Attachment L

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To: Colorado General Assembly Members

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Re: End of Life Options Act: H.B. 16-1054 and S.B. 16-025

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I. Summary

Every major disability rights organization that has taken a position on physician assisted-suicide opposes the practice. These national groups include ADAPT (American Disabled for Attendant Programs Today), Association of Programs for Rural Independent Living, Autistic Self Advocacy Network, Disability Rights Center, Disability Rights Education and Defense Fund, Justice For All, National Council on Disability, National Council on Independent Living, National Spinal Cord Injury Association, Not Dead Yet, TASH, The Arc of the United States, The World Association of Persons with Disabilities, and United Spinal Association.

Disability rights organizations oppose the legalization of physician assisted suicide from a perspective of social justice. If assisted suicide is legal, some people's lives will be ended without their consent, through mistakes and abuse. No safeguards have ever been enacted or even proposed that can prevent this outcome, which can never be undone.

There's a deadly mix between our broken, profit-driven health care system and legalizing assisted suicide, which will be the cheapest so-called treatment. Direct coercion is not even necessary. If insurers deny, or even merely delay, expensive live-saving treatment, people will be steered toward assisted suicide. Will insurers do the right thing, or the cheap thing?

Elder abuse, and abuse of people with disabilities, are rising problems. Where assisted suicide is legal, an heir (someone who stands to inherit from the patient) or abusive caregiver may steer someone towards assisted suicide, witness the request, pick up the lethal dose, and even give the drug. No witnesses are required at the death, so who would know?

Importantly, there is an alternative: anyone dying in discomfort that is not otherwise relievable, may -- legally, today, under the laws as they currently exist --, receive palliative sedation, wherein the patient is sedated to the point where the discomfort is relieved while the dying process takes place. So we already have a legal solution to any uncomfortable deaths that does not endanger others the way an assisted suicide law does.

II. Factual and Legal Background

A. Definitions: Physician Assisted Suicide, Assisted Suicide, 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 act."[1] The AMA gives this example: "[A] physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide."[2]

"Assisted suicide" is a general term in which the assisting person is not necessarily a physician. "Euthanasia," by contrast, is a direct administration of the lethal dose with the intent to cause another person's death.[3]

B. Withholding or withdrawing treatment is not assisted suicide or euthanasia

Withholding or withdrawing treatment is not assisted suicide or euthanasia when the purpose is to withhold or remove treatment. In contrast to an intent to

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[1] The AMA Code of Medical Ethics, Opinion 2.2II, Physician-Assisted Suicide.

[2] *Id.*

[3] *Id.* at Opinion 2.2i, Euthanasia.

kill the patient. More importantly, when removing treatment, the patient does not necessarily die. A Washington article regarding a man removed from a ventilator made this comment: "instead of dying as expected, [he] slowly began to get better.[4]

C. The American Medical Association rejects assisted suicide and euthanasia

The AMA rejects assisted suicide and euthanasia, stating they are: fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.[5]

D Elder abuse is already a large and uncontrolled problem

1. Elder abuse is on the rise.

Nationwide, elder abuse is a growing crime, with perpetrators often family members and new "best friends."[6] In Colorado, elder abuse reports have increased 300%, and nationally 11% of elders report being victims of abuse each year.[7] Each year 5.6% of elders experience financial exploitation by family members.[8]

Amy Mix, of the AARP Legal Counsel of the Elderly explains:

> The elderly are an at-risk group for a lot of reasons, including but not limited to diminished capacity, isolation from family and other caregivers, lack of sophistication when it comes to purchasing property, financing, or using computers. . . .[D]efendants are often family members. . ..[9]

Legalizing physician assisted suicide without stringent safeguards places elders at risk.

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[4] 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,* January 14, 2009.

[5] *See* AMA Code of Medical- Ethics, opinions 2.211 and 2'2I' *supra.*

[6] Metlife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention" March 2009 at https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf

[7] U.S. Department of Justice, National Elder Mistreatment Study, March, 2009. https://www.ncjrs.gov/pdffiles1/nij/grants/226456.pdf

[8] *Id.*

[9] Kathryn Alfisi, "Breaking the Silence on Elder Abuse, " *Washington Lawyer,* February 2015

2. Victims do not report

Elder abuse is prevalent in large part because victims do not report.[10] "One study estimated that only one in 14 cases of elder abuse ever comes to the attention of the authorities."[11] In another study it was one out of 24 cases that came to the attention of authorities.[12] "Many who suffer from abuse... don't want to report their own child as an abuser."[13]

E. Assisters can have their own agenda

People who assist in a suicide can have their own agendas. In Oregon, for example, Thomas Middleton's physician-assisted suicide was part of an elder abuse scheme perpetrated by a caregiver. Middleton's caregiver coerced him into assisted suicide and stole his estate.[14] While the caregiver was prosecuted for the theft, the coercion never appeared in the official reports in Oregon, and of course later prosecution cannot undo Mr. Middleton's death. In *People v Stuart*, an adult child killed her parent under circumstances that dovetailed with the child's financial interests. The court observed "Financial considerations [are] an all too common motivation for killing someone."[15] As discussed below these cases will become more difficult to prosecute if physician assisted suicide is legalized.

III. The Bills: End of Life Options Act: H.B. 16-1054 and S.B. 16-025

A. Bill "requirements" are not actually required due to good faith immunity.

There are currently two bills pending before the General Assembly that would grant immunity for all purposes to any person – including anyone who is

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[10] See e.g., National- Center on Elder Abuse, Administration on Aging, http://www.ncea.aoa.gov/library/data/, P.2
[11] *Id.*
[12] *Id.*
[13] "Adult Abuser" District of Columbia, Department of Human Services, as of July 23, 2015.
[14] See "Sawyer Arraigned on State Fraud Charges," KTVZ.com, 07/14/11, which states: "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 veer for more than $200,000' the documents show, and it was deposited into [accounts for Sawver's benefit].
[15] *People v. Stuart*, 67 Cal .Rptr.3d 1'29 (2007).

present at the time of death, allowing all involved to ignore the limited safeguards with impunity. There is no other medical situation grants such blanket immunity.[16]

The bills have an application process to obtain the lethal dose, which features patient protections described in mandatory terms. For example, the attending physician "shall" make the determination of whether a patient has a terminal illness, is capable of making an informed decision, and has made a voluntary request. These "mandatory" protections are not actually required due to good faith immunity for doctors and other participants in patient deaths.

The bills do not define the term "good faith." Common meanings include an honest intent to act, even when there is a lack of compliance with legal technicality. Consider, for example, this definition offered by the Colorado Supreme Court, defining good faith as "a state of mind indicating honesty and lawfulness of purpose: belief in one's legal title or right: belief that one's conduct is not unconscionable or that known circumstances do not require further investigation: absence of fraud, deceit, collusion, or gross negligence."[17]

With good faith immunity, doctors and other participants in patient deaths are not required to follow a particular protective procedure. "Requirements" are not actually required with good faith immunity provisions.

B. Patients are not required to be "dying."

The proposed bills seek to legalize "aid-in-dying." The phrase is misleading because the bills do not require dying patients, if, for the purpose of argument any bill requirement is actually required.

C. Patients may have years, even decades, to live

The proposed bills apply to "terminal" patients, meaning those predicted to have less than six months to live. Such persons can have years, even decades to live due to misdiagnoses and ineffective prediction of life expectancy. Predicting life expectancy is not an exact science.[18] Famously, Stephen Hawking was diagnosed

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[16] Immunity granted in last year's bill, HB 15-1135, was at least limited to situations where negligence, recklessness, or intentional misconduct didn't occur. The bills this year provide blanket immunity even in the context of negligence, recklessness, or intentional misconduct.

[17] *Lybarger v. People*, 807 P.2d 570, 577 (Colo. 1991).

[18] *See*, for example, Jessica Firger, "12 mill-ion Americans misdiagnosed each year,,, CBS NEWS, April- 17, 2014, and Nina Shapiro, "Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit

with motor neurone disease (ALS) in his 20s and was given a life expectancy of two years. Fortunately, he has outlived that diagnosis by decades. Last year when testifying in opposition to HB 15-1135, Julie Reiskin, the executive director of the Colorado Cross-Disability Coalition testified that she is a "hospice graduate," having long outlived a terminal diagnosis.

D. Terms in the bills are inconsistent with terms used elsewhere in the Colorado Revised statutes

There are many aspects of the bills that are redundant with, and potentially contradictory to, the Colorado Medical Treatment Decision Act (codified at § 15-18-101 C.R.S., *et seq.*).

1. Some terms have identical definitions elsewhere in the statute without cross-references

The Colorado Medical Treatment Decision Act contains many of the same definitions (word -for -word) as those used in the Bills. To avoid confusion, there should be a cross reference in § 25-48-102 to the definitions in § 15-18-103 for "Adult" (§ 15-18-103(1)), "Attending Physician" (§ 15-18-103(4)), and "Physician" (§ 15-18-103(12)) so that they can be interpreted consistently.

2. Some terms are similar, but with different definitions.

Further, the bills have definitions for "Capable", "Qualified Individual", and "Terminal Illness or Terminal Disease." The Colorado Medical Treatment Decision Act already has definitions for similar terms, including "Decisional Capacity" (§ 15-18-103(6)), "Qualified Patient" (§ 15-18-103(13)) and "Terminal Condition" (§ 15-18-103(14)).

Specifically the bills define capable as:

> "Capable" means that, in the opinion of a terminally ill individual's attending physician, consulting physician, psychiatrist, or licensed mental health professional, a terminally ill individual has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the individual's manner of communicating if that person is available.

§ 25-48-102(5). For other healthcare decisions, the decisional capacity is defined as:

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suicide - once they've determined that the patient has only six months to live. But what if they're wrong?" *The Seattle Weekly*, January 14, 2009.

> “Decisional Capacity” means the ability to provide informed consent to or refusal of medical treatment or the ability to make an informed health care benefit decision.

C.R.S. 15-18-103(6). The bills define qualified individual as:

> "Qualified individual" means a terminally ill adult who is capable, is a resident, and has satisfied the requirements of this article in order to obtain a prescription for aid-in-dying medication to end his or her life.

§ 25-48-102(11). Qualified patient elsewhere in the statutes is defined as”

> “Qualified patient” means a patient who has executed a declaration in accordance with this article and who has been certified by his or her attending physician and one other physician to have a terminal condition or be in a persistent vegetative state.

C.R.S. 15-18-103(13). Terminal illness is defined in the bills as:

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

§ 25-48-102(14). Terminal condition is defined elsewhere in the statutes as:

> "Terminal condition" means an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to prolong the dying process.

C.R.S. 15-18-103(14).

In both cases, why reinvent the wheel? Why not use terms with the same meanings that have been vetted in prior legislation?

E. The requirement to determine capacity is weaker than other parts of the statues.

Notwithstanding the above, the terms “Attending Physician” and “Consulting Physician” are used in § 25-4-102(3) and § 25-4-102(6) as a person determining whether the terminally ill individual is “Capable” (defined in that section). However, when defined in §§ 25-4-102(2) [Attending Physician] and 102(6) [Consulting Physician], the only skills that either must have are (in 102(2)) “care of the terminally ill individual and the treatment of the individual’s terminal illness” or (in 102(6)) “qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual’s illness.”

In neither case must the Attending Physician or the Consulting Physician have any expertise or even experience in determining whether the person they are treating is competent or "capable" of making the determination. Their only expertise needs to be in the illness itself. It is inappropriate for an unskilled person to be making a competency determination that may have fatal consequences. Only a licensed psychiatrist or psychologist (defined in § 25-48-102(9) should be able to make a decision that the terminally ill individual is capable of making a life-ending decision.

Similarly, one of the duties set forth in § 25-48-106(1)(c) is that the Consulting Physician (whether or not experienced or competent to make the determination) must "verify that the individual is capable." This should only be made by someone with the requisite experience and training and appropriate license or certification.

F. Someone else is allowed to speak for the patient

The proposed bills require patients to be "capable" or to have "capacity" to obtain the lethal dose. As discussed *supra* the meanings in SB 16-025 and HB 16-1054 do not align with the same terms elsewhere in the Statutes.

Capable is defined in the bills to allow someone else to speak for the patient – as long as the speaking person is "familiar with the patient's manner of communicating." § 25-48-102(6).

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

A patient's heir, wanting a quick inheritance, will have the same ability; a complete stranger will also have this ability. As long as individuals are familiar with the patient's manner of communicating, their requests will be legally sufficient to obtain the lethal dose.

With other people allowed to speak for the patient during the lethal dose request process, simply because they are familiar with the patient's manner of communicating, overreaching is invited. Patient choice and control are not guaranteed. Indeed patients are placed at extreme as individuals with other agendas are permitted to provide the crucial go-ahead for a lethal dose.

G. The proposed bills allow someone else to administer the lethal dose to the patient.

Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to patients. Common examples include parents administering drugs to their children, and adult children who administer drugs to their parents. This is a normal practice

The proposed bills say the patient "may" self-administer the lethal dose and describe the lethal dose as being "self-administered." §§ 25-48-102(2) 25-48-102(8)(a).

With self-administration not mandatory under the bills, generally accepted medical practice allows someone else to administer lethal dose to the patient. With someone else allowed to administer the lethal dose, the patient's choice and control are once again not guaranteed.

As defined in the bills, "'Self-administration' means, if a qualified individual, to engage [sic] in an affirmative and voluntary act to use prescribed medication to bring about his or her own peaceful and humane death." § 25-48-102(13). This definition does not preclude another individual giving the individual the medication, having been told to do so at the time of administration, or sometime in the past, even if the individual subsequently changed their mind about ingesting the lethal dose. This provision is ripe for abuse, particularly when considered in conjunction with provisions that do not require any witnesses at the time of death, as well as provisions allowing others to speak for the patient, and immunizing those administering the lethal dose.

H. Allowing someone else to administer the lethal dose to the patient is euthanasia

Allowing someone else to administer the lethal dose is euthanasia under generally accepted medical terminology. The AMA Code of Ethics, Opinion 2.21, states:

> Euthanasia is the administration of a lethal agent ***by another person to a patient***. . . (emphasis added).

Despite the Bills proponents' claims that the bills require self-administration, the use of "may" renders the term ambiguous. The term "may" is a precatory wish or advisory suggestion which does not have the force of the demand or request which under the law must be obeyed. Accordingly euthanasia under the statute cannot be prosecuted as discussed *infra*.

I. No oversight at the death.

If for the purpose of argument, the proposed bills only allow the patient to administer the lethal dose to himself or herself, the patient is still vulnerable to the actions of other people. This is because the bills do not require witnesses or even a doctor to be present when the lethal dose is administered. There is a complete lack of oversight at the death

This creates the opportunity for someone else to administer the lethal dose to the patient without his or her consent. If the patient struggles, who would know? The drugs used are water and alcohol soluble, as such they can be administered to a sleeping or other restrained person. They can also be hidden in drinks and food unbeknownst to the person who's ingesting the medication. Without any oversight at the death, abuse and coercion are completely hidden.

J. Provisions prohibiting individual opt-outs and modifying contracts are unconstitutional under both the U.S. and State Constitutions.

The bills do not allow patients to opt out of their provisions. Section 25-48-117(2) is manifestly unconstitutional. This statute attempts to invalidate existing private contracts that are based on "the making or rescinding of a request by a qualified individual for medication to end his or her life pursuant to this article." This is not only an effort by the General Assembly to impose its moral judgment on existing, bargained-for arrangements, it flouts a fundamental provision of the United States and Colorado Constitutions.

Article I, section 10, clause 1 of the US Constitution states, in relevant part: "No state shall [...] pass any bill [...] or Law impairing the Obligation of Contracts..." This clause has been widely interpreted by the courts to mean that no state may retroactively change existing contracts, or if it does, must have an extremely good reason for doing so. This clause was prompted by a fear that the states would continue a practice that was widespread under the Articles of Confederation—granting "private relief."[19]

Life insurance policies – for example – are contracts under law and the Bills would nullify *ex post facto* (after the fact) any provisions in such contracts that forbid attempting to take your own life.

Clauses forbidding suicide are fairly common in insurance contracts as well as in some wills and perpetual trusts established by wills.

Taking a cue from the Contract Clause of the U.S. Constitution, the Colorado Constitution likewise states in Article 2 Section II: "No ex post facto law, nor law

[19] *See*, generally, James W. Ely, Jr., *The Guardian of Every Other Right* (Oxford University Press 1998)

impairing the obligation of contracts, or retrospective in its operation [...] shall be passed by the general assembly." Because of language in the proposed bills specifically seeking to affect existing contracts, passing this bill would be a clear violation of Colorado's constitution.

The provisions of § 25-48-113 and 25-48-114 reflect an impermissible legislative effort to rewrite agreements between private parties. Contracts are contracts, and these should be considered when a person is making that decision. A person with insurance should not use a statute to get around a provision in an agreement that he/she has voluntarily entered into. Insurance and annuity companies should have the right to impose limitations on suicide of all sorts. It is part of their financial calculation. This statute will make insurance more expensive for all of us. These provisions are potentially broad enough to invalidate a provision in, say, a parent's will or trust that conditions a grant or bequest to a descendant who availed themselves of this statute. This is putting the Colorado General Assembly in the position of imposing morality decisions on Colorado citizens and their private contracts.

Likewise, § 25-48-113(2) is manifestly unconstitutional. This provision attempts to invalidate existing private contracts that are based on "the making or rescinding of a request by a qualified individual for medication to end his or her life pursuant to this article." This is not only an effort by the General Assembly to impose its moral judgment on existing, bargained-for arrangements, it flouts a fundamental provision of the United States Constitution.

This also invalidates personal choice. For example, an elderly woman with a house and a sizeable bank account, is concerned that her unemployed son will pressure her into assisted suicide or euthanasia. A possible protection is a will provision saying her child is disinherited if she uses assisted suicide. Under the bills such provisions are not valid. The bills state, "A provision in a contract, will, or other agreement, whether written or oral, that would affect whether a qualified individual may make or rescind a request for aid in dying pursuant to this article is invalid." § 25-48-113.

A person who does not want to get talked into suicide (or facilitating their own homicide), is not allowed to make legal arrangements to try and prevent it. Personal choice and control are non-existent.

K. The death certificate is required to list a terminal illness or condition as the cause of death.

The proposed bills require the death certificate to list the patient's underlying terminal illness or condition as a cause of death. § 25-48-109. The significance of the

lack of transparency and illegal inability to prosecute criminal behavior, for example, in the case of an outright murder for the money. In other words, with the cause of death pre-determined to be a terminal illness or condition, there can be no prosecution for murder as a matter of law. Perpetrators have little or no legal deterrent to curtail overreaching behavior.

1. Forced deception in medical records

"Actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide." § 25-48-120. The broad language presented in the proposed act is likely to be construed to mean that the medical records of patients who died pursuant to actions permitted by the bills will not ultimately reflect that they have taken their own lives (suicide) or that others may have assisted.

2. Forced deception in state records

Section 25-48-109 of the bills relieves a coroner of the requirement to perform an autopsy pursuant to § 30-10-606.5 (1) (a), C.R.S. Ostensibly this section allows a coroner to avoid the necessity of a forensic autopsy on the word of the attending physician who attests that the person had received lethal medication under this statute. Since no official witness to the actual death is required, it is likely that the physician was not present at the time of the patient's death, therefore the actual cause of death is speculation. As mentioned *supra,* there are any number of ways death can be encouraged, coerced, or deliberately caused to those who have received a lethal-dose prescription. This proposed section all but guarantees that any perpetrator of coercion or homicide can get away with it as the coroner does not have to determine if the patient actually died of a lethal overdose or if they died without a struggle and apparently "self-administered" the drug.

The language of the statute forbids acknowledgement of the reality of a patient's self-inflicted death by medical overdose, therefore the hands of coroners, medical examiners, doctors and others filling out official reports will reflect an untruth: that the patient died for reasons other than "suicide, assisted suicide, mercy killing or homicide." This forced legal deception will have many serious future repercussions:

a. Skewed statistics – Accurate reporting on cause(s) and manner(s) of death are important for a wide range of reasons. National research on patients dying from and the rates of death related to these diseases will be inaccurately reported under this law. This false reporting will also have an effect on census data.

b. Investigations hindered – Any future attempt for investigators – criminal or otherwise – to uncover the cause and manner of death will be hindered by sealed, inaccurate medical records. Law enforcement will be obligated to undergo a lengthy, expensive subpoena process to view these inaccurate records. The listed cause of death will be the disease with no official witnesses, or physicians capable of verifying the truth.

Coroners are not required to verify with the attending physician that the proper process has been followed, and are prohibited from reporting these deaths as related to assisted suicide.

L. Healthcare facility rights are not protected

The rights of a health care provider set forth in § 25-48-115 are too narrow. Why should a health care facility[20] permit any health care provider to practice within its walls if the health care facility has notified the health care provider of its (or its owner's) moral, ethical, or other objection to physician assisted suicide?

1, As written § 25-48-117 only permits the health care provider to prohibit physician assisted suicide "on the prohibiting health care provider's premises."

2. The health care provider should have the ability to take away privileges (etc.) as contemplated in § 25-48-117(2) regardless where the physician ("health care provider," in the terms of the statute) supports the patient's suicide. If it is morally, religiously or otherwise repugnant on the premises, it should be equally repugnant when performed by the same person on the premises of another health care provider.

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[20] The term "health care facility" is used in § 25-48-102(7) to define "Health Care Provider." The term "health care facility" is not defined in this act, but is defined by reference in § 25-1-124 as being a "health care facility licensed pursuant to section 25-3-101 or certified pursuant to section 25-1.5-103(1)(a)(II)." For information purposes, generally these include: (from § 25-1.5-103(1)(a)(I)(A)) "general hospitals, hospital units as defined in section 25-3-101(2), psychiatric hospitals, community clinics, rehabilitation hospitals, convalescent centers, community mental health centers, acute treatment units, facilities for persons with intellectual and developmental disabilities, nursing care facilities, hospice care, assisted living residences, dialysis treatment clinics, ambulatory surgical centers, birthing centers, home care agencies, and other facilities of a like nature, except those wholly owned and operated by any governmental unit or agency."

3. A physician choosing to participate in physician assisted suicide should ensure that the health care facilities with which the physician is associated do not object or risk sanctions.

M. The bills have no provisions for reporting data about the use of physician assisted-suicide

Proponents point to Oregon's law as the "gold standard" for protecting patients from abuse. Oregon's law requires an assigned state agency to conduct sample reviews of records, make rules to facilitate collection of information for legal compliance, and produce annual statistical reports for the public. These reports are the only records of how this law operates in Oregon.

Oregon's law (and Washington's and California's) require physicians to fulfil reporting and documentation requirements. This includes all oral and written requests by the patient, the diagnosis, prognosis, verification of competence and state residency by attending and consulting physicians, report of counseling outcome, and an offer to patient to rescind decision.

HB 15-1135, the physician assisted suicide bill introduced last year, had at least minimal reporting requirements. The 2016 bills remove all requirements for documentation, even from the patient's medical record.

This is unprecedented in existing law. Removing all accountability significantly increases the likelihood of abuse, removes statutory incentive for doctors to complete the defined process, leaves lethal medications at large and untracked in the community, and makes it nearly impossible for the state to prove or disprove violation of the law. This change increases protection for doctors and eliminates protection for vulnerable patients.

It will be easy for proponents to claim there are no problems with the law if coroners are prohibited from reporting the death as being a result of physician-assisted suicide, no oversight is provided over physicians prescribing lethal doses, and no data is reported.

N. A person who stands to inherit from the patient can witness the lethal prescription request

When drafting a will, the will is presumed to have been coerced if one of the witnesses to a will stands to benefit under that will. The bills, however, allow someone who stand to benefit from the death of the person requesting assisted-suicide to witness the request for a lethal prescription. § 25-48- 104(2)(b)(II).

This opens the door for fraud, abuse and coercion, in a society where one in ten elders experiences abuse.

O. Inadequate controls on unused prescriptions create child protection concerns.

While § 25-48-119 claims to require safe disposal of unused medications via prescription drug take-back programs, the provisions are woefully inadequate. First, they are unenforceable and without any tracking of the medication after it has been dispensed, nothing prohibits these drugs from being transferred to another individual. In many communities, prescription drug take-back programs occur only once or twice a year. Meanwhile, lethal drugs are available unsecured in the community. Without any tracking of the medication, and no statistics kept, it is impossible to know what happens to these unused prescriptions.

Furthermore, there are no requirements about safe storage of these lethal drugs. Children and teens can access these prescriptions, distribute them to others, or ingest them themselves. There are no requirements that these drugs be secured under lock and key, or other mechanism, to prevent their transfer to others.

P. Criminal penalties are unenforceable

While the bills purport to impose criminal penalties for forgery, coercion, exerting undue influence on a person or concealing or destroying a rescission, the criminal penalties are unenforceable. § 25-48-118. Proving these crimes when the death is not witnessed, the death certificate does not list the lethal dose as the cause or manner of death, and all actors have qualified immunity, makes them all but unenforceable.

Q. The bills encourage doctor shopping

Assuming arguendo that any of the provisions apply, if a doctor refuses to write a lethal prescription due to concerns about capacity or coercion, the bills actually encourage doctor shopping to circumvent the so-called safeguards,

If a physician declines to write a lethal prescription, the doctor is required to transfer the patient's medical records to another provider. § 25-48-116(2).

The lead organization advocating for assisted suicide, Compassion & Choices, facilitates most of Oregon's reported assisted suicides, often by referring individuals to assisted-suicide-friendly doctors.[21] Dr. Peter Goodwin, the group's former Medical Director, said that about 75 percent of those who died using Oregon's assisted suicide law through the end of 2002 did so with the organization's

[21] Kenneth R. Stevens, Jr., M.D., The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization, Physicians for Compassionate Care Educational Foundation, March 4, 2009, available at http://www.pccef.org/DOWNLOADS/AssistedSuicidesbyCC2009report.pdf

assistance.[22] By 2008, the proportion of deaths related to Compassion & Choices increased to 88%.[23]

An example of circumventive doctor shopping is the case of Kate Cheney, an 85-year-old woman.[24] Cheney saw two physicians. Her daughter thought the first doctor was "dismissive" and requested another opinion. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was then denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

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[22] Transcript of tape of Peter Goodwin, Oregon, January 11, 2003, Presentation at 13th National Hemlock Society Biennial Conference, "Charting a New Course, Building on a Solid Foundation, Imagining a Brighter Future for America's Terminally Ill," January 9 – 12, 2003, Bahia Resort Hotel, San Diego, California.
[23] Stevens, *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization.*
[24] Erin Hoover Barnett, "A Family Struggle: Is Mom Capable of Choosing to Die," *The Oregonian,* October 17, 1999, p. G–01