MEMORANDUM

TO: Chair Alexander and Members of the Health Committee.

FROM: Margaret Dore, Esq., MBA

Choice is an Illusion, a nonprofit corporation

RE: Vote “No” on B21-38. (No Assisted Suicide/Euthanasia)

DATE: July 24, 2015

EXECUTIVE SUMMARY

B21-38 is promoted as assuring patient choice and control, which is false. Points addressed by this memo include:

* There is a complete lack of oversight when the lethal dose is administered (even if the patient struggled, who would know?)

* The bill requires falsification of the death certificate to reflect a natural death. The significance is a lack of transparency and an inability to prosecute even in a case of outright murder.

* B21-38 will likely legalize assisted suicide and euthanasia for young adults with chronic conditions such as diabetes.

Even if you like the concept of assisted suicide and euthanasia, B21-38 is the wrong bill.
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APPENDIX
I. INTRODUCTION

I am a lawyer in Washington State where assisted suicide is legal. Our law is modeled on a similar law in Oregon. Both laws are similar to B21-38.

B21-38 is a recipe for elder abuse. "Eligible" persons include young adults with chronic conditions such as diabetes.

I urge you to reject this measure. Do not make Washington and Oregon's mistake.

II. FACTUAL AND LEGAL BACKGROUND

A. Elder Abuse.

This year, Washington Lawyer, the official publication of the D.C. Bar Association, put light on elder abuse, a hidden and largely uncontrolled problem: A feature article described Hattie Mae Goode, a former D.C. housekeeper. After her husband died, she trusted a lawyer to handle her affairs. The lawyer "just cleaned her out."

A major point of the article is that Goode's story is not

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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 President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. See www.margaretdore.com, www.choiceillusion.org and www.margaretdore.org.

2 A copy of B21-38 is attached hereto at A-1 through A-16.


4 Id., at A-17
unusual. The article also quotes Amy Mix of the AARP Legal Counsel of the Elderly, who explains:

The elderly are at an at-risk group for a lot of reasons, including . . . diminished capacity, isolation [by] family or other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers. . . .

We had a senior victim who had given her life savings away to some scammer who told her that she’d won the lottery and would have to pay the taxes ahead of time. The scammer found the victim using information in her husband’s obituary.

B. Victims Do Not Report.

Elder abuse is prevalent in part because victims do not report. One study estimated that just one in 24 cases is reported to the authorities. The D.C. Department of Human Services states:

Typically, the abuser is a relative, frequently an adult child of the victim . . .

Many who suffer from abuse . . . don’t want to report their own child as an abuser.

C. 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."9 "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.10

D. Withholding or Withdrawing Treatment.

Withholding or withdrawing treatment ("pulling the plug") is not assisted suicide or euthanasia: The purpose is to withhold or remove burdensome treatment, i.e., as opposed to an intent to kill the patient. More importantly, the patient does not necessarily die. 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.11

E. Assisters Can Have Their Own Agendas.

People who assist a suicide can have their own agendas. In Oregon, there is the Thomas Middleton case, in which legal physician-assisted suicide was part of an elder abuse fraud. The

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9 The AMA Code of Medical Ethics, Opinion 2.211. (Attached at A-22).
10 The AMA Code of Medical Ethics, Opinion 2.21. (Attached at A-23).

fraud financially benefited Middleton’s trustee, Tammy Sawyer.\textsuperscript{12}

Consider also People v. Stuart in which a daughter killed her mother with a pillow under circumstances that dovetailed with the daughter’s financial interests. Stuart observed:

Financial considerations [are] an all too common motivation for killing someone.\textsuperscript{13}

III. THE BILL

A. How the Bill Works.

B21-38 has an application process to obtain the lethal dose.\textsuperscript{14} Once the lethal dose is issued by the pharmacy, there is no oversight. The death is allowed to occur in private with no doctor or anyone else present.

B. No Right to Know about Feasible Alternatives for Cure or to Extend Life.

B21-38 says that a patient considering a lethal dose has the right to be fully informed, of:

\textsuperscript{12} See “Sawyer Arraigned on State Fraud Charges,” KTVZ.com, 07/14/11, http://www.ktvz.com/news/Sawyer-Arraigned-on-State-Fraud-Charges/619440?view=print, which states:

\begin{quote}
Middleton deeded his home to the trust and directed [Sawyer] to make it a rental until the real estate market improved.

Instead, Sawyer signed documents that month to list the property for sale, two days after Middleton died by physician-assisted suicide. The property sold in October of that year for more than $200,000, the documents show, and it was deposited into Sawyer’s accounts [for Sawyer’s benefit]. (Emphasis added) (Attached at A-28).
\end{quote}

\textsuperscript{13} People v. Stuart, 67 Cal.Rptr.3d at 143 (2007).

\textsuperscript{14} B21-38 is attached hereto at A-1 to A-16.
The feasible alternatives, including comfort care, hospice care and pain control.\textsuperscript{15}

With this language, however, patients have no right to be told of their feasible alternatives for cure or to extend life. This is due to the rule of statutory construction, \textit{ejusdem generis}, which applies when a law lists specific classes of persons or things, and also refers to them in general. The general statements only apply to the same kind of persons or things specifically listed.\textsuperscript{16} Example: if a law refers to automobiles, trucks, tractors, motorcycles and other motor-powered vehicles, "vehicles" would not include airplanes, since the list was of land-based transportation.\textsuperscript{17}

Here, the patient has the right to be told of "feasible alternatives." This general statement only applies to the same kind of persons or things specifically listed, i.e., "comfort care, hospice care and pain control," all of which have to do with death and dying. For this reason, the patient does not have the right to be told of feasible alternatives for cure or to extend life.

\textsuperscript{15} B21-38, \textsection 2(9)(E). (Attached at A-3, lines 58-59). Similar language is contained \textsection\textsection 3(c) and 4(2)(E), attached at A-5, lines 102-3 and A-7, lines 151-2, respectively


\textsuperscript{17} Id.
C. No Witness at the Death.

B21-38 does not require a witness at the death.\textsuperscript{18} Without disinterested witnesses, the opportunity is created for someone else to administer the lethal dose to the patient without his consent. And in case I’m being too subtle, the drugs used are water and alcohol soluble, such that they can be injected into a restrained or sleeping person.\textsuperscript{19} Even if the patient struggled, who would know?

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

D. If Washington D.C. Follows Washington State, the Death Certificate Will Be Required to Reflect a Natural Death: This Will Allow the Perfect Crime.

B21-38 states:

Actions taken in accordance with this act do not constitute suicide, assisted suicide, mercy killing, or homicide, under the law.\textsuperscript{20}

Washington State’s law has similar language, as follows:

Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.\textsuperscript{21}

\textsuperscript{18} See B21-38 in its entirety, attached hereto at A-1 to A-16.

\textsuperscript{19} The drugs used are Secobarbital and Pentobarbital (Nembutal). See Oregon’s annual report for 2014, page 5, listing these drugs. (Attached at A-33). They are water and alcohol soluble: \url{http://www.drugs.com/pro/seconal-sodium.html} and \url{http://www.drugs.com/pro/nembutal.html}

\textsuperscript{20} B21-38, § 16, second sentence. (Attached at A-15, lines 340-341).

\textsuperscript{21} RCW 70.245.180(1), second sentence. (Attached at A-39).
In Washington State, this similar language is interpreted to require the death certificate to reflect a natural death if Washington’s act was “used” (not complied with). Moreover, there must not be even a hint that the actual cause of death was assisted suicide or euthanasia. The Washington State Department of Health, “Instructions for Medical Examiners, Coroners and Prosecuting Attorneys: Compliance with the Death with Dignity Act,” states:

Washington [State’s] Death with Dignity Act (RCW 70.245) states . . . “Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law.”

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.”

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)

Attached hereto at A-40.
With the death required to be treated as “Natural” simply because the act was used, there is 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 without any indication of the true cause of death.

If Washington D.C. adopts a similar interpretation based on B21-38's similar language, there will be a similar situation. Patients will be unprotected under the law no matter how egregious the facts of the particular case. B21-38 will create the perfect crime.

E. There is a Further Lack of Transparency.

In addition to requiring the death certificate to reflect a natural death no matter what the facts, B21-38 has a further lack of transparency and accountability as follows:

1. Record keeping regarding the doctor’s compliance with the bill is private and under the doctor’s control.

B21-38 provides that doctor compliance with its provisions be tracked via self-reporting in the patient’s medical record, which is a private document protected by HIPPA and under the doctor’s control.22

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22 B21-38, §§ 4(10) & 7, attached at A-8, line 172, and A-9, lines 205-220.
2. Reporting will be based on confidential data.

B21-38 provides for an annual statistical report based on information collected by the Department of Health, which "will not be a public record." In Oregon, which has a similar requirement, regulations provide that:

"The identity of individual patients is not recorded in any manner. Approximately one year from the publication of the Annual Report, all source documentation is destroyed. (Emphasis added)."

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

B21-38 applies to "terminal" patients, meaning those predicted to have less than six months to live. Such persons may, 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 Washington D.C. follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for people with chronic conditions such as diabetes.

B21-38 states:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical

23 Id., §8(b), attached at A-10, lines 227-229.

judgment, result in death within six months.\textsuperscript{25}

Oregon’s law has a nearly identical definition:

“Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.\textsuperscript{26}

In Oregon, this nearly identical definition is interpreted to include chronic conditions such as insulin dependent diabetes.\textsuperscript{27} 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.\textsuperscript{28}

If Washington D.C. enacts B12-38 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.\textsuperscript{29}

\textsuperscript{25} B21-38, § 2(14), attached at A-3, lines 69 to 71.

\textsuperscript{26} Or. Rev. Stat. 127.800 s.1.01(12), attached at A-42.

\textsuperscript{27} See, for example, the most recent annual report for Oregon’s law (listing "chronic lower respiratory disease" and "diabetes mellitus" as qualifying underlying illnesses). See report excerpts attached hereto at A-33 & A-34.

\textsuperscript{28} Letter to the Editor, William Toffler MD, New Haven Register, February 24, 2014, ¶2. (Attached at A-43). (I verified the content with him).

\textsuperscript{29} Id.
2. Predictions of life expectancy can be wrong.

Patients may also have years to live because predicting life expectancy is not an exact science.\(^\text{30}\) 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.\(^\text{31}\) Her doctor convinced her to be treated instead.\(^\text{32}\) 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.\(^\text{33}\)

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\(^{30}\) Compare Terminal Uncertainty. (Attached hereto at A-24).

\(^{31}\) Affidavit of Kenneth Stevens, MD ¶¶ 3-7. (Affidavit, with attachments, attached at A-47 to A-55; Jeanette Hall discussed beginning at A-48).

\(^{32}\) Id.

\(^{33}\) Affidavit of Jeanette Hall, ¶ 4, attached hereto at A-56 to A-57. Jeanette is alive today, 15 years later.
G. There is No Requirement That Anyone Follow a Patient’s “Rescission” of the Request.

B21-38 indicates that patients have a right to rescind their request for the lethal dose “at any time.”\textsuperscript{34} There is, however, nothing that requires anyone to follow the rescission.\textsuperscript{35} This apparent protection is illusory.

H. B21-38 Legalizes Euthanasia.

Under B21-38, the lethal dose is a “covered medication,” which means:

[A] medication prescribed pursuant to this act for the purpose of ending a person’s life in a humane and dignified manner.\textsuperscript{36}

B21-38 also describes patients as “taking” the lethal dose.\textsuperscript{37} Nothing says that administration via taking is mandatory.\textsuperscript{38}

With taking not mandatory, generally accepted medical practice allows a doctor, or a person working under the direction of a doctor, to administer the lethal dose to the patient. This would include administration by family members. Oregon doctor, Kenneth Stevens, MD, explains:

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer

\textsuperscript{34} See e.g., B21-38, §4(8). (Attached at A-7, lines 168 to 169).

\textsuperscript{35} See B21-38 in its entirety, at A-1 through A-16.

\textsuperscript{36} B21-38, § 2(6).

\textsuperscript{37} See e.g., B21-38, § 2(9). (Attached at A-2, lines 55-56).

\textsuperscript{38} See B21-38 in its entirety, at A-1 through A-16.
prescription drugs to a patient. Common examples . . . include . . . adult children who act under the direction of a doctor to administer drugs to their parents in a home setting.\textsuperscript{39}

With other people allowed to administer the lethal dose to the patient, B21-38 allows euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

\begin{quote}
Euthanasia is the administration of a lethal agent by another person to a patient . . . . (Emphasis added).\textsuperscript{40}
\end{quote}

B21-38 legalizes euthanasia, including via family members.

I. \textbf{Euthanasia Is Not Prohibited.}

Proponents may counter that euthanasia is prohibited under B21-38, § 16, which states:

\begin{quote}
Nothing in this act 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.
\end{quote}


This prohibition is, however, defined away in the next sentence, which states:

\begin{quote}
Actions taken in accordance with this act do not constitute suicide, assisted suicide, mercy killing, [another word for “euthanasia”] or homicide, under the law.
\end{quote}

\textsuperscript{39} Declaration of Kenneth Stevens, MD, June 14, 2015, attached hereto at A-61.

\textsuperscript{40} AMA Opinion attached at A-23.
IV. PUBLIC POLICY, SAFETY AND WELFARE

A. Most States Have Rejected Assisted Suicide and/or Euthanasia.

The vast majority of states to consider legalizing assisted suicide or euthanasia have rejected it. In the last five years, four states have strengthened their laws against assisted suicide. These states are: Arizona, Idaho, Georgia and Louisiana. In another state, Minnesota, that state's assisted suicide law was recently clarified. In May, there was a conviction.

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

In Washington D.C., preventing elder abuse is official government policy. If assisted suicide and euthanasia are legalized pursuant to B21-38, new paths of abuse will be created against the elderly, which is contrary to that policy. Alex Schadenberg, Chair for the Euthanasia Prevention Coalition,

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41 See tabulation at http://epcdocuments.files.wordpress.com/2011/10/attempts_to_legalize_001.pdf
42 See materials at A-62 to A-65.
43 State v. Melchert-Dinkel, 844 N.W.2d 13 (Minn. 2014).
45 See e.g., Washington D.C. Code, Chapter 19, “Adult Protective Services” (providing protections for vulnerable adults).
International, states:

With assisted suicide laws in Washington and Oregon [and with B21-38], 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?”

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, of Montana, 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] 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.

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D. Assisted Suicide and Euthanasia Can Be Traumatic for Family Members as Well as Patients.

1. The Swiss study.

In 2012, a study was published, addressing trauma suffered by persons who witnessed a legal assisted suicide in Switzerland. The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized. These persons:

[E]xperienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide.

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

I have had two clients whose fathers signed up for the lethal dose. 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


Id.

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. If B21-38 Is Enacted, There Will be Pressure to Expand.

In Washington State, we have had informal “trial balloon” proposals to expand our law to non-terminal people. For me, the most disturbing one was in the Seattle Times, which is our largest paper. A column suggested euthanasia as a solution for people without funds in their old age, which could be any of us, say if the company pension plan went broke.51

If B21-38 is enacted in Washington DC, it’s not unlikely that there will be a similar push for expansion.

F. Enacting B21-38 Will Allow Health Care Providers to Steer Patients to Suicide.

If B21-38 is enacted, health care providers will be able to

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51 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-58).
follow the lead of Oregon’s Medicaid program to steer patients to suicide, i.e., through institutionalized coverage incentives. For more information, see the Affidavit of Kenneth Stevens, MD. (Attached hereto, at A-47 through A-56).

G. Compassion & Choices’ Mission is to Promote Suicide/ Euthanasia, and to Reduce Choice in Healthcare.

1. Compassion & Choices is a successor organization to the Hemlock Society.

Passage of B21-38 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.

One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.

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

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53 Id.


55 Id.
annual meeting.  

2. 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.\(^5\) The drug’s manufacturer subsequently provided the drug to Wagner for free, but she nonetheless died a short time later.\(^6\)

After Wagner’s death, C & C stepped forward to reveal its true mission: C & C’s president, Barbara Coombs Lee, published an opinion piece defending Medicaid.\(^7\) She 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.

C & C’s president, Barbara Coombs Lee, is a former “managed care executive.”\(^8\)

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56 See Compassion & Choices newsletter, attached at A-68.


60 See Coombs Lee bio, attached at A-71.
H. 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."\(^{61}\)

By 2000, Oregon's conventional suicide rate was "increasing significantly."\(^{62}\)

By 2007, Oregon's conventional suicide rate was 35% above the national average.\(^{63}\)

By 2010, Oregon's conventional suicide rate was 41% above the national average.\(^{64}\)

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

\(^{61}\) Oregon's assisted suicide report for 2014, attached at A-29.


\(^{63}\) Id.

\(^{64}\) Attached at A-77.
Oregon was over 680 million dollars.\textsuperscript{65}

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 B21-38, which seeks to legalize physician-assisted suicide in Washington D.C.

I. Pain is Not the Issue.

Oregon’s assisted suicide report for 2014 lists "concerns" as to why patients who ingested the lethal dose signed up to do so.\textsuperscript{66} Per the report, there were 33 patients who had a concern about: "inadequate pain control."\textsuperscript{67} There was no claim that any one of these patients was actually in pain.\textsuperscript{68}

This makes sense. A person actually in pain, would be focused on obtaining pain relief, which in a severe case could include sedation. Such relief could also legally hasten the patient’s death under current law. Dr. Stevens explains:

\begin{quote}
[This is the principle of double effect] in which dying patients receive medication for the intended purpose of relieving pain, which
\end{quote}

\textsuperscript{65} Attached at A-78.

\textsuperscript{66} Oregon Report, page 5, attached hereto at A-33.

\textsuperscript{67} Id.

\textsuperscript{68} See entire Oregon report at A-29 et seq.
may incidently hasten death.\textsuperscript{69}

Pain is not the issue.

V. CONCLUSION

If B21-38 becomes law, people with years, even decades to live, will be encouraged to throw away their lives; patients and their families will be traumatized.

With the \textbf{required} falsification of the death certificate, the bill allows the perfect crime. Even if you are for the concept of assisted suicide and euthanasia, B21-38 is the wrong bill.

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\textsuperscript{69} Affidavit of Kenneth Stevens, MD, ¶ 15. (Attached hereto at A-50).