MEMORANDUM

TO: California Senate Judiciary Committee
FROM: Margaret Dore, Esq., MBA
RE: Vote "No" on SB 128. (No Assisted Suicide/Euthanasia)
HEARING: April 7, 2015, 1:30 p.m.

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APPENDIX
I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.\(^1\) Our law is modeled on a similar law in Oregon. Both laws are similar to the proposed bill, SB 128.\(^2\)

SB 128 seeks to legalize “aid in dying,” more commonly known as physician-assisted suicide, assisted suicide and/or euthanasia. The term, aid in dying, is also misleading because eligible persons may have years, even decades, to live.

If SB 128 is enacted, the major change will be that other people will be able to encourage you to kill yourself, or to directly kill you, in certain circumstances. The bill’s thrust is to protect participants in patient deaths, not patients.

SB 128 is, regardless, a recipe for elder abuse, especially for people with money. Other problems include steerage to suicide by health care providers and the risk of suicide contagion. I urge you to vote “NO” on SB 128. Do not make Washington’s mistake.

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1 I have been licensed to practice law in Washington State since 1986. I am a former Law Clerk to the Washington State Supreme Court. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am also President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide. For more information, please see www.margaretdore.com, www.choiceillusion.org and www.margaretdore.org.

2 SB 128, as amended 03/17/15, is attached hereto at A-1 through A-14.
II. FACTUAL AND LEGAL BACKGROUND

A. Physician-assisted Suicide, Assisted Suicide and Euthanasia.

The American Medical Association defines "physician-assisted suicide" as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." "Assisted suicide" is a general term in which the aiding person is not necessarily a physician. "Euthanasia," by contrast, is the direct administration of a lethal agent with the intent to cause another person's death.

The American Medical Association rejects physician-assisted suicide and euthanasia, stating they are:

fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

B. Withholding or Withdrawing Treatment.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia. This is because the purpose is to remove treatment as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die.

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3 The AMA Code of Medical Ethics, Opinion 2.211 - Physician-Assisted Suicide. (Attached at A-25).
4 Cf. AMA Code of Ethics, Opinion 2.21 - Euthanasia. (Attached at A-26).
5 AMA Code of Ethics, Opinions 2.211 and 2.21, supra at footnotes 3 & 4.
Consider this quote from an article in Washington state regarding a man removed from a ventilator:

[I]nstead of dying as expected, [he] slowly began to get better.\textsuperscript{6}

C. Most States Have Rejected Assisted Suicide and Euthanasia.

The vast majority of states to consider legalizing assisted suicide and/or euthanasia have rejected it.\textsuperscript{7} Just two months ago, a bill similar to SB 128 was summarily defeated in Colorado.\textsuperscript{8}

In the last four years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana.\textsuperscript{9}

D. Existing Medical Killing Under the Guise of Treatment Withdrawal.

In California, medical killing already occurs under the guise of treatment withdrawal. Consider, for example, a California case against Kaiser Healthcare. Doctors allegedly killed Victorino Noval, a wealthy older man, through a "terminal

\textsuperscript{6} Nina Shapiro, Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?, Seattle Weekly, January 14, 2009. (Attached at A-27, quote at A-29).

\textsuperscript{7} See tabulation at http://epcdocuments.files.wordpress.com/2011/10/ Attempts_to_legalize_001.pdf

\textsuperscript{8} See article at A-33.

\textsuperscript{9} See materials at A-34 to A-37.
extubation."\textsuperscript{10} His daughters had allegedly urged this result in order to obtain large inheritances.\textsuperscript{11}

III. THE BILL

A. "Eligible" Patients May Have Years, Even Decades, to Live.

SB 128 applies to "terminal" patients, meaning those predicted to have less than six months to live.\textsuperscript{12} Such persons may, however, actually have years, even decades, to live, i.e., unless the bill passes and they commit suicide or are euthanized thereunder. This is true for at least three reasons:

1. If California follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for persons with chronic conditions such as diabetes.

SB 128 states:

"Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.\textsuperscript{13}


\textsuperscript{11} Id. See also Peter Whoriskey, "As More Hospices Enroll Patients who Aren't Dying, Questions About Lethal Doses Arise," The Washington Post, August 8, 2014.

\textsuperscript{12} SB 128, § 443.1(o). (Attached at A-5).

\textsuperscript{13} Id.
Oregon’s law has a similar definition, as follows:

“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\(^{14}\)

In Oregon, this similar definition is interpreted to include chronic conditions such as insulin dependent diabetes.\(^{15}\) Oregon doctor, William Toffler, explains:

Our law applies to "terminal" patients who are predicted to have less than six months to live. In practice, this idea of terminal has recently become stretched to include people with chronic conditions . . . . Persons with these conditions are considered terminal if they are dependent on their medications, such as insulin, to live.\(^{16}\)

If California enacts SB 128 and follows Oregon’s interpretation of “terminal disease,” assisted suicide and euthanasia will be legalized for people with chronic conditions such as diabetes. Dr. Toffler states:

Such persons, with treatment, could otherwise have years or even decades to live.\(^{17}\)

2. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life

\(^{14}\) Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-38.

\(^{15}\) See Oregon’s annual assisted suicide report for 2014, attached hereto at A-39 to A-44. “Chronic lower respiratory disease” and “diabetes” are listed at A-43 & A-44, respectively.

\(^{16}\) Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (Attached at A-45). (I verified the content with him).

\(^{17}\) Id.
expectancy is not an exact science. Consider John Norton who was diagnosed with ALS. He was told that he would get progressively worse (be paralyzed) and die in three to five years. Instead, the disease progression stopped on its own. In a 2012 affidavit, at age 74, he states:

If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.


3. Treatment can lead to recovery.

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and wanted to do assisted suicide. Her doctor convinced her to be treated instead. In a 2013 affidavit, she states:

This last July, it was 13 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.

B. If SB 128 Is Enacted, There Will be Pressure to Expand Eligibility.

In Washington State, our law went into effect in 2009. Since then, we have had informal proposals to expand our law to

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18 Compare Terminal Uncertainty. (Attached hereto at A-27).
19 Affidavit of Kenneth Stevens, MD ¶¶ 3-7. (Attached hereto at A-56 to A-65.
20 Id.
21 Affidavit of Jeanette Hall, ¶ 4, attached hereto at A-15 to A-17. Jeanette is still alive today, nearly 15 years later.
non-terminal people. For me, the most disturbing proposal was a column suggesting euthanasia for people without funds.\textsuperscript{22} This was in the Seattle Times, which is our largest paper.\textsuperscript{23} Meanwhile, in Oregon, there is an actual bill to expand eligibility.\textsuperscript{24}

If SB 128 is enacted in California, it’s not unlikely that there will be a similar pressure to expand.

C. How the Bill Works.

SB 128 has an application process to obtain the lethal dose, which includes a written lethal dose request form with two witnesses.\textsuperscript{25} One of the witnesses is allowed to be the patient’s heir, who will benefit financially from the patient’s death.\textsuperscript{26}

Once the lethal dose is issued by the pharmacy, there is no oversight.\textsuperscript{27} No doctor is required to be present.\textsuperscript{28} The death is

\textsuperscript{22} See Jerry Large, “Planning for old age at a premium,” The Seattle Times, March 8, 2012 (“After Monday’s column, ... a few [readers] suggested that if you couldn’t save enough money to see you through your old age, you shouldn’t expect society to bail you out. At least a couple mentioned euthanasia as a solution.”) (Emphasis added). (Attached at A-49).

\textsuperscript{23} Id.

\textsuperscript{24} See Oregon House Bill 3337, attached at A-50 and A-51 (proposing to expand legal assisted suicide to persons with less than a year to live).

\textsuperscript{25} The lethal dose request form can be viewed at SB 128, § 443.9. (Attached at A-9 to A-11)

\textsuperscript{26} See SB 128, §443.3(c)(1)(providing that one of two required witnesses on the lethal dose request form “may ... be entitled to a portion of the person’s estate upon death”).

\textsuperscript{27} See SB 128 in its entirety. (Attached at A-1 through A-14).

\textsuperscript{28} Id.
not required to be witnessed.29

D. A Comparison to Probate Law.

When signing a will, an heir's acting as a witness supports a finding of undue influence. California's probate code says that when one of two witnesses is a taker under the will, there is a rebuttable presumption that the taker/witness "procured the [gift] by duress, menace, fraud, or undue influence."30

The lethal dose request process, which allows an heir to act as a witness on the lethal dose request form, invites coercion.

E. Patient Control is an Illusion; Patients Are Not Protected.

SB 128 is promoted as providing an enhancement of patient choice and control, which is not the case. Patients are not protected. Please consider the following.

1. No witnesses at the death.

SB 128 does not require witnesses at the death.31 Without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without his

29 Id.

30 West's Ann.Cal.Prob.Code § 6112(c) states:

Unless there are at least two other subscribing witnesses to the will who are disinterested witnesses, the fact that the will makes a devise to a subscribing witness creates a presumption that the witness procured the devise by duress, menace, fraud, or undue influence.

31 See SB 128 in its entirety, attached hereto at A-1 to A-14.
consent.\textsuperscript{32} Even if he struggled, who would know? This situation is especially significant for people with money. People v. Stuart, 67 Cal.Rptr.3d 129, 143 (2007), states:

Financial considerations [are] an all too common motivation for killing someone.\textsuperscript{33}

Without disinterested witnesses, the patient’s control over the time, place and manner of his death is not guaranteed.

2. Adding witnesses will not fix the problem.

Requiring witnesses at the death would protect against overt murder. Generally, however, witnesses are not much of a safeguard. Many wills are properly witnessed and nonetheless set aside for undue influence, fraud, etc.

3. Witnesses can be coercive.

Witnesses can also be coercive. Consider Oregon resident, Lovelle Svart, who threw herself an “exit party,” during which she danced the polka with George Eighmey of Compassion & Choices. The party was reported in the Seattle Times, which wrote an article implying that she was in control.\textsuperscript{34} At the end of the

\begin{itemize}
\item \textsuperscript{32} The drugs used for assisted suicide in Oregon and Washington, Secobarbital and Pentobarbital (Nembutal), are water soluble, such that they can be injected without consent, for example, to a sleeping person. See "Secobarbital Sodium Capsules, Drugs.Com," at http://www.drugs.com/pro/secobarbital-sodium.html and http://www.drugs.com/pro/nembutal.html. See also Oregon’s report, page 5, attached at A-43 (listing these drugs).
\item \textsuperscript{33} An excerpt from Stuart is attached hereto at A-18.
\item \textsuperscript{34} See Don Colburn, “Last day of life all planned out, down to the polka,” October 26, 2007, available at http://seattletimes.com/html/localnews/2003918100_suicide02.html
\end{itemize}
party, however, when it was time for her to die, the paper also reported this exchange between her and Eighmey, which took place in front of ten people:

"Is this what you want?"

"Actually, I’d like to go on partying," Lovelle replied, laughing before turning serious. "But, yes."

"If you do take it, you will die."

"Yes."

The situation was similar to a wedding when it’s time to take your vows. Everyone’s watching and it’s the thing to do. So even if you’re having second thoughts or would rather "go on partying," you go forward to take the lethal dose. If Eighmey had wanted to give Lovelle an out, he could have said:

"You are having so much fun, you don’t have to do this today or even next week."

Instead, he proceeded according to the script that she would die at the end of the party. His role was to preside over her death. Her role was to comply. Once she was in this role, she no longer had control. The situation was inherently coercive.

4. Someone else is allowed to speak for the patient, including a stranger, as long as the speaking person is “familiar with the patient’s manner of communicating.”

Patients signing the lethal dose request form are required

35 Id.
to be "competent." This term is, however, specially defined to allow someone else to speak for the patient during the lethal dose request process, i.e., as long as the speaking person is "familiar with the patient's manner of communicating." SB 128 states:

Competent" means that . . . the individual has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual's manner of communicating . . . (Emphasis added)

Being familiar with the patient's "manner of communicating" is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but does not herself understand Spanish. That, however, would be good enough for the assistant to speak for the patient during the lethal dose request process.

Proponents may counter that not just anyone can speak for the patient, that a translator is required. This is only, however, if the lethal dose request form is in English and the patient speaks another language. If the form is in the patient's language, no translator is required. Regardless,

36 SB 128 § 443.1(m). ("Qualified" patients are required to be "competent"). (Attached at A-4).
37 SB 128, § 443.1(d). (Attached at A-3).
38 See SB 128, § 443.9(b). (Attached at A-10)
39 Id.

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someone else is allowed to speak for the patient as long as he or she is familiar with the patient’s “manner of communicating.”
This person could be the doctor’s janitor or practically anyone at all. The patient’s choice and control is not assured.

5. Individual "opt outs" are not allowed.

SB 128 does not allow people to opt out of its provisions. Consider, for example, § 443.10(a), which states:

A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for aid-in-dying medication, is not valid.

(Emphasis added).

So much for the patient’s choice and control.

6. There is no requirement that a doctor or anyone else comply with a patient’s “rescission” of the request.

SB 128 provides that a patient may, at any time, rescind her request for the lethal dose.\(^{40}\) There is, however, no provision, i.e., anywhere, that a doctor or anyone else is obligated to follow that request.\(^{41}\) This purported protection is illusory.

\[^{40}\text{SB 128, § 443.4(a) states:}
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\[^{41}\text{See SB 128 in its entirety, at A-1 though A-14.}\]
7. **Purported liability for undue influence appears to be illusory.**

SB 128 imposes criminal liability for undue influence. § 443.14(b) states:

Knowingly coercing or exerting undue influence on an individual to request medication for the purpose of ending his or her life or to destroy a rescission of a request is punishable as a felony.

This provision appears to be illusory. See below.

a. **Too vague to be enforced.**

SB 128 does not define undue influence or provide elements of proof. Undue influence is also a traditionally equitable concept "not susceptible of precise definition . . . ." For example, in Washington State, the test for undue influence consists of multiple nonexclusive factors. With this situation, at least under Washington’s law, the "crime" of undue influence appears to be too vague to be enforced.  

42 See SB 128 in its entirety. (Attached at A-1 through A-14).


44 Estate of Lint, 957 P.2d 755, 764 (Wash. 1998) (stating the test for undue influence: "The most important of such facts are (1) that the beneficiary occupied a fiduciary or confidential relation to the testator; (2) that the beneficiary actively participated in the preparation or procurement of the will; and (3) that the beneficiary received an unusually or unnaturally large part of the estate. Added to these may be other considerations, such as the age or condition of health and mental vigor of the testator, . . . .")

45 Compare City of Tacoma v. Luvene, 827 P.2d 1374, 1384 (Wash. 1992) (stating that prohibited conduct must be defined "with sufficiently specificity to put citizens on notice of what conduct they must avoid . . . ."); see also Mays v. State, 68 P.3d 1114, 1120-21 (Wash. App. 2003) (holding a statute unconstitutionally vague where "reasonably intelligent persons must guess at its meaning.")
b. A contradictory message.

SB 128 specifically allows conduct that would normally provide proof of undue influence, for example, having an heir act as a witness on the lethal dose request form. How do you prove that undue influence occurred when the bill prohibiting undue influence also specifically allows conduct used to prove undue influence? It’s hard to say.

8. If California follows Washington State, prosecutors will be required to treat deaths as natural if the act was "used," without even a hint of the true cause of death; there appears to be no recourse for patients.

SB 128 states that the cause of death on the patient’s death certificate "shall be the underlying terminal illness." SB 128 also states:

Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the law.

In Washington State, similar language is interpreted to require the death certificate to reflect a natural death if our act was "used" (not complied with). Moreover, there must not even be a hint that the actual cause of death was assisted

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46 See discussion, supra, regarding Cal.Pro.Code § 6112(c), creating a rebuttable presumption of undue influence when one of two witnesses is a taker under a will.

47 Id.

suicide or euthanasia. The Washington State Department of Health, “Instructions for Medical Examiners, Coroners and Prosecutors: Compliance with the Death with Dignity Act,” states:

If you know that the decedent used the Death with Dignity Act, you must comply with the strict requirements of the law when completing the death record . . .

2. The manner of death must be marked as “Natural.” (Emphasis added).

3. The cause of death section may not contain any language that indicates that the Death with Dignity Act was used, such as:

a. Suicide
b. Assisted suicide
c. Physician-assisted suicide
d. Death with Dignity
e. I-1000
f. Mercy killing
g. Euthanasia
h. Secobarbital or Seconal
i. Pentobarbital or Nembutal (Emphasis added)

With the death required to be treated as “Natural” simply because the act was used, there appears to be no criminal recourse if the patient was pressured into taking the lethal dose, or even outright murdered via the lethal dose. The Medical Examiner, the Coroner and the Prosecutor must certify the death as Natural.

If California adopts a similar interpretation based on SB 128's similar language, there will be a similar situation.

49 Attached hereto as A-52.
Patients will be unprotected under the law.

9. There is a lack of transparency and accountability.
   a. The cause of death is falsified.

SB 128 states that the cause of death on the death certificate, which is the official record of the patient’s death, "shall be the underlying terminal illness." This is as opposed to the true cause of death, which is, a lethal dose of medication. The official cause of death is thus falsified, which creates a lack of transparency regarding specific deaths and also a lack of transparency for the purpose of later review should anyone want to know how the law is working in practice.

A smaller point, vital statistics regarding disease survival rates will be distorted (and artificially pushed downward).

b. Any record that "may" be required is confidential.

SB 128 provides that doctors produce record documentation that "may" be required under § 443.16. Any such records are "confidential" as to the patient, the patient’s family, and any medical provider or pharmacist involved in a patient’s death. § 443.16(b) states:

The information collected shall be confidential and shall be collected in a manner that protects the privacy of the

50 SB 128, § 443.7(b), attached at A-8.

51 SB 128, §§ 443.5(11) and 443.6(d).
patient, the patient’s family, and any medical provider or pharmacist involved with the patient under the provisions of this part.

c. In Oregon, similar confidentiality precludes access by law enforcement and is strictly enforced.

In Oregon, similar confidentiality is interpreted to bar access to law enforcement. Consider this e-mail from Alicia Parkman, a Mortality Research Analyst in Oregon, which states:

We have been contacted by law enforcement . . . in the past, but have not provided identifying information of any type.52

Oregon also has an official policy to neither confirm nor deny that a death has occurred under its act.53 Any employee violating confidentiality requirements is reportedly subject to immediate termination.54

F. Other Issues.

1. SB 128 legalizes “aid in dying,” which means euthanasia.

SB 128 appears to prohibit “euthanasia,” which is another name for mercy killing.55 SB 128 states:

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52 E-mail from Alicia Parkman, Mortality Research Analyst for the Oregon Health Authority, January 14, 2012, attached hereto at A-91.

53 Id.


Nothing in this part may be construed to authorize a physician or any other person to end an individual’s life by lethal injection, mercy killing, or active euthanasia.56

This prohibition is, however, defined away in the next sentence. SB 128 states:

Actions taken in accordance with this part shall not, for any purposes, constitute . . . mercy killing, [another word for "euthanasia"], homicide, or elder abuse under the law.57

Euthanasia is also not prohibited because nothing in SB 128 requires patients to administer the lethal dose to themselves. The bill merely states that a patient "may" choose to self-administer a lethal dose to bring about her death.58 The bill does not say that administration of the lethal dose "must" be by self-administration.59 Euthanasia is not prohibited.

Moreover and regardless, the term, "aid in dying," means euthanasia.60 See e.g., this link to the 1989 "Model Aid-in-Dying Act," with the letters, "euthan," for "euthanasia," as follows:

56 SB 128, § 443.15. (Attached at A-13).
57 Id.
58 SB 128, § 443.1(b) states:

"Aid-in-dying medication" means medication . . ., which the qualified individual may choose to self-administer to bring about his or her death due to a terminal illness. (Attached hereto at A-3).
59 See SB 128 in its entirety. (Attached at A-1 to A-14)
60
The bottom line, SB 128 legalizes "aid in dying," which means euthanasia.

2. SB 128 applies to incarcerated persons who "may be treated involuntarily."

In SB 128, the definition of "health care provider" includes a health care facility "as identified in Section 1250." This is the Department of Corrections under the California Health & Safety Code, § 1250.4. This section also provides that an inmate "may be treated involuntarily" for "any communicable, contagious, or infectious disease." Would this involuntary treatment include assisted suicide or euthanasia?

2. Legal assisted suicide is Orwellian and discriminatory to people labeled terminal.

Consider also the comment in the footnote below, by Carley Robertson, a medical doctor whose patients include incarcerated persons.

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61 SB 128, § 443.1(h). (Attached at A-4).
63 Id., attached at A-20.
64 Dr. Robertson states:

Law enforcement, jails and prisons are mandated to monitor for signs of depression and suicidal ideation, and to identify, intervene and/or initiate treatment. We are told that our failure to do so would be a significant breach of an inmate's civil rights. Yet according to proponents of assisted suicide, patients also have a right to receive a doctor's assistance.
IV. PUBLIC POLICY, SAFETY AND WELFARE

A. Elder Abuse is a Large and Uncontrolled Problem.

In 2009, the MetLife Mature Market Institute released a landmark study on elder financial abuse. The estimated financial loss by victims in the United States was $2.6 billion per year. In 2011, Met Life released another study, which described how financial abuse can be catalyst for other types of abuse. Consider this example:

A woman barely came away with her life after her caretaker of four years stole money from her and pushed her wheelchair in front of a train.

with the suicide. This makes no sense.

On the one hand, you have a group of people (prisoners) who suffer from situational depression due to their circumstances. Suicide attempts in this population are not rare. On the other hand, you have a group of people (persons diagnosed with a terminal diagnosis) who suffer from situational depression due to their circumstances. Why is one group entitled to protection and the other is not? Is it because with the second group, you call it "aid in dying" because people are dying anyway? They may not be dying anyway. Doctors diagnoses can be wrong. I have seen patients in my own practice live longer than expected. What about an older inmate? Would he be entitled to protection or a lethal dose? This all strikes me as very Orwellian and also discriminatory to people labeled terminal.

Carley C. Robertson, MD, "Legal Assisted Suicide Orwellian and discriminatory, Ravalli Republic, November 28, 2012.

See


Available at

B. Legalization of Assisted Suicide and/or Euthanasia will Create New Paths of Elder Abuse.

In California, preventing elder abuse is official state policy. If assisted suicide and euthanasia are legalized pursuant to SB 128, new paths of abuse will be created against the elderly, which is contrary to that policy. Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, states:

With assisted suicide laws in Washington and Oregon [and with SB 128], perpetrators can . . . take a “legal” route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. . . . [E]ven if a patient struggled, “who would know?”

Consider also, the Thomas Middleton case in which physician-assisted suicide was part of an elder abuse fraud. (See A-80).

C. Any Study Claiming that Oregon’s Law is Safe, is Invalid.

In 2011, the lack of oversight over administration of the lethal dose in Oregon, prompted State Senator Jeff Essmann to make this observation: the Oregon studies claiming that assisted suicide is safe, are invalid. He stated:

[All] the protections end after the prescription is written. [The proponents]

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67 See e.g., “The California People’s Law Library: Abuse and Neglect of Elderly Persons.”

admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is [taken on a voluntary basis].

So frankly, any of the studies that come out of the state of Oregon’s experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.\(^{69}\)

D. Assisted Suicide and Euthanasia can be Traumatic for Family Members as well as Patients.

1. The Swiss study.

In 2012, a study was released in Switzerland, addressing trauma suffered by persons who witnessed an assisted suicide.\(^{70}\)

The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized.\(^{71}\) These persons:

[E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide.\(^{72}\)

2. My cases involving the Oregon and Washington assisted suicide laws.

I have had two clients whose fathers signed up for the


\(^{71}\) Id.

\(^{72}\) Id.
lethal dose.\(^3\) In the first case, one side of the family wanted the father to take the lethal dose, while the other did not. The father spent the last months of his life caught in the middle and traumatized over whether or not he should kill himself. My client, his adult daughter, was also traumatized. The father did not take the lethal dose and died a natural death.

In the other case, it's not clear that administration of the lethal dose was voluntary. A man who was present told my client that his father refused to take the lethal dose when it was delivered ("You're not killing me. I'm going to bed"), but then he took it the next night when he was high on alcohol. The man who told this to my client later recanted. My client did not want to pursue the matter further.

E. **Enacting SB 128 Will Allow Health Care Providers to Implement Formal Steerage to Suicide.**

If SB 128 is enacted, health care providers in California will be able to follow the lead of Oregon's Medicaid program to steer patients to suicide, i.e., through institutionalized coverage incentives. To learn more, see the affidavit of Oregon doctor, Kenneth Stevens. (Attached hereto at A-56 through A-65). Do you want this to happen to you or your family?


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V. COMPASSION & CHOICES, THE RISK OF SUICIDE CONTAGION AND A MISSION TO REDUCE PATIENT ACCESS TO CURES.

A. Compassion & Choices is a Successor Organization to the Hemlock Society.

Passage of SB 128 is being spearheaded by the suicide/euthanasia advocacy group, Compassion & Choices ("C & C"). C & C was formed in 2004 as the result of a merger/takeover of two other organizations. 74 One of these organizations was the former Hemlock Society, originally formed by Derek Humphry. 75

In 2011, Humphry was in the news as a promoter of mail-order suicide kits. 76 This was after one of the kits was used by the depressed son of a federal judge, to kill himself. 77 Later that year, C & C celebrated Humphry as the keynote speaker for its annual meeting. 78

B. C & C's Media Campaign Presents a Risk of Suicide Contagion.

It is well known that media reporting of suicide can encourage other suicides, for example, a "copycat suicide" or a "suicide contagion." A famous example is Marilyn Monroe. Her

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75 Id.

76 Randi Bjornstad, "Suicide Kits Sell Death by Mail," The Register-Guard, March 20, 2011 ("For $60, they blew his life apart"). (Attached at A-23 to A-24).

77 Id.

78 See Compassion & Choices newsletter at A-22.
widely reported suicide was followed by a increase in other suicides.

This encouragement phenomenon also occurs when the inspiring death is not a suicide. An example is the televised hanging of Saddam Hussein, which led to suicide deaths of children worldwide. An NBC News article begins:

The boys' deaths - scattered in the United States, in Yemen, in Turkey and elsewhere in seemingly isolated horror - had one thing in common: They hanged themselves after watching televised images of Saddam Hussein's execution.79

Groups such as the National Institute of Health have developed guidelines for reporting suicide. Key points include that the risk of additional suicides increases "when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage."80

The media campaign by C & C, to promote the assisted suicide of Brittany Maynard, violated and continues to violate all of these guidelines. We were told of the planned method, when and where it would take place and who would be there. There was, and

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continues to be, repeated extensive coverage in multiple media.

I have a physician friend, who recently committed a young man to mental health treatment. The man had become actively suicidal after reading about Ms. Maynard.81

The risk of suicide contagion associated with C & C’s media campaign is real. The persons at risk include children.

C. In Oregon, Other (Conventional) Suicides Have Increased with Legalization of Physician-Assisted Suicide; the Financial Cost is “Enormous.”

Government reports from Oregon show a positive statistical correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. The statistical correlation is consistent with a suicide contagion in which legalizing and normalizing physician-assisted suicide encouraged other suicides. Please consider the following:

Oregon's assisted suicide act went into effect “in late 1997.”82

By 2000, Oregon's conventional suicide rate was "increasing significantly."83

By 2007, Oregon's conventional suicide rate was 35% above the national average.84

81 Will Johnston, MD, Vancouver Canada.
84 Id.
By 2010, Oregon's conventional suicide rate was 41% above the national average.\textsuperscript{85}

The financial cost of these other suicides is huge. The 2010 report, page 3, elaborates:

The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.\textsuperscript{86}

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time. The enormous cost of increased (conventional) suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding SB 128, which seeks to legalize physician-assisted suicide in California.

D. C & C Seeks to Reduce Choice in Health Care.

In 2008, Oregon’s Medicaid program sent a letter to Oregon resident, Barbara Wagner, offering to cover her suicide instead of a drug to possibly cure her cancer.\textsuperscript{87} The drug’s manufacturer subsequently provided the drug, but she nonetheless died a short

\textsuperscript{85} Attached at A-77.

\textsuperscript{86} Attached at A-78.

\textsuperscript{87} See: Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (Excerpt attached at A-66).
time later.  

After her death, C & C stepped forward to reveal its true mission. Specifically, its president, Barbara Coombs Lee, published an opinion piece defending the Medicaid program.\(^8^9\) Coombs Lee also argued for a public policy change to discourage people from seeking cures. She said:

The burning public policy question is whether we inadvertently encourage patients to act against their own self-interest, chase an unattainable dream of cure, and foreclose the path of acceptance that curative care has been exhausted.\(^9^0\)

C & C’s’ president, Barbara Coombs Lee, is a former “managed care executive.”\(^9^1\)

For more insight into C & C’s true mission, see: Margaret Dore, “Compassion & Choices has a New Campaign to Reduce Patient Choice: Be Careful What You Sign,” December 1, 2014 (attached at A-85); and Montana State Senator Jennifer Fielder, “Beware of Vultures,” which states:

I found myself wondering, “Where does all the lobby money come from?” If it really is about a few terminally ill people who might seek help ending their suffering, why was

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89 Barbara Coombs Lee, “Sensationalizing a sad case cheats the public of sound debate,” The Oregonian, November 29, 2008. (Attached at A-81 to A-83)

90 Id.

91 See Coombs Lee bio, attached at A-84.
more money spent on promoting assisted suicide than any other issue in Montana?

Attached at A-87 to A-88.

VI. CONCLUSION

SB 128 is not limited to people who are dying. The bill’s thrust is to protect participants in the patient’s death, not patients. The bill does this by taking the teeth out of patient protections and requiring the death certificate to reflect a natural death. There is also a lack of transparency.

The bill is, regardless, a recipe for elder abuse, especially for people with money. The most obvious gap is the lack of witnesses at the death. Even if the patient struggled, who would know?

Don’t make Washington’s mistake. I urge you to reject SB 128.

Respectfully submitted April 5th, 2015

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