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>.

²⁰ See, e.g., *Assisted Suicide in the United States: Hearing before the Subcomm. on the Constitution of the Comm. on the Judiciary House of Representatives*, 104th Cong 127-38 (1996) (prepared testimony of Herbert Hendin, M.D.). During his testimony, Dr. Hendin stated:

Supreme Court concluded when it rejected a due process right to assisted suicide, “[w]e agree that the case for a slippery slope has been made out, but bearing in mind Justice Cardozo's observation of ‘[t]he tendency of a principle to expand itself to the limit of its logic,’ we also recognize the reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right.”²¹

Turning to the specifics of LB 1056, its language tracks the provisions of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State, including some additional ones. It does not require any waiting period between the oral and written request or the immediate dispensing of the medication by the physician,²² clearly discouraging any time for the patient to acclimate to a terminal prognosis, and to seek the physical, emotional and spiritual resources to overcome any sense of hopelessness and abandonment. Furthermore, unlike Washington's act,²³ LB 1058 specifically allows delivery of the legal dose by mail, with the attendant risk of accidental interception by young family members, or deliberate interception by vested family members, as any signature of receipt of delivery is allowed.²⁴ A second physician, independent from the attending physician's practice, must confirm the initial diagnosis, prognosis, and competence of the patient.²⁵ Though either attending or consulting physician can refer patients for psychological or psychiatric evaluation if, in their medical opinion, they suspect clinical depression or other psychological or psychiatric conditions that may impair the patient's judgment,²⁶ many physicians lack training to recognize such conditions,²⁷ and nothing in LB 1056

Over the past two decades, The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help *i.e.* euthanasia to those who could not affect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination.

²¹ *Glucksberg*, 521 U.S. at 733 (quoting B. Cardozo, *The Nature of the Judicial Process* 51 (1932)). Notably in this regard, H.B. 3337, introduced in the Oregon House on February 27, 2015, would extend the definition of “terminal disease” in the state's death with dignity act to include conditions that could result in death within one year.

²² See LB 1056, § 4 (1); *id.* at § 5 9 (2).

²³ Wash. Rev. Code Ann. § 70.245.040(1)(l)(ii)(B).

²⁴ See LB 1056, § 9 (3).

²⁵ See LB 1056, § 6 (7) (a-b).

²⁶ See *id.* at §§ 6 (3), 7 (3), and 8 (3). Nothing in LB 1056 requires a competency evaluation at the time the patient takes the lethal drug, which may occur months after the prescription is written.

²⁷ *Cf. Glucksberg*, 521 U.S. at 730-31 (“[A] New York [blue-ribbon] [t]ask [f]orce, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs.”) (Citations omitted).

requires that they have such training. Not surprisingly, referrals were almost never made in the eighteen-year history of the Oregon Act and, thus far, Washington is following suit.²⁸

Given that the Supreme Court has reported that many people, terminal or not, seeking suicide suffer from clinical depression and often lose the urge when the condition is treated,²⁹ the absence of reported referrals in these states is most troubling for the future of LB 1056.

LB 1056 allows persons with a financial interest in the patient's estate, or, for that matter, anyone "entitled to any portion of such person's estate upon death of the requestor under a will or any operation of law," to be one of the two witnesses to the written request, attesting to the patient's competency and the lack of coercion.³⁰ That same person can be the only witness present when the lethal drug is taken since LB 1056 fails to require an objective observer to the act. This is an open invitation to abuse since no one will know if the patient resisted.³¹ Further, LB 1056 requires that the patient's death certificate list the underlying condition as the cause of death.³² Despite the fact that the patient must agree to tell at least one family member of their intentions, that could be a family member who has a fiscally vested interest in the death of the patient, encouraging this death, while other family members may never know that their loved one died from a lethal prescription. This is especially problematic since the definition of "self-administer" is limited to "ingestion"³³ which is defined in medical dictionaries as "the taking of material (as food) into the digestive system."³⁴ Thus, a person can be "medicated" by a second party who instructs the patient to swallow the lethal dose, killing the patient. In fact, since one witness to the signed consent of the patient is allowed to be a fiscally vested family member, and the other witness is allowed to be "An owner, operator, or employee of a health care facility where the requestor is receiving medical treatment or where the requestor resides,"³⁵ the assurance of true

²⁸ For example, of the 991 Oregon residents who died from a lethal prescription in between 1998 and 2015, only fifty-two had been referred for a psychiatric or psychological evaluation. *See* 2015 DEATH WITH DIGNITY ACT REPORT, February 4, 2016, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>.

²⁹ *See Glucksberg*, 521 U.S. at 730-31 ("Research indicates... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.") (Citations omitted).

³⁰ *See* LB 1056, § 4 (4) (b). Section § 4 (4) (c) allows one of the witnesses to be, "An owner, operator, or employee of a health care facility where the requestor is receiving medical treatment or where the requestor resides." Thus, LB 1056 requires a witness to such patient's request who may have an interest in "freeing up the bed" for a paying resident.

³¹ *See* generally, Margaret K. Dore, *Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice*, 36-WTR Vt. B.J. 53 (2011).

³² *See* LB 1056, § 13.

³³ *See* LB 1056, § 1 (13).

³⁴ "Medical Definition of 'Ingestion,'" *Merriam-Webster Dictionary*, available at <http://www.merriam-webster.com/medical/ingestion>.

³⁵ *See* LB 1056, § 4 (4) (c).

informed consent is compromised. Furthermore, the sponsor of a health care facility, while being able to prohibit a physician from prescribing for a patient to ingest the medication while in the facility, cannot prohibit the writing of such a prescription on the premises for that patient, as long as the ingestion is to occur elsewhere.³⁶ This clearly is a violation of federal and state laws protecting the religious freedom of the sponsors.

The pre-bellum slave codes equated human beings with items of property, “reduced[ing] ... [slaves] to animals, or real estate, or even kitchen utensils[.]”³⁷ Reflecting on this shocking phenomenon, Judge Noonan of the Ninth Circuit has observed: “law can operate as a kind of magic. All that is necessary is to permit legal legerdemain to create a mask obliterating the human person being dealt with. Looking at the mask ... is not to see the human reality on which the mask is imposed.”³⁸ The most vulnerable and marginalized persons, those facing a terminal diagnoses fearing that they will be abandoned because of the perceived loss of dignity (as the Oregon experience demonstrates) will be discriminated against if LB 1056 is passed into law. While the law protects all other persons from engaging in suicide, those with a terminal diagnosis, thus clearly facing a disabling condition, are deemed less worthy of such protection. And as we have seen in the Belgium, Switzerland, and Netherland experiences, such legal provisions quickly move to allowing presumed consent, parents to euthanize their own children or allowing psychological diagnosis³⁹ to justify such “Patient Choice.”

LB 1056 operates as a kind of magic. By offering safeguards that serve instead to place patients at risk of abuse, it employs legal slight-of-hand. By calling “Patient Choice” practices that simply help patients make themselves dead, it recites empty incantations. By not affirming patients’ lives but rather abandoning them to their despair, it creates only an illusion of compassion. True compassion, however, “leads to sharing another’s pain; it does not kill the person whose pain we cannot bear.”⁴⁰ The plain fact is that LB 1056 will legalize assisted

³⁶ See LB 1056, § 18 (5) (c).

³⁷ John T. Noonan, *The Root and Branch of Roe v. Wade*, 63 NEB. L. REV. 668, 669 (1984).

³⁸ *Id.*

³⁹ See Ian Tuttle, “The Right to Die is Wrong,” *The National Review* (July 14, 2015), available at <http://www.nationalreview.com/corner/421150/right-die-wrong-reply-new-republic-updated-ian-tuttle>. Also See, Sydney Leach, “The European Court of Human Rights is Reviewing Two Cases that will Test its Commitment to Protect Life,” *The National Review* (February 13, 2015), available at <http://www.nationalreview.com/article/398521/europes-increasing-acceptance-euthanasia-and-assisted-suicide-sydney-leach>.

⁴⁰ Pope John Paul II, *Evangelium Vitae* [Encyclical Letter on the Gospel of Life] ¶ 66 (1995).

Testimony re LB 1056
Submitted by Marie T. Hilliard

suicide, and no legal magic can mask that reality. I urge the Committee to reject this dangerous and deceptive bill.

Sincerely Yours,

A handwritten signature in black ink that reads "Marie T. Hilliard". The signature is written in a cursive, flowing style.

Dr. Marie T. Hilliard, MS, MA, JCL, PhD, RN.

Director of Bioethics and Public Policy
The National Catholic Bioethics Center

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