Written Testimony of Steven H. Aden, Esq.
Chief Legal Officer & General Counsel, Americans United for Life
Opposing H.B. 5898
Submitted to the Joint Committee on Public Health
March 18, 2019

Dear Co-Chairs Daugherty Abrams and Steinberg, and Members of the Committees:

My name is Steven H. Aden, and I serve as Chief Legal Officer and General Counsel for Americans United for Life (AUL). Established in 1971, Americans United for Life is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. Our vision at AUL is a nation where everyone is welcomed in life and protected in law. In my practice, I specialize in life-related legislation and constitutional law, and in the constitutionality of end-of-life laws specifically. I appreciate the opportunity to submit legal written testimony against H.B. 5898, which would legalize drug-induced suicide in Connecticut.

I have thoroughly reviewed H.B. 5898, and it is my opinion that the Act would place already-vulnerable persons at greater risk and threaten the integrity and ethics of the medical profession. For these reasons, we urge you to vote against this bill.

The Majority of States Affirmatively Prohibit Physician-Assisted Suicide

Currently, the overwhelming majority of states—at least 39 states—affirmatively prohibit assisted suicide and impose criminal penalties on anyone who helps another person end his or her life. And since Oregon first legalized the practice in 1996, "about 200 assisted-suicide bills have failed in more than half the states."[1] In *Washington v. Glucksberg*, the United States Supreme Court summed up the consensus of the states: "In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life."[2]

[1] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 Human Life Rev. 51, 53 (2018). In the past week, New Mexico and Arkansas have both tabled bills to allow for assisted suicide. New Mexico H.B. 90; Arkansas H.B. 1536.
[2] 521 U.S. 702, 710 (1997).

This longstanding consensus among the vast majority of states is unsurprising when one considers, as the Court did, that "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages."[3] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide in the U.S. Constitution, and instead found that there exists for the states "an 'unqualified interest in the preservation of human life[,]' . . . in preventing suicide, and in studying, identifying, and treating its causes."[4]

Only by rejecting H.B. 5898 can this Committee further Connecticut's important state interest in preserving human life and advance the State's duty to protect the lives of its citizens, especially the lives of the most vulnerable members of society.

Physician-Assisted Suicide Places Already-Vulnerable Persons at Greater Risk

It is critical for Connecticut to protect vulnerable persons—including the poor, the elderly, and disabled —from abuse, neglect, and coercion. When considering the risks posed by assisted suicide to all of us, especially these vulnerable individuals, the availability of assisted suicide can be considered neither a compassionate nor an appropriate solution for those who may suffer at the end of life. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved physician-assisted suicide, which includes a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[5] Even the most vulnerable among us, such as the poor, the elderly, the terminally ill, the disabled, and the depressed, are worthy of life and of equal protection under the law, and state prohibitions on assisted suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[6]

And in fact, as the Supreme Court recognized in *Glucksberg*, "'intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia.'"[7] The AMA in its *amicus* brief informed the Court "that the demand for physician-assisted suicide does not come

[3] *Id.* at 711.
[4] *Id.* at 729–30.
[5] J. Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted"); *see also* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (2018), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf (In 2017, 56% of patients who died after ingesting a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).
[6] *Glucksberg*, 521 U.S. at 731–32.
[7] *Glucksberg*, 521 U.S. at 730 (quoting A. L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996)). In fact, Oregon admitted in its most recent report on legal suicide, "The three most frequently reported end-of-life concerns were loss of autonomy (91.7%), decreasing ability to participate in activities that made life enjoyable (90.5%), and loss of dignity (66.7%)." *Oregon Death With Dignity Act Data Summary 2018*, https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/ (last viewed March 15, 2019).

principally from those seeking relief from physical pain."[8] Instead, "[m]ost patients that request suicide do so out of concerns that, in the future, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families."[9] Many persons requesting physician-assisted suicide subsequently withdraw their request if their depression or fears are treated.[10]

Physician-Assisted Suicide Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on physician-assisted suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as the principles articulated in the Hippocratic Oath to "keep the sick from harm and injustice" and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[11] And today, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of their life. The AMA states that "permitting physicians to engage in assisted suicide would ultimately 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."[12] In fact, the AMA emphasizes that physicians must "aggressively respond to the needs of the patients" and "respect patient autonomy [and] provide appropriate comfort care and adequate pain control."[13]

In addition, the U.S. Supreme Court has stated, "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[14] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for physician-assisted suicide, he pointed out: "Virtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[15]

"Safeguards" Do Not Always Work

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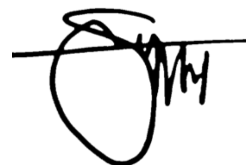
[8] *Gluckbserg*, Brief for American Medical Ass'n, et al., in Support of Petitioners, at 6.
[9] Id. at 8, 14-15 (emphasis added).
[10] Glucksberg, 521 U.S. at 730 (citing Herbert Hendin, Seduced by Death: Doctors, Patients and the Dutch Cure 24-25 (W W Norton & Co., 1st ed edition, 1997) (suicidal, terminally ill patients 'usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive').
[11] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . . [W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131–32 (1973).
[12] AMA CODE OF MEDICAL ETHICS OP. 5.7 (Physician-Assisted Suicide), https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf.
[13] *Id.*
[14] *Glucksberg*, 521 U.S. at 731.
[15] *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

Despite the so-called "safeguards," opening the door for physician-assisted suicide also opens the door to real abuse. For example, H.B. 5898 requires the physician refer the individual for a mental health assessment in order to determine the individual's competency to request life-ending medication if the physician thinks the individual "may be suffering from a psychiatric or psychological condition, including, but not limited to, depression, that is causing impaired judgment." However, this has several problems. First, as the most recent statistics from Oregon show, only five of the 143 patients who died from ingesting end-of-life drugs in 2017 were ever referred for a psychiatric evaluation.[16] One study from Oregon found that "[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[17] But without a requirement that a mental health professional see the requesting individual, it is difficult to argue this "safeguard" in H.B. 5898 will accurately assess an individual's mental state.

Second, the mental health assessment is only meant to determine whether the individual is "competent" to request medication to end his or her life. H.B. 5898 defines "competent" as the individual possessing the "capacity to understand and acknowledge the nature and consequences of health care decisions, including the benefits and disadvantages of treatment, to make an informed decision and to communicate such decision to a health care provider, including communicating through a person familiar with a patient's manner of communicating." There is nothing in the definition or requirement that would prevent an individual who was found to be depressed from going through with his or her request for life-ending medication so long as he or she was found to have the capacity to understand the nature of the request and communicate that decision.

In conclusion, Connecticut should reject physician-assisted suicide and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession by rejecting H.B. 5898. Thank you.

Very truly yours,



Steven H. Aden, J.D.

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[16] Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2017 DATA SUMMARY (Feb. 9, 2018) https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf (last visited Feb. 14, 2019).

[17] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, Am. J. Psychiatry 157:4, 595 (2000) https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.157.4.595.

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