Family Institute of Connecticut ACTION

March 18, 2015

Connecticut General Assembly
Joint Committee on Judiciary
Legislative Office Building 2500
Hartford, Ct. 06106

Re: R.B. 7015; An Act Concerning Aid in Dying for Terminally Ill Patients

Dear Sen. Coleman and Rep. Tong:

My name is Stephen L. Mikochik.[1] I am professor emeritus of Constitutional Law at Temple Law School in Philadelphia; visiting professor of Jurisprudence at Ave Maria Law School in Florida; and a former attorney with the Civil Rights Division, U.S. Department of Justice. On behalf of the Family Institute of Connecticut, I testify in opposition to R.B. 7015, 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,[9] the successor to the Hemlock Society, has a foothold in American law. By ballot initiative in 1994, Oregon became the first state to allow

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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] As a portent of things to come, the President of Compassion and Choices observed at a presentation in Hartford last fall that the case for making aid in dying available to those with dementia and cognitive decline (and thus not necessarily terminal or capable of giving informed consent) "is no less compelling[.]" Statement of Barbara Coombs Lee, panel discussion, Real Art Ways, Hartford, Ct., (Oct. 10, 2014) available at http://www.ctnewsjunkie.com/archives/entry/compassion_choices_draws_full_house_for_panel_discussion_film/

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physician-assisted suicide.[10] Its so-called "Death with Dignity Act" set the pattern for the successful 2008 ballot initiative in Washington State.[11] The Vermont legislature adopted its own version last May,[12] while the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state's public policy.[13] All other attempts to legalize assisted suicide by either 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.[14]

Before turning to the specifics of R.B. 7015, I will address two threshold questions. First, how can a procedure that requires patient consent involve 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 [.]"[15] As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.[16] Further, a core purpose of government is to preserve our lives by preventing suicide and prohibiting aid in its commission. When government secures that right for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying that class deserves less protection against suicide, 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,[17] terminal conditions are disabilities. Thus, to provide, as does R.B. 7015, that a patient is not qualified for assistance in suicide "solely" because of a disability[18] is

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[10] *See* O.R.S. § 127.800 *et seq.*
[11] *See* Wash. Rev. Code Ann. § 70.245.010 *et seq.* (West 2009).
[12] *See* 18 V.S.A. § 5281 *et seq.*
[13] *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.
[14] *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.
[15] THE DECLARATION OF INDEPENDENCE, para. 2 (U.S. 1776).
[16] 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.").
[17] *See, e.g.*, 42 U.S.C. §§12102(1)(A) (*Americans with Disabilities Act*).
[18] *See* R.B. 7015, § 6 (1).

simply incoherent. Moreover, predictions of death within six months required for aid in dying[19] are notoriously fallible.[20] Thus, even if terminal and disabling conditions are distinct, 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 enjoyable[21]—are the same reasons disabled people seek suicide.[22] If people with only six months to live can end such distress, why not those who face it for a lifetime?[23] As the Supreme Court concluded in rejecting a constitutional right to assisted suicide, "[w]e agree that the case for a slippery slope has been made out [.]"[24]

Turning to the specifics of R.B. 7015, its language tracks the structure of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State. [25]

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[19] *See id.* at § 1 (19).

20 Of course, for those who die from a lethal prescription, their terminal prognosis is a self-fulfilling prophesy.

21 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 "losing autonomy" was given as an end of life concern in 91.4% of cases; "loss of dignity" in 80.9% of cases; and "less 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 "inadequate pain control or concern about it" given as an end of life worry in only 23.7% of total cases. As in prior 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 *www.doh.wa.gov/portals/1/.../422-109-DeathWithDignityAct2012.pdf;* WASH. DEPT. PUBLIC HEALTH, 2013 DEATH WITH DIGNITY ACT REPORT, available at *www.doh.wa.gov/portals/1/.../422-109-DeathWithDignityAct2013.pdf.*

[22] *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.

[23] *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 non-voluntary 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.

[24] Glucksberg, 521 U.S. at 733, n. 23 ("[B]earing 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." *Id.* (quoting B. Cardozo, *The Nature of the Judicial Process* 51 (1932)). In this regard, it is worth noting that H.B. 3337 was introduced in the Oregon House on February 27, 2015, which 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.

[25] One difference is that R.B. 7015 requires patients to make two successive written requests for a lethal prescription, *see* R.B. 7015, § § 2 (a) & 3 (a), while Oregon and Washington both require three (one written and two oral) requests. *See* O.R.S. § 127.840; *see* Wash. Rev. Code Ann. § 70.245.090 (West 2009).

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,[26] clearly insufficient time to acclimate to a terminal prognosis.[27] Though either the attending or consulting physician can refer the patient for psychological or psychiatric evaluation if, in their medical opinion, they suspect clinical depression or other conditions that may impair the patient's judgment,[28] many physicians lack training to recognize such depression;[29] and nothing in R.B. 7015 requires that they have it. Not surprisingly, referrals were almost never made in the seventeen-year history of the Oregon Act and, thus far, Washington is following suit. [30]

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,[31] the absence of reported referrals in these states is most troubling for the future of R.B. 7015.

Though R.B. 7015 precludes persons with a financial interest in the patient's estate from witnessing the patient's requests for a lethal prescription,[32] they can be the only witnesses present when the lethal drug is taken since R.B. 7015 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.[33] The raised bill compounds the problem since self-administration merely means that the patient ingested, that is, swallowed, the lethal drug,[34] blurring the line between assisted suicide and euthanasia. Further, R.B. 7015 requires that the patient's death certificate list the underlying condition as the cause of death.[35] Consequently, family members may never know that their loved one died from a lethal prescription.[36]

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[26] *See* R.B.7015, § 3 (a); *id.* at § 9 (a) (6).

[27] Unlike Washington's act, *see* Wash. Rev. Code Ann. § 70.245.040(1)(l)(ii)(B), however, R.B. 7015 does not specifically prohibit delivery of the legal dose by mail, with the attendant risk of accidental interception by young family members.

[28] *See* R.B. 7015, § 8 (a). Nothing in R.B. 7015 requires a competency evaluation at the time the patient takes the lethal drug, which can occur months after the prescription is written.

[29] *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).

[30] For example, Oregon reported only three referrals for psychiatric or psychological evaluation in 2014. *See* OREGON'S DEATH WITH DIGNITY ACT—2014, supra note 21. Oregon's yearly reports from 1998 through 2013 reveal similar statistics, showing: only 2 in 2013; 2 in 2012; 1 in 2011; 1 in 2010; 0 in 2009; 2 in 2008; 0 in 2007; 2 in 2006; 2 in 2005; 2 in 2004; 2 in 2003; 5 in 2002; 3 in 2001; 5 in 2000; 10 in 1999; and 4 in 1998 were referred for such evaluations. Similarly, Washington State reported only 6 such referrals in 2013. *See* DEATH WITH DIGNITY ACT – 2013, *supra* note 21. Washington's yearly reports from 2009 through 2012 reveal similar statistics, showing: only 3 in 2012; 5 in 2011; 3 in 2010; and 3 in 2009 were referred for such evaluation.

[31] *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).

[32] *See* R.B. 7015, § 3 (b) (2). The patient's relatives; attending physician; and the owners,operators, and employees of any health care facility where the patient is receiving treatment are also disqualified from serving as witnesses. *See id.* at § 3 (b) (1, 3&4).

[33] 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).

[34] *See* R.B.7015, § 1 (18).

[35] *See* R.B. 7015, § 9 (b). Either the lethal drug will accelerate the patient's death from the underlying terminal condition or it will kill the patient whose terminal prognosis was wrong. In any event, ingesting the lethal drug is a

Finally, with one hand, R.B. 7015 protects patients from the civil negligence of their attending physicians;[37] with the other hand, it takes that protection away by providing that "an attending physician's dispensing of, or issuance of a prescription for medication for aid in dying ... in good faith compliance with the provisions ... of this act shall not constitute neglect for the purpose of any law [.]"[38] Given this anomaly, one can legitimately question whether the purpose of R.B. 7015 is more to protect doctors from liability for dispensing lethal medication than it is the promotion of patient choice.

The pre-bellum slave codes equated human beings with items of property, "reduced[ing] ... [slaves] to animals, or real estate, or even kitchen utensils [.]"[39] Reflecting on this 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."[40]

Like the slave codes, S.B. 7015 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."[41] The plain fact is that S.B. 7015 will legalize assisted suicide, and no legal magic can mask that reality. I urge the Committee to reject this dangerous and deceptive bill.

Respectfully submitted,

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cause in fact and, as either the sole or intervening cause, the legal cause of death. Thus, R.B. 7015 requires falsification of the death certificate since the drug, and not the underlying condition, is the cause of death.

[36] The raised bill excludes any person who "otherwise participates in the provision of medication for aid in dying to a qualified patient" from benefiting from such patient's estate. R.B. 7015, § 19. Except regarding health care providers, see *id.* at § 13 (a), the bill does not define "participates." For example, being the only other person present when the lethal drug is taken does not appear to constitute participation. *Cf. id.* at § 15 (c) (2). Though such person is guilty of murder if he, "without authorization ..., willfully ... conceals or destroys a rescission of ... a request for aid in dying ... or coerces or exerts undue influence on a patient to destroy a rescission of such request with the intent or effect of causing the patient's death[,]" *id.* at § 14 (a & b), who would know, since the only witness is dead.

[37] *See id.* at § 16.

[38] *Id.* at § 15 (d).

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

[40] *Id.*

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

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