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## ARTICLE

# UNWELCOME GUESTS: DISABLED PEOPLE AND THE NEW EUGENICS

STEPHEN L. MIKOCHIK\*

At present, four states permit assisted suicide by statute or ballot initiative.<sup>1</sup> All require a terminal condition as a prerequisite,<sup>2</sup> and three expressly forbid writing the lethal prescription “solely” based on disability.<sup>3</sup> Why then are disabled people so concerned about the rise of such legislation? Simply put, they are unwelcome guests and fear that assisted suicide will extend the unmistakable hint that they should leave.

The threat has its origins in the abortion of fetuses with genetic anomalies. We know, for example, that up to 85% of fetuses diagnosed with Down syndrome are aborted;<sup>4</sup> and rates for fetuses diagnosed with other serious anomalies are likely similar.<sup>5</sup> As prenatal testing advances,<sup>6</sup> we can expect comparable numbers for other genetic conditions. Laws declaring the equal dignity of a class of people<sup>7</sup> ring hollow when society makes it abundantly clear that they are not welcome in the first place.

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1. OR. REV. STAT. §§ 127.800–897 (2015); WASH. REV. CODE §§ 70.245.010–904 (2014); VT. STAT. ANN. TIT. 18, §§ 5281–93 (2015); CAL. HEALTH & SAFETY CODE §§ 443.1–22 (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.). Additionally, the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state’s public policy. *See Baxter v. Montana*, 2009 MT 449, ¶ 49, 354 Mont. 234, 224 P.3d 1211.

2. OR. REV. STAT. § 127.805(1); WASH. REV. STAT. § 70.245.020(1); VT. STAT. ANN. TIT. 18, § 5283(a); CAL. HEALTH & SAFETY CODE § 443.2(a) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

3. OR. REV. STAT. § 127.805(2); WASH. REV. STAT. § 70.245.020(2); CAL. HEALTH & SAFETY CODE § 443.2(b) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

4. Erin Biba, *Early Warning System*, WIRED, Jan. 1, 2013, 2013 WLNR 4557607.

5. Simple blood tests early in pregnancy can screen for other chromosomal disorders besides Down syndrome, including Edwards, Patau, Turner, and Klinefelter syndromes. *See id.*

6. *See id.*

7. *See, e.g.*, Americans with Disabilities Act of 1990 § 2, 42 U.S.C. § 12101(a)(1) (2012).

Next, if a severely disabled child makes it through the birth canal, he will first face in the neonatal unit the chance of infanticide by neglect<sup>8</sup> and then, should he survive, the continuing prospect of having needed treatment declared “futile.” That practice permits doctors to refuse provision of medical treatment they consider inappropriate, over patient or family objections.<sup>9</sup> The danger is that doctors will refuse treatment to patients whose lives they consider not worth living.<sup>10</sup> The most egregious example is a Texas law, allowing doctors to refuse life-sustaining treatment for patients incapable of caring for themselves or making medical decisions due to an “irreversible condition.”<sup>11</sup> If such refusal is affirmed by the hospital ethics committee—and there are no standards to ensure that the review is made on the quality of the treatment rather than the quality of the patient’s life—the patient has ten days to find another hospital willing to provide treatment before most life-support ends.<sup>12</sup> Given the high cost of care, the chance of finding a willing provider is slim.<sup>13</sup>

Finally, if all else fails, there is the offer of assistance in suicide. True, it is presently limited to patients with terminal conditions; but, as the practice takes hold, legislatures will doubtlessly extend the offer to people “solely” based on their disabilities. The incentive is simple: “[T]he primary reasons terminal patients give for requesting aid in dying—loss of autonomy, loss of dignity, inability to participate in activities that make life enjoyable—are the same reasons disabled people seek suicide. If people with

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8. See David P. Mortimer, *The New Eugenics and the Newborn: The Historical “Cousinage” of Eugenics and Infanticide*, *Ethics & Med.*, Oct. 1, 2003, at 155–69, 2003 WLNR 19752870.

9. See American Medical Association, *Opinion 2.035 - Futile Care*, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2035.page> (last visited Feb. 27, 2016).

10. See New York State Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* 196–97 (1992).

11. The statute permits physicians to refuse patients life-sustaining treatment if confirmed by the hospital’s ethics committee. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West, Westlaw current through the end of the 2015 Regular Session of the 84th Legislature 2016). Qualifying patients include those with terminal or irreversible conditions. *Id.* § 166.031(2). The latter term means a condition “that may be treated but is never cured or eliminated; . . . that leaves a person unable to care for or make decisions for the person’s own self; and . . . that, without life-sustaining treatment[,] . . . is fatal.” *Id.* § 166.002(9).

12. *Id.* § 166.046(e). Happily, the artificial administration of nutrition and hydration was exempted from this exclusion by amendment in 2015. *Id.*

13. It is worth noting that ObamaCare left the door largely open for taking quality of life into consideration when evaluating the effectiveness of clinical research: “Of the numerous instances where the Act authorizes adoption of quality measures, in one case only is the Secretary of Health and Human Services expressly forbidden from relying on comparative clinical effectiveness research that discounts the lives of disabled people.” Stephen L. Mikochik, *Rationing Human Life: Health Care Reform and Disabled People*, 26 *ISSUES IN L. & MED.* 199, 204 (2011). See *id.* at 201, n.8 (“As defined in the Patient Protection and Affordable Care Act, the term ‘comparative clinical effectiveness research’ means ‘research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items. . . .’” (citations omitted)).

only six months to live can end such distress, why not those who face it for a lifetime?"<sup>14</sup> As the Supreme Court has observed, "[a]n insidious bias against the handicapped—. . . coupled with a cost-saving mentality—makes them especially in need of . . . statutory protection."<sup>15</sup> Yet, the protections states have enacted, rather than safeguarding patients' choice, provide a recipe for their abuse instead.<sup>16</sup>

Those who argue that such concerns will dissipate if safeguards are tightened fail to recognize the "real risk of subtle coercion and undue influence in end-of-life situations."<sup>17</sup> Those who argue that dignity is affirmed when disabled people are given the right to choose to make themselves dead underestimate how devalued they are in society; how internalized such attitudes can become; how attractive the hint to leave can then appear. Finally, those who argue that assisted suicide is no prelude to euthanasia forget that unwelcome guests who "can't take a hint" are eventually helped to leave.

With the passage of A.B. 15 last year, California became the fourth state to permit assisted suicide by statute or ballot initiative. What follows is a letter to Gerry Brown,<sup>18</sup> detailing the bill's many dangers and urging, unsuccessfully, veto of such foolhardy legislation:

*September 1, 2015*

*The Honorable Edmund G. Brown Jr.  
c/o State Capitol, Suite 1173  
Sacramento, CA 95814*

*Re: Assembly Bill 15, "End of Life Option Act"*

*Dear Governor Brown:*

*My name is Stephen L. Mikochik.<sup>19</sup> I am Professor Emeritus of Constitutional Law at Temple University in Philadelphia and past Chair of the National Catholic Partnership on Disability (NCPD). NCPD was established thirty years ago to implement the Pastoral Statement on People with Disabilities of the U.S. Catholic bishops. On behalf of NCPD and the thousands of disabled Catholics it serves, I would urge you, should it reach your desk, to veto Assembly Bill (AB) 15 that, in legalizing assisted suicide, is an open invitation to patient abuse.*

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14. Letter of Stephen L. Mikochik to Gov. Edmund G. Brown on A.B. 15 (Sept. 1, 2015) [hereinafter Brown Letter] (attached to this commentary).

15. *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (quoting *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995) (panel decision)).

16. See *infra* Brown Letter notes 48–64 and accompanying text.

17. *Glucksberg*, 521 U.S. at 732 (citations omitted).

18. We have edited the form of some citations and updated certain references to reflect changes that have occurred since the letter was written.

19. B.A., M.A. in Rel. Stud., M.A. in Phil., J.D., LL.M.

*A brief survey of legal history will place my concerns in context. For over seven hundred years, Anglo-American law has condemned suicide.<sup>20</sup> Self-murder was a felony at common law; but since the deceased was beyond penalty, his property was forfeited as a deterrent to others.<sup>21</sup> Recognizing the harm this caused innocent families, English and American law gradually decriminalized suicide.<sup>22</sup> This development, however, did not mark the moral acceptance of suicide since aiding its commission remained a common law offense.<sup>23</sup> At the close of the Civil War, most states criminalized assisting a suicide.<sup>24</sup> By 1997, when the Supreme Court rejected the claim that physician-assisted suicide was a constitutional right,<sup>25</sup> the vast majority of states had made it criminal.<sup>26</sup>*

*Nevertheless, assisted suicide has recently become controversial and, spearheaded by Compassion and Choices, the successor to the Hemlock Society,<sup>27</sup> has gained a foothold in American law. By ballot initiative in 1994, Oregon became the first state to allow physician-assisted suicide.<sup>28</sup> Its so-called “Death with Dignity Act” set the pattern for the successful 2008 ballot initiative in Washington State.<sup>29</sup> The Vermont legislature adopted its own version in 2013,<sup>30</sup> while the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state’s public policy.<sup>31</sup> All other attempts to legalize assisted suicide, either by ballot initiative or legislative enactment, have failed. In 2014, for example, the New Hampshire House of Representatives defeated H.B. 1325 by a vote of 219 to 66,<sup>32</sup> and last year alone, legislative initiatives in Colorado, Connecticut, Delaware, Maine, Maryland, Nevada, New York, Utah, and Wyoming have failed.*

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20. See *Glucksberg*, 521 U.S. at 711.

21. See *id.* at 711–13.

22. See *id.* at 713.

23. See *id.* at 713–14.

24. See *id.* at 715.

25. See *id.* at 728.

26. See *Glucksberg*, 521 U.S. at 718.

27. See IAN DOWBIGGIN, *A CONCISE HISTORY OF EUTHANASIA* 146 (2007).

28. OR. REV. STAT. §§ 127.800–97 (2015).

29. WASH. REV. CODE §§ 70.245.010–904 (2014).

30. VT. STAT. ANN. tit. 18, §§ 5281–93 (2015).

31. See *Baxter*, 354 Mont. 234 at ¶¶ 49–50. An Albuquerque district judge in 2014 barred prosecution of physicians for assisting the suicide of terminal patients. James Monteleone, *Death Aid Case Appeal Possible*, ALBUQUERQUE J. (Jan. 24, 2014), <http://www.abqjournal.com/342190/news/attorney-general-might-appeal-ruling-on-assisted-suicide.html>. The New Mexico Attorney General appealed that ruling. Alex Schadenberg, *New Mexico Attorney General Appeals Court Ruling to Legalize Assisted Suicide*, LIFE NEWS (Mar. 12, 2014), <http://www.lifenews.com/2014/03/12/new-mexico-attorney-general-appeals-court-ruling-to-legalize-assisted-suicide.html>. The decision was reversed by the New Mexico Court of Appeals on August 11, 2015. *Morris v. Brandenburg*, 2015–NMCA–100, ¶ 54, 356 P.3d 564 (N.M. Ct. App.).

32. See ‘*Death with Dignity Act*’ finds little support in NH House, UNION LEADER (Mar. 6, 2014), <http://www.unionleader.com/article/20140306/NEWS0621/140309414>.

*Before turning to the specifics of AB 15, I will address three threshold questions. First, how can laws that require consent constitute government decisions about what lives are worth living? Americans hold as self-evident that all men are “endowed by their Creator with certain unalienable rights, that among these [is the right to] life . . . [and] [t]hat, to secure these rights, governments are instituted among men. . .”<sup>33</sup> As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.<sup>34</sup> When government secures such rights for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying this class deserves less protection of their lives, its members deserve less safeguards of their unalienable rights, in other words, they deserve less respect because in some way they are less human. In discounting such rights entrusted to its care, government thus compromises the very grounds on which it is instituted.*

*Second, how can ingesting a lethal drug constitute suicide when the patient is already dying from a terminal condition?<sup>35</sup> If the terminal prognosis is wrong, the lethal drug is the sole cause of death. If correct, it is an intervening cause. In either event, it is the cause in fact and, as either the sole or intervening cause, the legal cause of death.<sup>36</sup> Thus, the patient dies, not from the underlying condition, but from ingesting the lethal drug that, if self-administered, constitutes suicide.*

*Third, why should the disabled community in particular concern itself with laws legalizing assisted suicide that, on their face, are limited to terminal patients? As physical impairments that substantially limit life activities,<sup>37</sup> terminal conditions are disabilities. Thus, to provide, as does AB 15, that a patient is not qualified for assistance in suicide “solely” because of a disability<sup>38</sup> is simply incoherent. Moreover, those with disabling condi-*

33. THE DECLARATION OF INDEPENDENCE, ¶ 2 (U.S. 1776).

34. JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT, Ch. IV, § 23, <http://www.constitution.org/jl/2ndtr04.htm> (“[F]or a man, not having the power of his own life, cannot, by compact, or his own consent, enslave himself to any one, nor put himself under the absolute, arbitrary power of another, to take away his life, when he pleases. Nobody can give more power than he has himself; and he that cannot take away his own life, cannot give another power over it.”).

35. See CAL. HEALTH & SAFETY CODE § 443.1(b) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.) (implying that the underlying condition, not the lethal drug, is the cause of death).

36. Even if ingesting the lethal drug is regarded as merely hastening the patient’s death from the underlying terminal condition, it remains a cause in fact and a legal cause of death. See *Oxendine v. State*, 528 A.2d 870, 872–73 (Del. 1987) (an act that accelerates death from a prior lethal act is an actual cause of death). See also JOSHUA DRESSLER, UNDERSTANDING CRIMINAL LAW 198–99 (4th ed. 2006).

37. See, e.g., Americans with Disabilities Act of 1990 § 2, 42 U.S.C. § 12102(1)(A) (2012).

38. CAL. HEALTH & SAFETY CODE § 443.2(b) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

tions which can cause death within six months, but only if treatment were removed, are terminal for purposes of AB 15.<sup>39</sup> The high cost of keeping such people alive<sup>40</sup> will provide insurance carriers a powerful incentive merely to pay for a handful of barbiturates instead.<sup>41</sup>

Additionally, predictions of death within six months required for “aid in dying”<sup>42</sup> are notoriously fallible.<sup>43</sup> Thus, even if terminal and disabling conditions are different, the separating line is porous.<sup>44</sup> Further, people with disabilities are more likely than others to develop potentially terminal conditions and thus more likely than others to become candidates for “aid in dying.”<sup>45</sup>

Finally, the primary reasons terminal patients give for requesting aid in dying—loss of autonomy, loss of dignity, inability to participate in activities that make life enjoyable<sup>46</sup>—are the same reasons disabled people seek suicide.<sup>47</sup> If people with only six

39. The definition of “terminal disease” fails to specify that the condition will result in death within six months “notwithstanding available treatment.” *Id.* § 443.1(q).

40. Medicare, for example, paid \$72,000 annually for patient kidney dialysis in 2009. U.S. Renal Data System 2009 Annual Data Report, <http://www.usrds.org>. In contrast, secobarbital (Seconal) retails for \$5.23 per 100 mgs; and pentobarbital (Numbatal) for \$20.65 per 50 mgs. DrugBank.ca: Secobarbital, <http://www.drugbank.ca/drugs/DB00418>, and DrugBank.ca: Pentobarbital, <http://www.drugbank.ca/drugs/DB00312>.

41. Though AB 15 forbids any communication between insurance carriers and individuals from including “both the denial of treatment and information as to the availability of aid-in-dying drug coverage[.]” such information can be provided separately on request. CAL. HEALTH & SAFETY CODE § 443.13(c) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

42. *See id.* § 443.1(q).

43. As a prognostic standard, “reasonable medical judgment,” *id.*, requires the attending physician to predict that the underlying condition will, “*more likely than not*, RESULT IN DEATH WITHIN 6 MONTHS.” *Cf.* S.B. 676, § 5–6A–03(c) (Md. 2015) (emphasis added) (paraphrasing “reasonable medical judgment” in such lay terms).

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

45. *See Disability Status as an Antecedent to Chronic Conditions: National Health Interview Survey, 2006–2012*, Ctrs. for Disease Control and Prevention, [http://www.cdc.gov/pcd/issues/2014/13\\_0251.htm](http://www.cdc.gov/pcd/issues/2014/13_0251.htm) (“After adjusting for sociodemographic differences, adults with lifelong disabilities had increased odds of having the following chronic conditions compared with adults with no limitations: coronary heart disease (adjusted odds ratio [AOR] = 2.92 . . .) cancer (AOR = 1.61 . . .) diabetes (AOR = 2.57 . . .) . . . and hypertension (AOR = 2.18 . . .).”).

46. As in prior years, the three most frequently mentioned end-of-life concerns reported by Oregon in 2014 were: “loss of autonomy” in 91.4% of cases, “decreasing ability to participate in activities that made life enjoyable” in 86.7% of cases, and “loss of dignity” in 71.4% of cases. *See REP. OF OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT, 2014*, <https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year17.pdf> [hereinafter OREGON’S 2014 DEATH WITH DIGNITY ACT]. Washington State reported similar findings for 2014. *See WASH. DEPT. PUB. HEALTH, 2014 DEATH WITH DIGNITY ACT*, <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2014.pdf> [hereinafter WASHINGTON’S 2014 DEATH WITH DIGNITY ACT].

47. *Cf.* Diane Coleman, *State’s Rights Versus Civil Rights*, SEATTLE POST-INTELLIGENCER (Sept. 29, 2005), <http://www.seattlepi.com/local/opinion/article/States-rights-versus-civil-rights-1183888.php>.

*months to live can end such distress, why not those who face it for a lifetime?*<sup>48</sup>

*Turning to the specifics of AB 15, it is first worth noting that nothing in its terms requires the presence of or potential for insufferable pain as a qualifying condition.<sup>49</sup> Further, its language tracks the provisions of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State. Though it imposes a waiting period before the prescription is written, patients can have a lethal drug in hand fifteen days after the terminal diagnosis is made,<sup>50</sup> clearly insufficient time to acclimate to a terminal prognosis.*

*Though either the attending or consulting physician can refer patients for psychological or psychiatric evaluation if they suspect clinical depression or other mental disorders that can impair judgment,<sup>51</sup> many physicians lack training to recognize such de-*

48. See, e.g., *Assisted Suicide in the United States: Hearing before the Subcommittee on the Constitution of the Comm. on the Judiciary, House of Representatives*, 104th Cong. 2d Sess. 127–38 (1996) (prepared testimony of Herbert Hendin, MD). Dr. Hendin testified:

Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help *i.e.*, euthanasia to those who could not affect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination.

It was reported that “five children were euthanized in the Netherlands between 2002 and 2015: a 12 year-old and four young people aged 16 to 17.” *Dutch pediatricians give terminally ill children under 12 the right to die*, THE GUARDIAN (June 19, 2015), <http://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands>. Besides the Netherlands, three other European nations—Belgium, Luxembourg, and Switzerland—now “openly, legally,” authorize assisted suicide or euthanasia. World Laws on Assisted Suicide, EUTHANASIA RES. AND GUIDANCE ORG., [http://www.finalexit.org/assisted\\_suicide\\_world\\_laws\\_page2.html](http://www.finalexit.org/assisted_suicide_world_laws_page2.html).

In 2012 alone, Belgium recorded “[Fifty-two] cases of euthanasia on psychological grounds [two for every 100,000 persons.]” *Belgian helped to die after three sex change operations*, BBC NEWS EUR. (Oct. 2, 2013), <http://www.bbc.com/news/world-europe-24373107>. At that rate, the total of such deaths in the United States for 2012 would have been over thirty times greater.

49. Cf. CAL. HEALTH & SAFETY CODE § 443.2(a–b) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.) (listing qualifying conditions); *Id.* § 443.1(q) (defining “terminal disease” as “an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.”).

50. See *id.* § 443.3(a) (a patient seeking a lethal prescription “shall submit two oral requests, a minimum of 15 days apart, and a written request. . . .”). Cf. OR. REV. STAT. §§ 127.840, 127.850; WASH. REV. CODE §§ 70.245.090, 70.245.110(1) (2009). Both Oregon and Washington State, however, additionally require a forty-eight hour waiting period between signing the written request and writing the lethal prescription. See OR. REV. STAT. § 127.850; WASH. REV. CODE § 70.245.110(2) (2009).

51. See CAL. HEALTH & SAFETY CODE § 443.5(a)(1)(ii) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.) (“If there are indications of a mental disorder, the [attending] physician shall refer the individual for a mental health specialist assessment.”); *Id.* § 443.6(d) (same for consulting physician). Cf. OR. REV. STAT. § 127.825 (“If in the opinion of the attending physician or the consulting physician a patient may be suffering from a



*pression;*<sup>52</sup> and nothing in AB 15 or its exemplars requires that they have it. Not surprisingly, referrals were almost never made in the seventeen-year history of the Oregon Act and, thus far, Washington is following suit.<sup>53</sup> Given that the Supreme Court has reported that many people, terminal or not, seeking suicide suffer from clinical depression and often lose the urge when the condition is treated,<sup>54</sup> the absence of reported referrals in these states is most troubling for the future of AB 15.

*Further, the bill allows persons with a financial interest in the patient's death to be one of the two witnesses to the written request, attesting to the patient's competence and the lack of coercion.*<sup>55</sup> *Though patients can revoke their request "in any*

psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling.”); WASH. REV. CODE § 70.245.060 (2009) (same).

52. *Cf.* Washington v. Glucksberg, 521 U.S. at 730–31 (“[A] New York [blue-ribbon] [t]ask [f]orce, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients’ needs.” (citations omitted)).

53. For example, of the 105 Oregon residents who died from a lethal prescription in 2014, only three had been referred for a psychiatric or psychological evaluation. *See* OREGON’S 2014 DEATH WITH DIGNITY ACT, *supra* note 46. Oregon’s yearly reports from 1998 through 2013 reveal similar statistics; showing: two out of seventy-one in 2013, two out of seventy-seven in 2012, one out of seventy-one in 2011, one out of sixty-one in 2010, zero out of fifty-nine in 2009, two out of sixty in 2008, zero out of forty-nine in 2007, two out of forty-six in 2006, two out of thirty-eight in 2005, two out of thirty-seven in 2004, two out of forty-two in 2003, five out of thirty-eight in 2002, three out of twenty-one in 2001, five out of twenty-seven in 2000, ten out of twenty-seven in 1999, four out of twenty-one in 1998 were referred for evaluation. *See Or. Death with Dignity Act Annual Reps.*, OREGON.GOV, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>. Similarly, in Washington State, of the 176 residents for whom lethal drugs were dispensed in 2014, only six had been referred for such evaluation. *See* WASHINGTON’S 2014 DEATH WITH DIGNITY ACT REPORT, *supra* note 46. Washington State’s yearly reports from 2009 through 2013 reveal similar statistics; showing: six out of 173 in 2013, three out of 121 in 2012, five out of 103 in 2011, three out of eighty-seven in 2010, three out of sixty-three in 2009 were referred for evaluation. *See Wash. Death with Dignity Act Annual Reps.*, WASH. STATE DEPT. OF HEALTH, <http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>.

54. *See* Glucksberg, 521 U.S. at 730–31 (“Research indicates . . . that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.” (citations omitted)).

55. “Only one of the two witnesses at the time the written request is signed may . . . be entitled to a portion of the . . . [patient’s] estate upon death.” CAL. HEALTH & SAFETY CODE § 443.3(c)(1) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.). *Cf.* OR. REV. STAT. § 127.810(2)(b); WASH. REV. CODE § 70.245.030(2)(b) (2009). “Only one of the two witnesses at the time the written request is signed may . . . [o]wn, operate, or be employed at a health care facility where the . . . [patient] is receiving medical treatment or resides.” CAL. HEALTH & SAFETY CODE § 443.3(c)(2) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.). *Cf.* OR. REV. STAT. § 127.810(2)(c); WASH. REV. CODE § 70.245.030(2)(c) (2009). Since its two parts are separate, Subsection C would allow an interested heir as one witness and an owner, operator, or employee of the health care facility where the patient resides as the other. The latter witness could also have a financial interest in the patient’s death, for example, to “free up the bed” for a paying resident. Finally, if the phrase, “[t]he request shall be witnessed by at least two other adult persons” in Section 443.3(b)(3), is meant to add a second layer of informal witnesses, they would not necessarily come under the

manner[.]”<sup>56</sup> including, for those with difficulty speaking, “communicating through a person familiar with the patient’s manner of communicating[.]”<sup>57</sup> nothing prevents the interested witness to the patient’s written request from filling that role.<sup>58</sup> That same person can be the only witness present when the lethal drug is taken since AB 15 fails to require an objective observer to the act. This is an open invitation to patient abuse<sup>59</sup> since no one will know if the patient resisted.<sup>60</sup> The bill compounds the problem by repeatedly referring to patients “ingesting”<sup>61</sup> (that is, swallowing), rather than “self-administering,”<sup>62</sup> the lethal drug, blurring the line between assisted suicide and euthanasia.<sup>63</sup>

Astonishingly, under AB 15, information the attending physician must provide the Department of Public Health,<sup>64</sup> including the circumstances and cause of the patient’s death,<sup>65</sup> “shall not be disclosed, discoverable, or compelled to be produced in any civil,

restriction against having a financial interest in the patient’s death. Consequently, it is reasonable to construe “two other adult persons” as the witnesses already required by the prior paragraph. See CAL. HEALTH & SAFETY CODE § 443.3(b)(2) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.) (“The request shall be signed and dated, in the presence of two witnesses. . .”).

56. *Id.* § 443.5(a)(6).

57. *Id.* § 443.1(d).

58. Though AB 15 provides several safeguards for non-English speakers, see, e.g., *id.* § 443.11(b)(3) (translators who prepare written requests for lethal drugs in English shall not be “entitled to a portion of the . . . [patients’] estate upon death”), none apply to patients who are non-verbal or have difficulty speaking.

59. See generally Margaret K. Dore, *Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice*, 36 VT. B.J. 53 (2011) (discussing patient abuse).

60. Secobarbital (Seconal) and pentobarbital (Nembutal) are the drugs most prescribed in Oregon and Washington State for aid in suicide. See OREGON’S 2014 DEATH WITH DIGNITY ACT, *supra* note 46; WASHINGTON’S 2014 DEATH WITH DIGNITY ACT, *supra* note 46. Both drugs are water-soluble and can be mixed with alcohol, for example, in a reluctant patient’s drink. See Seconal Sodium (Secobarbital Sodium Capsules) Drug Information, <http://www.rxlist.com/seconal-sodium-drug.htm>; Nembutal (Pentobarbital) Drug Information, <http://www.rxlist.com/nembutal-drug.htm>.

61. See CAL. HEALTH & SAFETY CODE § 443.1(i)(4) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.) (“‘Informed decision’ means . . . [a decision] that is made after being fully informed of . . . [t]he possibility that the individual . . . may obtain the drug but may decide not to ingest it”); *id.* § 443.4 (“An individual may at any time . . . decide not to ingest an aid-in dying drug”); *id.* §§ 443.5(a)(2)(B–C), (5)(A–B, E) (“Before prescribing an aid-in-dying drug, the attending physician shall . . . [c]onfirm that the individual is making an informed decision by discussing . . . [t]he potential risks associated with . . . [and t]he probable result of ingesting the requested aid-in-dying drug . . . [and c]ounsel the qualified individual about . . . [h]aving another person present when he or she ingests the aid-in-dying drug[;] . . . [n]ot ingesting the aid-in-dying drug in a public place[;] . . . [and m]aintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.”).

62. See *id.* § 443.1(p) (“‘Self-administer’ means a qualified individual’s affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug. . .”).

63. Though AB 15 denies authorizing active euthanasia, see *id.* § 443.16, who would know if it occurred since, without objective observers, the only witness to the act is dead.

64. See *id.* § 443.9.

65. See *id.* § 443.22 (interim “Attending Physician Follow-Up Form”). Though not required to specify the surrounding circumstances if not personally present at the patient’s death, such

*criminal, administrative, or other proceeding.”<sup>66</sup> This would impede investigations by coroners and prosecutors into whether patients’ deaths involved foul-play. If enacted, AB 15 would thus supply a shield to crime.*

*Moreover, if California follows existing practice, the drug regimens of choice are,<sup>67</sup> to say the least, not risk-free.<sup>68</sup> For example, in 2005, an Oregon patient regained consciousness sixty-five hours after ingesting a lethal prescription and finally died fourteen days later.<sup>69</sup> Again, in 2011, one Oregon patient regained consciousness approximately fourteen hours following ingestion and died about thirty-eight hours later; another briefly regained consciousness and died approximately thirty hours later.<sup>70</sup> Further, in 2012, another Oregon resident regained consciousness two days following ingestion, but remained minimally responsive, and died four days later.<sup>71</sup> This is hardly ending life in “a humane and dignified manner.”<sup>72</sup>*

*Finally, once the prescription is written and the lethal drug dispensed, the attending physician’s duty to the patient ends.<sup>73</sup> He is not obliged to reevaluate the patient’s competence before the drug is taken,<sup>74</sup> even though weeks or months have passed.<sup>75</sup> He*

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attending physician, nonetheless, must indicate the cause of death, even if based, for example, on the hear-say of an interested heir who was present. *See id.*

66. *Id.* § 443.19(a).

67. *See* OREGON’S 2014 DEATH WITH DIGNITY ACT, *supra* note 46; WASHINGTON’S 2014 DEATH WITH DIGNITY ACT, *supra* note 46.

68. In our calculation, the total duration between ingestion and death set out in the Oregon annual reports ranges from one minute to 104 hours and, in the Washington State reports, from two minutes to forty-one hours.

69. *See* REP. OF OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT, 2005, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf>.

70. *See* REP. OF OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT, 2011, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>.

71. *See* REP. OF OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT, 2012, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>. Oregon also reported in 2010, without elaboration, that “[two patients] did not die after ingestion; [a]nother 2 regurgitated and regained consciousness.” REP. OF OR. PUB. HEALTH DIV., OREGON’S DEATH WITH DIGNITY ACT, 2010, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>.

72. OR. REV. STAT. § 127.897.

73. The attending physician, however, owes certain reporting duties to the Department of Public Health after the lethal prescription is written and then after the patient has died. *See* CAL. HEALTH & SAFETY CODE § 443.9 (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

74. California does require patients to sign a form forty-eight hours before consuming the lethal drug, attesting that they are of sound mind, exercising informed consent, and aware they can decline ingestion. *See id.* § 443.11. But neither witnesses nor any independent evaluation is required to ensure the patient is actually competent and acting voluntarily. Further, the form refers to “consum[ing]” and “ingest[ing]” the drug, rather than “self-administration,” *see id.*, suggesting that “swallowing” is all that is needed. The completed form is to be delivered to the attending

*is not obliged to be present when the drug is taken, and, in Oregon and Washington, seldom is.*<sup>76</sup> *Despite claims that it will vindicate patients' rights, what AB 15 really does is immunize doctors who prescribe lethal drugs, in "good faith" compliance with its check-list, from civil and criminal liability and professional sanctions.*<sup>77</sup> *At bottom, AB 15 is simply a safe-haven for doctors who would disavow that ancient oath "[t]o please no one will I prescribe a deadly drug, nor give advice which may cause his death."*<sup>78</sup>

*At a time not so long in the past, our laws were misused to mask reality. For example, the pre-bellum slave codes equated human beings with items of property, "reduced[ing] . . . [slaves] to animals, or real estate, or even kitchen utensils. . . ."*<sup>79</sup> *Reflecting on this shocking phenomenon, Judge Noonan of the Ninth Circuit has observed: "Law can operate as a kind of magic. All that is necessary is to permit legal legerdemain to create a mask obliterating the human person being dealt with. Looking at the mask . . . is not to see the human reality on which the mask is imposed."*<sup>80</sup>

*Like the slave codes, AB 15 operates as a kind of magic. By offering safeguards that serve instead to place patients at risk of abuse, it employs legal slight-of-hand.*<sup>81</sup> *By calling "aid in dy-*

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physician and included in the patient's record, but only if any unused drugs are not returned in the prescribed manner. *Compare id.* § 443.11(c)(1–2) *with id.* § 443.20. Thus, if no drugs remain or if they are flushed down the drain (and there is nothing to prevent that from happening), there is no duty to return the form. It is difficult to imagine a more illusory set of procedural protections.

75. For example, eleven Oregon patients, with prescriptions written in 2012 and 2013, died after ingesting the lethal drug in 2014. *See OREGON'S 2014 DEATH WITH DIGNITY ACT, supra* note 46. Similarly, Washington State reported a lapse of twenty-five weeks or more between the first oral request and death for fifteen patients in 2014. *See WASHINGTON'S 2014 DEATH WITH DIGNITY ACT, supra* note 46.

76. Though eighty-three physicians wrote lethal prescriptions for Oregon patients in 2014, they were present only when fourteen patients ingested the prescribed drugs. *See OREGON'S 2014 DEATH WITH DIGNITY ACT, supra* note 46. Similarly, though 109 physicians wrote lethal prescriptions for Washington State patients in 2014, they were present only when seven patients ingested the prescribed drugs. *See WASHINGTON'S 2014 DEATH WITH DIGNITY ACT, supra* note 46.

77. CAL. HEALTH & SAFETY CODE §§ 443.14(a–b) (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.). Of particular concern is section 443.14(c) that omits even the minimal safeguard of "good faith compliance." *See id.* ("[A] health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this part, including, but not limited to, [determining a patient's diagnosis, prognosis, capacity, and providing the patient with information or a referral]." (emphasis added)).

78. The Oath of Hippocrates, ASS'N OF AM. PHYSICIANS AND SURGEONS, <http://www.aapsonline.org/ethics/oaths.htm#hippo>.

79. John T. Noonan, *The Root and Branch of Roe v. Wade*, 63 NEB. L. REV. 668, 669 (1984).  
80. *Id.*

81. As one example of legal legerdemain, AB 15 provides that, on the one hand, "[n]othing in this part may be construed to authorize . . . mercy killing," and, immediately on the other hand, "[a]ctions taken in accordance with this part shall not, for any purposes, constitute . . . homi-

ing”<sup>82</sup> practices that simply help patients make themselves dead, it recites empty incantations.<sup>83</sup> By not affirming patients’ lives but rather abandoning them to their despair, it creates only an illusion of compassion. True compassion, however, “leads to sharing another’s pain; it does not kill the person whose suffering we cannot bear.”<sup>84</sup> The plain fact is that AB 15 will legalize assisted suicide, and no legal magic can mask that reality. Should it pass, I would urge you to veto this dangerous and deceptive bill.

*Respectfully submitted,*

*Stephen L. Mikochik*

Many factors have produced the threat disabled people face today. With fewer children being born, a premium is placed on bearing fetuses without imperfections. With the changing American family, no one is left home to care for disabled or elderly members.

Yet, the core reasons are more elemental: First, we have lost the sense of the transcendent, what we once called the fear of God. Without the conviction that there are values above human culture, “everything is negotiable, everything is open to bargaining: even the first of the fundamental rights, the right to life.”<sup>85</sup> Further, we have lost the sense that, able-bodied or not, we are each unique images of God and thus each of infinite worth. Finally and most tragic of all, we have lost the sense that God loves each of us, so much that He sent His Son to die on a cross for our redemption. Disabled people are threatened today because, to put it simply, we have lost the sense of God.

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cide. . . .” CAL. HEALTH & SAFETY CODE § 443.18 (West, Westlaw through Ch. 1 of 2016 Reg. Sess. and Ch. 1 of 2015–2016 2nd Ex. Sess.).

82. *See id.* § 443.9(a) (entitling the written request form: “REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER”); *Id.* § 443.1(b) (labeling the lethal drug as “Aid-in-Dying”).

83. The bill simply decrees that conforming actions “shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse[.]” *Id.* § 443.18. *See also id.* § 443.14(d)(2) (No conforming action “shall constitute or provide the basis for any claim of neglect or elder abuse[.]”).

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

85. *Id.* at ¶ 20.