TO: Maine Legislature, Committee on Health and Human Services

FROM: Margaret Dore, Esq., MBA, President
Choice is an Illusion, a nonprofit corporation[1]

RE: Reject S.P. 113; H.P. 749.

- No Assisted Suicide
- No Euthanasia
- Prevent People With Years to Live From Throwing Away Their Lives
- Stop Legal Elder Abuse
- Stop Legal Murder
- Don't Put Older People in the Crosshairs of Their Heirs and Other Predators
- Oregon is Not a Valid Case Study

HEARING: **Wednesday, April 5, 2017 at 9 a.m.**
Burton M. Cross Building, Room 209
111 Sewall St, Augusta, ME 04330

MEMO DATE: April 4, 2017

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.[1] Our law is based on a similar law in Oregon. Both laws are similar to the proposed bills, S.P. 113 and H.P. 749.[2]

The proposed bills seek to legalize physician-assisted suicide and euthanasia as those terms are traditionally defined. The bills sell these practices as a promotion of individual choice. The bills are instead stacked against the patient and a recipe for elder abuse.

The bills apply to persons with years or decades to live. Enactment will encourage people with years or decades to live to throw away their lives. I urge you to vote "No" on S.P. 113 and H.P. 749.

II. DEFINITIONS

A. Physician-Assisted Suicide; Assisted Suicide; and Euthanasia

The American Medical Association (AMA) 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

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1 I am an elder law and appellate attorney licensed to practice law in Washington State since 1986. I am also a former Law Clerk to the Washington State Supreme Court. I am president of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide and euthanasia. My CV is attached hereto at A-1 to A-4. See also www.margaretdore.com, www.choiceillusion.org

2 S.P. 113 is attached hereto at A-103; H.P. 749 is attached at A-107.

act."[3] For example:

> [T]he physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide.[4]

Assisted suicide is a general term in which an assisting person is not necessarily a physician. Euthanasia is the administration of a lethal agent to cause another person's death.[5]

B. Withholding or Withdrawing Treatment

Withholding or withdrawing treatment ("pulling the plug") is not euthanasia if the purpose is to remove burdensome treatment, as opposed to an intent to kill the patient. More importantly, the patient will not necessarily die. Consider this quote from Washington State regarding a man removed from a ventilator:

> [I]nstead of dying as expected, [he] slowly began to get better.[6]

III. ASSISTED SUICIDE AND EUTHANASIA

A. Few States Allow Assisted Suicide

Oregon and Washington legalized physician-assisted suicide by ballot measures in 1997 and 2008, respectively. Since then,

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3 The AMA Code of Medical Ethics, 2016, Opinion 5.7, "Physician-Assisted Suicide. (Attached hereto at A-5).

4 Id.

5 AMA Code of Medical Ethics, 2016, Opinion 5.8, "Euthanasia," attached hereto at A-5 (lower half of the page).

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?," *The Seattle Weekly*, 01/14/09; article at A-6, quote at A-8.

just three states and the District of Columbia have passed similar laws (Vermont, California and Colorado). These laws also allow euthanasia.[7]

B. Other States Push Back

In the last six years, five states have strengthened their laws against assisted suicide: Arizona, Louisiana, Georgia, Idaho and Ohio.[8]

Last year, the New Mexico Supreme Court overturned a lower court case recognizing a right to physician aid in dying, meaning physician assisted suicide.[9] Physician-assisted suicide is no longer legal in New Mexico.

IV. HOW THE BILLS WORK

The bills have an application process to obtain the lethal dose. Once the lethal dose is issued by the pharmacy, there is no oversight over its administration. No witness, not even a doctor, is required to be present at the death.

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[7] Consider, for example, Washington's law, which was sold to voters as limited to assisted suicide in which a patient would self-administer the lethal dose. In Washington's law, the term, "self-administer," is specially defined to allow someone else to administer the lethal dose to the patient, which is euthanasia. Cf. Margaret K. Dore, "'Death with Dignity': What Do We Advise Our Clients?," at A-16 to A-18.

[8] See: Associated Press, "Brewer signs law targeting assisted suicide," *Arizona Capitol Times*, 04/30/14, attached at A-19; Associated Press, "La. assisted-suicide ban strengthened," *The Daily Comet*, 04/24/12, attached at A-20); Georgia HB 1114 (attached hereto at A-21); Margaret Dore, "Idaho Strengthens Law Against Assisted Suicide," Choice is an Illusion, 07/04/11, at A-22 ("Governor Butch Otto signed Senate law 1070 into law. The law explicitly provides that causing or aiding a suicide is a felony"); and Ohio HB 470, at https://choiceisanillusion.files.wordpress

[9] *Morris v. Brandenburg*, 376 P.3d 836 (2016). (Excerpt attached at A-23).

V. BILL HIGHLIGHTS

A. Other People Are Allowed to Speak for the Patient as Long as They Are Familiar With the Patient's "Manner of Communicating"

A patient obtaining the lethal dose is required to be "capable."[10] This is a relaxed standard in which someone else is allowed to speak for the patient as long as he or she is familiar with the patient's "manner of communicating." The bills state:

> "Capable" means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient's manner of communicating if those persons are available. (Emphasis added).[11]

Note that the speaking person is not required to be the patient's designated agent, for example, under a power of attorney. Being familiar with the patient's "manner of communicating" is, regardless, a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but she, herself, does not understand Spanish. That, however, would be good enough for her to speak for the patient during the lethal dose request process. With this situation, patient choice and control is far from guaranteed.

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10 S.P. 113, page 2, lines 36 to 39, attached hereto at A-103; H.P. 749, page 2, lines 36 to 39, attached hereto at A-109.

11 S.P. 113, page 1, lines 10 to 12, attached hereto at A-102; H.P. 749, page 1, lines 10 to 12, attached hereto at A-108.

B. The Bills Create a New Path of Elder Abuse

1. Elder abuse is a widespread problem that includes the financial exploitation and murder of older adults

Elder abuse is a problem in Maine and throughout the United States.[12] Perpetrators are often family members who start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or to coercing victims to change their wills or to liquidate their assets.[13] Perpetrators can also be calculating criminals. Consider Melissa Ann Shepard, the "Internet Black Widow." She preyed on older men. A 2016 article states:

> [These men] sought companionship and found instead someone who siphoned their savings, slipped drugs into their food and, in the case of one man, ran him over with a car and left him dead on a dirt road.[14]

2. Victims do not report

Elder abuse is prevalent in part because victims do not report it. According to the Maine Council for Elder Abuse Prevention, reasons for the non-reporting include:

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12 See: Maine Council for Elder Abuse Prevention, at http://elderabuseprevention.info," and Met Life Mature Market Institute, Broken Trust: Elders, Family and Finances," March 2009, at https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

13 Met Life Mature Market Institute, supra.

14 Yanan Wang, "This 80-year-old 'Black Widow,' who lured lonesome old men to horrible fates, is out of prison again," *The Washington Post*, March 21, 2016. (Attached hereto at A-11 through A-13; quote at A-12).

- victims fear retaliation from abusers

- victims fear that the abuse will get worse if they report it.[15]

3. "Even if the patient struggled, who would know?"

The proposed bills have no required oversight at the death. In addition, the drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person without consent.[16] Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, elaborates:

> With assisted suicide laws in Washington and Oregon [and with the proposed bills], 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. Even if a patient struggled, "who would know?" (Emphasis added).[17]

C. Patient "Eligibility" Is Based on the Mere Opinion of a Physician

The bills require a physician to make a statement in the medical record that a patient meets the definition of "patient"

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15 Maine Council for Elder Abuse Prevention, http://elderabuseprevention.info/barriers-getting-help

16 The drugs used for assisted suicide in Oregon and Washington include Secobarbital and Pentobarbital (Nembutal). See "Secobarbital Sodium Capsules, Drugs.Com, at http://www.drugs.com/pr/seconal-sodium.html and http://www.drugs.com/pro/nembutal.html See also Oregon's government report, page 5, attached at A-34 (listing these drugs).

17 Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," *The Advocate*, Official Publication of the Idaho State Bar, October 2010, page 14, available at http://www.margaretdore.com/info/October_Letters.pdf

under the bills.[18] The bills also state:

> "Patient" means an adult who is a resident of this State and who is terminally ill and has a limited life expectancy in the opinion of the adult's physician. (Emphasis added).[19]

The bills do not define the criteria listed above for being a patient ("resident," "terminally ill" and "limited life expectancy) other than being "in the opinion of the adult's physician."[20] In short, there are no objective standards for the criteria listed.

D. If Maine Follows Oregon's Interpretation of "Terminal Disease," Assisted Suicide and Euthanasia Will Be Allowed for Chronic Condition Such as Insulin Dependent Diabetes

While the proposed bills do not define terminally ill, they do define "terminal condition." The bills state:

> "Terminal condition" means an incurable and irreversible disease that will, within reasonable medical judgment, result in death within 6 months.[21]

Oregon's law has a similar definition of "terminal disease," as follows:

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

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18 S.P. 113, 4.B(2)(e), attached at A-104; H.P. 749, 4.B(2)(g), at A-110.

19 S.P. 113, Sec. 1, 24 MRSA §2908, 1.H, attached hereto at A-108, and H.P 749, 1.H, attached hereto at A-108.

20 See S.P. 113 and H.P. 749 in their entirety, at A-101 to A-113.

21 See S.P. 113, ¶ 1.J, attached at A-102; H.P. 749, attached at A-108.

judgment, produce death within six months.[22]

In Oregon, this similar definition is interpreted to include chronic conditions such as "diabetes mellitus," better known as diabetes.[23] Oregon doctor, William Toffler, explains:

> [P]eople with chronic conditions are "terminal" [for the purpose of Oregon's law] if without their medications, they have less than six months to live. This is significant when you consider that a typical insulin-dependent 20 year-old . . . will live less than a month without insulin. <u>Such persons, with insulin, are likely to have decades to live</u> . . . . (Emphasis changed).[24]

If Maine enacts the proposed bill and follows Oregon's interpretation of "terminal disease," assisted suicide and euthanasia will be legalized for people with chronic conditions such as insulin dependent diabetes. People who, with their medications, can have decades to live.

E. Treatment Can Lead to Recovery

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and made a settled decision to use

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22 Or. Rev. Stat. 127.800 s.1.01(12), attached hereto at A-25.

23 Declaration of William Toffler, MD, ¶3, attached hereto at A-26. See also Oregon's annual report for 2015, attached hereto at A-34 & A-35 (listing chronic conditions, such as "chronic lower respiratory disease" and "diabetes mellitus" as underlying illnesses sufficient to justify death under Oregon's act).

24 Toffler, supra, ¶4, attached hereto at A-26 & A-27.

Oregon's law.[25] Her doctor convinced her to be treated instead.[26] In a 2016 declaration, she states:

> This July, it will be 16 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.[27]

F. There Is No Requirement of Voluntariness or Consent When the Lethal Dose is Administered

The bills do not require administration of the lethal dose to be voluntary.[28] Similarly, there is no requirement of patient consent to administration.[29] Without these requirements, patient choice and control is an illusion.

G. If Maine Follows Washington State's Definition of "Self-Administer," Someone Else Will Be Allowed to Administer the Lethal Dose to the Patient

The bills describe a patient as "self-administering" the lethal dose, a term not defined in the bills.[30] In Washington State, self-administer is defined as the "act of ingesting." Washington's law states:

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[25] Affidavit of Kenneth Stevens, MD, attached at A-40 to A-46, Jeanette Hall discussed at A-40 to A-41. See also the Declaration of Jeanette Hall, attached hereto at A-47.

[26] Id.

[27] Declaration of Jeanette Hall, ¶4, at A-47.

[28] The bills use the word, "voluntary," solely in relation to a <u>request</u> for the lethal dose, <u>not administration</u>. See the bills, attached hereto at A-103, A-104, A-109 and A-110.

[29] The bills use the word, "consent" in the context of the obtaining the lethal dose from a pharmacist, and with regard to consulting with a patient's primary care physician, <u>not with regard to administration of the lethal dose</u>. See the bills attached hereto at A-103, A-104, A-109 and A-110.

[30] See bills at A-101 through A-113.

> "Self-administer" means a qualified patient's act of ingesting medication to end his or her life . . ." (Emphasis added).[31]

Washington's law does not define "ingesting." Dictionary definitions include:

> [T]o take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing." (Emphasis added).[32]

With these definitions, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will be "swallowing" the lethal dose, *i.e.*, "ingesting" it. Someone else placing a medication patch on the patient's arm will qualify because the patient will be "absorbing" the lethal dose, *i.e.*, "ingesting" it. Gas administration, similarly, will qualify because the patient will be "inhaling" the lethal dose, *i.e.*, "ingesting" it. With self-administer defined as mere ingesting, someone else is allowed to administer the lethal dose to the patient.

If Maine enacts the proposed bills and follows Washington's definition of self-administer, someone else will be allowed to administer the lethal dose to the patient. Patient choice and control will not be guaranteed.

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[31] RCW 70.245.010(12), available at https://app.leg.wa.gov/rcw/default.aspx?cite=70.245.010, attached at A-37

[32] "Ingest" definitions attached hereto at A-38.

H. Allowing Someone Else to Administer the Lethal Dose is Euthanasia

Allowing someone else to administer the lethal dose to a patient is euthanasia under generally accepted medical terminology. Again, the AMA Code of Ethics, states:

> Euthanasia is the administration of a lethal agent by another person to a patient . . . . (Emphasis added.)[33]

I. The Bill Does Not Prohibit Euthanasia

The bills appears to prohibit euthanasia, which is also known as lethal injection and mercy killing.[34] The bills state:

> Nothing in this section may be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia.[35]

This prohibition is defined away in the next sentence:

> Action taken in accordance with this section may not be construed for any purpose to constitute suicide, assisted suicide, mercy killing [another word for euthanasia] or homicide.[36]

J. If Maine Follows Washington State, There Will Be an Official Legal Cover Up

Again, the bills state:

> Action taken in accordance with this section may not be construed for any purpose to constitute suicide, assisted suicide, mercy

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33 Attached hereto at A-5 (lower half of the page).

34 For definitions of "lethal injection" & "mercy killing," see A-52, A-53.

35 Attached hereto at A-106 and A-112.

36 Id.

killing or homicide.[37]

In Washington State, similar language is interpreted by the Washington State Department of Health (the "Department") to require the death certificate to list a natural death without even a hint that the actual cause of death was assisted suicide or euthanasia. Compliance with patient protections and other provisions is not required. The only relevant issue is whether Washington's Act was "used."

The Department's "Death Certificate Instructions for Medical Examiners, Coroners and Prosecuting Attorneys," states:

> Washington's [law] states that "...the patient's death certificate ... shall list the underlying terminal disease as the cause of death." The [law] also states that, "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 the decedent used [Washington's law], you must comply with the strict requirements of the law when completing the death record:
>
> 1. The underlying terminal disease must be listed as the cause of death.
>
> 2. The manner of death must be marked as "Natural."
>
> 3. The cause of death section may not contain any language that indicates that [Washington's law] was used, such as:
>
>   a. Suicide

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[37] Both bills, § 12

b. Assisted suicide
c. Physician-assisted suicide
d. Death with Dignity
e. I-1000 [Washington's law was passed by I-1000]
f. Mercy killing
g. Euthanasia
h. Secobarbital or Seconal
i. Pentobarbital or Nembutal (Emphasis added.)[38]

If Maine enacts either of the proposed bills and follows Washington's example, death certificates will not even hint that the actual cause of death was assisted suicide or euthanasia. There will be an official legal cover up. This will happen as long as the act was "used" and regardless of whether there was compliance with patient protections.

VI. OREGON IS NOT A VALID CASE STUDY

Oregon is not a valid case study due to a near complete lack of transparency regarding its law.[39] Even law enforcement does not have access to the information collected.[40] Source

38 A copy of the Washington State Department of Health death certificate instruction is attached hereto at A-54.

39 See: "Declaration of Testimony" by Oregon attorney Isaac Jackson, dated September 18, 2012, attached hereto at A-57 to A-62 (regarding the run-around he got when he attempted to learn whether his client's father had died under Oregon's law - the Oregon Health Authority would neither confirm nor deny whether the father had died under the law); E-mail from Alicia Parkman, Oregon Mortality Research Analyst, to Margaret Dore, dated January 4, 2012, attached at A-63-A-64 (law enforcement cannot get access to information); Excerpt from Oregon's website at A-67 (patient identities "not recorded in any manner"); E-mail from Parkman to Dore, January 4, 2012, attached at A-65 to A-66 ("all source documentation" destroyed after one year); and the "Confidentiality of Death Certificates" policy issued by the Oregon Department of Human Resources Health Division, December 12, 1997, attached at A-68 to A-69 (clarifying that employees failing to comply with confidentiality rules "will immediately be terminated"), as published in the *Issues in Law & Medicine*, Volume 14, Number 3, 1998. See also documents attached at A-70 to A-72.

40 Id.

documentation is destroyed.[41] The bottom line, Oregon's official data cannot be verified.

VII. OTHER CONSIDERATIONS

A. Compassion & Choices' Mission is to Promote Suicide

The bill's passage is being spearheaded by the suicide advocacy group, Compassion & Choices.

Compassion & Choices was formed in 2004 as the result of a merger/takeover of two other organizations.[42] One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.[43]

In 2011, Humphry was the keynote speaker at Compassion & Choices' annual meeting in Washington State.[44] He was also in the news as a promoter of mail-order suicide kits.[45] This was after a depressed 29 year old man used one of the kits to kill

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41 Id.

42 Ian Dowbiggin, A Concise History of Euthanasia 146 (2007)("In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices."). Accord. Compassion & Choices Newsletter attached at A-73 ("Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion in Dying to become Compassion & Choices").

43 Id.

44 Compassion & Choices Newsletter, regarding Humphry's October 22, 2011 speaking date. (Attached hereto at A-73.)

45 See Jack Moran, "Police kick in door in confusion over suicide kit," *The Register-Guard*, September 21, 2011 (""A spotlight was cast on the mail-order suicide kit business after a 29-year-old Eugene man committed suicide in December using a helium hood kit. The Register-Guard traced the $60 kit to [the company, which] has no website and does no advertising; clients find [the] address through the writings of Humphry.") (Attached hereto at A-74 to 75)(Emphasis added)

himself.[46] Compassion & Choices' newsletter, promoting Humphry's presentation, references him as "the father of the modern movement for choice."[47] Compassion & Choices' mission is to promote suicide.

B. In Oregon, Other 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. This statistical correlation is consistent with a suicide contagion in which legalizing physician-assisted suicide encouraged other suicides. Consider the following:

> Oregon's assisted suicide act went into effect "in late 1997."[48]
>
> By 2000, Oregon's conventional suicide rate was "increasing significantly."[49]
>
> By 2007, Oregon's conventional suicide rate was 35% above the national average.[50]
>
> By 2010, Oregon's conventional suicide rate

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46 Id.

47 Compassion & Choices Newsletter, at A-73.

48 Oregon's assisted suicide report for 2014, first line, at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf

49 *See* Oregon Health Authority News Release, 09/09/10. ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached at A-76)

50 *Id.*

was 41% above the national average.[51]

There is a significant financial cost associated with these other suicides. One reason is that people who attempt suicide (and fail) can injure themselves or become disabled by the attempt. A government report from Oregon states:

> [T]he estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.[52]

C. The Swiss Study: Physician-Assisted Suicide Can Be Traumatic for Family Members

In 2012, a European research study addressed trauma suffered by persons who witnessed legal physician-assisted suicide in Switzerland.[53] The study found that one out of five family members or friends present at an assisted suicide was traumatized. These people,

> experienced full or sub-threshold PTSD (Post Traumatic Stress Disorder) related to the loss of a close person through assisted suicide.[54]

D. My Clients Suffered Trauma in Oregon and Washington State

In Washington State and Oregon, I have had two cases where

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[51] Oregon Health Authority Report, Suicides in Oregon, Trends and Risk Factors (2012 Report), at A-78.

[52] See report at A-78.

[53] "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; *European Psychiatry* 27 (2012) 542-546, available at http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf (Cover page attached hereto at A-80)

[54] Id., at A-80.

my clients suffered trauma due to legal assisted suicide. In the first case, one side of the family wanted the father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether or not he should kill himself. My client, his adult daughter, was severely 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 my client's father had refused to take the lethal dose when it was delivered, stating, "You're not killing me. I'm going to bed," but then he (the father) took it the next night when he was intoxicated on alcohol. The man who told this to my client subsequently changed his story.

My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

VIII. CONCLUSION

Passing either one of the proposed bills will encourage people with years or decades to live to throw away their lives. The bills are sold as completely voluntary, but do not even have a provision requiring administration of the lethal dose to be voluntary. Administration of the lethal dose is allowed to occur in private without a doctor or witness present. If the patient objected or even struggled, who would know? I urge you to vote "No" on S.P. 113 and H.P. 749.

Respectfully Submitted,

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