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Statement to the Senate Judicial Proceedings Committee
Re: Senate Bill 676 – "Death with Dignity"
Tuesday, March 10, 2015
OPPOSE

Dear Chairman Zirkin:

My name is Stephen L. Mikochik.[1] I am professor emeritus of Constitutional Law at Temple Law School in Philadelphia and visiting professor of Jurisprudence at Ave Maria Law School in Florida. I also am chair emeritus of the National Catholic Partnership on Disability. NCPD was established to implement the 1978 *Pastoral Statement on People with Disabilities* of the U.S. Catholic bishops. On behalf of NCPD and the thousands of disabled Maryland Catholics it serves, I testify in opposition to S.B. 676, which, in legalizing assisted suicide, is an open invitation to patient abuse.

For over seven hundred years, Anglo-American law has condemned suicide.[2] Self-murder was a felony at common law; but, since the deceased was beyond penalty, his property was forfeited as a deterrent to others.[3] Recognizing the harm this caused innocent families, English and American law gradually decriminalized suicide.[4] This development, however, did not mark the moral acceptance of suicide, since aiding its commission remained a common law offense.[5] At the close of the Civil War, most states criminalized assisting a suicide.[6] Many states subsequently reaffirmed this ban. By 1997, when the Supreme Court rejected the claim that physician-assisted suicide was a constitutional right,[7] the vast majority of states made it criminal.[8]

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.[9] Its so-called "Death with Dignity Act" set the pattern for the successful 2008 ballot initiative in Washington State.[10] The Vermont legislature adopted its own version last May,[11] while the Montana Supreme

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[2] *See Washington v. Glucksberg*, 521 U.S. 702, 711 (1997).
[3] *See* id. at 711-13.
[4] See id. at 713.
[5] See id. at 713-14.
[6] See id. at 715.
[7] See id. at 735.
[8] See id. at 718.
[9] *See* O.R.S. § 127.800 *et seq*.
[10] *See* Wash. Rev. Code Ann. § 70.245.010 *et seq.* (West 2009).

Court held in 2009 that physician-assisted suicide was not against that state's public policy.[12] All other attempts to legalize assisted suicide, either by ballot initiative or legislative enactment, have failed. Last March, for example, the New Hampshire House of Representatives defeated H.B. 1325 by a vote of 219 to 66.[13]

Before turning to the specifics of S.B. 676, 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[.]"[14] As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.[15] 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,[16] terminal conditions are disabilities. Thus, to provide, as does S.B. 676, that a patient is not qualified for assistance in suicide "solely" because of a disability[17] is simply incoherent. Moreover, predictions of death within six months required for aid in dying[18] are notoriously fallible.[19] 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

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[11] *See* 18 V.S.A. § 5281 *et seq.*

[12] *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, appealed that ruling on March 12th, 2014. *See* Alex Schadenberg, Attorney General Appeals Court Ruling to Legalize Assisted Suicide, Life News, Mar. 12, 2014, available at http://www.lifenews.com/2014/03/12/new-mexico-attorney-general-appeals-court-ruling-to-legalize-assisted-suicide.html.

[13] *See Death with Dignity Act finds little support in NH House*, UNION LEADER, (March 06, 2014, 8:30PM), available at http://www.unionleader.com/article/20140306/NEWS0621/140309414.

[14] THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776).

[15] 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.").

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

[17] *See* S.B. 676, § 5-6A-04(2).

[18] *See id.* at § 5-6A-01(T).

[19] Under S.B. 676, the doctor need only inform the patient that the medical condition "will, more likely than not, result in death within 6 months. "S.B. 676, §5-6a-03.

autonomy, loss of dignity, inability to participate in activities that make life enjoyable[20]—are the same reasons disabled people seek suicide.[21] If people with only six months to live can end such distress, why not those who face it for a lifetime?[22] As the 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."[23]

Turning to the specifics of S.B. 676, its language tracks the provisions of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State. 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,[24] clearly insufficient time to acclimate to a

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[20] *See* REP. OF ORE. PUBLIC HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT--2013, available at https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year16.pdf. This report states that "[l]osing autonomy" was given as an end of life concern in 91.4% of cases; "[l]oss of dignity" in 80.9% of cases; and, "[l]ess able to engage in activities making life enjoyable" in 88.9% of cases. Surprisingly, fear of protracted pain was not a major reason given for requesting a lethal prescription, with "[i]nadequate pain control or concern about it" given as an end of life worry in only 23.7% of total cases. As in previous years, the three most frequently mentioned end-of-life concerns reported 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. *See also* WASH. DEPT. PUBLIC HEALTH, 2012 DEATH WITH DIGNITY ACT REPORT, available at http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-*DeathWithDignityAct 2013*.pdf.

[21] *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.

[22] *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:

> 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.

[23] *Glucksberg*, 521 U.S. at 733, n. 23. (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.

[24] *See* S.B. 676, § 5-6A-02(A); *id.* at § 5-6A-07(A)(I).

terminal prognosis.[25] A second physician, not excluding a member of the attending physician's practice, must confirm the initial diagnosis, prognosis, and competence of the patient.[26] 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,[27] many physicians lack training to recognize such conditions;[28] and nothing in S.B. 676 requires that they have such training. Not surprisingly, referrals were almost never made in the seventeen-year history of the Oregon Act and, thus far, Washington is following suit. [29]

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,[30] the absence of reported referrals in these states is most troubling for the future of S.B. 676.

The Senate Bill allows persons with a financial interest in the patient's estate, or, for that matter, anyone "entitled to any benefit on the patient's death," to be one of the two witnesses to the written request, attesting to the patient's competency and the lack of coercion.[31] That same person can be the only witness present when the lethal drug is taken since S.B. 676 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.[32] Further, S.B. 676 requires that the patient's death certificate list the

[25] Unlike Washington's act, *see* Wash. Rev. Code Ann. § 70.245.040(1)(l)(ii)(B), however, S.B. 676 does not specifically prohibit delivery of the legal dose by mail, with the attendant risk of accidental interception by young family members.
[26] *See* S.B. 676, § 5-6A-04(D); *id.* at § 5-6A-05.
[27] *See id.* at § 5-6A-06(A). Nothing in S.B. 676 requires a competency evaluation at the time the patient takes the lethal drug, which may occur months after the prescription is written.
[28] *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).
[29] For example, of the 105 Oregon residents who died from a lethal prescription in 2014, only three had been referred for a psychiatric or psychological evaluation; likewise, of the 71 Oregon residents who died from such prescription in 2013, only two had been referred for evaluation. *See* OREGON'S DEATH WITH DIGNITY ACT—2014 & 2013, supra note 9. Oregon's yearly reports from 1998 through 2012 reveal similar statistics; showing: 2 out of 77 in 2012; 1 out of 71 in 2011; 1 out of 65 in 2010; 0 out of 59 in 2009; 2 out of 60 in 2008; 0 out of 49 in 2007; 2 out of 46 in 2006; 2 out of 38 in 2005; 2 out of 37 in 2004; 2 out of 42 in 2003; 5 out of 38 in 2002; 3 out of 21 in 2001; 5 out of 27 in 2000; 10 out of 27 in 1999; and 4 out of 21 in 1998 were referred for evaluations. Similarly, in Washington, of the 104 residents who died of lethal drugs in 2012, only 3 had been referred for such evaluation. *See* 2012 DEATH WITH DIGNITY ACT REPORT, *supra* note 9. Washington's yearly reports from 2011 through 2009 show: 5 out of 94 in 2011; 3 out of 72 in 2010; and 3 out of 47 in 2009 were referred for evaluations.
[30] *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).
[31] S.B. 676, 5-6A-04(B)(1)(II). Section 5-6A-04(B)(2) provides that, "[i]f a patient is an inpatient or a resident of a health care facility at the time the written request to the patient's attending physician is signed, one of the witnesses shall be an individual designated by the health care facility [if such designation is made within forty-eight hours of a request]." Thus, S.B. 676 requires a witness to such patient's request who may have an interest in "freeing up the bed" for a paying resident.
[32] 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).

underlying condition as the cause of death.[33] Consequently, family members may never know that their loved one died from a lethal prescription.

The pre-bellum slave codes equated human beings with items of property, "reduced[ing] … [slaves] to animals, or real estate, or even kitchen utensils[.]"[34] 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."[35]

Like the slave codes, S.B. 676 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 "aid in dying" 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."[36] The plain fact is that S.B. 676 will legalize assisted suicide, and no legal magic can mask that reality. I urge the Committee to reject this dangerous and deceptive bill.

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[33] *See id*. at § 5-6A-06(c) (2). Moreover, since records concerning patients' requests for lethal prescriptions are only subject to legal process in order to "resolve matters concerning compliance with [S.B. 676] or as otherwise specifically provided by law[,]" *id*. at §15-6A-09, families are faced with a "Catch 22" since they must know their loved ones died from a lethal prescription rather than natural causes before they can review the records to determine whether a request for such prescription was made.

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

[35] *Id*.

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