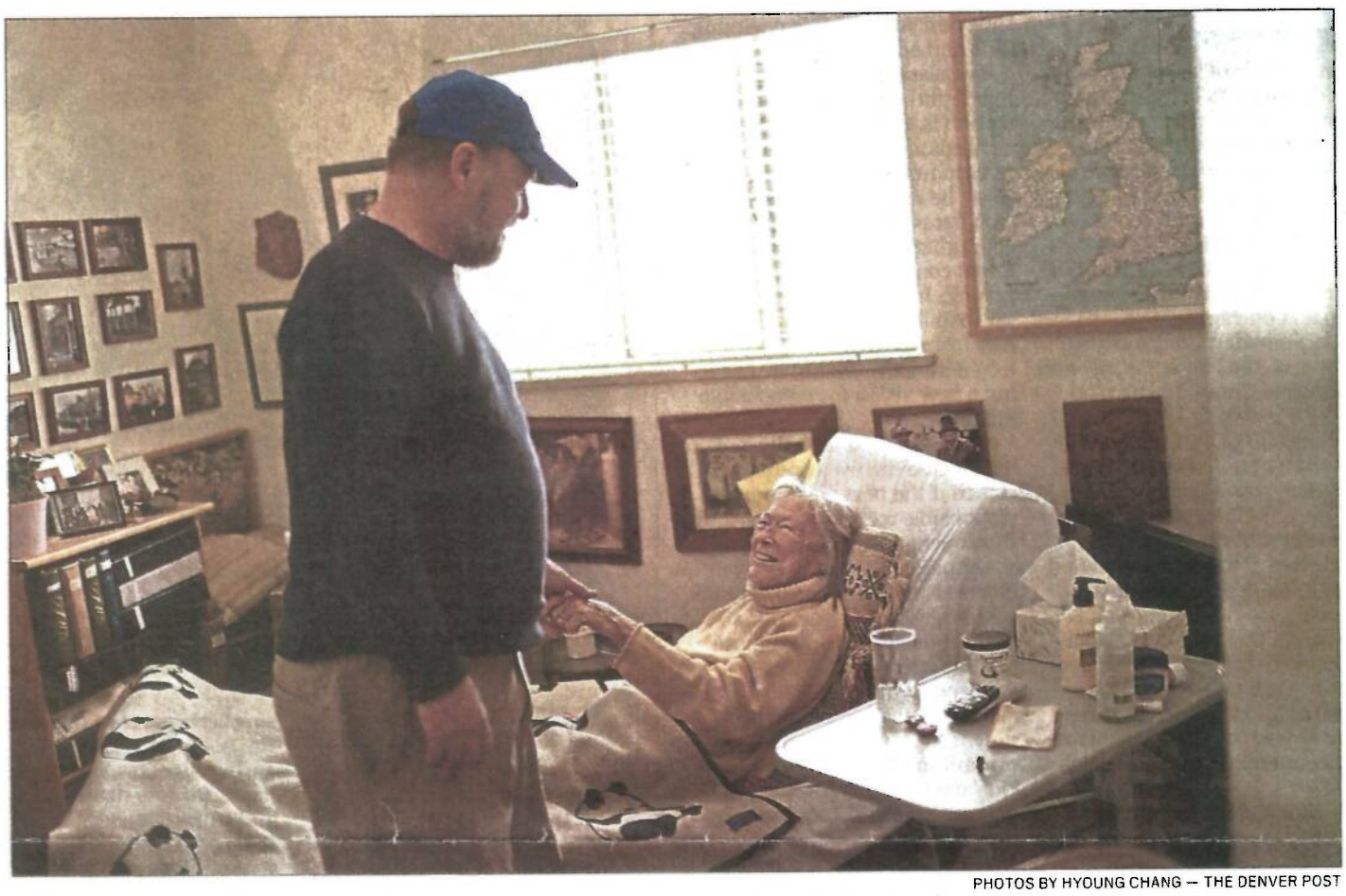
AID IN DYING

Mom's final wish

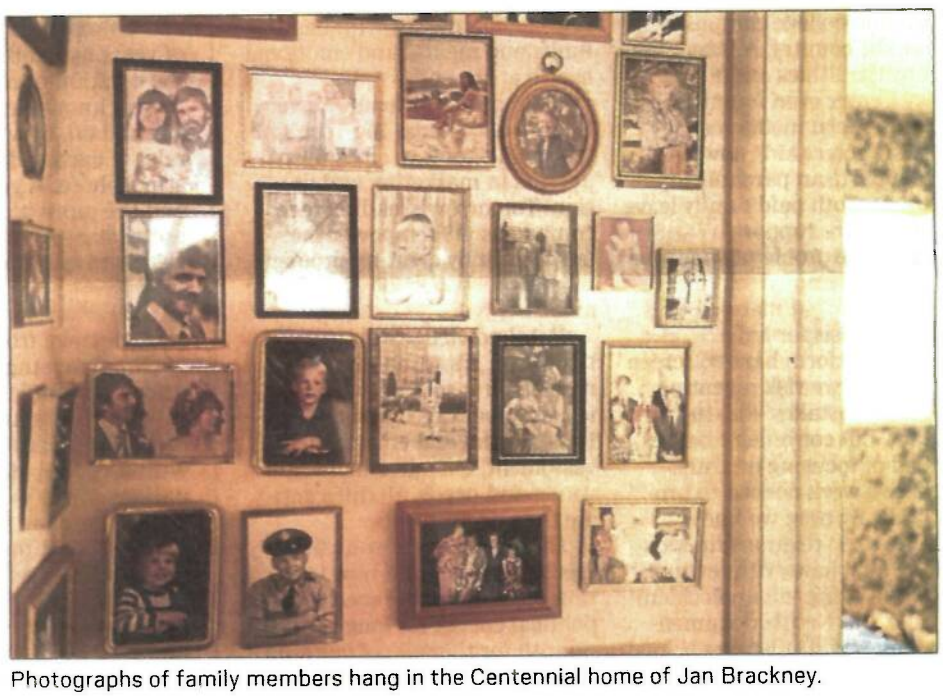
Jan Brackney used Colorado's Medical Aid in Dying law to take her own life



PHOTOS BY HYOUNG CHANG — THE DENVER POST

Jan Brackney, 91, holds hands with her youngest son, John, at her home on Feb. 15. Brackney had started the process of using Colorado's Medical Aid in Dying law.

By John Brackney
Guest Commentary



Photographs of family members hang in the Centennial home of Jan Brackney.

My mom, Jan Brackney, had a lovely common life with glimpses of the extraordinary. On Feb. 22, she died like she lived, with full intention and resolution.

In life, she desired a large family. So she had five kids with her husband, Milt, of 62 years. Other than that, she wanted travel, bridge games with friends, and time to read. Fairly common goals, yet she accomplished each with vigor: 48 states and 62 countries spanning nine decades; she started dozens of bridge groups and read an average of over 300 books a year for the last decade of her life.

I always thought Mom was terrific, but perhaps not too unlike other great moms. I never thought of her as courageous. I was wrong.

On the morning of her death, I re-read a note sent to her with love, "Jan, you're one of the most courageous people I've ever met." Until later that day, I had no idea how true that statement could be.

Even in death, at age 91, with her health deteriorating, she was intentional. Mom had very clear goals for her death: 1) she did not wish to die alone, 2) she did not wish to die in pain 3) she wanted to die in her own home of 56 years. 4) she wished to leave some assets to her children and grandchildren. Mom was clear in these goals and repeatedly told family, friends, and her doctors over decades.

When she had a severe stroke in late January, I effectively moved into my childhood room. After caring for her with the help of family, friends, and Denver Hospice, she added a fifth goal to her first four. She wished to live and die with dignity. She wished to feed herself, stand up and walk by herself, use the bathroom independently, and die on her own terms before she could no longer do those things.

She accomplished all five goals. At 3:30 p.m. on a Wednesday, she said goodbye to a dozen family members, a minister, and a close friend who had gathered to celebrate her life. She walked into her bedroom, sat down in her own bed, and without any pain or discomfort, chose to drink a doctor-prescribed overdose of medicines that ended her life under the Colorado Medical Aid in Dying law passed by voters in 2016.

My mother's death was calm and comfortable. It was the very best way for her to die, surrounded by her family after two days of celebration, prayer, conversations, singing, and love.

She urges you to consider this option for your life and death.

I must warn you, however, that it wasn't easy to achieve.

Currently, in Colorado, you likely need to be a voracious and steadfast advocate for your desire to die in the manner you choose. If you haven't been resolved enough, you'll likely not have a choice.

Americans should talk about living and dying more and better. We don't do this well in our culture, and Jan Brackney asked me — several times — to write about her life and death so that others could live well and die with dignity. In her final days, I read her my rough draft for this column — it was her wish — and as always, she got her way despite my struggle to write about a death I was dreading.

My earliest conversations about life and death with my parents consisted of

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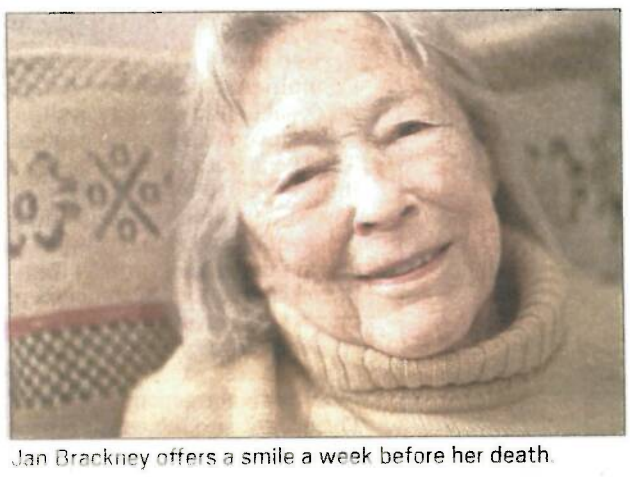


Jan Brackney offers a smile a week before her death.

PHOTOS HYOUNG CHANG — THE DENVER POST

Brackney rests on her sofa as she spends her last day of life with her family at her home in Centennial on Feb. 22. With Jan were daughter-in-law Meredith, left, son Kevin, center, and son John.

Jan Brackney shares family memories with her son John.

Brackney

FROM PAGE 1

them preaching that they should control their life and their death.

We had dozens of conversations over decades, and they never wavered in their belief. When Milt died nine years ago from complications from Alzheimer's disease, he wasn't eligible for aid in dying because he lacked the cognitive ability to decide. And, of course, more importantly, the law had not yet been passed by Colorado voters.

Although my Mom was a dutiful and loving caregiver, her husband eventually had to be moved to a neighborhood group home and then an intensive 24-hour locked-down Alzheimer's care facility. Although necessary for my dad, that process made Jan even more resolute in her end-of-life decisions.

When her body continued deteriorating, primarily due to congestive heart failure and related issues, she was clear with her doctors. She knew her body was giving out, and she continually asked her doctors and me to help end her life when it was time.

However, the law in Colorado is clear. A person must be of sound mind, emotionally stable, and have it certified by two medical doctors that he or she has a terminal illness with less than six months to live.

That time came shortly after my mother was forced by medical necessity to stop taking a blood thinner that had prevented strokes. We knew what that meant. In late January, Jan was playing bridge with three of her very best friends, and she had a moderate stroke. Instead of calling 911, they led her to lie down and rest on a couch. They later dropped her off at home and called me. Although slightly "off" and confused as to what happened earlier in the day she was comfortable staying alone.

I visited her again in the morning and she was better — hurray! But that afternoon with my brother, she had a major stroke.

We knew what not to do.

My brother didn't call 911; he just kept her comfortable until I arrived. As her Medical Power of Attorney, I called Kaiser, not for treatment for her stroke or diagnosis, but for a referral for palliative care.

That stroke started a 26-day wait for the end of Mom's life.

In addition to weakening and lack of ability to control her right arm and left leg, Mom had speech aphasia. She could hear, listen and understand, but she struggled to put even a few words together in a sentence for the last month of her life.

ABOVE LEFT: Brackney, 91, looks through pictures of herself with her husband, Milton Marshall Brackney. ABOVE RIGHT: Jan's pinned map shows the 62 countries where she and her husband traveled together.

Would she even be eligible for Medical Aid in Dying if she could not clearly articulate her desire? What if she had other strokes that worsened her speech or cognition? The last month of her life was very stressful for me, as I worried I might fail her in her quest to die with dignity.

Mom, however, carried herself with grace, dignity, style, and humor.

I began hoping (I feel horrible by thinking this and even worse writing it) that Mom would die in her sleep rather than with me mixing and handing her a fatal dose of prescribed drugs. Wouldn't we all like to die in our sleep?

As it turned out, that would have been unfortunate. Mom found unexpected closure in a deathbed conversation with one of her grandsons about the most painful part of her life — the death of her son, Michael.

She listened and smiled often. She laughed with some exasperation all day when her attempts at sentences turned into gibberish due to the aphasia from the stroke. She insisted on slowly dictating thank you notes to all her friends and family who had taken the time to write her letters.

Kevin Brackney holds the cellphone for his mother as she talks with her doctor, confirming all of the processes for her last day of life.

The night before her death, 25 of her kids, grandkids, and their spouses celebrated with Mom and effectively gave her a living eulogy. It was kind of awkward, nice, weird, wonderful and sad. It fit the moment and our family.

The day of her death, we gathered together for the second required-by-law meeting with Dr. Miles Corkern. Dr. Corkern was extraordinarily kind and thoughtful and answered all of our family's questions and concerns. Mom remained competent and confident, and he prescribed the overdose of medicine to be delivered later that day.

We laughed, we cried, and we prayed. When we recited the Lord's Prayer together, Mom was able to recite it word for word. It was the only time since her stroke that she could put more than a few words together.

My mother is a lover of people but has led a private life. In death, however, she wished to share her stories to encourage you to live your life fully and to determine how you wish it to end should you be so lucky.

These conversations with family about our intentions — even if we desire to die fighting like hell with medical intervention no matter our age or prognosis — will provide great comfort to all who know us.

Jan's death with dignity was a gift to her family and friends.

After drinking the liquid prescription herself, Jan heartily enjoyed some mostly melted orange sherbet, sat comfortably for another few minutes, then said something to the effect of "I can feel it." She carefully lay down and peacefully died a few minutes later.

Just like she wanted.

It was beautiful.

Georgeanne (Jan) Wolever, November 8, 1931 — Ash Wednesday, February 22, 2023.

John Brackney is a former elected official, Army officer, lifelong Coloradan and business leader. He hosts a weekly discussion on contemporary public policy with U.S. history professor Stephen Tootle on Facebook live and posted on Youtube and Spotify. Contact him at JohnBrackney@msn.com.

Dear Senate Representatives,

Thank you for allowing me to comment today on SB24-068 Medical Aid in Dying. My name is Dr. Thomas Jensen, I practice in the areas of Endocrinology and Metabolism with a focus on End Stage Liver Disease Patients, along with Cancer patients including pancreatic cancer, and pre and post transplant patients. I see many individuals near end of life due to those aforementioned conditions.

Although Colorodoans supported PAS back in 2016 with a strong emphasis on limitations and safeguards, my concern today is that not only are those current safeguards not being followed, but this bill may allow open the door for potential errors and abuse.

We already know that with lack of oversight of current MAID practices both with multiple cases of missing documentation such as 2022 82% Primary Physician Forms 81.6% Patient forms, 81% Secondary physician forms and 78% Medication Dispension Forms complete. We also have no oversight on how many actually take these pills or outcomes because reporting is poor such as how long it took for them to die or complications. Over the years of MAID there have been changes in the composition of the drug cocktail as you can see in Colorado data in hopes of a more "effective death" which makes me wonder if we are running ongoing experiments on Coloradoans when there is actually feedback given on how terrible earlier concoctions were. Oregon which actually has better data collection has shown annual complication rates at up to 14.8% including swallowing and regurgitation, aspiration, regaining consciousness, and seizures. Why do we not care about this data? Are we a place that lives by the 3 Wise Monkeys' maxim "see no evil, hear no evil, speak no evil."

But what should be more shocking about Colorado data is that <1% of patients were ever assessed for medical decision making capacity formally. And the reality is that terminally ill patients especially in the final days of their lives lack medical capacity to make such decisions. And physicians do a poor job identifying lack of capacity in terminally ill. A 2018 study from Am Journal of Geriaric Psychiatry of 55 Terminally ill cancer patients using the validated MacArthur Competence Assessment Tool for Treatment (MacCAT-T) to evaluate decision-making capacity found strong impairments in the areas of Understanding (44.2%), Appreciation (49.0%) and Reasoning (85.4%). Sadly Physicians believed that 35.9% were impaired. Another 2013 study found that in the last week of life 67% of patients have been found to have impaired decision capacity.

So if the push is to get shorter wait times for patients who may only have days or weeks to live, what confidence can we have that these patients have full medical decision capacity from the data I just gave? Why are proponents such as Compassionate Choices not simply focusing on earlier discussions with patients who legally can make these decisions rather than targeting vulnerable patients in the last days or weeks of life who cannot?

And the section on "self administration" being defined simply as an "affirmative act" could risk further abuse if this allows others to physically give the medication to the patient. My ESLD patients suffer from a mildly confused state called minimal hepatic encephalopathy (studies show up to 74% and much higher at the end of life) and may appear to appropriately respond, but can be quite easily suggestable from prompts of others. They also can suddenly become more acutely confused but retain the ability to swallow so that in the case where someone started to physically give the toxic cocktail into their mouth, the natural response many these patients would do is simply to swallow without full knowledge or

consent at this point. This bill will give only give greater legal cover to those who might wish to hasten their loved one's death on their own time rather than a clear decision from the patient.

So to conclude, even though Coloradoans supported MAID back in 2016, they did so with the assurance of safeguards for patients and loved ones. Current data suggests a disregard for full compliance with what the law voters agreed upon and SB24-068 will only loosen these safeguards further. I hope you will instead seek laws to ensure better compliance of safeguards and oversight of MAID, not loosen it and make this ongoing experiment available to visitors.

February 28, 2024

RE: SB 24-068

To the Members of the Colorado Senate Health & Human Services Committee,

I am writing in opposition to SB 24-068 which seeks to expand Colorado's current assisted suicide law by promising "safeguards." Let's be clear: this is cloak and dagger language. No safeguards are ever safe or acceptable to help usher vulnerable patients towards their death. SB 24-068 has multiple violations that remove critical "safeguards" to include:

- Not evaluating decision-making capacity and mental health problems in the terminally ill (patients under duress) ushers patients towards making rash decisions in response to their fears and concerns. Evaluations and palliative care and mental health interventions can address concerns and in doing so, many patients will no longer seek to hasten their deaths.
- Shortening the waiting period has no advantages and will only increase risks of abuse and violate patient autonomy. Hastened timeframes open wide the opportunity for abuse, discrimination and injustice because the people most likely to be adversely affected by these changes are those with mental illness and disabilities. There is no scientific data or plausible reason to eliminate the safeguards of time and expertise—the risk of harms for doing so outweigh any benefits. This shows reckless disregard for human life, period.
- Removing the residency requirement opens Colorado up to a host of more problems.
- Potential conscience violations by requiring healthcare professionals (particularly those with conscientious objections to assisted suicide) to record the patient's

request for lethal drugs and the date of request in their chart. This makes the healthcare professional/provider complicit in the act of providing lethal drugs.

As the American Academy of Medical Ethics, we believe that the role of the physician is to affirm human life, to relieve suffering, and to give compassionate, competent care as long as the patient lives—*to help the patient value all stages of life.* Assisted suicide and worse, expanding it, *removes restraints that would reign in* abuse, discrimination and injustice. Rather than hastening a patient's death, we must advocate for increased access to palliative care and hospice care.

For the above reasons, we urge you to vote 'NO' on SB 24-068. Coloradans absolutely deserve better.

Thank you.

Nicole D. Hayes, MPA
Executive Vice President, American Academy of Medical Ethics

February 26, 2024

Dear Honorable Members of the Colorado State Assembly Senate Health & Human Services Committee,

I write today to urge you to oppose SB 068 and its blatant attempt to welcome suicide tourism in Colorado and put Coloradans at risk by expanding assisted suicide access to non-residents. I implore you, not as a constituent but as a public policy scholar who is fearful of how Colorado could betray the safety of its own most vulnerable citizens simply to put the other states' citizens at risk as well. Your bill is a gross overstep to endanger the vulnerable residents in other states while serving only to increase the threat to your own constituents. I speak as an expert on this very topic, a bioethicist with a Ph.D. in Public Administration and Policy and a bibliography of scholarly peer-reviewed publications on assisted suicide and end-of-life medical decision-making. Where your duty is to the people of Colorado, entertaining the overreach inherent to SB 068 betrays the health and safety of those you are called to protect. This is why all eyes are upon you and non-residents like myself have an equal entitlement to weigh in on what should be the business of Colorado alone.

Regardless of what instigates it, suicide is generally an impulsive act of desperation, most often borne of fear. Enabling hasty irreversible decisions to self-destruct is not meant to limit any negative outcomes to the patient through delays, but simply to accommodate non-residents who travel to Colorado to obtain a deadly prescription from a total stranger who will only have them as a patient as long as it takes to dispense the lethal dose. SB 068 would create a market for these niche practices that do nothing but dispense deadly suicide drugs. The provisions negated in SB 068 include competent physician requirements, reflection and review periods, second opinions about prognoses and mental capacity, and the independence of physician assessments of each patient's case. This bill eschews any semblance of an existing doctor-patient relationship by a physician well acquainted with the patient and their particular set of circumstances. SB 068 does not feign to value doctor opinions at all, striking every use of the word "physician" in favor of provider in order to allow lesser-qualified non-physicians to dispense the deadly poisons in a fraction of the time. This appears to accommodate specialty death clinics of ideologically pro-euthanasia on-demand doctors and nurses who can blindly validate each other's conclusions out of their position that death on demand is a personal right, not a privilege for those who meet any legal or ethical criteria. This directly affronts the reason Colorado law requires consultative review: as a safeguard to independently assess and concur with the attending physician's conclusion that a patient is indeed terminally ill and mentally competent without signs of coercion or duress.

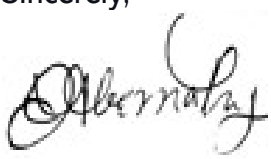
SB 068's embrace of logistics to enable vendor suicide businesses negates any remaining provisions meant to protect Colorado citizens as total smokescreens. Whereas 14 days was the length of time for a resident advised by their existing doctor, surrounded by their family, greater community, extended support network and familiar resources, now anyone can visit a clinic for a rubber-stamped approval to kill themselves within two days. It strikes time for an adequate review of each patient's case, limiting opportunity for further reflection by patients. There is no time for scrutiny or basic due diligence regarding someone's alleged terminal prognosis and increases the likelihood of patient misdiagnosis and the possibility of treatable depression. A review of studies also determined that physicians' medical diagnoses were often incorrect, both in declaring a patient to have a terminal condition and estimating their life expectancy at six months or fewer. Another study of physicians who were willing to prescribe

the lethal dose found that 27 percent were not confident that they could determine if a patient only had six months or fewer to live. There is also substantial evidence that many patients opting to end their lives suffer from treatable depression and physicians report that patients for whom interventions were made (like treating depression) were more likely to change their minds about wanting to end their lives.

Whereas tax exportation to increase state budgets by encouraging tourism is within your scope as lawmakers, this would only increase revenue at the invaluable health and safety expense of those citizens who no longer have any safeguards thanks to enabling non-residents, but furthermore, this does not factor in the actual monetary and human costs of cleaning up after the deceased. The bill assumes that non-residents would just be trying to subvert their own state laws against assisted suicide but how many might be trying to subvert loved ones back home as well or have no one to return to anyway? While it is true that most suicides (77%) occur at home, those who travel here from their homes out-of-state just to obtain deadly drugs because SB 068 designed this option for that express purpose might not ever leave. Where do suicidal people who don't have as ready access to their home as a place to end their lives? National parks are prime suicide destinations as is, particularly in the West where suicide the second leading cause of death and costs over a quarter-million dollars in recovery and identification efforts per victim. The Colorado National Monument attracts dozens of despondent people who self-destruct each year, but with the means to death in their pocket, any public place can become the spot someone chooses to die if they are inclined. There can only be added costs and psychological trauma to the Colorado residents who will face the aftermath of inviting this added violence. Mere exposure to suicide violence often leads to suicide among the responders and survivors, and this is true of those who discover a deceased loved one at home. For every quick, exported suicide that was started in Colorado but completed in a neighboring state for those residents to deal with the unpleasant consequences, there are sure to be secret, expedited death plans of residents enabled by SB 068. Making suicide so quick and easy can only mean more shocked survivors of hasty death plans by Coloradans hiding their intentions, leaving notes for their children or spouses explaining that they sought a hasty overdose from a nurse in Denver just days after learning their diagnosis because they "didn't want to be a burden," never knowing that their grieving survivors would give anything to have had a chance to tell them how desperately their family wanted to care for them for what precious time they had left.

In a state that ranks among the highest for per capita suicides (46 out of 50), so this would merely add a so-called legitimate form of self-violence to what your state calls a "public health crisis" and invest enormous sums of tax dollars to prevent, SB 068 only serves to usher in more death and destruction of Colorado residents by inviting the death and destruction of non-residents. Attempting to usurp the laws of other state legislatures to impose your will can only be done by endangering and burdening the citizens you are called to protect. Do your duty. Vote NO on SB 068.

Sincerely,



Jacqueline Harvey Abernathy, Ph.D., M.S.S.W.
1105 Irene Drive, Mesquite TX 75149

Why oppose SB24-068 – Medical Aid in Dying?

1) There are significant problems with the implementation of the End-of-Life Options Act which ***need to be fixed before expanding Assisted Suicide*** in Colorado.

a) Currently, required forms are not always submitted including the patient consent and attending physician forms. The laxity of compliance needs to be addressed because we don't know that patients are receiving the counseling and care the End-of-Life Options Act promised.

b) There is no peer review to establish whether the requirements for a 6-month terminal diagnosis and alternative treatment options are being met or that the patients aren't suffering from a clinically significant depression. This kind of best practice is required in some jurisdictions that allow assisted suicide and euthanasia. The bill continues to mandate only a "good faith" effort to comply with the requirements of the End-of-Life Options Act rather than the more robust "reasonable medical judgement".

c) There is no requirement to document complications from administration of the overdose drugs or the time till unconsciousness and death. This is a best practice mandated in other US jurisdictions.

d) There are inadequate referrals (<1%) for mental health consultation based on the evidence that a high percentage of patients (up to 48%) seeking assisted suicide are depressed. Shouldn't we require documentation of the performance of simple depression (such as PHQ-9) and mental capacity clinical tools (like MacCAT-T) in the Attending Physician form before we embark on a bill to lower safeguards. None of us want state sanctioned suicide to be an approved approach to clinical depression.

e) There is no state mandated oversight to ensure that patients seeking assisted suicide aren't being coerced for financial or other reasons. Shouldn't the state have the authority to review random cases where assisted suicide was pursued to be sure there is not a problem.

f) Since physicians are asked to falsify the death certificate for patients dying from assisted suicide, there is no accurate way to fully assess the quantity or the quality of the practice of assisted suicide in Colorado. We should change this so that we can pursue public health research into assisted suicide and its effects on Colorado.

g) There has been no public health effort to quantify the impact of assisted suicide on non-assisted suicide rates, especially in high-risk teen populations. In the last 3 legislative sessions alone, the Colorado Assembly appropriated over 33 million dollars for suicide prevention and another $900,000 has already passed one committee this year. Does it make sense to loosen the safeguards on an assisted suicide program that might undermine the state's suicide prevention programs.

h) There is no requirement that the drugs utilized to ensure death are stored safely even though some patients wait months before taking the drugs. We require safe gun storage but turn a blind eye to the storage of lethal drugs.

2) Coloradans don't want to earn the reputation as the state where people across the country come to die. It will have unintended consequences and counter the image of Colorado as a vital state with abundant natural resources.
3) Nurse practitioners serve a vital role in our medical system but aren't as qualified to make determinations for seriously ill patients regarding their mental capacity, advanced therapeutic options or establishing their 6-month terminal prognosis.
4) In Colorado, many physicians prescribing the drug overdose don't have an antecedent relationship with the patient. Doctor and NP shopping for a compliant medical provider with inadequate knowledge of the patient and their history will be exacerbated by SB24-068.
5) Access to assisted suicide should not be easy. Impulsive decisions will be facilitated when the waiting period is

abbreviated. Patients very near the end of life are not capable of understanding or implementing the decision to pursue suicide. This makes them susceptible to individuals who apply coercion to push them towards suicide for financial and other reasons.

6) Lowering the threshold to access assisted suicide will normalize the procedure and help promote an ableist mentality. The elderly and people with disabilities will be victims of this ableism in the medical office and in the community.
7) Participation in assisted suicide is increasing exponentially (355% since 2016) in Colorado which belies the characterization that access is difficult.
8) Suicide is not the best way to die a peaceful, comfortable death, surrounded by family. The overdose drug regimen that is prescribed is constantly changing which suggests advocates are still trying to find a regimen that "works" without side effects. We know that in other jurisdictions (such as Oregon), the death can sometimes take hours to days and can be complicated by nausea, vomiting, delirium, and seizures.
9) SB24-068 eliminates the language that ensures the overdose is self-administered. This is a dangerous loosening of the safeguards envisioned by the Colorado End-of-Life Options Act.

Thomas J. Perille MD FACP FHM
President, Democrats for Life of Colorado

Written Testimony of John Mize
CEO, Americans United for Life
In Opposition to SB 24-068
Submitted to the Senate Health and Human Services Committee
February 29, 2024

Dear Chair Fields and Members of the Committee:

My Name is John Mize, and I serve as CEO at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides on end-of-life issues,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states. Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law. As CEO, I specialize in life-related legislation, constitutional law, and end-of-life public policy.

Thank you for the opportunity to provide written testimony against Senate Bill No. 24-068 ("bill"). I have thoroughly examined this bill, and it is in my opinion that the bill goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable persons at greater risk, and fails to protect the integrity and ethics of the medical profession.

I. *Suicide by Physician Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion*

Colorado has a responsibility to protect its most vulnerable persons—including people living in poverty, the elderly, and those living with disabilities—from abuse, neglect, and coercion. These individuals are already exposed to greater risks, thus, expanding suicide by physician is neither "compassionate" nor an appropriate solution for those who may suffer depression or loss of hope at the end of their lives.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management reasons. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control" or just *concern* about inadequate pain control as a reason for choosing suicide by

[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE (last visited Feb. 26, 2024), https://aul.org/law-and-policy/.
[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE (last visited Feb. 26, 2024), https://aul.org/law-and-policy/state-legislation-tracker/.

physician.[3] Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington).
- Losing autonomy (86.3% in Oregon, 83.0% in Washington).
- Loss of dignity (61.9% in Oregon, 69.0% in Washington).
- Burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington).
- Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[4]

Physicians should ensure that their patients receive the best palliative care and help them cope with feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, in states that have legalized assisted suicide, vulnerable patients are being encouraged to take their own lives, which opens the door to real abuse, especially for the elderly and those with disabilities.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states which have decriminalized suicide by physician. These include a lack of reporting and accountability, coercion, and failure to ensure the competency of the requesting patient.[5] A case study from a Denver based doctor recommended and prescribed medications for suicide to individuals suffering from the eating disorder anorexia nervosa.[6] This is not uncommon. In Oregon and Washington, individuals have died by assisted suicide even though they were not terminally ill and did not have the capacity to consent.[7] Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.[8] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[9] These examples from Oregon and Washington evidence the wide-spread abuse vulnerable end-of-life patients face when considering to engage in assisted suicide.

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[3] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9, 14 (Mar. 8, 2023); WASH. DISEASE CONTROL & HEALTH STATS., 2022 DEATH WITH DIGNITY ACT REPORT 7 (June 2, 2023).

[4] *Id.*

[5] José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see also* WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).

[6] Jennifer Brown, *Denver doctor helped patients with severe anorexia obtain aid-in-dying medication, spurring national ethic debate*, The Colorado Sun (Mar. 14, 2022), https://coloradosun.com/2022/03/14/denver-doctor-gaudiani-aid-in-dying-aneroexia-patients/ (last visited Feb. 26, 2024).

[7] *See* Disability Rights Education & Defense Fund, *Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DREDF, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_edn1 (last visited Feb. 7, 2024).

[8] *See Id.*

[9] Richard Doerflinger, *Lethal Non-Compliance with Washington's "Death with Dignity Act"*, CHARLOTTE LOZIER INST. (Dec. 20, 2022), https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/.

Notably, in November 2023, the American Medical Association (AMA) affirmed its opposition to assisted suicide and euthanasia.[10] The current policy will remain in place, which states,

> [e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.[11]

The AMA also refused to change the term "assisted suicide" to the misleading and inaccurate euphemism, "medical aid in dying."[12]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, advocacy groups continue to promote its expansion. This has led to a "suicide contagion," or the Werther Effect.[13] As an example, empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[14] One study demonstrates that legalizing suicide by physician in certain states has led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[15] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[16] Unfortunately, these effects are even greater for individuals older than 65, which

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[10] Wesley J. Smith, *AMA Retains Policy Against Assisted Suicide*, NAT'L REV. (Nov. 13, 2023), https://www.nationalreview.com/corner/ama-retains-policy-against-assisted-suicide/.

[11] American Medical Association, *CEJA Report B – A-91 Decisions Near the End of Life*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/5.8%20Euthanasia%20--%20background%20reports.pdf (last visited Feb. 6, 2024).

[12] Smith, *supra* note 13.

[13] *See, e.g.*, Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOVERNMENT (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.*, Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/.

[14] *See id.*; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RES. 137 (2004).

[15] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (2015), https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CENTRE (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf.

[16] Jones & Paton, *supra* note 18, at 601.

has seen a 14.5% increase in overall suicide rates for that demographic.[17] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[18]

Furthermore, the spread of physician-assisted suicide disincentivizes developing and improving palliative care as well as treatment and care options for the chronically or terminally ill.[19] For example, after legalizing physician-assisted suicide, Washington, Montana, and Vermont fell "below the national average in hospice utilization rate."[20] In the end, "legalizing assisted suicide for *any* [person] will undermine healthcare for *everyone*."[21]

SB 24-068 takes these concerns further by targeting vulnerable individuals who are suffering from depression and hopelessness and communicates the message that their lives are not worth living. This bill will only stoke the flames of the suicide contagion, which may result in more unassisted suicides. However, vulnerable individuals are indeed worthy of life and equal protection under the law, and state prohibitions on assisted suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[22]

II. *The Bill's Expansion of Providers and Reduction in Wait Time Further Erodes Inadequate and Ineffective Safeguards Protecting Vulnerable Patients*

This bill opens Colorado's physician-assisted suicide law to further abuse by expanding the category of providers that may assisted suicide and reducing the wait time from 15 days to 48 hours. Both proposed changes exacerbate the existing issues with the general inability of providers to give an accurate prognosis and heavy prevalence of depression amongst the targeted population. In particular, the reduction in wait time would allow already limited doctor-patient relationships to become nearly non-existent undercutting other existing "safeguards" such as screening requirements for capacity. This is the model of those pursuing this type of legislation – to continually move the goal posts. The existing law is created with "safeguards" then those "safeguards" are diminished, undermined, or entirely removed.

In Colorado, the law's current "safeguards" are already inadequate to protect vulnerable patients. For example, the bill fails to address the need for a mental health assessment requirement. The underlying law requires the physician to determine that the individual making the request is a "qualifying patient." "Qualifying patient" is merely defined as someone "who (i) has been determined to possess capacity to make an

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[17] *Id.* at 603.
[18] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, Jan-Feb 2015, available at https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").
[19] *See* Clarke D. Forsythe, *The Incentives and Disincentives Created by Legalizing Physician-Assisted Suicide*, 12 ST. JOHN'S J. LEGAL COMMENT. 680, 684, 687 (1996–1997).
[20] O. CARTER SNEAD, WHAT IT MEANS TO BE HUMAN: THE CASE FOR THE BODY IN PUBLIC BIOETHICS 263 (2020)
[21] Forsythe, *supra* note 22, at 687 (emphasis added).
[22] *Washington v. Glucksberg*, 521 U.S. 702, 731-32 (1997).

informed decision[23] regarding consent to medical aid in dying and (ii) has complied with the requirements of this article related to obtaining medical aid in dying." Yet, the patient is only referred to a "licensed mental health provider"[24] for a mental health assessment if the physician is "uncertain as to whether he is capable of making an informed decision regarding consent to medical aid in dying . . . ."

These safeguards are ineffective because the bill fails to define "capacity" or what makes an individual "capable of making an informed decision." This means that even if the individual is suffering from depression, that will not preclude a physician from prescribing them life-ending medication. Significantly, scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[25] "[A]round 25–50% of patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed."[26] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[27] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[28]

Despite the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.[29] In Oregon in 2021, assisted suicide physicians prescribed lethal drugs to 383 patients yet only referred two of these patients for counseling—approximately 0.5% of patients.[30] Even when there is counseling, psychiatrists have limited ability in diagnosing depression. One study shows that "[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[31] If trained psychiatrists have difficulty adequately assessing the mental wellbeing of end-of-life patients, social workers will encounter even more difficulties in making such assessments, especially given their limited training and qualifications compared to psychiatrists. Nevertheless, this bill allows for

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[23] Defined in the bill as "A decision by a mentally capable individual to request and obtain an prescription for medication pursuant to this article 48, that the qualifies individual may self-administer to bring about death, after being fully informed by the attending provider and the consulting provider of: (a) the individual's diagnosis and prognosis; (b) the potential risks associated with taking the medication to be prescriber; (c) the probable result of taking the medication to be prescribed; (d) the feasible end-of-life care and treatment options for the individual's terminal disease, including comfort care, palliative care, hospice care, and pain control, and the risks and benefits of each of these options; and € the individual's right to withdraw a request pursuant to this article 48 or withdraw consent for any other treatment at any time."

[24] Defined in COLO. REV. STAT. § 25-48-102 as "a psychiatrist licensed under article 240 of title 12 or a psychologist licensed under part 3 of article 245 of title 12."

[25] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).

[26] *Id*. at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").

[27] *Id*.

[28] *Id*.

[29] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 54 (2018).

[30] Or. Pub. Heath Div., Oregon Death With Dignity Act: 2021 Data Summary 8 (Feb. 28, 2022).

[31] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996).

social workers to determine if an individual has the "capacity" to take their own life. This raises serious concerns because if the physician refers the patient to a "capacity reviewer," the bill allows for just one session between the psychologist or social worker and the patient before the patient can be deemed to have the necessary "capacity." For these reasons it is difficult to argue that this "safeguard" in SB 24-068 will allow for an accurate assessment of an individual's mental health.

In addition, the bill assumes that advance practice registered nurses, let alone physicians, can make the correct diagnosis that a patient has a terminal disease, injury, or condition which "will result in the patient's death within the next six months." This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating terminal illness life expectancy. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[32] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[33]

Studies have shown "experts put the [misdiagnosis] rate at around 40%,"[34] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[35] which resulted in the individual's death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their diagnosis.[36] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care,"[37] and Arthur Caplan, the director of the Center for Bioethics at the University of Pennsylvania, considers a six month requirement arbitrary.[38] Even the Oregon Health Authority admitted, "[t]he question is: should the disease be allowed to take its course, absent further treatment, is the patient likely to die within six months? . . . [Y]ou could also argue that even if the treatment [or] medication could actually cure the disease, and the patient cannot pay for the treatment, then the disease remains incurable."[39]

Given these inadequate "safeguards," Colorado's current physician-assisted suicide law already subjects vulnerable persons to coercion and abuse. SB 24-068 will only exacerbate the harms of assisted suicide by allowing a broader scope of practitioners to be involved, regardless of qualifications; does little to address underlying mental health issues; and further degrades the provider/patient relationship.

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[32] Nat'l Council On Disability, The Danger Of Assisted Suicide Laws, Bioethics And Disability Series 21 (2019).
[33] *Id*. at 22.
[34] Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VeryWell Health (Aug. 2, 2018), https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481
[35] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, The Local, Apr. 24, 2014 (reporting the doctor was not held accountable for his negligence).
[36] Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[37] *See id.*
[38] *See id.*
[39] Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan. 2018 (emphasis added), available at https://www.masscitizensforlife.org/oregon-health-authority-reveals-hidden-problems-with-the-oregon-assisted-suicide-model.

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession and Allows for Physicians to Experiment with Lethal Drugs on End-of-Life Patients*

Prohibitions on suicide by physician protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[40] Despite these ethical obligations, physicians are using experimental lethal drugs when assisting in suicide. There is no standardized drug nor required dosage for assisted suicide. "Of course, there is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[41] The Food and Drug Act regulates pharmaceuticals at the federal level and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[42] Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[43] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[44] As the U.S. Food and Drug Administration ("FDA") notes on its website, "[c]ompounded drugs are not FDA-approved. *This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients.*"[45] This means physicians have experimented their lethal drug compounds on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients." Thus, Colorado has permitted the use of experimental lethal drug compounds directly upon end-of-life patients.[46] Since the bill is silent as to what drugs doctors must use, the bill will only perpetuate the issue of doctors using experimental lethal drug compounds directly on patients.[47]

Additionally, by the Americans with Disabilities Act definition of disability, people with terminal illness have a disability.[48] Since the statute only permits people

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[40] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

[41] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 Temp. PolL. & Civ. Rts. L. Rev. 323, 339 (2006).

[42] *Id*. at 340.

[43] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).

[44] *See* Robert Wood et al., *Attending Physicians Packet*, End OF Life Wash. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors' experiments with different lethal drug compounds).

[45] Compounding Laws and Policies, U.S. Food & Drug Admin (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies (emphasis added).

[46] CO. DEPT. OF PUBLIC HEALTH & ENV., COLORADO END-OF-LIFE OPTIONS ACT, 2022 DATA SUMMARY, WITH 2017-2022 TRENDS AND TOTALS (2023).

[47] Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, The Atl. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.

[48] 42 USC § 12103.

with terminal illness (and other conditions) to access assisted suicide, the statute is carving out suicide for persons with physical disabilities. So, the state is perpetuating the use of experimental lethal drug compounds by doctors directly on patients *with physical disabilities*.

Ultimately, SB 24-068 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. It opens the door for advance practice registered nurses and others to be forced to violate their conscience rights[49] and medical ethics, such as the Hippocratic Oath, in the same way the current law forces physicians to violate their consciences. It also increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits. Even the U.S. Supreme Court has acknowledged that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[50] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, he pointed out: "Virtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[51]

IV. The Bill Furthers the Harms Created by Colorado's Physician-Assisted Suicide Statute

As stated in Section II, Colorado's assisted suicide statute "safeguard" provisions cannot adequately protect vulnerable end-of-life patients, including people living in poverty, the elderly, and those living with disabilities. However, if the legislature removes Colorado's residency requirement, vulnerable persons *in other states* could become subject to the same coercion and abuse. Out of the eleven jurisdictions that allow for physician-assisted suicide, nine states have residency requirements.[52] Yet, suicide activists have pushed to deregulate physician-assisted suicide and eliminate residency requirements. Removing Colorado's residency requirement opens the state for suicide tourism by out-of-state residents creating additional informed consent issues and conflicts of law issues.

a. *This Bill Creates Additional Informed Consent Issues*

This bill targets vulnerable end-of-life patients in other states who do not actually desire to end their lives but are dealing with depression and hopelessness. Despite the high probability that patients seeking physician-assisted suicide have impaired decision-

[49] *Cf. Christian Med. & Dental Ass'ns v. Bonta*, No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022) (issuing a preliminary injunction against California's requirement that doctors medically document a patient's lethal drug request, which counts towards the two required drug requests, despite doctors' conscientious objections to assisting a suicide); *Lacy v. Balderas*, No. 1:22-cv-953 (D.N.M. filed Dec. 14, 2022) (alleging New Mexico provisions that require doctors to tell patients of the availability of suicide assistance and refer for the practice infringe upon conscience rights).

[50] *Glucksberg*, 521 U.S. at 731.

[51] *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

[52] OR. HB 2279 (enacted 2023). VT. H 190 (enacted 2023).

making due to depression, physicians in Colorado are nevertheless prescribing lethal drugs to these patients. This bill will only open the door for physicians to engage in this same abuse towards out-of-state residents.

Additionally, the bill will encourage "doctor shopping", where an out-of-state resident will seek a physician in Colorado if a physician in their home state refuses or denies prescribing lethal drugs to the patient.[53] This is concerning because government data shows that the median duration of an assisted suicide patient-physician relationship *was only five weeks*.[54] Doctor shopping also raises serious concerns about a physician's ability to diagnose depression and accurately determine the new patient's life expectancy. Added to the fact that doctors have difficulty in accurately dating terminal illness life expectancy, this creates a dangerous environment for patients. by allowing Colorado physicians to prescribe lethal drugs to out-of-state residents even though they do not have a pre-existing patient/physician relationship. Consequently, this will increase the rate of physicians inaccurately dating patients' life expectancies and make it harder for physicians to identify depression in out-of-state residents.

b. *The Bill Creates Conflicts of Law Issues*

If passed, this bill will wreak havoc in Colorado and other jurisdictions. Under conflicts of law principles, states cannot apply the criminal laws of another state. Colorado law carves out suicide assistance from homicide laws, but other states cannot apply this criminal law exemption as a defense. This means that under Colorado law, an individual who is with the end-of-life patient at the time they self-administer the lethal drug cannot be held civilly or criminally liable for being present or for not preventing the end-of-life patient from taking the lethal drugs. However, this is not a viable defense in states where physician-assisted suicide is illegal. Likewise, an individual who assists an end-of-life patient to travel to Colorado to receive assisted suicide drugs may be civilly or criminally liable in states that proscribe suicide assistance.

The law also will create probate issues. Probate is the judicial proceeding that distributes a decedent's estate.[55] Probate likely will not occur in Colorado for out-of-state residents, even though an end-of-life patient died from assisted suicide drugs received under Colorado law. This is problematic because under Colorado's assisted suicide law, medical coroners must state on the death certificate that the end-of-life patient died from their terminal illness, even though the lethal drug overdose directly cause the patient's death.[56] States that seek to protect those at the end of life do not permit medical coroners to lie upon the death certificate. This discrepancy must be dealt with in probate. Additionally, assisted suicide implicates the slayer statute given a person assisted in the decedent's self-killing. Finally, it impacts insurance beneficiaries. For an insurance policy created in a state that prohibits assisted suicide, there will be issues because either it will implicate a clause that changes distribution of the assets

[53] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 27 (2019).
[54] OR. PUB. HEALTH DIV., *supra* note 6, at 13.
[55] https://www.law.cornell.edu/wex/probate
[56] Colo. Rev. Stat. 25-48-109.

when the decedent dies by suicide, or it will again implicate the slayer statute because a person assisted in the decedent's self-killing.

V. *The Majority of States Affirmatively Prohibit Medical Suicide*

The majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Colorado should remain in this majority. Since Oregon first legalized the practice in 1996, "about 200 assisted-suicide bills have failed in more than half the states."[57] In *Washington v. Glucksberg*, the U.S. Supreme Court summed up the consensus of the states: "In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life."[58]

This longstanding consensus among the vast majority of states is unsurprising given the "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages."[59] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to suicide by physician in the U.S. Constitution, finding instead that there exists for the states "an 'unqualified interest in the preservation of human life[,]' . . . in preventing suicide, and in studying, identifying, and treating its causes."[60]

Thus, only by rejecting SB 24-068 can this Committee further Colorado's important state interest in preserving human life, as well as its duty to protect the lives of her citizens, especially the lives of the most vulnerable groups in our society.

VI. *Conclusion*

Physician-assisted suicide is not healthcare. Instead, it acts as a limited exception to homicide liability under state law and allows physicians to use experimental drugs directly upon patients without FDA approval nor clinical trials. Despite Colorado already faltering in curtailing the suicide contagion, this committee should uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession by rejecting expansion of suicide by physician and voting against SB 24-068.

Respectfully Submitted,

John Mize
CEO
AMERICANS UNITED FOR LIFE

[57] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 Human Life Rev. 51, 53 (2018).
[58] *Glucksberg*, 521 U.S. at 710.
[59] *Id.* at 711.
[60] *Id.* at 729–30.

Supportive Testimony of Samantha Trad, Coloradan and National Director of Advocacy for Compassion & Choices
SB24-068: Medical Aid in Dying: Concerning End-of-Life Options for an Individual with a Terminal Illness
Senate Health & Human Services
Thursday, February 29, 2024, 1:30 p.m.

Dear Chair Fields and members of the committee,

My name is Samantha Trad. I am a 3rd generation Coloradan and the National Director of Advocacy for Compassion & Choices and Compassion and Choices Action Network. We are the nation's oldest and largest national nonprofit organization, working to expand options and empower everyone to chart their own end-of-life journey. We had the honor of being the lead organization supporting Proposition 106 in 2016, which Colorado voters overwhelmingly approved, creating the Colorado End-of-life Options Act (EOLOA).

Proposition 106 passed by 65% of Colorado voters in 2016. At the time, it was the widest margin of victory in Colorado history for a ballot initiative, with over 1.7 million Coloradans supporting this safe, compassionate medical practice.

In the 7+ years since the EOLOA went into effect, we have worked with clinicians, health systems, hospices, and volunteers to ensure that the law was implemented well and that eligible dying people could access it. During this time, we learned that some well-intentioned parts of the law were actually barriers to access.

After carefully evaluating how the current law is working and comparing it to other states that have similar laws, SB24-068 proposes data-driven modifications to the law that will allow more eligible patients to safely access this compassionate end-of-life option while still protecting medically vulnerable populations. This bill, based on data from decades of experience across all of the states that have similar medical aid in dying laws, half of which have made similar amendments over the years, seeks to update the Colorado law to better achieve its original intention of allowing eligible terminally ill people the option to end their terminal suffering on their terms.

The proposed amendments keep intact the same basic eligibility requirements and core safeguards that have always protected vulnerable people. Adults must have a terminal illness with six months or less to live, be mentally capable, and be able to self-administer the medication. This law does not allow physicians, family, or anyone else, including the dying

person, to administer the medication by IV injection or infusion. Advanced age, disability, and chronic health conditions are not qualifying factors for medical aid in dying.

End-of-Life Options Act: Proposed Improvements

Reducing the 15-Day Mandatory Minimum Waiting Period and Adding a Waiver Provision

Even without a mandatory minimum waiting period, it takes weeks to months for many patients to get through the request process, which includes being evaluated by two different providers, one of the providers must evaluate you twice, and submitting a written request signed by two qualified witnesses. It generally takes much longer than 15 days to get through the whole process, in fact, it can sometimes take up to 7-14 days just to fill the prescription.

Terminally ill patients don't have the luxury of time on their side. That is why it is critical to reduce the 15-day mandatory minimum waiting period between the two oral requests and allow prescribing providers to waive it. Patients will still need to go through the entire process to access the law.[1]

According to data from Denver Health, one of the best health systems for ensuring that eligible dying people can access the law, nearly 1 in 4 of their eligible dying patients, who wanted the opiton of medical aid in dying, died trying to access the law. This is not what the EOLOA intended.

Half the states that have similar medical aid-in-dying laws have reduced waiting periods and/or allow the prescribing provider the ability to waive it entirely.

In 2021, California reduced its mandatory minimum waiting period from 15 to 2 days.[2] The data from the California Department of Public Health shows that in the first year of the reduced waiting period, 47% MORE eligible dying people were able to access California's law and end their terminal suffering.[3]

In 2019, the Oregon legislature updated its medical aid in dying law by allowing physicians to waive the mandatory minimum waiting period if the patient is unlikely to survive. The Oregon Health Authority's annual report on the law shows that 1 in 5 terminally ill patients had a physician who waived the waiting period in order to make it through the process.[4]

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[1] Colorado: Introduction to Medical Aid in Dying (2016) Available from: https://www.compassionandchoices.org/docs/default-source/colorado/co-medical-aid-in-dying-final-5.20.19.pdf

[2] *California SB 380 End of Life Option Act. Enacted October 2021.* Available from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB380

[3] California End of Life Option Act Annual Report (2016-2022) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

[4] Oregon Death with Dignity Act, Annual Report (2020) Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf; Oregon Death with Dignity Act. Annual Report, (2021). Available

These are astounding examples of how many patients are unnecessarily dying, deprived of a law that is supposed to bring compassion, as a result of an arbitrary mandatory minimum waiting period between the two oral requests. We urge Colorado to join Oregon, California, New Mexico, Washington, and Hawai'i in modifying the needless suffering period.

Allowing Advanced Practice Registered Nurses to Participate Within Their Scope of Practice

The current law only allows for physicians and osteopathic physicians to act as the attending and consulting providers, even though Advanced Practice Registered Nurses (APRNs) have it within their scope of practice to do this important medicine.[5] This proposed amendment allows APRNs to be able to practice within their scope and support patients who want the option of medical aid in dying.

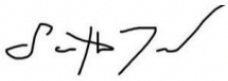
This is particularly important in rural areas where there is a shortage of doctors and in areas with religious health systems that do not allow their doctors to practice medical aid in dying. Health systems, hospices, doctors, and APRNs will still be able to opt-out if they decide not to participate in the EOLOA.[6]

Allowing APRNs to participate as providers under the EOLOA is consistent with their scope of practice. It would help address the disparity in access to participating providers, particularly in areas where it can be difficult to find doctors.

Closing

The amendments in this bill are data-driven and have been tested in other states. They are necessary to ensure that the Colorado End of Life Options Act acts as intended and all eligible dying people will be able to access the law. On behalf of our Colorado supporters and terminally ill residents, thank you for considering these improvements to the Colorado End-of-Life Options Act.

Sincerely,



Samantha Trad
National Director of Advocacy
Compassion & Choices

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from:
https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

[5] Nurse Practitioner Practice Authority: A State-by-State Guide, Nurse Journal, Updated Nov 10, 2023. Available at: https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/.

[6] Nurse Practitioner Practice Authority: A State-by-State Guide, Nurse Journal, Updated Nov 10, 2023. Available at: https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/.

Data from Denver Health

Table 2. Patients With Only One Visit Who Died Within 15 Days of First Visit

Year	Total Number of Patients	Patients with Only 1 Visit (%)	Patients with Only 1 Visit and Death Date Available (%)	Patients with Only 1 Visit and Death Date Available Who Died Within 15 Days of First Visit (%)
2018	11	2 (18)	2 (100)	0
2019	32	10 (31)	8 (80)	6 (75)
2020	57	12 (21)	1 (8)	0
2021	92	24 (26)	3 (13)	3 (100)
2022	149	34 (23)	18 (53)	17 (94)
2023 (first half)	92	18 (20)	14 (78)	12 (86)
Totals	433	100 (23)	46 (46)	38 (83)

Testimony- End of Life Options Act SB24-068

I would like to say hello and thank you to the Health and Human Services Chair and Committee for hearing my testimony today.

Senator Fields and Senator Ginal

Senators: Buckner, Jaquez Lewis, Kirkmeyer, Simpson and Smallwood

My name is Di Larson from district 32. I am a native Coloradoan and proud to live in the great state of Colorado. I am here to wholeheartedly ask for your support of SB24-068 the Colorado End of Life Options Act.

I am intimately familiar with the need for modifications to the existing law. My dear husband, Erick was one of the 23 people with ALS that chose to utilize the end-of-life option in 2022. Erick and I had over 30 wonderful years together and our journey included seeking Medical Aid in Dying. We both had voted in favor of the law in 2016 and I remember our discussion then about individual choice being so important to each of us.

I was Erick's only caregiver at home and I cherish those days. Erick could not eat or speak and relied on a G-tube for feeding and mediation and a manual ventilator to assist with his breathing. As his physical deterioration rapidly progressed, he was ready to die and we were in a race to find support for his decision. My husband's greatest fear was being hospitalized due to the manual ventilation system not being enough to support his labored breathing. We found support through his Pulmonologist that that referred us to Denver Health MAiD (Medical Aid in Dying) program.

Denver Health MAiD (Medical Aid in Dying) helped us with compassion and empathy to make sure he satisfied all the legal requirements. We had our first meeting where Erick stated his desire to obtain and inject the medication through his G-tube, he stated that his quality of life was over and it was his choice to end his life. He was ready on that day and before that day to end his suffering.

It was then that we began the 15-day waiting period. Erick's end of life wish was that he could utilize the medication at home with me, our son and his partner. Those 15 days were filled with fear that he may require hospitalization, sleeplessness and tears as we waited and waited for what were the most stress filled and longest days of our lives.

Erick's one last choice of a dignified death by his choosing was delayed.

Erick was alive after the 15 days of waiting and he had the second meeting where he reiterated his desires. He was able to exercise his last choice to die with dignity in his home with his loved ones on November 25, 2022. I am asking you, not for me, but for the other Ericks and their loved ones who should not have to suffer through an extended waiting period but be allowed the medication access sooner, which this bill does.

I humbly ask that you support the necessary modifications that are included in SB24-068 and I thank you for your time.

Statement on SB24-068: Concerning end-of-life options for an individual with a terminal illness.
Charmaine Manansala, Chief Advocacy Officer, Compassion & Choices
Health and Human Services Committee
Thursday, February 29, 2024 1:30 p.m.

Good afternoon, Chair Sen. Fields, Vice Chair Sen. Ginal, and members of the Health and Human Services Committee,

My name is Charmaine Manansala. I am here today as a Colorado resident and a person living with a disability in support of medical aid in dying.

I have multiple sclerosis and was diagnosed in 1999. This debilitating disease has affected me physically with more than a dozen exacerbations, affecting my general wellness, mental health, energy, vision, speech, amongst others on and off over the last 23 years. It has also permanently taken away my use of my right hand and my mobility. I now use a wheelchair on a daily basis. Throughout my career, I have advocated on behalf of the community. Disabilities was amongst the issues in my portfolio as Senior Advisor to Speaker Nancy Pelosi when I worked in Congress.

I am also the Chief Advocacy Officer at Compassion & Choices Action Network. We are the nation's oldest and largest national consumer-based nonprofit organization working to improve the quality of end-of-life care. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life. On behalf of our Colorado supporters and terminally ill residents, thank you for considering this bill.

Thank you for passing the Colorado End-of-Life Options Act, which has provided peace of mind to the terminally ill since it went into effect in 2016; and thank you for your consideration of SB24-068. We are here today and pleased to offer our support for these crucial amendments to the Colorado End-of-Life Options Act.

Holding true to the intent of the Colorado End-of-Life Options Act - to ensure that all terminally ill individuals have access to the full range of end of-life care options - the bill before you seeks to ensure eligible patients can access medical aid in dying by amending the law to:

- Reduce the current mandatory 15-day waiting period between the first and second oral requests to seven days.
- Allow attending providers to waive the mandatory minimum waiting period if the eligible patient is unlikely to survive the waiting period but meets all other criteria.
- Allow qualified Advanced Practice Registered Nurses (APRNs) to support patients in the option of medical aid in dying by acting as the attending and consulting providers in alignment with their scope of practice.

All of these amendments will reduce unnecessary burdens terminally ill individuals face when trying to access medical aid in dying.

Today, a few have testified or will testify about the risk and harm they believe medical aid in dying poses to people with disabilities. I understand their concerns. As a member of the community, I experience first hand the discrimination that people living with a disability deal with every day. However, the fears related to medical aid in dying are unfounded.

We now have over 25 years of data since Oregon first implemented its law in 1997, and eight years of experience since the law was authorized in Colorado, including annual statistical reports published by the Colorado Department of Public Health and Environment.

Let me share some facts. First, there is no data that suggests that people with disabilities represent a significant percent of the people seeking this option. Second, there have been no documented or substantiated incidents of abuse or coercion across the authorized jurisdictions since Oregon implemented the first medical aid-in-dying law. According to Disability Rights Oregon, there has never received a complaint that a person with disabilities was coerced or being coerced to make use of the Act. Also, people with disabilities overwhelmingly support having the option for medical aid in dying. A nationwide poll conducted in early 2023 by the disabilities organization Us for Autonomy found that 79% of people with disabilities support medical aid in dying.

If we truly value and respect people with disabilities, we need to acknowledge and protect their individual autonomy.

Members of the committee, I would not do this work as I have done for almost ten years if it put people with disabilities in harm's way. I urge you to let the evidence, experience, data, and strong public support for this end-of-life care option guide your policymaking. At its core, this bill is about alleviating unbearable suffering and increasing access to this option, all within the framework of proven safeguards.

Thank you again, Chair and Members of the Committee, for your leadership on this important issue.

February 26, 2024

Committee Name:
Senate Health & Human Services

Sponsor(s):
Senator Joann Ginal

Hearing Item Title:
SB24-068: Medical Aid in Dying : Concerning End-of-Life Options for an Individual with a Terminal Illness

Submitted electronically to:
https://www2.leg.state.co.us/CLICS/CLICS2024A/commsumm.nsf/signIn.xsp

Dr. Ashley D. Fry
1601 N. Nevada Ave.
Colorado Springs, CO 80907
217-402-5105

Position on the Hearing Item: For
Representing: Organization - Compassion & Choices

Madame Chair Fields and Members of the Committee:

Thank you for the opportunity to comment in support of this bill. My name is Ashley Fry and I am a board-certified adult-gerontology acute care nurse practitioner with advanced certification as a hospice and palliative nurse. I have been a nurse for 16 years, the majority of which has been spent working in hospice and palliative care. I currently serve as a clinical educator in my role as Director of Clinical Engagement at Compassion & Choices.

I moved to Colorado Springs in 2019 having previously lived in states where medical aid in dying is not legal. I was ready to learn more about it so that I could support my patients as they explored all of the end-of-life options available to them here. What I was not anticipating was just how complicated the process is for people.

Repeatedly, I have heard patients say to me that the process to find physicians who are willing to participate in medical aid in dying is time consuming, exhausting, and discouraging. On average for my patients, securing the two physicians takes 2-3 months. For those who receive health care services from a religiously affiliated organization in my community, they have to establish with new physicians. For my patients who live in rural communities, they often share that their primary care provider is an advanced practice registered nurse (APRN), and we currently cannot participate in this process for our own patients.

SB24-068 will help patients by reducing the barriers to accessing medical aid in dying. It keeps safeguards in place – like requiring witnesses on the written request and requiring two expert prognoses. Looking at examples from other states such as New Mexico, Washington,

and Hawaii, we know that the amendments being proposed here in Colorado are realistic options that can help Coloradans who are interested in exploring medical aid in dying.[1] [2] [3]

Coloradans were clear when they voted in favor of medical aid in dying in our state.[4] We should do what we can to make sure that there is equitable access to resources for those who want to participate - this bill would help do that. Please vote yes in support of this bill.

Thank you for your time and consideration.

Very Respectfully,

Ashley D. Fry, DNP, APRN, AGACNP-BC, ACHPN

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[1] End of Life Options New Mexico. (n.d.). *Steps for using the end-of-life options act.* https://endoflife optionsnm.org/end-of-life-options-act/steps-for-using-the-eolo-act/

[2] Washington State. (2023). *Death with Dignity Act - Various Provisions.* https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5179-S.SL.pdf?q=20230510092955

[3] Kokua Mao. (n.d.). Our Care Our Choice Act in Hawaii. https://kokuamau.org/our-care our-choice-act-in-hawaii/#:~:text=2023%20UPDATE%3A%20The%20Our%20Care,the%20Attending%20or%20Consulting%20Provider

[4] Death with Dignity. (n.d.) *Colorado*. https://deathwithdignity.org/states/colorado/

Dear Chair Fields, Vice Chair Ginal and members of the Senate Committee on Health and Human Services,

My name is Katie Sue Van Valkenburg, constituent of Senate District 4 and Representative District 13, based in Bailey, Colorado. I wish to express my support of SB24-068, which is an amended bill for the Colorado End of Life Options Act. I am an end of life medical social worker, having worked professionally with Coloradans nearing death since 2016- ironically, the same year this initial bill passed in Colorado. Today, I am the program coordinator for a centralized Medical Aid in Dying program, speaking daily with people from across the country interested in learning more about this option.

At this time, our program is considered the gold standard of Medical Aid in Dying care. We consist of an interdisciplinary team consisting of physicians and a social worker who spend great care in reviewing each case that comes our way. We field between 2 and 7 intake calls each day, and each caller is offered a full biopsychosocial assessment while also being assessed for access to appropriate resources. Our program regularly connects patients with not only hospice and palliative services if needed, but also general needs like financial support, emotional counseling, or even access to basic safety needs like food and shelter.

Before an appointment is even scheduled with a physician, we ensure that patients have access to as many tools in the community that they may want or need. We also have the ability to see patients within a week, if not the same day, to start their request process. If a patient has symptoms of imminent death, we often schedule their visit for the same day to ensure they wait only the minimum amount of time of 15 days. But even in these cases, we are often unable to prescribe the medication before a patient dies.

Within our program, we have found that 1 in 4 people die before their second consultant visits. **1 in 4.** In recent weeks, our program was scheduled to see 7 patients in one day for their second visit. Of those 7, 4 died. These 4 all died between day 10-15 of their mandatory 15 day waiting period. Had the waiting period been 7 days, all 7 of those humans could have accessed this option instead of having to experience anguish over the lack of bodily autonomy they had in their own dying process. In the days since the patients died, I have personally fielded emotional calls from their loved ones, saying they ‘feel like they failed their loved one’ and ‘it was torture to have their loved one ask daily ‘when they could have the medication’ and having to tell them it was still DAYS away.’ The 15 day waiting period is unnecessary suffering for humans who have already suffered enough.

In addition to my professional career, I am also a Coloradan with a disability. Due to an accident in 2020, I developed debilitating mental health diagnoses that resulted in a 7 month leave from work, with continued dependence on medication and aids such as my service animal. As someone part of the disabled community, I am confident that this law is written in such a way that no medical professional would prescribe or coerce me to utilize the act due to my disability, but would allow me the appropriate option to request the medication should I develop a terminal disease with a prognosis of 6 months or less to live and want to have this option for myself.

While it is a gift that Colorado is one of 11 jurisdictions with access to medical aid in dying, the current law NEEDS to change. **The initial bill was a great starting point, but having had seven years to see the law in action, there are opportunities to improve so that we don't continue to fail our terminally ill neighbors with unnecessary barriers to care.** Thank you for your time.

My name is Don Copper, from El Paso County. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act.

As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners.

My Wife Lynn Copper was diagnosed with Bulbar ALS.
She was gone in 14 months.
Need to speed up the process of the MAID program the 14-day waiting period is way too long when all you want to do is die.
No cure no hope no treatment.

Summary

- Unable to eat or speak. All feeding through a Peg feeding tube.
- Lost 80 pounds before death.
- Unable to walk without help.
- Unable to do daily task without help. Getting dressed going to the bathroom.
- Can't get out of bed without help.
- Mind is still there, but you are locked inside your body Just waiting to die.

If you have never experienced it or been a care giver you have no idea.
Lynn was going to take her own life and commit suicide and then we found the Maid program.

Thank goodness for the MAID program.

Thank you for your consideration.

Dear Chair Sen. Rhonda Fields and Vice Chair Sen. Joann Ginal and members of the Committee. It is an honor to write to you all today.

My name is Christine Nguyen from Denver, and I am a volunteer with Compassion & Choices.I am writing today in support of CO bill S24-068, the Colorado End-of-Life Options Act Bill.

I find it ironic that I am writing this on the 42nd anniversary of when my mom took an oath at her naturalization ceremony to become a US Citizen; where she would go on to volunteer most of her life here in America, to canvassing for campaigns she believed in, including this bill in 2016. I remember her saying “I canvassed for this bill and now I’m able to utilize it. How blessed am I.”

My mother passed away 60 days ago and just 5 days before her final interview. I wish I could tell you she was surrounded by her loved ones while she passed away peacefully, but unfortunately those circumstances did not play out the way she (or her family) had hoped because of the 14 day wait period in between interviews.

I understand this is a major privilege in itself, but I don’t believe it’s something you could fault anyone for hoping to be surrounded by the people they love when the time comes.

We found out my mom had stage 4 cancer in March 2023 after going through surgeries and chemo from her first diagnosis in February 2021. She decided to forgo chemo for quality of life.

On December 10th 2023 my mom went to bed completely normal and on December 11, 2023 she was completely gone with a fever and couldn’t get up off the toilet. I thought she was going to die right then.

I remember my mom asking me daily when the next interview was and saying “I’m so sorry. I shouldn’t keep asking because all I keep thinking about is when this pain will be gone”. For as long as I can remember she’s always told us “I want to die holding all my kid’s hands in my sleep” and she was so extremely excited that she was able to do one last act of volunteering (creating a video of why she chose this route and why she believes the waiting period should be shorter).

She felt so much joy after her first interview, knowing that all her children would be present and she could face death head on in the most peaceful and serene way, surrounded by her loved ones.

The way she passed is forever seared in my memory. My sister (who lives in Washington) had just left a few days prior because she had been with us for 2 weeks and had to go back to work.

My mom suddenly came down with a fever and I had no idea she was so close to death because she had gone through the “terminal lucidity” day where she had a burst of energy, or

else I would have called my sister back. Hospice only does so much, so I had no knowledge this was a huge sign of going into the active dying stage. I thought her fever would pass.

I remember the Hospice nurse walking in that day and me asking her “will you be here next week since you are going on vacation?” and her heart breaking when she told me my mom only had 2-3 days tops to live.

My sister jumped on the first flight she could and my brother was packing up his dogs and belongings to be there for my mom’s last few days.

Little did we know, my mom had 3 hours to live after the news broke.

My mom had her eyes closed most of the time, but as she passed she opened them and was looking directly at me as the death rattle started. I know everyone says that they don’t feel pain at this time, but they were not there in my shoes looking at my mom with fear in her eyes and her face grimacing in pain.

My friend, who had experienced 3 other deaths, happened to be there. She said she had never seen someone so coherent and aware of what was happening to her very last breath.

I was soothing my mom as best as I could, not knowing these were her actual dying moments because you are told the death rattle could last days and a long amount of time can elapse during breaths. I remember turning to my friend and asking “is she gone?” and not believing what just happened.

My friend sadly nodded. As I turned to see one single tear drop rolled down from my mom’s beautiful face.

This image and the experience is seared in my mind. I am the youngest of three, with a 14 year age gap between us. Her not having all her children there (and my mom LOVED her children), not having my siblings there, and having to walk my mom over to the other side alone, not knowing my mom was actively dying, and her passing on my brother’s birthday. It’s all so much. The nightmares are still happening to me.

My mom would have chosen to peacefully leave this world while my sister was in town and my brother would have been sure to be present. This could have played out so much differently if the waiting period had been shorter.

I urge you to move the Colorado End-of-Life Options Act quickly and favorably out of committee to help bring inner peace for us going through this traumatic experience.

Thank you, from the bottom of mine (and my family’s) heart for hearing our story. It makes me feel closer to my mom to share.

Title: Opposition to SB24-068, the Medical Aid in Dying Bill

Dr. David Murphy – Feb 20, 2024

Dear Colorado Legislator

I am opposed to the adoption of the so-called "Medical Aid-in-Dying" Bill. The bill goes much further than voters previously approved with the 2016 Proposition 106 on physician-assisted suicide.

Once adopted, a culture of death expands rapidly. Assisted suicide now accounts for four percent of all deaths in Canada. The ill-advised Medical Aid In Dying (MAID) program has already increased the number of physician-assisted suicides to over 13,000 in 2022. MAID was initially scheduled to expand to mental health cases this March, but the proposed delay to 2027 is merely to prepare their medical system for implementation, not because it's an inherently immoral plan. Other states in the US have experienced similar issues with the inability to protect at-risk patients.

Expansion of the so-called "right to die" in Colorado will not stop with SB24-068 and will fundamentally alter the nature of medical care and societal views concerning death. Once unleashed, the medical profession has an almost limitless ability to bring misery and death. Assisted suicide is particularly immoral in a broken, profit-driven healthcare system. People choose suicide when they are depressed and in fear, exactly when they most need help from the medical system and their support networks.

Those who choose suicide to "reduce the pain" are acting on a logical error called an appeal to ignorance. How does one know that death eliminates pain? Most world religions accept some form of existence beyond the grave; to assume they are all incorrect is risky. Most people do not choose suicide to "reduce the pain," but for other reasons. In addition, research indicates a reduction in the quality of palliative care at the end of life since Oregon expanded PAS.

The immoral expansion of suicide authorized by SB24-068 will follow the same path as Canada until even those in a mental health crisis, who most need the empathy of medical professionals, may be encouraged instead to commit suicide. Eventually, suicide will be argued as the moral high ground, perhaps even a moral imperative. Assisted suicide is particularly attractive to venerable people and those with disabilities. How many parents have we seen lauding the unexpected suicide of one of their children? Is suicide by the venerable ever a moral good?

There is a better way, enshrined in the Judeo-Christian understanding that God ordains life from conception until natural death. Accordingly, the US Declaration of Independence posits that we are endowed by our Creator with a "right to life," not a right to death. America has long understood and protected the value of life, even and especially for those in the most difficult and painful circumstances.

The wonders of modern medicine have produced massive improvements to the quality of life and medical care during all seasons of life. Why would the Colorado legislature reverse that progress, negatively influence the medical profession, and continue the rush to cheapen life and encourage suicide?

I am a resident of the 7th Congressional District, Golden, Colorado.

Thank you for fielding my concerns.

David Murphy

David Murphy, Colonel (Ret.), USAF, Ph.D.
Dean of Behavioral and Social Sciences
College of Adult and Graduate Studies
Colorado Christian University

Colorado Oral Testimony, Patrick Massaro

SB24-068: Medical Aid in Dying: Concerning End-of-Life Options for an Individual with a Terminal Illness

Senate Health & Human Services

Thursday, February 29, 2024, 1:30 p.m.

Dear Chair Senator Rhonda Fields and members of the committee,

My name is Patrick Massaro and I am here in support of SB68, and to urge the members of this committee to vote in favor of it today.

In March of 2015, my uncle, Tom, died from terminal cancer. I am here because, as anyone who has had to experience it will tell you, watching a family member suffer and slip away in the days before they die can be a profound and life changing experience.

Tom lived in Durango, and was a high school English teacher there for 18 years. Once it was clear that his cancer was terminal, he became an advocate for medical aid in dying, even though he knew it wouldn't happen in time for him to be able to utilize it.

But since my uncle didn't have that choice, he took back the only control he had over his illness, and eventually entered home hospice care and voluntarily stopped eating and drinking.

My family and I expected him to die within days, so we made our way to Durango to say our goodbyes and be with him at the end. But as the days turned into a week, the rest of our family had to return to their obligations at home. My uncle was a big man - 6'6" and probably 250 pounds - and despite getting no nutrition and his body withering away, his death was taking much longer than expected, and he suffered more with each day.

Unfortunately, I too had to return home after spending nearly two weeks with him. He died days later, 15 days after deciding to stop eating and drinking, and none of my family was able to be with him. While he did what he could to die on his own terms, it didn't prevent the suffering that comes with any death from a terminal illness.

Before he died, my uncle was quoted in the local newspaper and he said:

"... what I find terrifying is… being unable to control my life. Of no longer taking the least satisfaction from having awoken, as the day holds no hint or suggestion of value… Of pain, the real pain, that racks my pathetic body, my only recourse being heavy medication that fills my waking moments and leaves me a bleary hollow-eyed hulk."

In the end, that's exactly what happened. Each morning that I woke up in my uncle's house and walked out to the living room where his hospital bed was set up, I hoped that he had died during the night. Waking up and being heartbroken that your uncle didn't die the night before is a horrible feeling, and it has taken me a long time to wrestle with that.

After aid-in-dying legislation failed twice in the legislature, CO voters stepped up and overwhelmingly supported a ballot measure authorizing medical aid in dying in 2016. While it was too late for my uncle, I am proud to live in a state where voters authorized medical aid in dying, but it is time for our legislature to take action, so I urge you and your colleagues to support this critical piece of legislation, which will improve access to medical aid in dying in Colorado.

Thank you,

Patrick Massaro

STATEMENT IN SUPPORT OF S.B. 68 BEFORE THE COLORADO SENATE HEALTH AND HUMAN SERVICES COMMITTEE - FEBRUARY 29, 2024

Thaddeus Mason Pope, JD, PhD
www.thaddeuspope.com

I am a law professor at Mitchell Hamline School of Law in Saint Paul, Minnesota. I have published over 300 articles and two books on end-of-life decision making. I write in favor of the bill in my personal capacity.

S.B. 68 follows the general trend in MAID laws. Most states with medical aid in dying laws have amended those laws to better assure access to terminally ill capacitated adults who have determined that MAID is the healthcare option that best fits their preferences, goals, and values.

In case it might aid the committee, I attach three of my articles reviewing the legal history of medical aid in dying. I also attach a chart comparing S.B. 68 to 2024 MAID bills in other states.

FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

REFERENCE

Pullman, D. 2023. Slowing the slide down the slippery slope of medical assistance in dying: Mutual learnings for Canada and the US. *The American Journal of Bioethics* 23 (11):64–72. doi:10.1080/15265161.2023.2201190.

THE AMERICAN JOURNAL OF BIOETHICS
2023, VOL. 23, NO. 11, 89–91
https://doi.org/10.1080/15265161.2023.2256244

OPEN PEER COMMENTARIES

Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws

Thaddeus Mason Pope

Mitchell Hamline School of Law

Pullman argues that when it comes to medical aid in dying (MAID), "Canada … has much to learn from California" (Pullman 2023). Canada and California have similar populations: each about 40 million citizens. But, each year, while fewer than 1,000 Californians take MAID medications, more than 10,000 Canadians use MAID. This ten-fold difference is astonishing and merits attention. But how should we interpret it?

Pullman describes the Canadian numbers as "disturbingly high." I take the opposite approach and contend the California numbers are disturbingly low. Pullman rightly notes that MAID in California is subject to "strict eligibility criteria" and that we take a "more cautious approach in the United States" (Pullman 2023). But even Pullman concedes ingenuousness in how best to strike the balance between safety and access. He does not know whether the Californian "criteria are too restrictive" or the "Canadian criteria are too liberal" (Pullman 2023).

But we already have the evidence. Significant data and testimony gathered by researchers and state legislatures show that U.S. criteria for MAID are too restrictive and impede access to individuals who want to relieve suffering at the end of life (Kusmaul et al. 2023). Similar evidence is emerging in other restrictive MAID jurisdictions like Australia and New Zealand. In this Open Peer Commentary, I describe the top ten new and needed expansions of U.S. MAID laws. These are not the only indicated reforms. We need better data to identify other barriers and disparities (Riley 2023).

PERMIT NON-PHYSICIAN PROFESSIONALS

For decades, only physicians could provide MAID in the United States. But it became increasingly obvious that this limited access (Pope 2020). Especially in rural areas, physicians weren't always available. So, when New Mexico enacted its MAID statute in 2021, it also authorized advanced practice registered nurses and physician assistants to provide MAID. In 2023, Hawaii and Washington followed suit. Today, both current and prospective MAID states are considering legislation that would authorize not only physicians but also APRNs and PAs. Furthermore, the states are also expanding the types of clinicians authorized to conduct the mental health exams always required in Hawaii and required in other states when the attending or consulting clinician is uncertain of the patient's capacity.

SHORTEN OR WAIVE WAITING PERIODS

Another way states are already expanding access to MAID is by reducing or waiving waiting periods. For decades, one of the standard safeguards in U.S. MAID statutes required that the patient make two separate oral requests, the second after a waiting period of at least 15 days. The rationale was to permit patients to calmly reflect and deliberate about their decision. But over two decades of experience with MAID shows that many patients cannot wait that long. Since many patients don't seriously consider MAID until the late stages of their illness, they either die or lose decision-making capacity before the end of the 15-day period. In

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short, the waiting period frequently constitutes an undue burden.

In response, several states have either shortened or waived the waiting period. Both California and New Mexico reduced their waiting periods from 15 days to 48 h. Hawaii, Vermont, and Washington also reduced their waiting periods (Meisel, Cerminara, and Pope 2023). Today, bills in both current and prospective MAID states propose similar reductions. In addition to, or instead of, shortening the waiting period, some states exempt patients from having to satisfy the waiting period, however long it is, when the patient isn't expected to survive that period. New Mexico and Oregon, have already enacted such waiver laws. Bills in both current and prospective MAID states propose the same.

DROP RESIDENCY REQUIREMENTS

Traditionally, states limited MAID to their own residents (Pope 2020). Many patients have been able to satisfy these residency requirements by, for example, briefly renting an apartment in the MAID jurisdiction. But while surmountable, residency requirements still pose an obstacle. Consequently, physicians and patients brought federal lawsuits challenging residency requirements in Oregon and Vermont as violating the privileges and immunities clause of the U.S. Constitution. After settling the lawsuits, those states removed the residency requirement. That opened the door to patients traveling to Oregon and Vermont for MAID from other states. Now, bills in other states similarly propose authorizing MAID without a residency requirement. States appear to recognize that they can't constitutionally limit healthcare services to their own residents. A new lawsuit is proceeding in New Jersey.

ENFORCE TRANSPARENCY LAWS

All U.S. MAID laws include broad conscience clauses for both institutions and individual clinicians. Invoking these rights, many religiously affiliated institutions have opted out of participating in MAID. But to help patients make informed decisions about where to seek treatment, California and Washington require facilities to publicly post their MAID policies. That way, patients seeking MAID can make informed choices, for example to avoid enrolling in a nonparticipating hospice. Unfortunately, compliance is poor and states have not enforced the transparency requirements. Colorado now seems poised to do a better job.

PERMIT ASSISTED SELF-ADMINISTRATION

Some individuals otherwise currently eligible for MAID are unable to self-administer their medications because of neurological conditions like ALS. A recent debate in this Journal discussed whether the Americans with Disabilities Act permits, or even requires, clinicians or others to assist these patients in self-administering MAID medications when their physical disability prevents them from completing administration by themselves (Shavelson et al. 2023). Even Pullman admits that California should permit this much (Pullman 2023).

DROP THE SIX-MONTH REQUIREMENT

All U.S. MAID jurisdictions require that the patient have a prognosis of six months or less to live. This strict temporal requirement is unusual compared to other countries, such as Canada, which require only that the patient have a "grievous and irremediable medical condition." Indeed, many seriously and irreversibly ill individuals not within six months of dying may still suffer greatly every day from their disease. A growing number of advocates (including within Pullman's target jurisdiction, California) want U.S. laws to be more like broader laws in Australia, Belgium, Canada, Luxembourg, Netherlands, Spain, and Switzerland (www.abetterexit.org).

PERMIT INTRAVENOUS ADMINISTRATION

Under U.S. MAID laws, medications can be self-administered orally, rectally, or through a feeding tube. All three methods require ingestion (through the stomach and intestines). But evidence from other countries shows that intravenous infusion is more reliable and faster than ingestion (Pope 2020). Unfortunately, IV administration is unavailable in the United States because MAID laws specifically prohibit ending a patient's life "by lethal injection." To allow safer and more effective IV administration, state legislatures should repeal that prohibition. This would not cross the line from MAID to euthanasia. While clinicians would set up the IV, the patient would take the final step of opening the valve to let the medication into their body.

REQUIRE PATIENT DECISION AIDS

All MAID laws have multiple safeguards that help assure the patient's voluntary and informed consent. But because the stakes are so high, we should use the best means available. Patient decision aids are evidence-based educational tools that dramatically improve patient understanding of their options compared to clinician discussion alone (Pope 2022). Other end-of-life decisions

are already supported by decision aids. We must develop a PDA for MAID. And we must get it certified by the Washington State Health Care Authority (Pope 2017).

PERMIT ADVANCE REQUESTS

Many older Americans fear living with late-stage dementia. But MAID isn't an option for these individuals. By the time they're terminally ill, they no longer have capacity. And when they still have capacity (for example, in early stages of Alzheimer's), they're not yet terminally ill. In response, some advocates are pushing to permit individuals to arrange MAID through an advance directive. This is already permitted in some European countries and is being actively considered in Canada. In the meantime, there has been a significant interest in VSED advance directives which direct caregivers to stop providing food and fluid by mouth (Pope 2021; Quill et al. 2021).

REPEAL ASFRA

While MAID is primarily a state matter, many terminally ill patients are on Medicare. That impedes access because the Assisted Suicide Funding Restriction Act of 1997 prohibits federal money from being spent on MAID. Consequently, patients must find another way to pay roughly $750 for the medications. Furthermore, ASFRA deters many hospices and other providers from offering MAID because they worry about inadvertently billing Medicare for it. For these reasons, while most advocacy has been at the state level, some advocates seek to repeal ASFRA.

CONCLUSION

The Dubai World Cup is often referred to as the "world's richest horse race." In 2017, one of the favorites was Highland Reel, an Irish thoroughbred racehorse. He took an early lead and kept it for most of the race. But Highland Reel lost his lead 400 meters from the finish line. Worse, he was then passed by the entire field and relegated to a dead last finish. Analogously, the United States took an early worldwide lead with MAID when Oregon enacted its Death with Dignity Act in 1994. But like Highland Reel, the United States has lost its lead. And it is quickly falling to the back of the pack in terms of MAID safety and access.

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Featured Article

Medical Aid in Dying: Key Variations Among U.S. State Laws

Thaddeus Mason Pope

ABSTRACT: Medical aid in dying (MAID) is legal in eleven U.S. jurisdictions representing one-fourth of the U.S. population, but despite its legality, MAID is practically available to only a subset of qualified patients in these states. MAID's eligibility requirements and procedural safeguards may impede a patient's access. In response, state legislatures have begun to craft more flexible rules as they recalibrate the balance between safety and access. There is already significant variability among U.S. MAID statutes in terms of eligibility requirements, procedural conditions, and other mandates. While the Oregon Death with Dignity Act has served as the template for all subsequent MAID statutes, the states have not copied the Oregon law exactly. Furthermore, this nonconformity grows as states continue to engage in an earnest and profound debate about the practicality of MAID.

Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, J. Health and Life Sci. L., Oct. 2020, at 25.

MAID Variations Among U.S. State Laws

ARTICLE CONTENTS

INTRODUCTION

Medical Aid in Dying (MAID) is an end-of-life option that has been spreading across the United States.[1] It provides assurance that a terminally ill patient can die when she wants based on her own criteria and enjoy life for a longer period of time. Twenty years ago, MAID was available in only one state.[2] Ten years ago, it was available in only two states.[3] Today, MAID is available in eleven U.S. jurisdictions that comprise 25% of the U.S. population.[4]

The expansion of MAID is notable not only for its size but also for its pace. States have been legalizing MAID at an increasingly accelerated speed. Five of today's eleven MAID jurisdictions enacted their statutes in the past four years. Six jurisdictions enacted statutes within the past five years. Two states enacted statutes in 2019 alone,[5] and half of the remaining forty states considered MAID legislation in 2020.[6]

Because of growing public and legislative interest in MAID, it is useful to identify and assess lessons that can be drawn from the existing laws. The eleven MAID jurisdictions have taken three different legal paths to legalization: (1) legislative, (2) judicial, and (3) standard of

1 MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

2 In 1994, Oregon voters approved a ballot initiative enacting the Orgon Death with Dignity Act. *See* Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. Rev. 267 (2018), https://digitalrepository.unm.edu/nmlr/vol48/iss2/6/; Alan Meisel, *A History of the Law of Assisted Dying in the United States* 73 SMU L. Rev. 119 (2020), https://scholar.smu.edu/smulr/vol73/iss1/8/.

3 In 2008, Washington voters approved a ballot initiative enacting the Washington Death with Dignity Act. *See* Pope, *supra* note 2.

4 *See infra* notes 9, 42, and 47 (collecting citations for California, Colorado, Hawaii, Maine, Montana, New Jersey, North Carolina, Oregon, Vermont, Washington, and Washington, DC). The population of these eleven states totals 82 million. That is 25% of the U.S. population, 330 million. *QuickFacts: United States,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/map/US/PST045219 (last visited Sept. 8, 2020).

5 Maine Death with Dignity Act, Me. Stat. tit. 22, § 2140 (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-1 to -20 (2020).

6 Eighteen state legislatures considered bills to legalize MAID in 2020. Ariz. H.B. 2582 (2020); S.B. 1384, 54th Leg., 2nd Sess. (Ariz. 2020); H.B. 5420, Gen. Assemb., Feb. Sess. (Conn. 2020); H.B. 140, 150th Gen. Assemb. (Del. 2020); S.B. 1800 (Fla. 2020); Ga. S.B. 291 (2020); H.B. 1020, 121st Gen. Assemb., 2nd Reg. Sess. (Ind. 2020); Iowa S.F. 2156 (2020); S.B. 2156, 88th Gen. Assemb. (Iowa 2020); H.B. 224, Reg. Sess. (Ky. 2020); Md. H.B. 643 (2020); Md. S.B. 701 (2020); H.B. 2152, 91st Leg. (Minn. 2020); S.B. 2286, 91st Leg. (Minn. 2020); N.H. H.B. 1659 (2020); A.B. 2694, Reg. Sess. (N.Y. 2019); H.B. 2033, Reg. Sess. (Pa. 2020); H.B. 7369, Gen. Assemb. (R.I. 2020); H.B. 93, Gen. Sess. (Utah 2020); H.B. 1649 (Va. 2020); A.B. 552 (Wis. 2019); S.B. 499 (Wis. 2020). Some of these bills might have been enacted but for the COVID-19 pandemic. *Legislative Sessions and the Coronavirus,* Nat'l Conference of State Legislatures (Sept. 10, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-sessions-and-the-coronavirus.aspx. Commentators expect that the next states to enact MAID statutes will be Maryland, Massachusetts, New Mexico, and New York.

care[7]—but most have taken a legislative approach.[8] Nine jurisdictions authorize and regulate MAID through a detailed statute.[9] All nine of these statutes have many common features.

Commentators incessantly emphasize this resemblance. Referencing Oregon, the first state to enact a MAID statute, commentators frequently say that all U.S. MAID laws "have similar provisions based on the Oregon model."[10] Some law professors write that the states have taken a "follow the leader approach."[11] Some write that the states mimic the Oregon "model" or "template."[12] Others write that U.S. MAID laws "closely mirror," "follow" "parrot," or "pattern" the Oregon Act.[13]

However, these commentators overstate the point with this Xerox-like language. While U.S. MAID statutes may copy the Oregon model, they do not copy it exactly. Their approach is better described as "imitation" rather than as "duplication." The nine MAID statutes are not identical. There are material variations among them.[14] This Article identifies and contrasts these differences.

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7 *See* Pope, *supra* note 2.

8 *Id.*

9 End of Life Option Act, Cal. Health & Safety Code §§ 443.1–.22 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-101 to -123 (2020); Death with Dignity Act of 2016, D.C. Code §§ 7-661.01–.16 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-1 to -25 (2020); Me. Stat. tit. 22, § 2140; N.J. Stat. §§ 26:16-1 to -20; Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–.897 (2020); Vt. Stat. Ann. tit. 18, §§ 5281–93 (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010-.220–.904 (2020). One of the best places for tracking the history and status of MAID law is the website of the Death with Dignity National Center and Death with Dignity Political Fund: Death with Dignity, http://www.deathwithdignity.org (last visited Sept. 10, 2020).

10 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 35 (2020), https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf [hereinafter Rep. No. 34].

11 Ben White & Lindy Willmott, *Now that VAD Is Legal in Victoria, What Is the Future of Assisted Dying Reform in Australia?*, ABC, June 24, 2019, https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116.

12 *See, e.g., id;* Anita Hannig, *Assisted Dying Is Not the Easy Way Out*, The Conversation, Feb. 18, 2020; Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017), https://theconversation.com/assisted-dying-is-not-the-easy-way-out-129424.

13 Cody Bauer, *Dignity in Choice: A Terminally Ill Patient's Right to Choose*, 44 Mitchell Hamline L. Rev. 1024, 1036 (2018), https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1138&context=mhlr; Edward Davies, *Assisted Dying: What Happens after Vermont?*, 346 Brit. Med. J. f4041 (2013); Arthur Svenson, *Physician-Assisted Dying and the Law in the United States: A Perspective on Three Prospective Futures, in* Euthanasia and Assisted Suicide: Global Views on Choosing to End Life 13 (Michael J. Cholbi ed. 2017), https://publisher.abc-clio.com/9781440836800/14; Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 181 n.154 (2020), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3207&context=sdlr; Mary C. Deneen, *Bioethics—"Who Do They Think They Are?": Protecting Terminally Ill Patients Against Undue Influence by Insurers in States Where Medical Aid in Dying Is Legal*, 42 W. New Eng. L. Rev. 63, 76 (2020), https://digitalcommons.law.wne.edu/cgi/viewcontent.cgi?article=1832&context=lawreview ("All nine jurisdictions with MAiD statutes provide similar provisions . . . ."). *See also* Rep. No. 34, at 35 ("Eight other states followed Oregon with similar laws....").

14 This exemplifies the role of states as "laboratories" that try novel social experiments. *See* Wash. v. Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

In Section One, the author defines MAID and describes its place in end-of-life health care. Section Two describes non-statutory approaches to legalizing MAID that two states have taken. The remainder of the Article focuses on the nine statutes and describes three types of variations.

Section Three describes two variations in eligibility requirements. These differences concern which patients are qualified to receive MAID. The states vary both in how they assess the patient's state residency and in how they assess the patient's decision-making capacity. Section Four describes three variations in procedural requirements. These differences concern how patients obtain and take MAID prescriptions. The states vary in the permitted routes of drug administration and in the duration of the oral and written request waiting periods. Section Five describes five other variations. The states vary in how they permit clinicians and facilities to opt-out; how they permit telehealth; and how they collect and report data. The states also vary in whether they include a sunset clause.

Finally, in Section Six, the author identifies imminent variations in U.S. MAID laws. During the first two decades of U.S. MAID, policymakers placed heavy emphasis on safety at the expense of access. Today, more states are working to recalibrate the balance between safety and access. Consequently, over the next several years, one can expect additional variations among state MAID laws.

Two innovations are particularly likely. First, all states now require the attending and consulting clinician to be a physician; however, some states will probably extend MAID to advanced practice registered nurses (APRNs). Second, all states now require that the patient be terminally ill with a prognosis of six months or less, but some states will probably extend that to twelve months or longer.

MEDICAL AID IN DYING

Before comparing differences among MAID laws, it is important to first clarify what MAID is. Why would someone hasten their own death? How do they do that with MAID? Who is using this end-of-life option?

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying)

rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death.[16] For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[17]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[18] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely.[19] Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer period of time.[20]

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15 *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, 2008 Hematology 475, 475 (2008), https://ashpublications.org/hematology/article/2008/1/475/95873/Patient-and-Family-Requests-for-Hastened-Death ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 Archives Internal Med. 489, 489 (2009), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824 ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. Pain & Symptom Mgmt. 100, 104 (2006), https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2805%2900631-7; Joan McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. Med. Ethics 454, 456 fig. 2 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med. 1193, 1195 (1998), https://www.nejm.org/doi/pdf/10.1056/NEJM199804233381706?articleTools=true.

16 For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

17 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

18 Peter M. Marzuk, *Suicide and Terminal Illness*, 18 Death Stud. 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. Clinical Oncology 4720, 4722 (2008), https://ascopubs.org/doi/pdf/10.1200/JCO.2007.14.3990.

19 Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. Am. Med. Directors Ass'n 1353 (2019).

20 *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA Neurology (Aug. 24, 2020); Stanley A. Terman, The Best Way to Say Goodbye: A Legal Peaceful Choice at the End of Life 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

Certainly, life is valuable, and societal values reinforce attempting to extend life indefinitely. However, death is unavoidable. People suffering from the diseases that cause the most deaths in this country will often experience significant suffering and/or loss of independence.[21] In this situation, the preference, for some, may be to hasten death so that death can be on the individual's own terms and with some predictability, rather than risk the unknown and potential loss of comfort and dignity.[22] Advocates often remark that MAID does not result in more people dying, just in fewer people suffering.

What Is MAID?

MAID is one key last resort "exit option."[23] With MAID, a physician writes a prescription for life-ending medication for an adult patient who is terminally ill and mentally capacitated.[24] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient.

Indeed, since the practice is so tightly regulated, the standard of care maps onto the statutory requirements. All nine U.S. MAID statutes have nearly identical conditions and safeguards.[25] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to take the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[26]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that

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21 Judith K. Schwarz, *Stopping Eating and Drinking*, 109 Am. J. Nursing 52, 53–54 (2009).

22 Hastening Death by Voluntarily Stopping Eating and Drinking: Clinical, Ethical, and Legal Dimensions (Timothy Quill et al. eds., Oxford Univ. Press, forthcoming 2021); Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 Widener L. Rev. 363 (2011). Most suffering can be alleviated through palliative care. Therefore, MAID is really for the subset of cases where palliative care is insufficient. As palliative care's toolbox expands, the demand for MAID may diminish. *Cf.* Kathryn L. Tucker, *Oregon's Pioneering Effort to Enact State Law to Allow Access to Psilocybin, a New Palliative Care Tool*, Willamette L. Rev. (forthcoming 2020).

23 *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, *in* Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy: An International Perspective 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

24 David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 259 (2016).

25 Thaddeus Mason Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, ASCO Post (Dec. 25, 2017); Thaddeus M. Pope, *Current Landscape: Implementation and Practice*, Nat'l Acads. of Scis., Eng'g, & Med. Health & Med. Div. (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM. While Montana and North Carolina have no MAID statute. But the conditions and safeguards are similar. *See infra* notes 65 to 71.

26 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04[C] (3rd ed. 2020).

the patient's judgment is impaired, then they must refer the patient for a mental health assessment by a third clinician.[27]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[28] However, price increases and supply problems have led physicians to prescribe other drugs.[29] These include compounded ones like D-DMA or DDMP2.[30] Importantly, the patient must ingest the drugs herself.[31] The patient alone takes the final overt act that causes her death.[32]

Who Uses MAID?

The United States has over sixty years of experience with MAID, when one sums the experience of each state where MAID has been available.[33] Data on most of that experience has been systematically collected and reported by both state departments of health and by academic researchers.[34] They show that physicians wrote prescriptions for over 5,000 individuals. Many

27 *Id*. *But see infra* notes 75 to 78 (explaining how Hawaii requires an automatic mental health assessment for everyone).

28 April Dembosky, *Drug Company Jacks Up Cost of Aid-In-Dying Medication*, NPR (Mar. 23, 2016, 3:24 PM), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

29 Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, Scientist (Aug. 16, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

30 D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, Quillette (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

31 Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 Chapman L. Rev. 421, 421 (2017).

32 *See infra* notes 97 to 101.

33 California (2015); Colorado (2016); DC (2017); Hawaii (2018); Maine (2019); Montana (2009); North Carolina (2019); New Jersey (2019); Oregon (1997); Vermont (2017); Washington (2008). There is a longer history of "underground" physician-assisted death. *See generally* Diane E. Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med 1193 (1998); Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 Annals Internal Med. 527 (2000); Damien Pearse, *Michael Caine: I Asked Doctor to Help My Father Die,* Guardian (Oct. 8, 2010, 7:56 PM), https://www.theguardian.com/film/2010/oct/09/michael-caine-father-assisted-suicide#:~:text=Sir%20Michael%20Caine%20has%20revealed,he%20agrees%20with%20voluntary%20euthanasia. Because this practice is not transparent, it is not properly described as "MAID."

34 *See infra* notes 168 to 173. *See also* Luai Al Rabadi et al., *Trends in Medical Aid in Dying in Oregon and Washington*, 2 JAMA Network Open 1/7 (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692; Charles Blanke et al., *Characterizing 18 Years of the Death with Dignity Act in Oregon*, 3 JAMA Oncology 1403 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5824315/; Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

patients get MAID prescriptions for their peace of mind, to have as "insurance" just in case their condition becomes intolerable. Since that intolerability often does not happen, only 70% of patients take their prescription.[35]

Nearly 90% of these 5,000 terminally ill patients had cancer or amyotrophic lateral sclerosis (ALS).[36] Other terminally ill patients with cardiovascular, respiratory, or other illnesses have rarely used MAID. The average age has been 74, and over 90% were on hospice.[37] Most were college educated.[38] Patients receiving MAID prescriptions have been almost evenly split male and female, but they have been overwhelmingly white even in racially diverse states like California.[39]

NON–STATUTORY APPROACHES

Most states have legalized MAID through a statute enacted either through the legislature or through a ballot initiative.[40] Those nine statutes are the primary focus of this Article. For the sake of completeness, however, the reader should recognize that two other states took a non-statutory approach. Montana legalized MAID through a court decision, and North Carolina took a "standard of care" approach.[41]

Montana

Montana law has long permitted one individual to help another person hasten death with consent, so long as that assistance is not against public policy.[42] In 2009, the Montana Supreme Court held that this exception in the homicide law applies to MAID. Therefore, a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent terminally ill patient.[43] Relying upon this decision, patients and physicians participate in MAID in Montana.[44]

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35 Compassion & Choices, Medical Aid in Dying: A Policy to Improve Care and Expand Options at Life's End (2020), https://compassionandchoices.org/wp-content/uploads/Medical-Aid-in-Dying-report-FINAL-2-20-19.pdf.

36 *Id.*

37 *Id.*

38 *Id.*

39 *Id.*

40 *See supra* notes 9, 42, and 47; Pope, *supra* note 2.

41 The Montana court only removed the criminal prohibition. It did not supply any standards or rules. Therefore, the practice in Montana is properly described as a standard of care approach. *Cf.* Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 207 (2020); Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y. L. Sch. L. Rev. 259 (2013/14). North Carolina is different because there is no statute, regulation, or court decision authorizing MAID. North Carolina might be described as taking a "pure" standard of care approach.

42 Mont. Code. Ann. § 45-2-211 (2020).

43 Baxter v. State, 224 P.3d 1211 (Mont. 2009).

44 *Hearing on H.B. 284 Before the H. Judicial Comm.* (Mont. 2019); Eric Kress, *Thoughts from A Physician Who Prescribes Aid in Dying*, Missoulian (Apr. 7, 2013), https://missoulian.com/news/opinion/columnists/thoughts-from-a-physician-who-prescribes-aid-in-dying/article_07680d28-9e0b-11e2-84f1-001a4bcf887a.html; Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 Mont. L. Rev. 117 (2020).

The Montana Supreme Court declared the permissibility of MAID for capacitated, terminally ill adult individuals, but it otherwise provided no rules or standards. In the following eleven years, neither the legislature nor the health care licensing boards filled this gap and provided rules and standards. The notable consequence is that Montana does not formally require the procedural requirements that are present in the nine statutory states.[45] Still, since MAID, like any medical practice, is governed by the standard of care, Montana guidelines are probably similar to the rules in the statutory states.[46]

North Carolina

Montana is not the only state to take a non-statutory approach to legalizing MAID. Some commentators argue that MAID is legal in North Carolina for the same reason that it is legal in Montana.[47] While there is no state supreme court decision addressing the question in North Carolina, there is arguably no need for such a decision. In North Carolina, as in Montana, MAID is not prohibited under current law. Therefore, like most areas of medical practice, it is permitted so long as it complies with the standard of care.[48]

Given the well-known legal risk averseness of clinicians, a standard of care approach might seem quixotic. Will physicians really write lethal prescriptions without the bright line clarity and permission of black letter law? In fact, the answer may be "yes." In closely analogous areas of end-of-life medicine such as Physician's Orders for Life-Sustaining Treatment (POLST), legal experts also recommend a non-statutory, standard of care approach.[49] Such an approach has been working in states like Minnesota where clinicians both write and follow these transportable do-not-resuscitate orders.[50]

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45 *See infra* §§ III to V.

46 David Orentlicher et al., *Clinical Criteria for Physician Aid-in-Dying*, 19 J. Palliative Med. 259 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/pdf/jpm.2015.0092.pdf.

47 *See, e.g.*, John Carbone et al., *Aid in Dying in North Carolina*, 80 N.C. Med. J. 128 (2019), https://www.ncmedicaljournal.com/content/ncm/80/2/128.full.pdf; Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. Rev. Addendum 1 (2019); Jeffrey Segal, *Can NC Physicians Legally Prescribe Meds to Suffering Terminally Ill Patients to Precipitate a Peaceful Death?*, Med. Just. (Jan. 12, 2019), https://medicaljustice.com/can-nc-physicians-legally-prescribe-meds-to-suffering-terminally-ill-patients-to-precipitate-a-peaceful-death/. *But see* Bryant A. Murphy et al., *No Consensus on AID, But We Can Agree on Palliative Care*, 81 N.C. Med. J. 213 (2020), https://www.ncmedicaljournal.com/content/81/3/213.

48 Kathryn L. Tucker, *Vermont Patient Choice at End of Life Act: A Historic Next Generation Law Governing Aid in Dying*, 38 Vt. L. Rev. 687 (2014); Daniel Schweppenstedde et al., RAND Europe, Regulating Quality and Safety of Health and Social Care International Experiences 13 (2014), https://www.rand.org/pubs/research_reports/RR561.html. Of course, North Carolina physicians must also comply with many other rules like those from the state Board of Medicine.

49 Charles P. Sabatino & Naomi Karp, AARP Pub. Policy Inst., Improving Advanced Illness Care: The Evolution of State POLST Laws 17, 45 (2011), https://polst.org/wp-content/uploads/2016/06/POLST-Report-04-11.pdf; National POLST Paradigm, POLST Legislative Guide 24 (2014).

50 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020) [hereinafter The Right to Die].

Other Non–Statutory Approaches

While Montana and North Carolina are the only current MAID states that have taken a non-statutory approach, other states previously attempted to follow this pathway.[51] For example, before enacting a statute in 2018, Hawaii attempted to follow a standard of care approach like North Carolina.[52] Vermont nearly took the opposite approach of following a standard of care approach ***after*** enacting a statute. The Vermont Patient Choice at End of Life Act originally included a sunset clause for the procedural requirements. Had that clause not been later repealed, Vermont MAID would have been governed by the standard of care.[53] Finally more than a dozen other states tried (albeit unsuccessfully) to legalize MAID through a court decision like Montana.[54]

VARIATIONS IN ELIGIBILITY REQUIREMENTS

Montana and North Carolina are the exceptions. Nine of eleven U.S. MAID jurisdictions authorize MAID with a statute. Because all nine of these statutes are based on the Oregon "model," they are quite similar, but these nine MAID statutes are not 100% identical. They vary along three dimensions in terms of (1) eligibility requirements, (2) procedural requirements, and (3) other dimensions. Eligibility requirements are addressed in this section, and other variations are addressed in the next two sections.

To qualify for MAID a patient must satisfy several eligibility requirements. She must be (1) an adult, (2) who is terminally ill, (3) a state resident, (4) with decision-making capacity. Every MAID statute includes these four requirements, but they differ in how they measure the last two and in how they mandate assessment of the patient's residency and capacity.

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51 Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, Advocate, at 1-8 (2010); S.B. 1070, 61st Leg., 1st Reg. Sess. (Idaho 2011), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2011/legislation/S1070E1.pdf.

52 Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices,* 8 J. Health & Biomed. L. 9 (2012), https://cpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/e/1232/files/2016/12/Aid-in-Dying-An-End-of-Life-Option-Governed-by-Best-Practices.pdf. *See also* Morris v. Brandenburg, 356 P.3d 564, 570 (N.M. 2015); Kevin B. O'Reilly, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, Am. Med. News (Apr. 17, 2012), https://amednews.com/article/20120417/profession/304179996/8/. *But cf.* Jim Mendoza, *AG Denounces Aid in Dying Ad*, Haw. News Now (Sept. 24, 2013), https://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad/.

53 The Right to Die, § 12.02.

54 *See* Pope, *supra* note 2. One such lawsuit is currently on appeal. Kligler v. Healey, No. 2016-03254-F (Mass. Super. Ct. Dec. 31, 2019), https://compassionandchoices.org/wp-content/uploads/Kliger-Memorandum-of-Decision-and-Order-wm.pdf.

State Residency: How to Prove It?

Every MAID statute requires that the terminally ill, adult patient be a resident of that state.[55] For example, the California End of Life Options Act (EOLOA) provides that only "qualified individuals" can access MAID and that only residents of California are qualified individuals.[56]

While every state requires residency, they vary in terms of what evidence is enough to prove it. Most states permit the following four documents to prove state residency:

1. Possession of a driver license or other state-issued identification
2. Registration to vote
3. Evidence that the person owns or leases property in the state
4. Filing of a state return for the most recent tax year[57]

Some statutes specify fewer types of evidence as sufficient to establish residency. For example, Washington permits only the first three.[58] Other states specify more than these four types of evidence, such as Maine, which permits five additional types of evidence.[59] Washington, D.C. lists twelve additional types of evidence, and requires that the patient submit at least two of them.[60]

The ease with which a patient can prove state residency is important. Because only nine jurisdictions have MAID statutes, patients regularly move from non-MAID jurisdictions to MAID jurisdictions.[61] For example, Brittany Maynard, one of the most famous people to use

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55 End of Life Option Act, Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(13) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.01(13) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(K), (15) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. § 26:16-3 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800(11), .805 (2020); Vt. Stat. Ann. tit. 18, § 5281(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010(11), .020(1) (2020).

56 Cal. Health & Safety Code §§ 443.1(o), 443.2(a)(3).

57 *Id.* § 443.2(a)(3); Colo. Rev. Stat. § 25-48-102(14); Haw. Rev. Stat. § 327L-13; N.J. Stat. § 26:16-11; Or. Rev. Stat. § 127.860. The Vermont statute does not specify what makes someone a Vermont resident, but the state Department of Health specifies these same four factors. Vt. Dep't of Health, Act 39 Frequently Asked Questions https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf.

58 Wash. Rev. Code § 70.245.130. While Washington lists only three documents, it also permits other "[f]actors demonstrating Washington state residency". *Id.*

59 Me. Rev. Stat. Ann. tit. 22, § 2140(15) (also including: the location of a dwelling currently occupied by the person; place where a motor vehicle is registered; address where mail is received, address shown on a hunting or fishing license, receipt of public benefits conditioned upon residency, and any other objective facts tending to indicate a person's place of residence).

60 D.C. Health, Death with Dignity: Patient Education Module (Apr. 26, 2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Patient.DC%20HEALTH%20Version.04.26.18.pdf (including: utility bill, telephone bill, mail from a government agency, or student loan statement).

61 *See, e.g.,* Kevin Roster, Opinion, *I'm Dying from Cancer. I Have to Move Across the Country to Die on My Own Terms*, USA Today, June 7, 2019, https://www.usatoday.com/story/opinion/2019/06/07/medical-aid-dying-face-death-own-terms-column/1365567001/.

MAID, moved to Oregon specifically for the purpose of establishing residency and thus eligibility for MAID.[62] This is a form of medical tourism.[63] Because these patients are terminally ill, they must quickly acquire the necessary documents to prove state residency.

Capacity Assessments: Two or Three?

Every MAID statute requires not only that the patient be a terminally ill adult state resident but also that the patient have decision-making capacity. This means two things: first, it means that the patient can understand the significant benefits, risks, and alternatives to MAID, and second, it means that the patient can make and communicate an informed health care decision.[64]

To confirm the patient's capacity, every statute requires at least two assessments by two different physicians.[65] Both an attending physician and a consulting physician must "[d]etermine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision."[66]

If both the attending and consulting physicians are sure that the patient has capacity, then she is qualified. If either the attending or consulting physician is sure that the patient lacks capacity, then she is not qualified. However, if either the attending or consulting physician is unsure or has concerns about the patient's capacity, then they must refer the patient for a third capacity assessment.[67]

For example, the California End of Life Options Act states: "If there are indications of a mental disorder, refer the individual for a mental health specialist assessment."[68] The District of Columbia statute mandates referral when the attending or consulting physician suspects a "psychiatric or psychological disorder or depression causing impaired judgment."[69]

The clinician who performs this third capacity assessment is a mental health specialist, usually a psychiatrist, psychologist, or clinical social worker. They must determine whether

62 Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, People, May 9, 2017, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/.

63 *See* I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics ch.8 (2014).

64 End of Life Option Act, Cal. Health & Safety Code § 443.1(c) (2020).

65 Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4, -5 (2020).

66 Cal. Health & Safety Code §§ 443.6(c), .8(c)-(d). Some states use the terms "competent" or "capable."

67 Cal. Health & Safety Code §§ 443.5(a)(1), .6(d); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-106, -107 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.03–.04 (2020); Haw. Rev. Stat. § 327L-1; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(6)–(7) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-6, -8 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.815, .820, .825 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(8) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040, .060 (2020).

68 Cal. Health & Safety Code §§ 443.5(a)(1)(A)(ii), .6(d).

69 D.C. Code § 7-661.03–.04.

the patient "is mentally capable and making an informed decision."[70] They do this by determining whether the patient is suffering from impaired judgment due to a mental disorder.[71]

However, decades of government-collected and reported data show that physicians rarely refer patients for this third capacity assessment. Attending and consulting physicians refer only 4% of patients who receive a MAID prescription.[72] Consequently, few MAID patients receive a mental health specialist capacity assessment.[73] Some commentators suggest that this rate may be too low.[74]

But not in Hawaii, where capacity assessment works differently. In Hawaii, every MAID patient gets a third capacity assessment.[75] It is not contingent or conditional on the judgment of the attending or consulting physician. It is automatically and always required.[76] Recognizing that making a terminally ill patient obtain a third clinical assessment could be burdensome, Hawaii

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70 Colo. Rev. Stat. § 25-48-108.

71 Cal. Health & Safety Code § 443.7; Colo. Rev. Stat. § 25-48-108; D.C. Code § 7-661.01(4); Haw. Rev. Stat. § 327L-6; Me. Rev. Stat. Ann. tit. 22, § 2140(8); N.J. Stat. Ann. § 26:16-8; Or. Rev. Stat. § 127.825; Vt. Stat. Ann. tit. 18, § 5283(8); Wash. Rev. Code § 70.245.060.

72 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Wash. State Dep't of Health, Disease Control & Health Statistics, Ctr. for Health Statistics, DOH 422-109, 2018 Death with Dignity Act Report (2019), https://www.doh.wa.gov/YouandYourFamily/ IllnessandDisease/DeathwithDignityAct/DeathwithDignityData. Notably, Canada has a similarly low referral rate. James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043822/pdf/192e173.pdf. Not every state reports data on the rate of mental health referrals. *See infra* note 170.

73 *See generally* Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 Hastings L.J. 637 (2020), http://www.hastingslawjournal.org/wp-content/uploads/Weithorn_Psychological-Distress-Mental-Disorder-and-Assessment-of-Decisionmaking-Capacity-Under-U.S.-Medical-Aid-in-Dying-Statutes.pdf; Brian D. Carpenter & C. Caroline Merz, *Assessment of Capacity in Medical Aid in Dying, in* Assessing Capacities of Older Adults: A Casebook to Guide Difficult Decisions 243 (Jennifer Moye ed., 2020).

74 *See, e.g.,* Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. Rev. 76 (2016), https://www.deathwithdignity.org/wp-content/uploads/2015/11/623-2243-1-PB-1.pdf; Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA Intern Med. 427 (2016); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 11-12, 16 (2017).

75 While not legally required in any state except Hawaii, some institutions in other states automatically require a third capacity assessment in their own policies. For example, while California law does not automatically require a third capacity assessment, individual facilities like UCSF do. *See, e.g.,* Barbara Koenig, *Reflections on Preparing for And Responding to Legalization in California, in* Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop 89–98 (2018); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 Psychosomatics 441 (2018), https://escholarship.org/uc/item/7xj942bb.

76 Haw. Rev. Stat. §§ 327L-4(a)(5), -4, -6.

permits it to be performed not only by a physician but also by a psychologist or clinical social worker.[77] Hawaii also permits this third capacity assessment to be performed through telehealth.[78]

VARIATIONS IN PROCEDURAL REQUIREMENTS

MAID statutes vary not only in their eligibility requirements (like residency and capacity) but also in their procedural requirements that dictate how qualified patients may access MAID. Every state requires that the patient: (1) make two oral requests, (2) make one written request, and (3) take the prescription drug themselves. However, the states differ on the details. They vary on the duration of mandated waiting periods between oral requests, the duration of mandated waiting period after the written request, and on the routes by which the drug may be administered.

Oral Request Waiting Period: 0, 15, or 20 Days?

Every MAID statute requires that the patient make two oral requests for MAID. Every statute further requires that those two requests be separated by at least fifteen days.[79] For example, California mandates that "[a]n individual seeking to obtain a prescription for an aid-in-dying drug . . . shall submit two oral requests, a minimum of 15 days apart. . . ."[80] This is designed to assure that the request reflects a considered and voluntary choice by the patient.[81]

While 15 days is the most common duration, some states have longer waiting periods, and some have potentially shorter waiting periods. For example, the Hawaii Our Care, Our Choice

77 *Id*. § 327L-1. Some propose extending this to also include psychiatric mental health nurse practitioners. *Testimony Before the S. Comm. on Commerce, Consumer Protection, and Health* (Haw. 2020), https://www.capitol.hawaii.gov/Session2020/Testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF.

78 Haw. Rev. Stat. § 327L-1.

79 End of Life Option Act, Cal. Health & Safety Code § 443.3(a) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-10 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.840, .850 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.090, .110(1) (2020).

80 Cal. Health & Safety Code § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. Colo. Rev. Stat. § 25-48-104(1) ("separated by at least fifteen days"); D.C. Code § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. Stat. Ann. §§ 26:16-10 ("at least 15 days shall elapse"); Or. Rev. Stat. §§ 127.840, .850 ("no less than 15 days after"); Vt. Stat. Ann. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); Wash. Rev. Code §§ 70.245.090, .110(1) ("at least fifteen days after").

81 State laws often require waiting periods for major life-impacting decisions like abortion, sterilization, marriage, divorce, and adoption. *See* Paul Stam, *Woman's Right to Know Act: A Legislative History*, 28 Issues L. & Med. 3, 66 (2012).

Act requires that the patient's oral requests be separated by at least twenty days, instead of just fifteen days.[82] Hawaii has the longest required waiting period in the United States.[83]

Oregon took the opposite approach, shortening rather than lengthening its waiting period. Between 1994 and 2019, the Oregon Death with Dignity Act required a 15-day waiting period, and this was the model followed by every other state except Hawaii. Effective January 1, 2020, however, Oregon amended its statute to permit waiver of the entire 15 days when the patient will not survive that long.[84]

> [I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician ***at any time*** after making the initial oral request.[85]

Consequently, an imminently dying patient in Oregon could make both her first and second oral requests on the same day (with no waiting period).

Other states are looking to follow Oregon's lead.[86] They are apparently motivated by significant evidence demonstrating that the 15-day waiting period impedes patient access to

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82 Haw. Rev. Stat. §§ 327L-2, -9 & -11.

83 Mara Buchbinder & Thaddeus M. Pope, *Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?*, Health Aff. Blog (Aug. 13, 2018) [hereinafter Buchbinder & Pope]. In fact, it often takes Hawaii patients 34 days to navigate the process. *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/HB2451_TESTIMONY_HLT_01-31-20_.PDF [hereinafter *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*]; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF [hereinafter *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*]. A significant number of patients die before the end of the 20-day waiting period. *Id.* (statement of Charles F Miller, Director, Kaiser Hawaii Medical Aid in Dying Program).

84 S.B. 579, 80th Leg. Assemb., Reg. Sess., 2019 Laws Ch. 624, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled.

85 Or. Rev. Stat. § 127.840(2) (emphasis added); see also *id.* § 127.850(2).

86 *See, e.g.,* H.B. 2739 (Haw. 2020), https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf; Dep't of Health Office of Planning, Policy, & Program Dev., Report to the Thirtieth Legislature State of Hawaii 2020: Pursuant to Act 2 Session Laws of Hawaii 2019 (HB2739 H.D. 1) (2019), https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf; H.B. 2419, 66th Leg., Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200913182845; H.B. 171, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf; S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf, https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf. *See also* Voluntary Assisted Dying Act 2019 § 48(2)(b) (W. Austl. 2019), https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement.

MAID.[87] Many terminally ill patients do not begin exploring the option until late in their illness trajectory. By that point, they have little remaining time and cannot survive 15 days.[88] For example, one California study shows that one-fourth of patients died or lost capacity during the waiting period.[89] Similarly, in Canada, which has only a 10-day waiting period, more than one-fourth of patients cannot wait even that long.[90]

Written Request Waiting Period: 0 or 48 Hours?

Every MAID statute requires not only that the patient make two oral requests but also that they make a written request.[91] Patients must make this written request on a specified form.[92] Furthermore, just as there is a waiting period between the two oral requests, some states require a 48-hour waiting period between the written request and the writing of the prescription.[93] For example, the New Jersey statute provides: "[A]t least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . . ."[94]

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87 *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*.

88 Buchbinder & Pope, *supra* note 83.

89 Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

90 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020). *See also* Debbie Selby et al., *Medical Assistance in Dying (MAiD): A Descriptive Study from a Canadian Tertiary Care Hospital*, 37 Am. J. Hospice & Palliative Med. 58 (2020) (10 days reduced 39% of the time). Lori Seller et al., *Situating Requests for Medical Aid in Dying Within the Broader Context of End-of-Life Care: Ethical Considerations*, 45 J. Med. Ethics 106 (2019); Health Canada, First Annual Report on Medical Assistance in Dying in Canada: 2019, at 6 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf (26.5% did not result in a MAID death, because the patients died before receiving MAID). Canadian law permits a waiver of the waiting period if the patient will die or lose capacity before that. S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

91 End of Life Option Act, Cal. Health & Safety Code § 443.3(b) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-2, -9 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(4)–(5), (24) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-4 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.810 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(4) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.030, .090 (2020).

92 Cal. Health & Safety Code § 443.11; Colo. Rev. Stat. § 25-48-112; D.C. Code § 7-661.02(b)–(c); Haw. Rev. Stat. §§ 327L-2, -23; Me. Rev. Stat. Ann. tit. 22, § 2140; N.J. Stat. Ann. §§ 26:16-5, -20; Or. Rev. Stat. §§ 127.810, .897; Wash. Rev. Code § 70.245.220. The Vermont statute does not specify a form, but the state Department of Health has designed forms. https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life. There is variability regarding who may serve as a witness.

93 D.C. Code § 7-661.02(a)(2); Haw. Rev. Stat. § 327L-11; Me. Rev. Stat. Ann. tit. 22, § 2140(13); N.J. Stat. Ann. § 26:16-10; Or. Rev. Stat. § 127.850(1); Wash. Rev. Code § 70.245.110(2). California and Colorado do not require a 48-hour waiting period after the written request. Oregon's waiver of the oral request waiting period also permits waiver of the written request waiting period. Or. Rev. Stat. §§ 127.840(2), .850(2).

94 N.J. Stat. Ann. §§ 26:16-10(a)(6).

Unlike the oral request waiting period, this 48-hour requirement typically does not delay patient access, because this waiting period can run concurrent to the oral request waiting period. For example, the patient could make both her first oral request and her written request on January 1.[95] She could make her second oral request on January 16 and receive a prescription that same day. In this example, the patient satisfies ***both*** the oral and written request waiting period requirements in just 15 days.

However, this is not possible in Vermont. There, the written request waiting period runs consecutively to, not concurrently with, the oral request waiting period. The Vermont Patient Choice at End of Life Act requires that the physician not write the prescription until at least 48 hours "after the last to occur" whether that is the patient's written request or the patient's second oral request.[96] Therefore, the minimum total waiting period in Vermont is 17 days. This is the second longest mandatory waiting period after Hawaii's 20 days.

Route of Drug Administration: GI or IV?

MAID statutes vary not only on the duration of oral and written request waiting periods but also in exactly how the patient can take the prescription drug. Every MAID statute requires that the patient herself take the lethal medication. The patient must take the final overt act causing her death. Accordingly, the California End of Life Options Act requires that the patient "has the physical and mental ability to self-administer the aid-in-dying drug."[97] After all, nobody else may administer it to her or for her.[98]

If the physician or another individual administered the lethal medication to the patient, that would be euthanasia.[99] That is not permitted in any U.S. jurisdiction. Legalizing euthanasia has not even been proposed in any U.S. jurisdiction for over thirty years.[100] Self-administration is a consistent centerpiece of U.S. MAID laws.[101]

But while the MAID statutes uniformly require patient self-administration, they use different verbs to describe how the patient may take the drug. Five statutes use the word

95 There is some variability regarding when the patient may make her written request. Most states permit it after both physicians have confirmed eligibility. New Jersey permits it at the time of the first oral request. *Id.* §§ 26:16-10(a)(3). The District of Columbia permits it between the first and second oral requests. D.C. Code § 7-661.02(a)(2).

96 Vt. Stat. Ann. tit. 18, § 5283(a)(12).

97 Cal. Health & Safety Code § 443.2(a)(5).

98 Confusingly, the term "MAID" in Canada refers to both patient self-administration and to clinician administration (euthanasia). *See* S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

99 Compassion in Dying v. Wash., 79 F.3d 790, 840 (9th Cir. 1996) (Beezer, J., dissenting) ("Euthanasia occurs when the physician actually administers the agent which causes death.").

100 Pope, *supra* note 2.

101 In contrast, Belgium, Canada, and the Netherlands also permit clinician administration. Australian jurisdictions permit clinician administration only when self-administration is not possible. *See Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, Can. Dep't of Justice, https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/toc-tdm.html (last modified Jan. 23, 2017).

"ingest."[102] California, for example, requires that the individual "self-administer" the drug which means the "individual's affirmative, conscious, and physical act of administering and ***ingesting*** the aid-in-dying drug to bring about his or her own death."[103] Indeed, the California's End of Life Option Act (EOLOA) uses the term "ingest" fifteen times to refer to the manner by which the patient must take the drug.[104]

This language is legally and practically significant. The term "ingest" indicates that the route of administration is gastrointestinal.[105] This usually means the patient will drink the medication from a cup or straw.[106] But some patients cannot consume the medication orally. Fortunately, for them, there are two other ways to "ingest" drugs. Patients dependent upon clinically assisted nutrition and hydration can press a plunger on a feeding tube.[107] Other patients can press the plunger on a rectal tube.[108]

With any of these three modes of ingestion, clinicians or family members can assist the patient (for example, by opening the medication, by mixing it in a cup, or by inserting a tube), but the patient herself must make the drug enter her body. The California End of Life Options Act emphasizes the distinction between preparing the drug and ingesting the drug. "A person who is present may, without civil or criminal liability, ***assist*** the qualified individual by ***preparing*** the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug."[109] Without this language, preparing the drugs would probably constitute felony assisted suicide.[110]

The remaining four states do not use the word "ingest." Instead, they use broader language like "take"[111] "administer"[112] or "self-administer."[113] Again, this language is legally and practically

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102 End of Life Option Act, Cal. Health & Safety Code § 443.1(p); Death with Dignity Act of 2016, D.C. Code §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.875 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.010(12) (2020).

103 Cal. Health & Safety Code § 443.1(p) (emphasis added).

104 *Id. passim.*

105 United States v. Ten Cartons, 888 F. Supp. 381, 393–94 (E.D.N.Y. 1995), *aff'd*, 72 F.3d 285 (2d Cir. 1995).

106 This is usually a powder mixed with liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259 (2016); McGehee v. Hutchinson, No. 4:17-cv-00179, ¶ 310 (E.D. Ark. May 31, 2020).

107 *Id.* ¶ 309.

108 Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, Am. Clinicians Acad. on Med. Aid in Dying, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

109 Cal. Health & Safety Code § 443.14(a) (emphasis added).

110 *See* Cal. Penal Code § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

111 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020) (defining "self-administer" to means an "individual performing an affirmative, conscious, voluntary act to ***take into the individual's body*** prescription medication to end the individual's life") (emphasis added).

112 Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020).

113 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-102(7), (15) (2020); Vt. Stat. Ann. tit. 18, § 5284 (2020).

significant. These verbs permit routes of administration other than gastrointestinal.[114] Most notably, these other statutes permit intravenous administration. So, rather than having to administer the medication through the gut, the patient can inject it with a needle into a vein.[115]

This is important for two reasons. First, some patients cannot effectively take the drugs through a gastrointestinal route.[116] They may have a bowel obstruction, poor absorption, or uncontrolled vomiting. While ingestion may be possible it is not as effective as intravenous administration, especially for these patients.[117] Second, intravenous administration is safer and faster. The rate of complications (like regurgitation) from ingestion is significant in "ingest only" states like Oregon.[118] These complications could be substantially reduced with intravenous administration.[119]

Furthermore, IV administration is workable. Patients self-administer antibiotics and other medications through IV at home.[120] Evidence on this practice shows that home IV therapy is

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114 *See, e.g.,* Texas Controlled Substances Act, Tex. Health & Safety Code § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

115 Bettie Lilley Nosek & Deborah Trendel-Leader, IV Therapy For Dummies (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

116 *Hearing on H.B. 2217 Before the S. Comm. on Judiciary* (Ore. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198434 (statement of Charles Blanke); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 426 (1994).

117 H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

118 Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Washington State Department of Health, 2018 Death with Dignity Act Report 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. Times (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, Or. Legis. Pol'y & Res. Off. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

119 Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. Health Can., Fourth Interim Report on Medical Assistance in Dying in Canada (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018).

120 *See generally* Antonella Tonna et al., *Home Self-Administration of Intravenous Antibiotics As Part of an Outpatient Parenteral Antibiotic Therapy Service: A Qualitative Study of the Perspectives of Patients Who Do Not Self-Administer*, 9 BMJ Open 1 (2019), https://bmjopen.bmj.com/content/bmjopen/9/1/e027475.full.pdf; Deepak Agrawal et al., *Patients Welcome IV Self-Care; Physicians Hesitate*, NEJM Catalyst (Dec. 6, 2017); Elizabeth D. Mitchell et al., *Clinical and Cost-Effectiveness, Safety and Acceptability of Community Intravenous Antibiotic Service Models: CIVAS Systematic Review*, 7 BMJ Open 1 (2017), https://bmjopen.bmj.com/content/bmjopen/7/4/e013560.full.pdf.

safe and cost-effective. Consequently, hospitals are increasingly discharging patients with prescriptions for home IV medications.[121] Still, many physicians are uncomfortable with allowing patients to self-administer IV medications. So, the practice is not yet widespread.[122]

Even with MAID specifically there are precedents for patient intravenous self-administration. Physician advocates Jack Kevorkian and Phillip Nitschke created mechanical devices and used them with patients.[123] Note that while Kevorkian set up the IV line for his first patient, "Mrs. Adkins was the one who pushed the button, which began the flow of pain killer and potassium chloride into her system."[124]

Some object that intravenous administration is prohibited even in states that use broad language to define the permissible routes of drug administration.[125] They point to the following language in every MAID statute: "Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia."[126]

However, this prohibition does not apply on its face. It does not prohibit lethal injection ***by the patient***.[127] The prohibitory language proscribes only lethal injection by "a physician or any

121 *Discharge Instructions: Administering IV Antibiotics,* Fairview, https://www.fairview.org/patient-education/86488 (last visited Sept. 15, 2020).

122 Kavita P. Bhavan et al., *Achieving the Triple Aim Through Disruptive Innovations in Self-Care* 316 JAMA 2081 (2016).

123 Nicole Goodkind, *Meet the Elon Musk of Assisted Suicide, Whose Machine Lets You Kill Yourself Anywhere*, Newsweek (Dec. 1, 2017 8:00 AM), https://www.newsweek.com/elon-musk-assisted-suicide-machine-727874; George J. Annas, *Physician Assisted Suicide: Michigan's Temporary Solution*, 328 New Eng. J. Med. 1573 (1993). Gary Schnabel, a pharmacist with the Oregon Board of Pharmacy, also developed a device. Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997).

124 Jennifer Zima, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needs*, 23 Rutgers L.J. 387, 387 n.4 (1992). *See also* Susan Clevenger, Dying to Die - The Janet Adkins Story: A True Story of Dying with the Assistance of Doctor Jack Kevorkian (2019).

125 Personal communications to author after NCCMAID. Lethal injection was proposed and rejected in early MAID bills and ballot initiatives. Pope, *supra* note 2. However, that was lethal injection by the clinician, not by the patient. *See, e.g.,* Washington Physician-Assisted Death, Initiative 119 (1991).

126 End of Life Option Act, Cal. Health & Safety Code § 443.18 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-121 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.15(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-18(a) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(20); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-15(a) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.880 (2020); Vt. Stat. Ann. tit. 18, § 5292 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.180(1) (2020).

127 Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 8 (2017) (interpreting the "other" as a third person). The language of the prohibition may also not extend to intravenous "infusion" into the blood which is distinct from "injection" which may be intermuscular or subcutaneous.

other person." It references "the individual" as the subject of the injection but not as the agent of the injection.[128] Therefore, this prohibitory language is irrelevant to self-administered MAID.

Legislative history confirms this reading. This "lethal injection" language originated with the 1994 Oregon Death with Dignity Act. The voter pamphlet for the ballot initiative included this language indented under a bold heading that stated: "Under Measure 16, only the dying person may self-administer the medication."[129] This clarifies that "lethal injection" was focused on the agent of administration and not the manner of administration.

An even broader look at the legislative history confirms this. Before 1994, bills and ballot initiatives aimed to legalize both MAID and euthanasia.[130] Those efforts failed because having the physician be the final agent was comparatively more controversial. Therefore, reform efforts since 1994 have focused only on MAID.[131] In short, the point of the prohibition was to authorize MAID yet prohibit euthanasia.[132]

Self-administered IV MAID is consistent with this requirement. It changes only the route of administration, not the agent of administration. The patient ***herself*** pushes the lethal medication. The patient herself causes the "lethal injection." With self-administered IV MAID, the physician only establishes the intravenous line. This is analogous to a third person preparing the medication that the patient then drinks herself.[133] As a recent government report describes it, "the person who provides the assistance, such as a relative or doctor, does not perform the final act that causes the death. The death is caused by the person themselves."[134]

This has already been judicially tested. In December 1990, a Michigan court dismissed criminal charges against Jack Kevorkian for assisting in the death of Janet Adkins. While

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128 Contrast a new law in Victoria, Australia that permits physician administration when the patient cannot self-administer. That changes not only the *route* of administration but also *who* administers the lethal medication. Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020), http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/06/02-WHITE-ET-AL.pdf.

129 State of Or. Sec'y of State, Voter's Pamphlet 127 (1994) (although the booklet also says the Measure does not allow "suicide machines").

130 *See, e.g.,* Initiative 119 (Wash. 1991); S.B. 1141 (Or. 1991); Proposition 161 (Cal. 1992); Allan Parachini, *Bringing Euthanasia Issue to the Ballot Box: Group Sponsors State Initiative to Legalize 'Physician-Assisted Suicide'* , L.A. Times (Apr. 10, 1987), https://www.latimes.com/archives/la-xpm-1987-04-10-vw-165-story.html.

131 Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

132 Several authors of the Oregon Death with Dignity Act opined that it did not prohibit self-administered IV MAID. *See, e.g.,* Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997) ("Peter Goodwin . . . a co-author of Measure 16, said, 'My own belief is that medication would cover intravenous medication.'"); Mark O'Keefe, *House Takes Up Assisted Suicide*, Oregonian (May 13, 1997) ("Cheryl Smith, who helped write Measure 16 . . . said, `I believe that Measure 16 allows a machine like Kevorkian's.'"). There were later extensive hearings about routes of administration. H.B. 2954 (Or. 1997).

133 *Cf.* Baxter v. State, 224 P.3d 1211, 1217 (Mont. 2009) ("[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision").

134 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 12 (2020).

Michigan has not affirmatively authorized MAID, it had not yet prohibited it. The court explained that "Mrs. Adkins was the proximate cause of her own death."[135] For the same reason, other Michigan courts dismissed charges against Kevorkian in the deaths of Shery Miller and Marjorie Wantz.[136]

The prohibition on lethal injection is written to require self-administration and thereby prohibit euthanasia. It does not address the route of administration.[137] MAID statutes are silent as to the specific means of self-administration. Consequently, commentators have concluded that despite the prohibition on "lethal injection," "self-administered lethal intravenous infusion . . . may not be prohibited."[138] It is permissible if the patient "pushes a switch to trigger a fatal injection after the doctor has inserted an IV needle."[139]

Furthermore, we can look to Swiss law for guidance. Like U.S. MAID laws, Swiss law requires self-administration. "The final action in the process leading to death must always be performed by the patient."[140] Swiss providers have reconciled this self-administration requirement with IV administration. They openly and regularly have patients administer MAID through IV drips.[141] Some have even developed an "easy to handle remote control" that the patient can "activate through a small movement (e.g. a finger, toe, or jaw) to start the

135 George J. Annas, *Physician Assisted Suicide -- Michigan's Temporary Solution*, 20 Ohio N.U. L. Rev. 561 (1993-1994); People v. Kevorkian, No. CR-92-115190 (Mich. Cir. Ct. Oakland Cnty. July 21, 1992).

136 *Michigan v. Kevorkian*, 9 Issues L. & Med. 189, 200 (1993) ("Ms. Miller pulled the screwdriver which caused the flow of carbon monoxide to commence . . . Ms. Miller took her own life."). *Cf.* Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908) (distinguishing furnishing poison from "placing it in the mouth or other portions of the body"), *overruled on other grounds*, 277 S.W. 1080 (Tex. Crim. App. 1925).

137 *But see Hearing on H.B. 2217 Before the S. Judiciary Comm.*, Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198274 (statement of Geoff Sugerman, Death with Dignity National Center).

138 Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. Legis. 269, 287 (2001), http://www.ethesis.net/cohen/Oregon.pdf.

139 Lynn D. Wardle, *A Death in the Family: How Assisted Suicide Harms Families and Society*, 15 Ave Maria L. Rev. 43, 47 n.11 (2016-2017).

140 Swiss Acad. of Med. Scis., *Medical-Ethical Guidelines: Management of Dying and Death*, 148 Swiss Med. Weekly w14664 § 6.2.1 (2018), https://smw.ch/article/doi/smw.2018.14664.

141 *See, e.g., Swiss Law & Requirements*, Pegasos Swiss Ass'n, https://pegasos-association.com/requirements/ ("Pegasos offers VAD using intravenous transfusion, and even though it is a doctor who will insert the cannula into the person's arm, it is the person, themselves, who must activate the drip delivering the drug."); Dignitas, Dignitas Brochure 7 (15th ed. 2019), http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf ("In every case, for legal reasons, the patient must be able to undertake the last act . . . to open the valve of the intravenous access tube") [hereinafter Dignitas]. *See also* Luke Harding, *A Little Sightseeing, a Glass of Schnapps, then a Peaceful Death in a Suburban Flat*, Guardian (Dec. 4, 2004), https://www.theguardian.com/society/2004/dec/04/health.medicineandhealth1 (interview with Ludwig Minelli, founder of Dignitas Clinic); Susan Stefan, Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law (American Psychology-Law Society Series 190 (1st ed. 2016); Daniel Sperling, Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions 33 (2019); Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 34 & n.182 (2020).

attached pump."[142] They even videotape the procedure to document that the patient opened the valve all by herself.[143] There is no legal obstacle to administering MAID the same way in Colorado, Hawaii, New Jersey, and Vermont.

OTHER VARIATIONS AMONG U.S. MAID STATUTES

We have examined five ways in which U.S. MAID statutes vary. Two concern patient eligibility requirements: (1) how to assess the patient's state residency, and (2) how to assess the patient's decision-making capacity. Three differences concern the manner of accessing MAID: (3) the duration of the oral request waiting period, (4) the duration of the written request waiting period, and (5) the permitted route of drug administration.

But the nine MAID statutes vary not only in terms of eligibility and procedural requirements but also along five other dimensions.[144] These include: (a) how clinicians can assert conscience-based objections, (b) how facilities can assert conscience-based objections, (c) whether assessment and counseling can be done through telehealth, (d) how death certificates are completed, (e) how states collect and report data, and (f) whether the statute includes a sunset clause.

Conscience–Based Objections by Clinicians

Every MAID statute makes participation voluntary not only by patients but also by clinicians and facilities.[145] Individual clinicians may assert a conscience-based or personal objection and they cannot be punished for refusing to participate.[146] This means that clinicians can refuse to discuss or educate the patient on eligibility or process. They can refuse to conduct eligibility

142 Dignitas, How Dignitas Works 16 (May 2014), http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf.

143 George Mills, *What You Need to Know About Assisted Suicide in Switzerland*, Local (May 10, 2018), https://www.thelocal.ch/20180503/what-you-need-to-know-about-assisted-death-in-switzerland.

144 There are also other variations. For example, will state Medicaid (or other insurance) pay for MAID consultations and prescriptions? Must facilities post their policies on MAID? How should patients and families dispose of unused drugs? Yet, many of these rights and obligations come from other sources of law, not from the MAID statutes themselves. *See, e.g.,* H.B. 2326, 66th Leg., Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2326-S.pdf?q=20200915125826. *But cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf.

145 End of Life Option Act, Cal. Health & Safety Code § 443.14(e) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-117 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.10(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-19(a)(2) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(21) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.885(2), (4) (2020); Vt. Stat. Ann. tit. 18, § 5285 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.190(1)(b), (d) (2020).

146 While physicians play a central role, MAID also involves pharmacists, non-physician mental health specialists like social workers and psychologists. Cal. Health & Safety Code § 443.1(l); Colo. Rev. Stat. § 25-48-102(6); Me. Rev. Stat. Ann. tit. 22, § 2140(2)(E) (also including clinical social workers and clinical professional counselors); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020) (including clinical social worker).

assessments, write prescriptions, or fill prescriptions for MAID. They can even refuse to make or assist referrals to participating providers.

But the right to refuse is not unlimited. When the patient finds a new physician who is willing to participate, the original objecting physician must transfer the patient's medical records and must do that even if they think it makes them complicit in what they judge to be an immoral act.[147]

The scope of permitted refusal is narrower in Vermont. Most MAID statutes permit objecting physicians not to inform a patient regarding his or her rights and not to refer the patient to a physician who participates.[148] But Vermont has a separate end-of-life informed consent rights statute.[149] A federal court interpreted this statute to require that objecting physicians must either inform patients about their MAID rights or refer them somewhere they can learn their options.[150]

Conscience–Based Objections by Facilities

Not only individual clinicians but also health care entities assert conscience-based objections—many facilities have opted-out. For example, few religiously affiliated institutions participate with MAID.[151] But what about non-objecting individual clinicians that work for such entities (as either employees or independent contractors)? May they participate when their hospital or health care system has opted out?

MAID statutes in every state permit health care facilities to prohibit their employees and staff from participating with MAID while on the premises or while acting within the purview of the entity.[152] The general understanding has been that such clinicians may participate in MAID on their own time. In Colorado, however, a large Catholic system is litigating a claim

147 Cal. Health & Safety Code § 443.14(e)(3); Colo. Rev. Stat. §§ 25-48-113(2), -117; D.C. Code § 7-661.10(b); Haw. Rev. Stat. § 327L-19(a)(4); Me. Rev. Stat. Ann. tit. 22, § 2140(21); N.J. Stat. Ann. § 26:16-17(c); Or. Rev. Stat. § 127.885(4); Wash. Rev. Code § 70.245.190(1)(d).

148 *See, e.g.,* Cal. Health & Safety Code § 443.14(e)(2).

149 Vt. Stat. Ann. tit. 18, § 5282.

150 Vt. All. for Ethical Health Care v. Hoser, 274 F. Supp. 3d 227 (D. Vt. Apr. 5, 2017) (citing Vt. Stat. Ann. tit. 18, § 1871 and Vt. Stat. Ann. tit. 12, § 1909(d)). *Cf.* Mara Buchbinder, *Aid in Dying Laws and the Physician's Duty to Inform,* 43 J. Med. Ethics 666 (2017).

151 Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA Internal Med. 985 (2019). With mergers and consolidation, fewer health systems may participate in the future. *See* Ian D. Wolfe & Thaddeus M. Pope, *Hospital Mergers and Conscience-Based Objections — Growing Threats to Access and Quality of Care,* 382 New Eng. J. Med. 1388 (2020); Harris Meyer, *Proposed Virginia Mason-CHI Franciscan Merger Increases Worry about Catholic Limits on Health Care in Washington State*, Seattle Times (Aug. 3, 2020, 8:24 AM), https://www.seattletimes.com/seattle-news/health/proposed-virginia-mason-chi-franciscan-merger-increases-worry-about-catholic-limits-on-health-care-in-washington-state/.

152 Cal. Health & Safety Code §§ 443.15–.16; Colo. Rev. Stat. § 25-48-118; D.C. Code § 7-661.10(c)-(e); Haw. Rev. Stat. § 327L-19(b)–(e); Me. Rev. Stat. Ann. tit. 22, § 2140(22); Or. Rev. Stat. § 127.885(5); Vt. Stat. Ann. tit. 18, § 5286; Wash. Rev. Code § 70.245.190(2). The New Jersey statute does not contain this language.

that it can prohibit its physicians from participating in MAID even when they act outside the purview of their employment.[153]

Telehealth Assessment and Counseling

Particularly since the COVID-19 pandemic, there has been an increased interest in and use of telehealth.[154] This includes MAID.[155] Indeed, a new professional society, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) released guidance on how to provide MAID through telehealth.[156]

The Hawaii MAID statute addresses telehealth explicitly in the context of the mental health counseling. This is the third clinical assessment for determining that the patient is capable and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with her ability to make an informed decision.[157] The Hawaii law states that these mental health consultations with a psychiatrist, psychologist, or clinical social worker "may be provided through telehealth."

But what about the attending and consulting physician who assess terminal illness and capacity?[158] No U.S. MAID statute specifically says that may be done by telehealth, and none specifically prohibits it. Consequently, one might conclude that clinicians may provide MAID through telehealth to the same extent as they can provide other health care services through telehealth.

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153 Morris v. Centura Health Corp., No. 2019-CV-31980 (Arapahoe Cnty. Dist. Ct., Colo., Dec. 20, 2019). Relatedly, the U.S. Supreme Court is hearing a case that questions the thirty-year old rule that government can enforce laws that burden religious beliefs or practices as long as the laws are "neutral" or "generally applicable." Fulton v. City of Phila., Pa., No. 19-123 (U.S. Nov. 4, 2020) (oral argument). Federal regulations may permit an even broader scope of conscience-based refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88). These regulations have been enjoined and those injunctions are on appeal. New York v. U.S. Dept. Health & Human Servs., No. 19-4254 (2d Cir. 2020); City and County of San Francisco v. Azar, No. 20-35044 (9th Cir. 2020).

154 Cathleen Calhoun, *Strategic Perspectives: Telehealth Has Taken a Giant Step Forward, But Will the Momentum Continue?*, Wolters Kluwer Health L. Daily (May 20, 2020).

155 *See* Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325 (2020), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1650&context=healthmatrix.

156 Comm. to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic, *Telemedicine Policy Recommendations*, Am. Clinicians Acad. on Med. Aid in Dying (Mar. 25, 2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf. Medical licensing boards in other jurisdictions have also issued telehealth guidance during the COVID-19 pandemic. *See, e.g.,* Coll. of Physicians & Surgeons of N.S., Temporary Amendments to the College's MAiD Standard (2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf; College of Physicians and Surgeons of British Columbia, *Practice Standard: Medical Assistance in Dying* (Mar. 26, 2020).

157 Haw. Rev. Stat. § 327L-1.

158 *Cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf (allowing telehealth for all clinicians when the patient is unable to leave her residence).

On this analysis, telehealth for MAID is not equally available in every state. For example, in Vermont, telehealth can only be provided in the context of a "[b]ona fide physician-patient relationship."[159] That requires not only assessment of the patient's medical history and current medical condition but also a "personal physical examination."[160] So, both the attending and consulting physician must have visited with the patient in person before or concurrent with providing MAID.

Other constraints may also be manageable. For example, California requires that the physician "[c]onfirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, ***outside of the presence*** of any other persons."[161] While it may be more difficult to know that the patient is alone when meeting through a phone or computer camera, the physician can confirm this by asking the patient to move the camera around the room.[162]

Death Certificate Completion

While most provisions in MAID statutes focus on how patients may obtain MAID, some provisions address what happens ***after*** MAID. One perennially controversial issue concerns whether the patient's death certificate identifies MAID as the cause of death. Here, the states take three different approaches.[163]

Four MAID statutes prohibit MAID from being listed as the cause of death on the patient's death certificate. Instead, the death certificate must list the underlying terminal illness.[164] In four other states the statute is silent, but state agency guidance directs listing the underlying terminal illness.[165] For example, the California Department of Public Health states:

159 Vt. Stat. Ann. tit. 18, § 5281(1) (2020).

160 *Id.*

161 End of Life Option Act, Cal. Health & Safety Code § 443.5(a)(4) (2020).

162 Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325, 343 (2020).

163 Canadian provinces also vary in whether they require or prohibit MAID from being listed as the cause of death. Janine Brown et al., *Completion of Medical Certificates of Death After an Assisted Death: An Environmental Scan of Practices*, 14 Healthcare Pol'y 59 (2018).

164 Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-109(2) (2020); D.C. Code § 7-661.05(h); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4(b) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040(2) (2020). Many bills in prospective MAID states also require listing the terminal illness. *See, e.g.*, A.B. 2694 § 2899-p, Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A02694&term=2019&Summary=Y&Text=Y.

165 New Jersey Medical Aid in Dying for the Terminally Ill Act Frequently Asked Questions 3–4 (July 31, 2019), https://www.state.nj.us/health/advancedirective/documents/maid/MAID_FAQ.pdf ("NJDOH Office of Vital Statistics and Registry recommends that providers record the underlying terminal disease as the cause of death and mark the manner of death as 'natural'."); Or. Health Auth., *Frequently Asked Questions: Oregon's Death with Dignity Act (DWDA)*, Oregon.gov, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#deathcert (last visited Sept. 14, 2020) (same); Vt. Dep't of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life 4 (2018), https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf ("100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.").

"Certifiers . . . report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law . . . and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act."[166] Only Maine offers no guidance on whether to list MAID on the patient's death certificate.[167]

Data Collection and Reporting

Conscience-based objection and telehealth affect how patients access MAID, but the states also vary in how they collect and report data. Every MAID statute requires that state agencies publish annual reports on usage.[168] The data reports from the first two states (Oregon and Washington) demonstrate a strong safety record that paved the way for enactment of legislation in the subsequent seven states.[169]

But the states vary in terms of what information they collect and report.[170] Oregon and Washington collect and report the broadest range of data. California does less.[171] Colorado, Vermont, and Washington, DC collect and report the least.[172] This variability is unfortunate, because reform is more difficult when one knows less about how the law is working.[173]

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166 Cal. Dep't of Public Health, California End of Life Option Act 2019 Data Report 5 (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf. *But see Document #3459: The California End of Life Option Act* ¶ 26, CMA Legal Counsel (2016), https://www.uclahealth.org/workfiles/eol/cma-guidance-end-of-life-option-act-on-call.pdf (directing physicians to list the cause "they feel is the most accurate").

167 Maine legislation originally followed the approach taken in Colorado, DC, Hawaii, and Washington, but as in California and Vermont, that was amended in later versions of the bill.

168 End of Life Option Act, Cal. Health & Safety Code §§ 443.9, .19 (2020); Colo. Rev. Stat. § 25-48-111(2); D.C. Code § 7-661.07; Haw. Rev. Stat. §§ 327L-14, -25; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(17) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-13 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.865 (2020); Wash. Rev. Code § 70.245.150.

169 N.J. Stat. Ann. § 26:16-2(b). Oregon and Washington data were also important to reform in jurisdictions around the world. *See, e.g.,* Carter v. Canada (Attorney General), 2013 BCCA 435, https://www.canlii.org/en/bc/bcca/doc/2013/2013bcca435/2013bcca435.html.

170 Jean T. Abbott et al., *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-In-Dying*, Health Aff. Blog (Nov. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.33370/full/ [hereinafter Abbott et al.]. This study was published before Maine and new Jersey enacted their statutes, but that would not change the analysis, although the state agencies could promulgate regulations that promote the collection ad reporting of broader data. *See* Me. Rev. Stat. Ann. tit. 22, § 2140(17); N.J. Stat. Ann. § 26:16-13.

171 But in addition to the annual DOH reports, the California Assembly holds periodic hearings on the implementation of the EOLOA. *See, e.g.,* Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video.

172 Abbott et al.

173 *See* Thaddeus M. Pope, *Extrajudicial Resolution of Medical Futility Disputes: Key Factors in Establishing and Dismantling the Texas Advance Directives Act*, *in* International Perspectives on End of Life Reform: Politics, Persuasion, and Persistence (Ben White & Lindy Wilmott eds., forthcoming 2021); Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019 9 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf ("Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law.").

Sunset Clauses

The future of most MAID statutes has been threatened by litigation or legislation.[174] But as enacted, those laws were intended to be permanent options. None was enacted on a trial or pilot basis.[175]

In contrast, when California enacted its End of Life Option Act during an extraordinary legislative session in October 2015, it included a sunset clause.[176] "This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date."[177] Unlike other MAID statutes, the EOLOA expires.[178] Therefore, unless reauthorized, MAID will cease to be a legal practice in California.[179]

FORTHCOMING VARIATIONS

The previous sections described current differences among U.S. MAID laws, but the variability will likely continue to grow as states continue studying "barriers to access."[180] Many are already seeking to recalibrate the balance between safety and access.[181]

Two aspects of MAID laws are especially primed for change: scope of practice and terminal illness. The states are currently uniform in permitting only physicians to provide

174 *See, e.g.,* Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal.), https://compassionandchoices.org/legal-advocacy/recent-cases/ahn-v-hestrin/; Glassman v. Grewal, No. MER-C-53-19 (Mercer Cnty. Sup. Ct., NJ), https://compassionandchoices.org/legal-advocacy/recent-cases/glassman-v-grewal/.

175 While the Vermont statute's legalization of MAID was permanent, the procedural safeguards were initially designed to sunset. *See* Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.05 (3rd ed. 2020).

176 A.B. 15 (Cal. 2015), codified at End of Life Option Act, Cal. Health & Safety Code §§ 443 to 443.22 (2020). The law went into effect on June 9, 2016.

177 Cal. Health & Safety Code § 443.215.

178 *Id.*

179 Without the EOLOA, MAID would be a felony in California. Cal. Penal Code § 401(a) (2020) (Any person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.").

180 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915155130 (passed both chambers but vetoed on April 3, 2020 because of COVID-19); Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video. *See also* Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417, 442–43 (2020) (noting that many patients "find the process overwhelming and too difficult to navigate" and that "few medical practitioners will agree to be involved"); Rosalind McDougall & Bridget Pratt, *Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation*, 21 BMC Med. Ethics 1 (2020), https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5 (arguing that aiming to maximize safety has negative implications for access).

181 Not every new bill seeks to expand access. For example, one of the newer MAID statutes, in Hawaii, added or increased several procedural requirements. Buchbinder & Pope, *supra* note 83. More recently, a Maryland bill would have significantly constrained access. Md. S.B. 311 / H.B. 399 (2019). On the other hand, states can also expand access through non-legal means like public education and provider outreach.

MAID. However, some states are likely to allow APRNs to provide MAID. The states are also currently uniform in how they define terminal illness, but some states are likely to define terminal illness more broadly than a six-month prognosis. The states may also diverge along several other dimensions.

Scope of Practice: MD or APRN?

Every U.S. MAID statute now requires that both the attending and the consulting clinician (who assesses eligibility, provides counseling, and writes the prescription) be a physician. While most statutes are more flexible about who can perform the mental health assessment (*e.g.* clinical social worker or psychologist), none permit a non-physician to otherwise determine eligibility or write the prescription.

But limiting MAID to physicians constrains access to MAID, especially in rural areas where there is a shortage of physicians. In response, some states have proposed legislation that would allow APRNs to perform these tasks.[182] Already, 6% of MAID in Canada is performed by APRNs,[183] and this makes sense. Across the United States, many states have already expanded scope of practice to permit APRNs to assess capacity and write POLST orders regarding life-sustaining treatment.[184]

Terminal Illness: Six Months or Longer

Every U.S. statute now requires that the patient have a terminal illness. This is typically defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[185] Both the attending and consulting physician must certify a prognosis that the patient has a terminal disease that will cause her death within six months.

At first glance, the six-month prognosis seems reasonable. It aligns with the eligibility for hospice under Medicare.[186] Hospice, a program of care and support for people who are

182 S.B. 2582, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB2582_SD1_.pdf; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf; H.B. 171, Reg. Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf (also extending to physician assistants); S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252JUS.pdf (same); A.B. 10059 (N.Y. 2016), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Text=Y. MN. *See also* Western Australia Voluntary Assisted Dying Act of 2019 § 54(1)(a), http://www.austlii.edu.au/cgi-bin/viewdb/au/legis/wa/consol_act/vada2019302/. *See also Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020); *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020).

183 James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020).

184 Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020).

185 Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020).

186 42 C.F.R. §§ 418.3, .20 (2020).

terminally ill, focuses on comfort (palliative care) rather than curing illness. Because there are over 4000 hospices used by more one million patients each year, this six-month terminal illness requirement is familiar and salient.[187]

But the six-month requirement has been a big limit on MAID access.[188] Among other things, it wrongly assumes that life expectancy can always be accurately predicted.[189] The arbitrary time scale has meant that patients with cancer are the primary users of MAID. While cancer deaths comprise just 20% of total deaths, cancer accounts for 80% of MAID. Canadian studies have found that an even more flexible standard substantially limits access.[190]

In response, current MAID states have sought to amend their statutes to relax the temporal limit.[191] For example, Oregon has considered bills to extend the terminal illness requirement from six months to ***twelve months***.[192] Bills in other states go even further, eliminating the temporal requirement altogether. For example, a New Mexico bill defines terminal illness as a "disease or condition that . . . will result in death ***within a reasonable time***."[193] Such a standard has proven workable in Canada for years.[194]

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187 *National Center for Health Statistics*: *Hospice Care,* CDC, https://www.cdc.gov/nchs/fastats/hospice-care.htm (last visited Sept. 15, 2020).

188 Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 120 (2020); Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020).

189 *See* All-Party Parliamentary Grp. for Terminal Illness, Six Months to Live?: Report of the All-Party Parliamentary Group for Terminal Illness Inquiry into the Legal Definition of Terminal Illness (2019), https://www.mariecurie.org.uk/globalassets/media/documents/policy/appg/all-party-parliamentary-group-for-terminal-illness-report-2019.pdf.

190 Truchon v. Procureur Général du Canada, 2019 QCCS 3792, https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html [hereinafter Truchon].

191 H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915162544 (commissioning a study on barriers to access).

192 H.B. 2232, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2232/Introduced [hereinafter Or. H.B. 2232].

193 H.B. 171 § 2(F), 53rd Leg., 1st Sess. (N.M. 2017) (emphasis added).

194 *Truchon*, *supra* note 190. Even though this is a comparatively flexible standard compared to the U.S. terminal illness requirement, the Quebec court held it unconstitutional, since it is more restrictive than the Supreme Court of Canada judgment that declared a right to MAID.

Other Future Variations

Variability along other dimensions is not as likely as variability in terms of scope of practice and terminal illness. However, there are ongoing academic and policy debates concerning whether MAID should be available: (1) to mature minors,[195] (2) through advance requests,[196] and (3) through third party administration.[197]

CONCLUSION

Medical aid in dying is a legal end-of-life option for one in four Americans. It is, however, one of the most heavily regulated health care services. The scope and manner of that regulation already varies materially across the eleven U.S. MAID jurisdictions. As more states enact MAID statutes and as current states amend their existing statutes, variability is likely to increase. Innovation and non-conformity are positive developments. States considering reform are now less likely to blindly copy and paste older statutes and more likely to engage in "critical review."[198]

In 1997, the U.S. Supreme Court observed: "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[199] More than two decades later, the debate is continuing. Innovation is continuing in the "laboratory of the states."[200] Over the next five years, we will see more states legalize MAID.[201] We will also see more differences among MAID states as some move to recalibrate the balance between access and safety.

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195 Council of Canadian Acads., The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors (2018), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf .

196 S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017), https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB893/Introduced [hereinafter Or. S.B. 893]; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf. *See also* Council of Canadian Acads., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID (2018), https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf. *Cf.* Nicholas Goldberg, *California's Aid in Dying Law is Working: Let's Expand It to Alzheimer's Patients*, LA Times (July 15, 2020); Elie Isenberg-Grzeda et al., *Legal Assistance in Dying for People with Brain Tumors,* Annals Palliative Med. 1, 4 (2020), http://apm.amegroups.com/article/view/48382/pdf ("Patients with neurologic disease . . . sought MAID earlier in their illness trajectory than if the law allowed for an advanced directive to choose MAID.").

197 *See, e.g.,* Or. S.B. 893 (2017) (allowing request by agent); Or. H.B. 2232 (2019) (changing definition of "self-administration").

198 Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020); Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 185, 217 (2020). *Cf.* Ed Longlois, *Efforts to Expand Assisted Suicide Underway,* Catholic Sentinel (Oct. 9, 2020).

199 Wash. v. Glucksberg, 521 U.S. 702, 735 (1997).

200 *Id.* at 737 (O'Connor, J., concurring).

201 These states will probably include Maryland, Massachusetts, New Mexico, and New York.

SUMMARY OF VARIATIONS AMONG MAID LAWS									
	CA	CO	DC	HI	ME	NJ	OR	VT	WA
Indicia of residency	4	4	16	4	9	4	4	4	3
Minimum capacity assessments	2	2	2	3	2	2	2	2	2
Minimum total waiting period (days)	15	15	15	20	15	15	0	17	15
Route of administration	GI	Any	GI	GI	Any	Any	GI	Any	GI
Conscience based objection by clinicians	B	B	B	B	B	B	B	N	B
Conscience based objection by institutions	B	XB	B	B	B	B	B	B	B
Death certificate	TI	TI	TI	TI	MAID	TI	TI	TI	TI
Data collection & reporting	B	N	N	M	TBD	TBD	B	N	B
Sunset clause	Yes	No	No	No	No	No	No	No	No

B (broad), GI (gastrointestinal), M (medium), N (narrow), X (extra)

Author Profile

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Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures

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LEGAL HISTORY OF MEDICAL AID IN DYING: PHYSICIAN ASSISTED DEATH IN U.S. COURTS AND LEGISLATURES

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I. INTRODUCTION

Terminally ill patients in the United States have four medical options for controlling the time and manner of their death.[1] Three of these are legally available to certain clinically qualified patients. First, all patients may withhold or withdraw life-sustaining treatment. Second, all patients may voluntarily stop eating and drinking. Third, patients with intractable suffering may receive palliative sedation to unconsciousness.[2] In contrast, the fourth option is available in only seven U.S. jurisdictions.[3] Only there may patients legally obtain a prescription for a lethal medication that they can later self-ingest.

Medical aid in dying (MAID) is not yet legally available in 49 of 56 U.S. jurisdictions.[4] But its legal status has been in a state of rapid change across the country over the past ten years.[5] Before 2008, MAID was legal only in Oregon. Today, it is explicitly lawful in seven U.S. jurisdictions. Moreover, the rate and pace of legalization has been accelerating. Three of the now seven MAID jurisdictions enacted their statutes within only the past two years.[6] Moreover, there are widespread and ongoing legislative and judicial efforts to legalize MAID in more than thirty other states.[7]

I have designed this Article to help inform and guide these expanding law reform efforts. Because a "page of history is worth a volume of logic,"[8] it summarizes earlier efforts (both successful and unsuccessful) to legalize MAID in the United States.[9] In other words, this Article provides a descriptive legal history. It does not normatively assess either whether any efforts to legalize MAID were good public policy. Nor does it assess whether advocates grounded their arguments on

1. There are also non-medical options of hastening death. *See generally, e.g.*, PHILIP NITSCHKE & FIONA STEWART, PEACEFUL PILL HANDBOOK (Exit International, 2017); Michael Majchrowicz, *The Volunteers Who Help People End Their Own Lives,* THE ATLANTIC (July 6, 2016), https://www.theatlantic.com/health/archive/2016/07/the-volunteers-who-help-people-end-their-own-lives/489602.

2. *See, e.g.*, Thaddeus M. Pope & Lindsey Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 WIDENER L. REV. 363 (2011).

3. *See infra* Sections IV.C, IV.D, and VII.A.

4. MAID is legal in California, Colorado, District of Columbia, Montana, Oregon, Vermont, and Washington. *See infra* Sections IV and VII.A.

5. Other writers have described the same exit option with other terms. These terms include "physician assisted suicide," "physician assisted death," "death with dignity," "aid in dying," and "physician aid in dying." I use "MAID," because that term seems to have the most currency in the primary literature. *See, e.g., Compassion & Choices, Understanding Medical Aid in Dying,* https://www.compassionandchoices.org/understanding-medical-aid-in-dying *(last visited Jan. 31, 2017).*

6. California legalized MAID in October 2015. Colorado legalized MAID in November 2016. Washington DC legalized MAID in 2017. *See infra* Sections IV.B and IV.C.

7. *See infra* Section IV.E.

8. New York Trust Co. v. Eisner, 256 U.S. 345, 349 (1921) (Holmes, J.).

9. *Cf.* Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84 (2016) (discussing exploratory approach in addressing relevant legal pathways).

solid legal analysis. Instead, this Article offers an objective, systematic, and thorough account of what those efforts were.[10]

In Section One, I describe MAID. We must first understand what MAID is before examining attempts to legalize it. Once we grasp the nature of MAID, it starts to become clear why law reformers have concluded that they must affirmatively legalize it. In Section Two, I explain that MAID falls within the prohibitory scope of criminal assisted suicide statutes in almost every state. In other words, MAID is "assisted suicide." Assisted suicide is a crime. Therefore, MAID is a crime. Moreover, in addition to its actual legal status, MAID is widely perceived to be illegal.[11] Therefore, both patients who want to access MAID and physicians who want to provide MAID have strong incentives to change (or at least clarify) its legal status.

In the remainder of the Article, I examine five different paths that reformers have taken to legalize MAID. In Section Three, I start with the most successful approach, statutory enactment. Six states have enacted MAID statutes: three through ballot initiatives and three through legislation. I discuss these six states. I also briefly discuss a few more states that have come close to enacting MAID statutes. Furthermore, more than one-half of the remaining states have recently considered legislation. They are likely to continue this deliberation and debate throughout the 2020s.

In Section Four, I examine attempts to legalize MAID through federal constitutional litigation. Because the U.S. Supreme Court definitively rejected such arguments in 1997, advocates have since refocused their litigation arguments using state law theories. In Section Five, I review cases seeking to legalize MAID through state constitutional litigation. Unfortunately, like federal constitutional claims, state constitutional claims have also been uniformly unsuccessful.

In Section Six, I discuss attempts to legalize MAID through state statutory interpretation litigation. These lawsuits argue that MAID does not even constitute "assisted suicide" in existing criminal statutes. Finally, in Section Seven, I examine two final paths toward "legalizing" MAID: constraining prosecutorial discretion and jury nullification. Unlike other approaches, these do not change the legal status of MAID. Yet, they do change whether prosecutors will or can penalize patient or physician participants.

In sum, the expanded legalization of MAID seems inevitable. Surveys consistently show that more than 70 percent of the American public supports

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10. This Article focuses on only affirmative efforts to legalize MAID. It does not address state efforts to criminalize MAID. *See, e.g.*, SB 202, 64th Leg., Reg. Sess. (Mont. 2015); SB 220, 63d Leg. Reg. Sess. (Mont. (2013); S.B. 167, 62d Leg., Reg. Sess. (Mont. 2011). Nor does it address federal efforts to challenge the legitimacy of state MAID statutes. *See, e.g.*, Assisted Suicide Funding Restriction Act, 42 U.S.C. § 14401 (2012): Gonzales v. Oregon, 546 U.S. 243 (2006); Assisted Suicide Prevention Act, S. 3788, 109th Cong. (2006); Pain Relief Promotion Act, H.R. 2260 & S. 1272, 106th Cong. (1999); Lethal Drug Abuse Prevention Act, H.R. 4006 & S. 2151 105th Cong. (1998).

11. *But cf.* Kathyrn L. Tucker, *Aid in Dying: An End-of-Life Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9 (2012); Scott Foster, *Expert Panel Concurs: Hawaii Physicians Can Provide Aid in Dying*, HAWAII REPORTER (Oct. 5, 2011), http://www.hawaiireporter.com/expert-panel-concurs-hawaii-physicians-can-provide-aid-in-dying.

MAID.[12] But the battle will be fought bill-by-bill and lawsuit-by-lawsuit in each state. I hope to inform these efforts with lessons from the legal history of MAID described below.

II. WHAT IS MEDICAL AID IN DYING?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[13] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death. For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[14]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[15] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely. Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer time.[16]

Certainly, life is valuable; and societal values reinforce attempting to extend life indefinitely. But death is unavoidable. People suffering from the diseases that cause most deaths in this country will often experience significant suffering and loss

12. *Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults*, COMPASSION & CHOICES, https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Survey-Results-FINAL-7.21.16-Approved-for-Public-Distribution.pdf (last visited Feb. 23, 2017).

13. *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death,* HEMATOLOGY 475, 457 (2008) ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying,* 169 ARCHIVES INTERNAL MED. 489, 489 (2009) ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study,* 31 J. PAIN & SYMPTOM MGMT. 100, 104 (2006); J. McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. MED. ETHICS 454, 456 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States,* 338 NEW ENG. J. MED. 1193, 1195 (1998).

14. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

15. Peter M. Marzuk, *Suicide and Terminal Illness,* 18 DEATH STUDIES 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. CLINICAL ONCOLOGY 4720, 4722 (2008).

16. *See* STANLEY A. TERMAN, THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 326–27 (2007).

of independence.[17] In this situation, the preference, for some, may be to hasten death so that death can be on an individual's terms and with some predictability, rather than risking the unknown and potential loss of comfort and dignity.

MAID is one key "exit option."[18] With MAID, a physician writes a prescription for life-ending medication for a terminally ill and mentally capacitated adult.[19] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient. All six statutes have nearly identical conditions and safeguards.[20] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to self-ingest the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[21]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that the patient's judgement is impaired, then they must refer the patient for a mental health assessment.[22]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[23] However, price increases have led physicians to prescribe other drugs including compounded ones.[24] Importantly, the patient must ingest the drugs herself.[25] The patient alone takes the final overt act that cases her death.

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17. Judith K. Schwarz, *Stopping Eating and Drinking*, AM. J. NURSING, Sept. 2009, at 53, 54.

18. *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, in* GIVING DEATH A HELPING HAND: PHYSICIAN-ASSISTED SUICIDE AND PUBLIC POLICY: AN INTERNATIONAL PERSPECTIVE 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

19. David Orentlicher, Thaddeus M. Pope & Ben A. Rich, *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

20. Thaddeus M. Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, THE ASCO POST (Dec. 25, 2017), http://www.ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/; National Academies of Science, Engineering, and Medicine, *Physician Assisted Death: Current Landscape: Implementation and Practice*, YOUTUBE (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM (presentation by Thaddeus M. Pope). While Montana has no statute, the conditions and safeguards are similar.

21. ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 12.04[C] (3d ed. 2017 Supp.) [hereinafter THE RIGHT TO DIE].

22. *Id.*

23. April Dembosky, *Drug Company Jacks Up Cost Of Aid-In-Dying Medication*, NPR (Mar. 23, 2016), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

24. Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, THE SCIENTIST (Aug. 17, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

25. Amanda M. Thyden: *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 CHAPMAN L. REV. 421, 421 (2017).

III. MOST STATES CRIMINALLY PROHIBIT ASSISTED SUICIDE, AND THEREFORE MAID

Almost every U.S. jurisdiction criminally prohibits assisting another person to commit suicide.[26] Moreover, as the Supreme Court has observed, these assisted suicide prohibitions are deeply rooted in our nation's legal history.[27] In fact, those roots date back 150 years. As early as 1868, most states held that assisting suicide was a criminal offense. The criminal status of assisted suicide has persisted ever since. Nearly one hundred years later, the American Law Institute included the crime in its 1962 Modern Penal Code, the seminal work on substantive criminal law.[28] Most recently, many states have reexamined and reaffirmed their bans on assisted suicide.[29]

Assisted suicide statutes typically include plain yet broad language. For example, the New Mexico statute provides: "Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth-degree felony."[30] Similarly, the California Penal Code states: "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."[31] Penalties for violation include felony probation, up to three years in state prison, and/or a fine up to $10,000.[32]

In addition, for physicians, assisted suicide also constitutes "unprofessional conduct" that may result in state medical board discipline up to and including

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26. ALASKA STAT. § 11.41.120 (2006); ARIZ. REV. STAT. ANN. § 13-1103 (2014); ARK. CODE ANN. § 5-10-104 (2007); CAL. PENAL CODE § 401 (1995); COLO. REV. STAT. § 18-3-104 (2012); CONN. GEN. STAT. § 53a-56 (1971); DEL. CODE ANN., tit. 11, § 645 (1995); FLA. STAT. ANN. § 782.08 (1971); GA. CODE ANN. § 16-5-5 (2015); HAWAII REV. STAT. § 707-702 (2006); IDAHO CODE § 18-4017 (2011); 720 III. COMP. STAT. ANN., § 5/12-34.5 (2012); IND. CODE ANN. § 35-42-1-2.5 (2014); IOWA CODE ANN. § 707A.2 (1996); KAN. STAT. ANN. § 21-3406 (2011); KY. REV. STAT. ANN. § 216.302 (1994); LA. STAT. ANN. § 14:32.12 (1995); MD. CODE, CRIM. LAW, § 3-102 (2002); ME. REV. STAT. ANN. tit. 17-A, § 204 (1977); MICH. COMP. LAWS ANN. § 750.329A (1998); MINN. STAT. ANN. § 609.215 (1998); MISS. CODE ANN. § 97-3-49 (2013); MO. ANN. STAT. § 565.021(2017); MONT. CODE ANN. § 45-5-105 (1981); NEB. REV. STAT. § 28-307 (1977); N.H. REV. STAT. ANN. § 630:4 (1973); N.J. STAT. ANN. § 2C:11-6 (1979); N.M. STAT. ANN. § 30-2-4 (1963); N.Y. PENAL LAW § 120.30 (1965); N.D. CENT. CODE § 12.1-16-04 (1991); OHIO REV. CODE § 3795.02 (2003); OKLA. STAT. ANN., tit. 21, § 813 (1910); OR. REV. STAT. § 163.125 (1999); 18 PA. CONSOL. STAT. ANN. § 2505 (1973); P.R. LAWS ANN., tit. 33, § 4738 (2005); R.I. GEN. LAWS § 11-60-3 (1996); S.C. CODE ANN. § 16-3-1090 (1998); S.D. CODIFIED LAWS § 22-16-37 (2005); TENN. CODE ANN. § 39-13-216 (1993); TEX. PENAL CODE ANN. § 22.08 (1994); VA. CODE § 8.01-622.1 (2015); V.I. CODE, tit 14, § 2141 (1993); WASH. REV. CODE ANN. § 9A.36.060 (2011); WIS. STAT. ANN. § 940.12 (2001). Statutes in other states imply criminal prohibition of assisted suicide. *See, e.g.*, ALA. CODE § 22-8A-10 (1997); D.C. CODE § 7-651.13 (2016); NEV. REV. STAT. § 449.670 (1995); W. VA. CODE § 16-30-15 (2000); WYO. STAT. § 6-2-107 (1985).

27. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring).

28. MODEL PENAL CODE § 210.5 (AM. LAW INST., Proposed Official Draft 1962).

29. Washington v. Glucksberg, 521 U.S. 702, 716 (1997) ("Though deeply rooted, the States' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed.").

30. N.M. STAT. ANN. § 30-2-4.

31. CAL. PENAL CODE § 401.

32. CAL. PENAL CODE § 18(a) (2011); CAL. PENAL CODE § 672 (1983).

revocation of the license.[33] For example, in Minnesota "aiding suicide or aiding attempted suicide" is "prohibited and is grounds for disciplinary action" even without a criminal conviction, guilty plea, or other judgment under the assisted suicide statute.[34]

While most states have only a "general" assisted suicide statute, six states have enacted statutes that target MAID specifically. Alabama, Arkansas, Georgia, Idaho, Ohio, and Rhode Island do not just outlaw assisted suicide. They expressly outlaw MAID specifically.[35] For example, Arkansas provides that "it is unlawful for any physician or health care provider to commit the offense of physician-assisted suicide by . . . prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient's life."[36]

Specifically targeting MAID in a penal statute eliminates any residual uncertainty. It sends a clear, strong message to both patients and clinicians. Yet, this degree of precision is probably unnecessary. Even broad, general assisted suicide statutes probably also cover MAID.[37] First, courts have specifically held that criminal assisted suicide statutes cover MAID.[38] Second, almost all legislative and litigation efforts to legalize MAID have assumed that MAID is illegal. Moreover, advocates imply (though certainly do not concede) MAID's illegality by their efforts to legalize it affirmatively. If the penal code does not now prohibit MAID, then why do we need legislation to permit it?

Notably, during the 1980s and 1990s, clinicians were concerned that even long-accepted treatment decisions like Do-Not-Resuscitate (DNR) orders and withholding or withdrawing life-sustaining treatment might fall within the scope of assisted suicide prohibitions.[39] This fear of criminal liability is logical. "[W]hen life-sustaining treatment is withheld or withdrawn, the patient's death results from the acts or omissions of those who have withheld or withdrawn treatment and those who have authorized this conduct."[40] The Washington Supreme Court summed up the reasoning this way:

Under Washington's criminal code, homicide is "the killing of a human being by the act, procurement or omission of another" and it is murder in the first degree when, "with a premeditated intent to cause the death of another person, [one] causes the death of such person." Thus, the potential for criminal liability for withdrawing life-sustaining mechanisms appears to exist.[41]

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33. THE RIGHT TO DIE, *supra* note 21, § 12.04[C]; *see, e.g.*, VA. CODE ANN. § 8.01-622.1(D) (2015); *In re* Egbert, No. 2011-0870 (Md. State Bd. Physicians Dec. 12, 2014) (revoking physician license for assisted suicide).

34. MINN. STAT. § 147.091(1)(w) (2017).

35. Assisted Suicide Ban Act, Ala. H.B. 96 (2017); ARK. CODE ANN. § 5-10-106(b) (2007); GA. CODE ANN. § 16-5-5(b) (2015); IDAHO CODE § 18-4017(1) (2011); N.D. CENT. CODE ANN. § 12.1-16-04(1) (1991); OHIO REV. CODE § 3795.04 (2003); 11 R.I. GEN. LAWS § 11-60-3 (1996).

36. ARK. CODE ANN. § 5-10-106(b)(1) (2007).

37. In addition, many states have enacted civil legislation that provides for the issuance of an injunction, an award of damages, and attorneys' fees. THE RIGHT TO DIE, *supra* note 21, § 12.04[B].

38. *See infra* Part VII.

39. *Cf.* Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *In re* Farrell, 529 A.2d 404, 411 (N.J. 1987); *In re* Requena, 517 A.2d 886, 887 (N.J. Super. Ct. Ch. Div. 1986).

40. THE RIGHT TO DIE, *supra* note 21, § 12.01.

41. *In re* Colyer, 660 P.2d 738, 751 (Wash. 1983) (en banc) (internal citations omitted).

To eliminate uncertainty or fear of criminal liability, many state legislatures amended their healthcare decision-making acts to exclude such acts.[42] For example, the Virginia Code provides: "This section shall not apply to a . . . health care [professional] who . . . withholds or withdraws life-prolonging procedures."[43]

MAID statutes are designed to offer this same type of clear exemption. For example, a 2017 New Mexico bill redefined "assisted suicide" to exclude "an attending health care provider who provides medical aid in dying, in accordance with the provisions of the End of Life Options Act, to an adult patient who has capacity and who has a terminal illness."[44]

IV. LEGALIZING MAID THROUGH STATUTE

Before 1990, there were few serious efforts to legalize MAID.[45] After all, policymakers were focusing their attention on other end-of-life medical decision-making issues. Specifically, during the 1970s and 1980s, courts and legislatures across the country were still struggling with defining a right to die. They were articulating a right to refuse 1960s medical technology such as CPR, mechanical ventilation, and dialysis. By 1990, the patient's "right to die" through passive refusal was substantially settled.[46] Therefore, policymakers turned their attention to active means of hastening death like MAID.

Since the early 1990s, the most successful strategy for legalizing MAID has been through enacting a statute. Six states have enacted nearly identical statutes. These statutes have two types of distinctive features. First, they specify detailed procedures for accessing life-ending medication. Second, they offer civil, criminal, and disciplinary immunity for compliance.

Three key events accelerated the public policy discussion of MAID by drawing massive academic and community attention to the issue. First, in January 1988, the Journal of the American Medical Association published a provocative op-ed. In *It's Over, Debbie*, the anonymous physician author described administering a lethal dose of morphine to a terminally ill patient.[47] The article stimulated "substantial reaction from the medical profession, the public, the media, and legal authorities."[48]

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42. THE RIGHT TO DIE, *supra* note 21, § 12.02[C][5].

43. VA. CODE ANN. § 8.01-622.1(E) (2015); *see also* N.M. STAT. ANN. § 24-7A-13(B)(1) (1997) ("Death resulting from the withholding or withdrawal of health care in accordance with the Uniform Health-Care Decisions Act does not for any purpose . . . constitute a suicide, a homicide or other crime.").

44. H.B. 171, 53d Leg., 1st Sess., § 10 (N.M. 2017).

45. *But cf. DEATH WITH DIGNITY An Inquiry into Related Public Issues: Hearing Before the Special Committee on Aging*: *Hearings Before the Special Committee on Aging*, 92d Cong. 2d Sess. (1972).

46. The Supreme Court issued its decision in *Cruzan decided on June 25, 1990. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).*

47. *Name Withheld by Request, It's Over, Debbie,* 259(2) JAMA 272, 272 (1988).

48. George D. Lundberg, *'It's Over, Debbie' and the Euthanasia Debate*, 259(14) JAMA 2142, 2142 (1988).

Second, in June 1990, Jack Kevorkian received enormous media attention when he helped Janet Adkins commit suicide.[49] Over the following three and a half years, Kevorkian was present at the deaths of 20 other individuals.[50] Michigan state attorneys prosecuted him (unsuccessfully) four times.[51] Through these and other newsworthy events, Kevorkian received "international attention" and "provoked a national discussion."[52] MAID pervaded the public consciousness.

Third, in 1991, Derek Humphry published Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. This how-to guide for terminally ill people who wish to kill themselves remained on the New York Times bestseller list for 18 weeks.[53] In short, both through high-profile publications and through high profile, colorful advocates, the issue of MAID was placed squarely on the public policy table by the early 1990s.

A. Very Early Efforts in the 1900s

Long before and wholly unconnected with contemporary efforts to legalize MAID were several bills in the early 20th century.[54] In 1906, the Ohio legislature considered a bill titled "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons."[55] The bill applied to "any person of lawful age and of sound mind" who is "so ill of disease that recovery is impossible or who is suffering great pain or torture."[56] If "three reputable physicians" concurred with the patient's request to "be put to death," then clinicians could administer an anesthetic until death ensures.[57]

That same year, Iowa considered a similar bill titled "A Bill for An Act Requiring Physician to Take Human Life."[58] In 1937, Nebraska considered an even

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49. *See, e.g.*, Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES (June 6, 1990), http://www.nytimes.com/1990/06/06/us/doctor-tells-of-first-death-using-his-suicide-device.html.

50. Silvia Sara Canetto & Janet D. Hollenshead, *Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990–1997*, 40(1) OMEGA - J. DEATH & DYING 165, 170–71 (2000).

51. Charles H. Baron, *Assisted Dying: As the Population Ages, Assisted Suicide—With the Help of a Physician or Loved One—Will Continue to be Controversial*, 35-JUL TRIAL 44, 50 (1999). Kevorkian was eventually convicted for active euthanasia, not MAID. *See infra* Section VIII.

52. *Jack Kevorkian: How He Made Controversial History*, BBC NEWS (June 3, 2011), http://www.bbc.com/news/world-us-canada-13649381.

53. MICHAEL R. LEMING & GEORGE E. DICKINSON, UNDERSTANDING DYING, DEATH, AND BEREAVEMENT 273 (Wadsworth Cengage Learning, 7th ed.).

54. These bills extended an earlier debate about the ethics of euthanasia. The most notable contribution to that debate was Samuel Williams' widely printed proposal in 1870. *See* Ezekiel J. Emanuel, *Whose Right to Die?*, THE ATLANTIC (Mar. 1997); *see also* Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121(10) ANNALS INTERNAL MED. 793, 794 (1994).

55. *See* GIZA LOPES, DYING WITH DIGNITY: A LEGAL APPROACH TO ASSISTED DEATH 20 (2015) (citing H.B. 145 (Ohio 1906)); *Euthanasia*, 8 ST. LOUIS MED. REV. 66, 66 (1906).

56. *See id.*

57. Jacob M. Appel, *A Duty to Kill? A Duty to Die? Rethinking the Euthanasia Controversy of 1906*, 78(3) BULLETIN HIST. MED. 610, 618 (2004).

58. *See* LOPES, *supra* note 55, at 21 (citing H.F. 367 (Iowa 1906)); *see also* DEMETRA M. PAPPAS, THE EUTHANASIA/ASSISTED-SUICIDE DEBATE 444 (2012).

broader MAID bill.[59] All three of these Midwestern state bills were soundly defeated. MAID legislation then entered a nearly fifty-year dormancy. Expectedly, interest in this type of legislation waned after World War II.[60] Euthanasia had become too closely associated with Nazi eugenics and involuntary killing.

B. Early Efforts in the 1980s and 1990s

Interest in MAID reemerged in the late 1980s and early 1990s as a logical extension of the then newly established right to refuse life-sustaining treatment. Initially, efforts to enact MAID statutes focused on the ballot initiative process. Available in half the states, this process allows a public vote on a proposed statute based on a petition signed by a certain minimum number of registered voters.[61] Between 1988 and 1994, advocates proposed MAID ballot initiatives in California, Washington, and Michigan.[62]

In 1988, California organizers did not get enough signatures to place the "Humane and Dignified Death Act" on the ballot.[63] Apparently, the inclusion of both euthanasia and MAID dissuaded voters. Therefore, organizers later removed "mercy killing" from the ballot language and required the patient to take the final overt at causing death. They obtained enough signatures, and placed Proposition 161 on the 1992 ballot. Still, the initiative was defeated 54% to 46 percent.[64] In 1991, Washington placed Initiative 119 on the ballot. Like the California initiative, it was also defeated 54 to 46 percent.[65]

In January 1994, Jack Kevorkian launched a petition drive to place MAID on the November ballot in Michigan. Kevorkian's petition offered an amendment to the state constitution that read: "The right of competent adults, who are incapacitated by incurable medical conditions, to voluntarily request and receive medical assistance with respect to whether or not their lives continue, shall not be restrained or abridged."[66] Like the 1988 California ballot initiative that similarly included both MAID and euthanasia, Kevorkian's effort did not obtain enough signatures.[67]

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59. *See* IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD, AND MEDICINE 85 (2005); LOPES, *supra* note 55, at 48 n.14 (2015).

60. *But cf.* Morton L. Yanow, Letter to the Editor, *Continue the Debate* N.Y. TIMES (July 25, 1997), http://www.nytimes.com/1997/07/27/opinion/l-continue-the-debate-335681.html (noting the Connecticut Act to Legalize Euthanasia in 1959, the Idaho Voluntary Euthanasia Act in 1969 and the Oregon Voluntary Euthanasia Act and the Montana Euthanasia Act in 1973). *See also* JOEL FEINBERG, HARM TO SELF 367 (1986).

61. *Initiative Process 101,* NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/research/elections-and-campaigns/initiative-process-101.aspx (last visited Jan. 25, 2018).

62. *See infra* notes 64–68 and accompanying text.

63. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 138 (2016).

64. *The California Propositions in Brief*, LONG BEACH PRESS- TELEGRAM, Nov. 5, 1992, 1992 WLNR 1033302.

65. *See* Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at A10.

66. *Kevorkian Begins Ballot Drive for Suicide Measure*, N.Y. TIMES, Jan. 31, 1994, http://www.nytimes.com/1994/01/31/us/kevorkian-begins-ballot-drive-for-suicide-measure.html.

67. *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, http://www.nytimes.com/1994/07/06/us/kevorkian-s-ballot-drive-on-suicide-aid-stumbles.html.

C. Three Successful Ballot Initiatives

The earliest ballot initiative efforts in California, Washington, and Michigan failed. Yet, three other ballot initiatives successfully passed. Oregon, Washington, and Colorado all legalized MAID through the ballot initiative process. Furthermore, other states have come very close, and more states are still trying to emulate Oregon, Washington, and Colorado.

1. Oregon 1994 Ballot Initiative

Building off the earlier experience in California and Washington, Oregon placed a ballot measure in the November 1994 election. In contrast to the earlier ballot initiatives, the citizens of Oregon approved Measure 16 by a vote of 51 to 49 percent.[68] Two factors leading to success included avoiding the term "mercy killing" and reframing the legislation as the "Death with Dignity Act."[69]

Before the Death with Dignity Act became effective, litigation delayed its implementation for three years.[70] Nevertheless, the delay did not dampen enthusiasm. In November 1997, the margin of approval grew even wider when Oregon citizens rejected a ballot measure to repeal the law 60 to 40 percent.[71] Subsequently, while the Oregon Death with Dignity Act was the subject of several (ultimately unsuccessful) federal challenges for years, it has remained in effect since 1998.[72] Notably, once those federal challenges stopped in 2006, remaining "clouds" of legal uncertainty lifted. Other states began more seriously to consider copying the Oregon model.

The Oregon Death with Dignity Act is so carefully crafted, so narrowly drawn, and so laden with procedural safeguards, that it may well demand more energy and fortitude to comply with it than some terminally ill people are likely to have.[73] To qualify for "death with dignity," a person must be a resident of the state,[74] over age 18,[75] "capable"[76] (that is, in possession of decision-making capacity),[77] and suffering from a terminal disease that will lead to death within six months.[78]

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68. DEPARTMENT OF HUMAN RESOURCES, OREGON HEALTH DIVISION, CENTER FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (Feb. 18, 1999).

69. Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1594 (2008).

70. Lee v. Oregon, 869 F. Supp. 1491 (D. Or. Dec. 27, 1994) (issuing preliminary injunction), 891 F. Supp. 1429 (D. Or. Aug. 3, 1995) (issuing permanent injunction), *vacated and remanded*, 107 F.3d 1382 (9th Cir. Feb. 17, 1997) (lack of federal jurisdiction), *cert. denied sub nom.* Lee v. Harcleroad, 522 U.S. 927 (Oct. 14, 1997).

71. William Claiborne & Thomas B. Edsall, *Oregon Suicide Law May Spur Movement*, WASH. POST, Nov. 6, 1999, http://www.washingtonpost.com/wp-srv/politics/daily/nov99/suicide6.htm.

72. THE RIGHT TO DIE, *supra* note 21, § 12.06[A][1] (citing federal cases).

73. *See* OR. REV. STAT. §§ 127.800 to .897 (1995). *See also* OR. ADMIN. R. 333-009-0000 to -0030 (2001).

74. OR. REV. STAT. §§ 127.805, .860.

75. *Id.* §§ 127.800, .805.

76. *Id.* § 127.805.

77. *Id*. § 127.800.

78. *Id.* § 127.805, .800.

The patient must make one written[79] and two oral requests[80] for medication to end his life. The written request must be "substantially in the form" provided in the Act, signed, dated, witnessed by two persons, in the presence of the patient, who attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request."[81] There are stringent qualifications as to who may act as a witness.[82]

The patient's decision must be an "informed" one.[83] Therefore, the attending physician is obligated to provide the patient with information about the diagnosis, prognosis, potential risks and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control."[84] Another physician must confirm the diagnosis, the patient's decision-making capacity, and voluntariness of the patient's decision.[85] There are requirements for counseling, if either the attending or consulting physician thinks the patient is further suffering from a mental disorder.[86] There are requirements for documentation in the patient's medical record,[87] for a waiting period,[88] for notification of the patient's next of kin,[89] and for reporting to state authorities.[90] The patient has a right to rescind the request for medication to end his life at any time.[91]

Having complied with these requirements, the patient is entitled only to a prescription for medication. The Act does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."[92] In other words, the statute accepts MAID but rejects what the law calls active euthanasia.

The Oregon legislature amended the Death with Dignity Act in 1999.[93] The definitional sections clarified that an "adult" is a person 18 years of age or older[94] and that pharmacists fall within the definition of "health care provider."[95] The amendments expanded and clarified the responsibilities of attending physicians. One important added responsibility is to counsel patients "about the importance of having another person present when the patient takes the medication . . . and of not taking the medication in a public place. . . ."[96] Some pharmacists have wished to refrain

79. *Id.* § 127.805, .840.
80. *Id.* § 127.840, .897.
81. *Id.* §127.810.
82. *Id.*
83. *Id.* § 127.815, .830.
84. *Id.* § 127.815.
85. *Id.* § 127.820.
86. *Id.* § 127.825.
87. *Id.* § 127.855.
88. *Id.* § 127.850.
89. *Id.* § 127.835.
90. *Id.* § 127.865.
91. *Id.* § 127.845.
92. *Id.* § 127.880.
93. 1999 Or. Laws 1098.
94. OR. REV. STAT. §127.800(1).
95. *Id.* §127.800(6).
96. *Id.* §127.815.

from dispensing lethal prescriptions.[97] In recognition of this, the legislation included a provision in the Act expressly authorizing physicians to dispense the lethal medications rather than having pharmacists do so.[98]

To address the concerns that have been raised that people will be motivated by depression to seek a physician's assistance in ending their lives, the 1999 amendments to the Act added "depression causing impaired judgment" to the generic "psychiatric or psychological disorder" that the attending physician must determine the patient does not have before medications may be prescribed.[99]

A concern about the original statute was that although its provisions were limited to Oregon residents, there was no definition of "residence." Thus, the 1999 amendments specified factors demonstrating Oregon residence.[100] The amendments also added an important new reporting requirement: any health care provider who dispenses medication under the statute must file a copy of the dispensing record with the state health division.[101]

Finally, the 1999 amendments included several provisions expanding immunities. The Act now permits a health care provider to prohibit another health care provider from participating in "death with dignity" on the premises of the first health care provider if they gave prior notice of such prohibition.[102] This is probably the most far-reaching aspect of the amended legislation.

If a health care provider violates this prohibition, the provider issuing the prohibition may impose sanctions including loss of medical staff privileges, termination of a lease or other property contract, and termination of employment contract.[103] However, even if prohibited from doing so under one of the preceding provisions, a health care provider may provide assistance under the statute if he does so outside the course of employment.[104]

The Death with Dignity Act requires the state health division to issue an annual report summarizing the experience with the statute.[105] The statistics summarized in these reports do not seem to bear out the fears of the opponents of "death with dignity." Individuals availing themselves of this statute were insured, were disproportionately white rather than racial minorities, were better educated than the general population, and were not disproportionately female.[106] Individuals who requested lethal prescriptions were concerned with loss of autonomy, their

97. *See* Jennifer Fass & Andrea Fass, *Physician-assisted Suicide: Ongoing Challenges for Pharmacists*, 68(9) AM. J. HEALTH SYS. PHARMACISTS 846, 848 (2011).

98. *See* OR. REV. STAT. §127.815.

99. *See id.* §127.825.

100. *Id.* §127.860.

101. *See id.* §127.865; *see also* Or. Admin. R. 333-009-0000 to -0030 (2011) (regulations implementing the reporting requirements).

102. OR. REV. STAT. §127.885; *see also* 49 Or. Op. Att'y Gen. 161, No. 8264 (1999) (interpreting OR. REV. STAT. §127.885).

103. OR. REV. STAT. §127.885.

104. *Id.*

105. *See id.* §127.865(3).

106. PUB. HEALTH DIV., OREGON HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT DATA SUMMARY 2017 (Feb. 9, 2018); *see also* Barbara Coombs Lee, *Oregon's Experience with Aid in Dying: Findings from the Death with Dignity Laboratory*, ANN. N.Y. ACAD. SCI. 94, 96 (2014).

decreasing ability to participate in activities that made their lives enjoyable, and loss of bodily functions.[107]

2. Washington 2008 Ballot Initiative

Based on the thorough and virtually unblemished record from Oregon, other states have followed. The first state to copy Oregon was its northern neighbor, Washington. In November 2008, Washington State voters approved an initiative modeled closely on Oregon's law. Initiative 1000 passed by a 58 to 42 percent margin.[108] The Washington Death with Dignity Act became effective in early 2009.[109] Data from Washington State's annual published reports show operation and usage very similar to that in Oregon.[110]

3. Colorado 2016 Ballot Initiative

In 2016, Colorado voters approved an initiative modeled closely on Oregon's law by a 65 to 35 percent margin.[111] The Colorado End of Life Options Act went into effect on December 16, 2016.[112] Data from Colorado's first annual report is consistent with Oregon and Washington data.[113]

D. Three Successful Legislative Enactments

After Oregon and Washington legalized MAID through ballot initiatives in 1994 and 2008, many commentators thought that direct democracy voting was the only viable path.[114] They determined that the issue was just too controversial for the political process. It turned out that this assessment was too pessimistic. Since 2013, three states have legalized MAID through a legislative process: Vermont, California, and Washington, DC. Furthermore, several other states have come close.

1. Vermont 2013 Legislation

In 2013, Vermont joined the list of states affirmatively approving the practice of MAID, this time through legislation rather than a ballot initiative

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107. *Id.*

108. Robert Steinbrook, *Physician-Assisted Death — From Oregon to Washington State*, 359 NEW ENG. J. MED. 2513, 2513 (2008).

109. WASH. REV. CODE §§ 70.245.010 to .220, 70.245.901 to .903 (effective Mar. 5, 2009); WASH. ADMIN. CODE §§ 246-978-001 to -040 (2009). *See generally* Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA INTERNAL MED. 427 (2016).

110. *See* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE 2016 DEATH WITH DIGNITY ACT REPORT (Sept. 2017).

111. Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 8, 2016), https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results.

112. COLO. REV. STAT. §§ 25-48-101 to -123 (effective Dec. 16, 2016); 6 COLO. CODE REGS. § 1009-4 (effective June 14, 2017).

113. *See Medical Aid in Dying,* COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/cdphe/medical-aid-dying (last visited Jan. 31, 2018).

114. *But see* GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 127 (Oxford Univ. Press) (2011) (Oregon State Senator Frank Roberts introduced legislation in 1987, 1989, and 1991).

process.[115] Uniquely, as originally enacted, the Vermont MAID law would have diverged from those in California, Oregon, and Washington after July 1, 2016. As originally enacted, on that day, the section of the Vermont statute imposing stringent procedural safeguards would sunset.[116] In 2015, the Vermont legislature repealed that sunset provision.[117] Like the Oregon Death with Dignity Act, opponents attacked the Vermont law in court.[118] Those challenges have been unsuccessful.

2. California 2015 Legislation

On October 5, 2015, California became the fourth state to enact a statute allowing physicians to prescribe terminally ill patients medication to end their lives.[119] The California End of Life Option Act is virtually identical to MAID statutes in Oregon, Washington, and Vermont. [120] Still, unlike the other MAID statutes, the California law will sunset on January 1, 2026.[121] The first published report from California shows operation and usage very similar to that in Oregon and Washington.[122]

Finally, reminiscent of the post-statute litigation in Oregon and Vermont, physicians and advocacy groups filed suit to enjoin the operation of the California statute, arguing that the law was unconstitutional for a variety of reasons.[123] The court refused to enjoin operation of the law, but also refused to dismiss the case.[124]

3. Washington, DC 2017 Legislation

In 2017, the District of Columbia enacted a statute also modeled closely on Oregon's law.[125] Just as there was federal interference with the Oregon legislation, there has also been federal interference with the D.C. legislation. Given the District of Columbia's unique status in the federal system, Congress sought to exert its authority to disapprove the law. Nevertheless, the D.C. law became effective in February 2017, after Congress failed to pass a "resolution of disapproval."[126] In

115. VT. STAT. ANN. tit. 18, §§ 5281–5293 (effective May 20, 2013). *See* Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687 (2014).

116. 2013 Vt. Acts & Resolves 292, 296.

117. 2015 Vt. Acts & Resolves 296.

118. Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2017 WL 1284815 (D. Vt. Apr. 5, 2017); *see also* Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2016 WL 7015717 (D. Vt. Dec. 1. 2016).

119. *Assemb. B 15, Stats. 2015, Ch.1 (2015).*

120. *See* CAL. HEALTH & SAFETY CODE §§ 443.1 to 443.22 (effective June 9, 2016).

121. *See* CAL. HEALTH & SAFETY CODE § 443.215 (2016) ("This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.").

122. *See* CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2016 DATA REPORT (2017).

123. Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 8, 2016) (Complaint).

124. Ahn v. Kestrich, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 9, 2017) (Order denying preliminary injunction but allowing lawsuit to proceed).

125. D.C. Act 21-577 (Dec. 19, 2016).

126. H.R.J. Res. 27, 115th Cong. (2017). The law went into effect in February 2017 after Congress failed to pass resolution of disapproval within 30 legislative days after the city government passed the law.

September 2017, the House of Representatives passed a bill that would repeal the D.C. Death with Dignity Act.[127]

E. Other Notable Efforts to Enact MAID Statutes

By the end of 2017, only Oregon, Colorado, and Washington have successfully passed ballot initiatives. Yet, other states have come very close. For example, a 2012 Massachusetts ballot initiative failed on a 49 to 51 percent vote.[128] Similarly, a 2000 Maine ballot initiative also failed on a 49 to 51 percent vote.[129] A 1998 Michigan ballot initiative did not do as well, failing on a 71 to 29 percent vote.[130] Additional states are continuing to explore the ballot initiative process to legalize MAID.[131]

By the end of 2017, only California, Vermont, and Washington, DC have enacted legislation. Yet, other states have come very close. For example, in 2017, the Hawaii Senate passed a MAID bill on a vote of 22 to 3. The Hawaii House later deferred the bill.[132] Also in 2017, the Maine Senate passed a MAID bill that died in the House.[133] Likewise, in 2015 the Maine Senate passed a bill that died in the House.[134] In 2016, the New Jersey Assembly passed a MAID bill on a vote of 41 to 28. That bill even then passed a key Senate committee.[135] As in Maine, this was not the first time that legislation advanced in New Jersey. In 2014, the Assembly passed a bill by a vote of 41 to 31.[136]

Recent near successes in Hawaii and Maine are not the only reason to expect more states to legalize MAID. First, nearly half of the states considered MAID legislation in 2016 and 2017.[137] Second, proponents are introducing more and more bills in more and more states. Third, today, there is more support from the public, healthcare professionals, medical societies and medical associations.[138]

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127. H.R. 3354, 115th Cong. § 818 (2017); J. Portnoy, *House Votes to Repeal D.C.'s Death with Dignity Law; Senate Has Yet to Act,* WASH. POST, Sept. 14, 2017.

128. *See* Carolyn Johnson, *Assisted Suicide Measure Narrowly Defeated; Supporters Concede Defeat,* BOSTON GLOBE, Nov. 7, 2012.

129. Michael Moore, *Suicide Opponents Claim Win*, BANGOR DAILY NEWS (Nov. 8, 2000).

130. *1998 Michigan Election Results*, MICH. DEP'T OF ST., http://miboecfr.nictusa.com/election/results/98gen/ (last visited Mar. 12, 2018).

131. *See, e.g.*, *Voters May See Cannabis, Tobacco Tax on South Dakota Ballot,* ARGUS LEADER, Nov. 6, 2017. Some states have considered ballot initiatives not only to enact a MAID statute but also to amend the state constitution.

132. *See* S.B. 1129, 29th Leg. (Haw. 2017).

133. *See* Legis. Doc. 347, 128th Leg., 1st Sess. (Me. 2017).

134. *See* Legis. Doc. 1270, 127th Leg., 1st Sess. (Me. 2015).

135. Assemb. B. 2451, 217th Leg. (N.J. 2016).

136. Assemb. B. 2270, 216th Leg. (N.J. 2014).

137. Two public websites appear to collect state-by-state legislation comprehensively and accurately. DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/take-action/ (last visited Jan. 31, 2018); PATIENT RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/laws-issues-by-state/ (last visited Jan. 31, 2018).

138. *See* COMPASSION & CHOICES, *supra* note 12; Michael Ollove, *Aid in Dying Gains Momentum as Erstwhile Opponents Change their Minds,* STATELINE, (Mar. 9, 2018), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/09/aid-in-dying-gains-momentum-as-erstwhile-opponents-change-their-minds.

V. LEGALIZING MAID THROUGH FEDERAL CONSTITUTIONAL LITIGATION

While the most successful method of legalizing MAID has been by enacting statutes, the most prominent early method was by seeking a right under the U.S. Constitution. During the 1990s, physician and patient plaintiffs brought several cases in state and federal courts. Several even sought certiorari from the U.S. Supreme Court. That court ultimately agreed to adjudicate the issue. In 1997, the Court ruled that state criminalization of MAID does not violate constitutional due process or equal protection rights.[139]

A. Early Efforts before 1997

Before the U.S. Supreme Court issued its decisions in June 1997, four other courts had already ruled that there was no federal constitutional right to MAID.

1. Donaldson v. Lundgren *(Cal. App. 1992)*

The earliest case was not a typical MAID case. Indeed, it was so unusual that it was not really a MAID case at all. Mathematician and computer software scientist, Thomas Donaldson, suffered from an incurable brain disease. He wanted to cryogenically preserve his body in hopes that sometime in the future, when a cure for his disease is found, his body may be brought "back to life."[140] Since the process would require Donaldson's death, the court interpreted the request for declaratory and injunctive relief for "pre-mortem cryogenic suspension" as seeking a right to assisted suicide. The trial court dismissed the action and the court of appeals affirmed.[141]

2. State v. Kevorkian *(Mich. 1994)*

Jack Kevorkian was one of the most prolific litigants in the MAID movement. Most of his lawsuits were criminal prosecutions and not actions for declaratory and injunctive relief like most other cases discussed in this article. Yet, in at least one of these cases, Kevorkian raised constitutional arguments before the Michigan Supreme Court.

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions

139. Washington v. Glucksberg, 521 U.S. 702 (1997). Coincidentally, the same year that the U.S. Supreme Court found no constitutional right to MAID, the Constitutional Court in Colombia found there was such a right. Mariana Parreiras Reis de Castro et al., *Euthanasia and Assisted Suicide in Western Countries: A Systematic Review,* 24(2) REV. BIOETHICS 355 (2016); s*ee also* Carter v. Canada, [2015] S.C.R. 331 (Can.).

140. Donaldson v. Lungren, 4 Cal. Rptr. 2d 59, 60 (Ct. App. 1992). The television series, *LA Law,* dramatized the case. *LA Law: The Good Human Bar*, YOUTUBE (Jan. 31, 2018), https://www.youtube.com/watch?v=Rzpda6cpYQU.

141. *Donaldson*, 4 Cal. Rptr. 2d 59. The court rejected claims under both the U.S. Constitution and the California Constitution. *Id.*

and in an action for declaratory relief.[142] Kevorkian met with some success at the trial level. In 1994, the Court of Appeals consolidated those several cases. The appellate court then overturned the new statute outlawing assisted suicide. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[143]

The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[144] The court held that there was a valid distinction between the right to refuse life-continuing treatment and the right to insist on life-ending treatment.

3. Kevorkian v. Arnett *(C.D. Cal. 1996)*

While most of Kevorkian's cases were in Michigan state courts, he had two in federal court. He filed one in Los Angeles.[145] There, he asserted claims under the Fourteenth Amendment Due Process clause and the Equal Protection clause. He also asserted privacy and equal protection claims under the California Constitution. Notably, the U.S. District Court for the Central District of California decided the case after the favorable federal appellate decisions in *Glucksberg* and *Quill*.[146] Nevertheless, the court still denied all of Kevorkian's claims.[147] The Ninth Circuit dismissed the appeal because by then the U.S. Supreme Court had already adjudicated the issues in other cases.[148]

4. Kevorkian v. Thompson *(E.D. Mich. 1997)*

Kevorkian filed his second federal action in Michigan with Janet Good, a patient with terminal pancreatic cancer.[149] Like the California federal court, the U.S. District Court for the Eastern District of Michigan declined to follow the still-standing federal appellate decisions in *Glucksberg* and *Quill*.[150] The court held that a mentally competent, terminally ill or intractably suffering adult does not have a liberty interest protected by the Fourteenth Amendment's Due Process Clause in MAID. The court further held that the Equal Protection Clause of the Fourteenth Amendment is not violated by denying a mentally competent, terminally ill or intractably suffering adult not on life support the right to MAID.

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142. *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959 (1995).

143. Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. App. 1994).

144. People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied*, 514 U.S. 1083 (1995).

145. Kevorkian v. Arnett, 939 F. Supp. 725 (C.D. Cal. Sept. 11, 1996).

146. *See infra* Sections V.B & V.C.

147. *See Kevorkian*, 939 F. Supp., at 731–732. *The court also rejected an asserted right under the California constitution,* c*iting Donaldson* v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992)*. Id.*

148. Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. Mar. 31, 1998) (vacating judgment and dismissing appeal).

149. Kevorkian v. Thompson, 947 F. Supp. 1152 (E.D. Mich. Jan. 6, 1997).

150. *See infra* Sections V.B & V.C.

B. SCOTUS 1: *Quill v. Vacco*

During the early 1990s, several cases in California and Michigan had sought a federal constitutional right to MAID. Still, the most notable constitutional rights cases were out of Washington and New York. In 1994, advocates filed two federal lawsuits challenging the constitutionality of Washington and New York statutes criminalizing aiding suicide.

The Washington and New York lawsuits claimed that criminal assisted suicide statutes constituted denials of due process and equal protection as applied to terminally ill, competent persons voluntarily requesting assistance from licensed physicians. These claims met some success. In both cases, federal courts of appeals upheld the claims and held the statutes unconstitutional. Nevertheless, the U.S. Supreme Court reversed, holding that there is no constitutional barrier to states criminalizing MAID.

The specific question presented in the Second Circuit case was whether New York's ban on MAID violated the Fourteenth Amendment's Equal Protection Clause.[151] The plaintiffs alleged that the law treats similarly situated terminally ill patients disparately. On the one hand, New York law (like laws in almost every state) allows competent terminally ill adults to hasten their death by withholding or withdrawing their own lifesaving treatment. On the other hand, New York law denies the same right to patients who could not withdraw their own treatment even if they are terminally ill or in great pain.

The District Court rejected these claims and ruled for the State of New York.[152] The Second Circuit reversed, holding that New York's ban was unconstitutional.[153] The court of appeals held that the statute treated similarly situated terminally ill patients differently. On the one hand, those who required life-sustaining treatment were entitled under New York law to die by having that treatment withheld or withdrawn. On the other hand, patients whose suffering might be equal or greater, but who did not require life-sustaining treatment, were denied the same right to die because New York statutory law made it a crime to provide them with the assistance necessary to die.

The U.S. Supreme Court reversed, holding that there was no fundamental liberty interest and that New York's distinction between active and passive means of death was legitimate. Having determined that there was no fundamental right at stake, the Court needed only to apply a minimal scrutiny test and was able to accord the statute a strong presumption of validity. Thus, the Court would uphold the law so long as it bore a rational relation to some legitimate end.

Employing a rationality test to examine the guarantees of the Equal Protection Clause, the Court held that New York's ban bore a rational relationship to the state's legitimate interest in protecting medical ethics, preventing euthanasia, shielding the disabled and terminally ill from prejudice that might encourage them to end their lives, and, above all, the preservation of human life. Moreover, while acknowledging the difficulty of its task, the Court distinguished between the refusal of lifesaving treatment and assisted suicide, by noting that the latter involves the

151. Quill v. Vacco, 521 U.S. 793 (1997).

152. Quill v. Vacco, 870 F. Supp. 78 (S.D.N.Y. 1994).

153. Quill v. Vacco, 80 F.3d 716, 718 (2d Cir. 1996).

criminal elements of causation and intent. It found the distinction between assisting suicide and withdrawing life-sustaining treatment to be a rational one because it is "a distinction widely recognized and endorsed in the medical profession and in our legal traditions."[154]

C. SCOTUS 2: *Washington v. Glucksberg*

While the New York case presented an equal protection question, a parallel case from Washington State presented the question whether Washington State's ban on MAID violated the Fourteenth Amendment's Due Process Clause. The plaintiffs alleged that the same principle that grounded the right to refuse treatment also encompassed a right to choose the time and manner of one's death. Therefore, they argued, Washington's law denied competent terminally ill adults this fundamental liberty.

The District Court ruled for the plaintiffs.[155] While a three-judge panel of the U.S. Court of Appeals for the Ninth Circuit reversed,[156] a rare en banc Ninth Circuit affirmed the district court.[157] The U.S. Supreme Court granted certiorari to the state of Washington, and upheld the constitutionality of the state law.[158]

The Supreme Court concluded that no fundamental right was at stake. It further concluded that the state's interests were legitimate and that the statute bore a rational relationship to furthering those interests. Accordingly, the Court held that the Washington statute making assisted suicide a crime "does not violate the Fourteenth Amendment, either on its face or as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."[159]

D. Later Efforts after 1997

By June 1997, the U.S. Supreme Court had rejected both due process and equal protection arguments. Nevertheless, some litigants continued to press such claims in federal courts. Predictably, those courts denied the claims.

1. Mahorner v. Florida *(M.D. Fla. 1998)*

Unlike the patient plaintiffs in most other MAID lawsuits, James Mahorner was not terminally ill. Instead, the seventy-six-year-old former practicing attorney was suffering increasing "diminished mental capacity."[160] Mahorner sought judicial approval to "hire a physician to inject him with 'a lethal pain-relieving' drug to hasten his demise."[161] The court expectedly held that to the extent that the complaint

154. *Quill*, 521 U.S. at 800.

155. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1467 (W.D. Wash. May 3, 1994).

156. Compassion in Dying v. Washington, 49 F.3d 556 (9th Cir. Mar. 9, 1995).

157. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. Mar. 8, 1996) (en banc).

158. Washington v. Glucksberg, 521 U.S. 702 (1997).

159. *Id.* at 732.

160. *See* Mahorner v. Florida, No. 3:08-cv-300-J-33TEM, 2008 WL 2756481 (M.D. Fla. July 14, 2008).

161. *See id.* Technically, the plaintiff was seeking active euthanasia and not MAID.

sought relief under the Fourteenth Amendment, it was subject to dismissal under *Glucksberg*, *Vacco*, and *Krischer*.[162]

2. Calon v. United States *(D. Kan. 2009)*

In 1999, John Calon asserted a constitutional right to MAID in a claim for benefits before the U.S. Court of Appeals for the Tenth Circuit.[163] That court held that Calon could not state a cognizable claim that state laws prohibiting MAID violated the First Amendment, the Due Process Clause, or the Equal Protection Clause. The court further ruled that any other constitutional claim challenging state laws regarding assisted suicide was too vague to confer federal question jurisdiction.

Nearly ten years later, Calon made similar claims in the U.S. District Court for the District of Kansas.[164] He asserted various violations of federal law, including the First, Eighth, Ninth, Thirteenth, and Fourteenth Amendments to the United States Constitution. Yet, Calon did not assert any such claims in his complaint. Nor did he allege sufficient facts to allege a real and immediate threat of injury to support any claim for prospective relief.

VI. LEGALIZING MAID THROUGH STATE CONSTITUTIONAL LITIGATION

Because the U.S. Supreme Court decided that there is no constitutional right to MAID, litigation efforts after June 1997 have focused elsewhere.[165] Specifically, they have focused either on grounding the right in state constitutions or on establishing that MAID falls outside the scope of assisted suicide statutes. This section examines cases asserting state constitutional claims. The next section examines cases asserting statutory interpretation claims.

Initially, advocates identified the most promising theories to be state constitutional privacy claims. After all, some state supreme courts had previously given rather expansive readings to the privacy clauses in their state constitutions. Nonetheless, the courts have proved unwilling to strike down criminal prohibitions on assisted suicide as a violation of a terminally ill person's right to privacy.

Admittedly, some plaintiffs have obtained favorable state constitutional judgments from trial courts.[166] Yet, no plaintiff has ever obtained an appellate court ruling that the prohibition of MAID violates a right afforded by state constitution. Indeed, "not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban."[167]

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162. *See supra* Sections V.B-C & *infra* Section VI.A.2.

163. Calon v. Apfel, No. 98-3190, 1999 WL 415340, at *1 (10th Cir. Apr. 26,1999).

164. Calon v. United States, No. 08–2608–JWL, 2009 WL 248430 (D. Kan. Feb 3, 2009) (dismissing for lack of jurisdiction).

165. Litigation has appeared an attractive pathway, because ballot initiatives are cumbersome and legislation is controversial. *See* Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URBAN L.J. 817, 819 (1997).

166. *See* discussion of the state constitutional litigation in Florida, Montana, and New Mexico *infra* Section VI.A.2, 4, 5

167. Myers v. Schneiderman, 85 N.E.3d 57, 92 (N.Y. Ct. App. 2017) (Garcia, J., concurring).

A. State Supreme Court Rulings

Six constitutional rights cases have reached the state supreme courts in Michigan, Florida, Alaska, Montana, New Mexico, and New York. I discuss those six cases immediately below. In the next section, I discuss constitutional rights cases decided by trial courts or intermediate appellate courts.

1. Michigan v. Kevorkian *(Mich. 1994)*

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions and in an action for declaratory relief.[168] Several circuit court judges held that MAID was a constitutional right.[169] As discussed above, neither the intermediate court of appeals nor the Michigan Supreme Court found there was a federal constitutional right.[170]

Nevertheless, the Court of Appeals overturned the new statute outlawing assisted suicide on state constitutional grounds. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[171] The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[172]

2. Krischer v. McIver *(Fla. 1997)*

Charlie Hall was terminally ill with AIDS. Along with his physician, Hall sought a declaratory judgment that Florida's assisted suicide statute was unconstitutional as applied to MAID. Hall contended that Florida's statutory prohibition on assisted suicide violated the state constitutional right of privacy.[173] The trial court rejected the fundamental liberty interest but accepted the equal protection argument and enjoined the attorney general.[174]

The Florida Supreme Court reversed.[175] The court held there was no fundamental right and that there were compelling state interests in any case. The court's analysis was a straightforward rejection of the application of the

168. *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959, 962 (1995).

169. *See, e.g.*, Hobbins v. Attorney General, No. 93-306-178CZ, 1993 WL 276833 (Mich. Cir. Ct. May 20, 1993), *aff'd in part, rev'd in part,* 518 N.W.2d 487 (Mich. Ct. App. May 10, 1994), *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. December 13, 1994).

170. *See* discussion *supra* Section V.A.2.

171. Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. Ct. App. 1994) (quoting MICH. CONST. art. 4, §24) *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. Dec. 13, 1994).

172. *See* People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied sub nom.* Hobbins v. Kelley, 514 U.S. 1083 (1995).

173. FLA. CONST. art. I, §23; *see also* Eryn R. Ace, *Krischer v. Mciver: Avoiding the Dangers of Assisted Suicide,* 32 AKRON L. REV. 723, 724 (1999).

174. *See* McIver v. Kirscher, No. CL-96-1504-AF, 1997 WL 225878 (Fla. Cir. Ct. Jan. 31, 1997).

175. *See* Krischer v. McIver, 697 So. 2d 97 (Fla. 1997).

constitutional privacy provision to permit terminally ill patients to obtain the aid of physicians in actively ending their lives. Central to the holding was the court's acceptance of the conventional distinction between passive and active means of dying, reaffirming its commitment to the former while rejecting the latter.

The Florida Supreme Court followed the U.S. Supreme Court's analysis in *Glucksberg* in finding that important state interests justify the differential treatment of actively and passively hastening death. Specifically, the court held that "three of the four recognized state interests are so compelling as to clearly outweigh Mr. Hall's desire for assistance in committing suicide" [176] These interests are preserving life,[177] preventing suicide,[178] and protecting the ethical integrity of the medical profession.[179]

3. Sampson v. Alaska *(Alaska 2001)*

In 1998, a patient with breast cancer and a patient with AIDS sought a declaratory judgment that Alaska's assisted suicide statute was unconstitutional as applied to MAID. The trial court rejected the plaintiffs' claims. The Alaska Supreme Court affirmed. The court held there was no fundamental right and that the state had a rational basis for prohibiting MAID. The court also denied the equal protection claim holding that the active passive distinction was valid. Furthermore, the court concluded that this was a "quintessentially legislative matter" and it would not make social policy.[180]

The Alaska Supreme Court found that, "[t]o the extent that the . . . statute's general prohibition of assisted suicide prevents terminally ill patients from seeking a physician's help in ending their lives, . . . the provision substantially interferes with [patients'] general privacy and liberty interests, as guaranteed by the Alaska Constitution."[181] Nevertheless, the court determined that the state's ban on such assistance, through its manslaughter statute, was constitutional because it both served a legitimate governmental purpose and bore a substantial relationship to that purpose.[182]

The court also expressed concern that permitting assisted suicide in cases involving competent, terminally ill patients would put courts in difficult positions in terms of determining competency and terminal condition.[183] Finally, the court seemed concerned that permitting assisted suicide in the case of competent patients would open the door to assisted suicide by advance directive.[184]

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176. *McIver*, 697 So. 2d at 103.

177. *Id.* (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990)).

178. *Id.* ("[L]egal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.").

179. *Id.* at 104.

180. Sampson v. State, 31 P.3d 88, 98 (Alaska Sept. 21, 2001).

181. *Id.* at 95.

182. *Id.* at 95–96.

183. *Id.* at 97–98.

184. *Id.* at 97.

4. Baxter v. State *(Mont. 2009)*

In December 2008, a Montana trial court ruled that the Montana Constitution protected MAID.[185] While the trial court rejected the equal protection argument, it accepted the privacy and dignity argument. The court also found there were no compelling state interests requiring the state to treat MAID as homicide. As discussed below, the Montana Supreme Court resolved the right to MAID at the statutory level, obviating the need to resolve the constitutional question.[186]

5. Morris v. Brandenburg *(N.M. 2016)*

In early 2014, a trial court in New Mexico invalidated that state's statutory prohibition on MAID, ruling that it violated the provision of the New Mexico constitution guaranteeing not only "the rights of enjoying life and liberty" but also "the right to seek and obtain happiness."[187]

In 2015, the intermediate court of appeals reversed that judgment.[188] In 2016, the New Mexico Supreme Court affirmed the appellate court's reversal of the trial court ruling.[189] While agreeing that New Mexico could grant its citizens more constitutional rights than those guaranteed by the federal Constitution, the court followed the reasoning of *Glucksberg*. The court held there was no "special characteristic of New Mexico law that makes physician aid in dying a fundamental right in this state."[190] In doing so, it refused to hold that United States Supreme Court jurisprudence had moved beyond "the careful substantive due process approach announced in *Glucksberg*, effectively overruling it."[191]

Finally, the court interpreted Article II, Section 4 (the Inherent Rights Clause) of the New Mexico Constitution as creating no judicially enforceable rights but instead guaranteeing New Mexicans an expansive view of rights otherwise existing in its constitution. While the portion of New Mexico's Constitution that refers to "seeking and obtaining . . . happiness" might, under other circumstances, ensure greater due process protections that those of the federal government, "the Inherent Rights Clause has never been interpreted to be the exclusive source for a fundamental or important constitutional right, and on its own has always been subject to reasonable regulation."[192]

The court ruled that the New Mexico statute bore a rational relationship to the legitimate governmental interest in "providing positive protection to ensure that a terminally ill patient's end-of-life decision is informed, independent, and procedurally safe." Setting forth such procedures is a job for the legislature, not the judiciary. The New Mexico legislature can and should draw the line between the

185. Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009).

186. Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009).

187. Morris v. Brandenburg, No. D-202-CV 2012-02909, 2014 WL 10672986, at *6–7 (2d Jud. D. Ct. N.M., Jan. 13, 2014) (citing to N.M. CONST. art. II, §4) *rev'd* Morris v. Brandenburg, 2015-NMCA-100, 356 P.3d 564, *aff'd*, Morris v. Brandenburg, 2016-NMSC-027, 376 P.3d 836.

188. *See Morris*, 2015-NMCA-100 (decided Aug. 11, 2015).

189. *See Morris*, 2016-NMSC-027 (decided June 30, 2016).

190. *Id.* ¶ 36.

191. *Id.* ¶ 23 (citing Obergefell v. Hodges, 135 S.Ct. 2584, 2620–21 (2015) (Roberts, C.J., dissenting).

192. *Id.* ¶ 51.

state's legitimate interest and the state's conceded lack of "interest in preserving a painful and debilitating life that will end imminently."[193]

6. Myers v. Schneiderman *(N.Y. 2017)*

Constitutional litigation in New York turned out no better than in New Mexico. The Appellate Division dismissed plaintiffs' state equal protection claim quickly, saying that the right to equal protection under the New York Constitution was coextensive with the right under the United States Constitution, and the Supreme Court in *Vacco v. Quill* had already decided that issue. The Appellate Division also rejected arguments that a strong liberty interest existed for due process purposes. The court refused to alter its constitutional analysis based on evidence amassed over the two decades since *Vacco* and *Glucksberg*. "We are not persuaded . . . aid-in-dying is an issue where a legitimate consensus has formed. . . . we defer to the political branches of government. . . . "[194]

The Court of Appeals affirmed, holding that applying New York's statutes criminalizing assisted suicide to MAID violated neither due process nor equal protection rights under the New York state constitution. "Although New York has long recognized a competent adult's right to forgo life-saving medical care, we reject plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as they define it. We also reject plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests."[195]

B. *Baxter v. Montana* (1st Jud. Dist. Ct. 2008)

As with lower courts in Florida and New Mexico, Montana plaintiffs were able to obtain a trial court judgment that Montana's prohibition of MAID violated patients' privacy, and dignity rights under the state constitution.[196] In December 2008, the Montana First Judicial District Court ruled that the state constitution protected MAID.[197] Yet, as discussed below, the Montana Supreme Court vacated the judgment.[198] That court found a right to MAID at the statutory level, obviating the need to resolve the constitutional question.[199]

The plaintiff argued that the statute was unconstitutional under the Montana Constitution's equal protection clause, individual dignity clause, and express right of privacy. The trial court ruled that the statute did not violate the state constitution's equal protection clause for the same reasons the United States Supreme Court had ruled to that effect with respect to the U.S. Constitution's Equal Protection Clause.

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193. *Id.*

194. Myers v. Schneiderman, 140 A.D. 3d 51, 65 (N.Y. App. Div. 2016).

195. Myers v. Schneiderman, 85 N.E.3d 57, 65 (N.Y. Ct. App. 2017) (decided Sept. 7, 2017).

196. *See* Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009) (holding that the prohibition violated MONT. CONST. art. II, §§ 4, 10).

197. *Id.*

198. *See infra* Section VII.A.

199. Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009). One Justice wrote separately to express agreement with the trial court's reasoning on the constitutional issue. *Id.* at 1223.

Nevertheless, the trial court ruled that the statute was unconstitutional, holding that the state constitution's individual dignity clause and right of privacy combined to "mandate that a competent terminally ill person has the right to choose to end his or her life." [200]

Moreover, the right necessarily includes a right to have the assistance of a physician, for if a patient were forced to proceed without physician assistance he might end his life "sooner rather than later . . . and the manner of the patient's death would more likely occur in a manner that violates his dignity and peace of mind."[201]

The trial court then considered the state interests that Montana had advanced to convince the court that the statute was constitutional. The state asserted an interest in the preservation of life. The court ruled that such an interest is compelling in general, but "diminishes in the delicate balance against the individual's constitutional rights of privacy and individual dignity" when a patient is terminally ill.[202]

The court ruled that the state did have compelling state interests in "protecting vulnerable groups from potential abuses" and "protecting the integrity and ethics of the medical profession." Yet the court held the statute unconstitutional despite the existence of these compelling state interests because it was overbroad. The court suggested that the state of Montana should seek to serve these compelling state interests by enacting statutory protections such as those contained within Oregon's Death with Dignity Act rather than by prohibiting suicide assistance as a blanket matter, sweeping within the reach of its statutes decisions of competent, terminally ill patients choosing to end their own lives with the assistance of physicians.[203]

C. Other Court Rulings

While only six state supreme courts have analyzed the constitutionality of MAID under state constitutions, seven other trial and intermediate appellate have also adjudicated state constitutional claims. Trial courts in Florida, Montana, and New Mexico ruled that prohibition of MAID violated state constitutional rights. Yet, no appellate court sustained those judgments. Nearly fifteen other trial and appellate courts to reach the issue all found that there was no state constitutional right to MAID.

Two California cases asserted both federal and state constitutional claims. The adjudication of the federal claims is discussed above.[204] The state claims fared no better. First, Thomas Donaldson brought claims under both the U.S. Constitution and the California Constitution. Both the Superior Court and the Court of Appeal denied the states claims just as they denied the federal claims.[205] Second, Jack Kevorkian brought claims under both the U.S. Constitution and the California

200. *Baxter*, 2008 Mont. Dist. LEXIS 482, at *26. The court recognized that the state may want to erect some safeguards but could do so afterwards. *Id.* at *29.

201. *Id*. at *29.

202. *Id*. at *30.

203. *See id.* at *15.

204. *See supra* Section V.A.

205. *See* Donaldson v. Lungren, 4 Cal.Rptr.2d 59, 60 (Cal. Ct. App. Jan. 29, 1992).

Constitution. The U.S. District Court denied the states claims just as it denied the federal claims.[206]

1. Sanderson v. Colorado *(Colo. App. 2000)*

The MAID issue in Sanderson differed significantly from that in other cases. Robert Sanderson was an 81-year-old former judge. Although in good health, Sanderson wanted to execute an advance directive authorizing his wife "to end his life by euthanasia, provided that two physicians agree his medical condition is hopeless."[207] He sought a declaratory judgment to assure himself that neither his wife nor the physician who actually engaged in the euthanasia would be subject to criminal liability.

Sanderson asserted claims under several federal constitutional provisions, but on appeal after dismissal of the complaint, he pursued only a claim under the free exercise clause of the First Amendment. Sanderson described his personal religious beliefs as including beliefs that the free will of man included an ability to direct euthanasia, and that man could delegate to another to authorize euthanasia.

The Colorado Court of Appeals ruled that the free exercise clause did not exempt the plaintiffs from the state law criminalizing their conduct, in large part because the law was an "'across-the-board' criminal prohibition on a particular form of conduct." Because Colorado's prohibition of assisted suicide fell into this category, the court ruled, it constituted a "valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate."[208]

In addition to its unique First Amendment argument, *Sanderson* is interesting, and differs from the other cases, in that the plaintiff was asserting a right to choose death through an advance directive rather than a right to commit suicide with assistance. Thus, the plaintiff was arguing that, while competent, he could direct others to euthanize him later, when he was incompetent. Rather than asserting his own right to take action, Sanderson sought to authorize others to take action, and he wanted to ensure that the state would not prosecute those who acted at his request.

The court noted the incongruity by describing his claim as weak, because he does not just seek a limited exemption from the assisted suicide statute for himself so that he may freely practice his religion without fear of criminal prosecution. He also seeks exemptions for third parties—his wife and his physician—based on his personal religious beliefs, which they may not share. Even assuming Sanderson had standing to raise such claims on behalf of third persons, the court found "no precedent for such a broad application of the Free Exercise Clause in First

206. *See* Kevorkian v. Arnett, 939 F. Supp. 725, 731–32 (C.D. Cal. 1996), *vacated, appeal dismissed*, Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. 1998).

207. *See* Sanderson v. People, 12 P.3d 851 (Colo. App. June 8, 2000); *see also* Allison Sherry, *Ex-Judge Seeks Right to Die*, DENVER POST (June 9, 2000), www.extras.denverpost.com/news/news0609.htm (explaining that Sanderson was in good health despite his interest in the medical aid in dying cause).

208. *Sanderson*, 12 P.3d at 854.

Amendment jurisprudence."[209] The Colorado Supreme Court declined to hear the case.[210]

2. People v. Kevorkian *(Mich. App. 2001)*

In 1999, a Michigan jury convicted Jack Kevorkian of second-degree murder and unlawful delivery of a controlled substance.[211] Kevorkian appealed. [212] He contended that his conviction was unlawful under the Ninth and the Fourteenth Amendments of the U.S. Constitution, as well as under their counterparts in the Michigan Constitution.[213]

The Ninth Amendment provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."[214] Dr. Kevorkian claimed that the "right to be free from inexorable pain and suffering must be among" the rights so protected.[215] The court summarily rejected this argument because of Kevorkian's failure to pursue it beyond its mere assertion.

The court dealt far more extensively, however, with Dr. Kevorkian's Fourteenth Amendment liberty interests argument. Using the U.S. Supreme Court's assisted-suicide jurisprudence as a base, Kevorkian argued that the "necessary and direct corollary" of the concern expressed in *Quill* about patients dying in pain was "that a person should not be forced to suffer unbearably."[216] While acknowledging the Supreme Court's concerns about pain, the court refused to rule that it was unconstitutional to apply Michigan's murder statute to active euthanasia based on those concerns.

The court articulated three bases for its ruling. First, the court expressed a concern that "expanding the right to privacy would begin, as the steps in the progression of defendant's argument supporting voluntary euthanasia clearly indicate, the slide down the slippery slope toward euthanasia."[217] Second, the court hesitated to take such a step because it believed that "[i]f society is to recognize a right to be free from intolerable and irremediable suffering, it should do so through the action of the majority of the legislature, whose role it is to set social policy, or by action of the people through ballot initiative."[218]

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209. *Id.*

210. *See id.* (indicating that certiorari was denied on October 23, 2000 due to an unsuccessful attempt at making a first amendment challenge); *cf.* Final Exit Network, Inc. v. Georgia, 722 S.E. 2d 722, 725 (Ga. 2012) (making a successful first amendment challenge); *see also* State v. Melchert-Dinkel, 844 N.W.2d 13, 18 (Minn. 2014), rev'g 816 N.W.2d 703 (Minn. Ct. App. 2012) (succeeding on first amendment grounds).

211. *See* Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. Times, (Apr. 14, 1999) http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html.

212. People v. Kevorkian, 639 N.W.2d 291, 296 (Mich. App. 2001).

213. *See id.* at 300–303; *see also* Monica Davey, *Kevorkian Speaks After His Release From Prison*, N.Y. TIMES, (June 4, 2007), http://www.nytimes.com/2007/06/04/us/04kevorkian.html (indicating that even after eight years of imprisonment, Dr. Kevorkian still felt strongly about MAID).

214. U.S. CONST. amend. IX.

215. *Kevorkian*, 639 N.W.2d at 303.

216. *Id.* at 304 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

217. *Id.* at 306.

218. *Id.*

Finally, the court expressed concern about judging quality of life. "Expanding the right of privacy to include a right to commit euthanasia . . . to end intolerable and irremediable suffering we would inevitably involve the judiciary in deciding questions that are simply beyond its capacity."[219]

3. Hooker v. Slattery *(Davidson County, Tenn. 2016)*

In May 2015, John Jay Hooker filed a lawsuit asserting a right to MAID under the Tennessee Constitution. In September 2015, the trial court held that Hooker had no right to MAID under the Tennessee Constitution.[220] In any case, the state had compelling state interests to prohibit MAID. Hooker unsuccessfully sought review directly from Supreme Court of Tennessee.[221] Hooker then voluntarily dismissed the appeal before a ruling from the intermediate appellate court.[222]

4. Donorovich-O'Donnell v. Harris *(Cal. App. 2015)*

Before California enacted the End of Life Options Act in October 2015, two separate sets of plaintiffs filed separate lawsuits seeking to establish a state constitutional right to MAID. In May 2015, Christy Lynne Donorovich-O'Donnell with other terminally ill patients and a physician filed in San Diego Superior Court.[223] In July 2015, the court sustained the defendants' demurrers, holding that no state constitutional right to privacy, free speech, or equal protection extended to MAID.[224]

By the time the California Court of Appeal issued its opinion, the legislature had already enacted the End of Life Options Act. Yet, that did not moot the case because the law was not yet in effect.[225] In October 2015, the Court of Appeal affirmed the Superior Court.[226] The California Supreme Court declined to hear the case.[227]

The plaintiffs in *Donorovich-Odonnell* argued that, as applied to competent, terminally ill persons seeking lethal medication to end their lives, the application of the criminal assisted suicide law to MAID deprived citizens of "autonomy privacy."[228] The California Constitution's explicit grant of a right to privacy could indeed protect more than the federal Constitution does, but the court in refused to so hold because the plaintiffs had not "parse[d] out why the reasoning of *Glucksberg* or *Vacco* is ostensibly inapplicable."[229] It also cited *Donaldson* as holding that the state

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219. *Id.* at 307 (emphasis in original).

220. *See* Hooker v. Slatery, No. 15061511 (Davidson Cty. Ch. Ct., Tenn. Sept. 29, 2015).

221. *See* Hooker v. Slatery, No. M2015-01982-SC-RDM-CV (Tenn. Nov. 9, 2015).

222. *See* Hooker v. Slatery, No. M2015-01982-COA-R3-CV (Tenn. Ct. App. May 20, 2016).

223. *See* Complaint at 1, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. May 15, 2015).

224. *See* Ruling on Demurrer, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. July 24, 2015).

225. In addition, it is worth ruling on the constitutionality of MAID, because the California End of Life Options Act is scheduled to sunset in 2026.

226. *See* Donorovich-O'Donnell v. Harris, 194 Cal. Rptr. 3d 579, 582 (Ct. App. Oct 29, 2015).

227. *Donorovich-Odonnell v. Harris*, No. S230918, 2016 Cal. LEXIS 646 (Feb. 3, 2016).

228. *See Donorovich-O'Donnell*, 194 Cal. Rptr. 3d at 590.

229. *Id.* at 594.

constitution could not shield a third person from criminal liability for assisting a person in committing suicide.[230]

In sum, the court ruled that the plaintiff's asserted right to obtain "assistance of a third party in committing suicide" was not fundamental. Even if it were, the state had compelling interests in enforcing its statutory prohibition of suicide assistance in cases of MAID. Specifically, the state has an interest in ensuring that people are not influenced to kill themselves, and interests in preserving life, maintaining the ethics of the medical profession, protecting vulnerable groups, and guarding against a slippery slope toward involuntary euthanasia.

Overridingly, however, the court opined that the matter was one for the legislature rather than the courts. In doing so, it focused on the legislative imposition of many safeguards on the process of MAID in California's End of Life Options Act. "If the law were changed by judicial opinion, these extensive safeguards would not be in place."[231]

5. Brody v. Harris *(San Francisco Sup. Ct. 2016)*

In February 2015, another set of California plaintiffs filed in San Francisco Superior Court. They also made state constitutional claims. In February 2016, the court sustained the defendants' demurrers.[232] The trial court ruled that the right to privacy did not include MAID.[233] It also ruled that disallowing MAID did not violate equal protection.[234] Moreover, the court observed that the legislature had recently acted. The plaintiffs appealed but later voluntarily dismissed.[235]

D. Ongoing Litigation in 2018

While plaintiffs have been unable to establish a state constitutional right to MAID in any jurisdiction, they keep trying. There are two active cases: one in Hawaii and one in Massachusetts.

1. Radcliffe v. Hawaii *(1st Cir. Ct., Haw. 2016)*

In January 2017, John Radcliffe filed a lawsuit seeking declaratory and injunctive relief. But in July 2017, the trial court refused to address the merits of Radcliffe's challenge to the Hawaii assisted suicide statute, deferring the questions to the political branches of government.[236] First, the court held that plaintiffs cannot challenge a criminal statute through declaratory judgment. Second, the court held that it would not interfere with the state medical board and declare that MAID was

230. *See id.* at 592–93 (citing Donaldson v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992)).

231. *Id.* at 595.

232. Order Sustaining Demurrers at *4–5, Brody v. Harris, 2016 Cal. Super. LEXIS 1564 (No. CGC-15-544086) (San Francisco Sup. Ct. Feb. 16, 2016).

233. *See id.* at 3 (citing *Donorovich-O'Donnell*, 194 Cal. Rptr. 3d 579 and *Donaldson*, 4 Cal. Rptr. 2d 59).

234. *See id.* at 3–4 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

235. Brody v. Harris, No. A148572 (Cal. Ct. App. Oct. 14, 2016).

236. Radcliffe v. Hawai'i, No. 17-1-0053-1-KKH, slip op. at 12–13 (1st Cir., Haw. July 14, 2017).

legitimate medical practice. Third, the court refused to issue an injunction, because the statute was presumed valid. The case is now on appeal.[237]

2. Kligler v. Healy *(Suffolk County Sup. Ct., Mass. 2017)*

In October 2016, two physicians filed a lawsuit in Suffolk County, Massachusetts court seeking a declaration that the state attorney general and a district attorney could not prosecute them for engaging in MAID.[238] One of the plaintiff physicians was terminally ill and seeking the option, while the other was willing to write the prescription if he would not be criminally punished for doing so. The plaintiffs asserted that the state's prohibition of MAID violated the Massachusetts constitution. Specifically, the plaintiffs alleged that MAID was protected by the state constitutional rights to privacy, liberty, free speech, and equal protection.

In May 2017, the trial court denied the defendants' motions to dismiss.[239] The court ruled that the case could proceed in the face of arguments that the court lacked jurisdiction over it and that the court should dismiss it either because any judicial decision would not completely resolve the dispute or because the matter of MAID is best left to the legislature. The court noted several times that it was not opining on the merits of the case, merely ruling that it had jurisdiction and would retain the case on the docket.

VII. LEGALIZING MAID THROUGH STATUTORY LITIGATION

In addition to making claims under the U.S. Constitution and under state constitutions, advocates have also brought statutory interpretation claims. They argue that MAID is not encompassed within the criminal prohibition of "assisted suicide." Advocates maintain that MAID and assisted suicide are such different acts that the prohibition of one does not entail the prohibition of the other.

The argument maintains that the choice of a competent dying patient for a peaceful death through MAID is not "suicide." MAID involves the rational choice of a competent, terminally ill patient who finds herself trapped in an unbearable dying process to precipitate death in order to avoid further suffering and preserve her personal dignity. Suicide, by contrast, is a person's choice to prematurely cut short a viable life, usually for reasons of a transient nature and often involving depression or other mental health impairments, recovery from which may be possible with counseling, support, and/or medication. Because MAID is not suicide, it is not covered by the assisted suicide statutes.

Indeed, a growing consensus of medical, mental health and health policy professionals recognize that the choice of a dying patient for a peaceful death through aid in dying is not "suicide." For example, the American Psychological Association

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237. *See* Radcliffe v. State, No. CAAP-17-000594, ECOURT KŌKUA, http://www.courts.state.hi.us/legal_references/records/jims_system_availability (follow "Click Here to Enter eCourt* Kokua"; then follow "Search for case details by case ID or citation number," and search with case ID: "CAAP-17-0000594") (last visited Jan. 31, 2018).

238. *See* Kligler v. Healy, 34 Mass. L. Rptr. 239 (Super. Ct. 2017). *See generally* Roger Kligler, *The Death I Want,* BOS. MAG. (Jan. 15, 2017, 6:05 am), http://www.bostonmagazine.com/health/2017/01/15/the-death-i-want-roger-kligler/.

239. *See id.*

recognizes that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."[240] Even more recently, the American Association of Suicidology concluded that "suicide and physician aid in dying are conceptually, medically, and legally different phenomena."[241]

Yet, despite the semantic and logical cogency of the argument differentiating "suicide" and "MAID," no court has ever accepted it. On the other hand, the Supreme Court of Montana did accept a statutory interpretation argument based on the unique consent defense in its statute.

A. *Baxter v. Montana* (Mont. 2009)

As discussed above, the Montana trial court in Baxter found a state constitutional right to MAID.[242] The Montana Supreme Court neither affirmed nor reversed that holding, but vacated it. Because the court found a statutory ground for MAID, it did not need to reach the constitutional issue. The Montana Supreme Court ruled that physicians may legally assist competent, terminally ill patients in dying by writing prescriptions for lethal medications at their request.[243]

Suicide is not a crime in Montana, and aiding or soliciting a suicide is only a crime if the victim does not die. Instead, the crime that applies to aiding or soliciting a successful suicide is homicide.[244] Yet, the Montana legislature provides that consent is generally a defense to criminal charges, except in four enumerated situations.

The issue for the Montana Supreme Court was whether the consent that a competent, terminally ill patient would be giving for MAID was against public policy.[245] The court ruled that it was not, in part based on statutory interpretation and in part based on the "legislative respect for the wishes of a patient facing incurable illness" that appeared throughout Montana's statutes authorizing withholding and withdrawal of treatment.[246] Significantly, the Montana Supreme Court noted: "In light of the long-standing, evolving and unequivocal recognition of the terminally ill patient's right to self-determination at the end of life in [the Montana statutes], it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy."[247]

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240. *Patients' Rights to Self-Determination at the End of Life*, AM. PSYCHOL. ASS'N (Oct. 28 2008), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life.

241. AM. ASS'N OF SUICIDOLOGY, STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: "SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING" 4 (2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf.

242. *See supra* Section VI.B.

243. *See* Baxter v. State, 2009 MT 449, ¶ 50, 224 P.3d 1211 (2009).

244. *See id.* ¶ 11.

245. *See id.* ¶ 13 ("Consent is ineffective if: . . . it is against public policy to permit the conduct or the resulting harm, even though consented to.") (quoting MONT. CODE ANN. § 45-2-211(2)).

246. *Id.* ¶ 38.

247. *Id.*

Unlike the six states that enacted MAID statutes, Montana has no legal requirements concerning eligibility criteria or request and prescription procedures. Consequently, the practice of MAID in Montana is presumably governed by the professional standard of care and regulatory process.[248]

B. *Blick v. Connecticut* (Hartford Jud. Dist., Conn. 2010)

In October 2009, Gary Blick brought a lawsuit seeking a declaratory judgment that the Connecticut assisted suicide statute did not cover MAID. The court rejected the argument, observing that the statute's application to MAID is amply demonstrated by multiple legislative attempts to amend the assisted suicide law to permit MAID.[249] The court declined to usurp a legislative function. Furthermore, because the attorney general would not exceed its authority by prosecuting MAID, the lawsuit was barred by sovereign immunity.[250]

C. Other Cases

Almost every recent case asserting state constitutional claims has also made statutory interpretation claims.[251] Yet, not a single court has accepted the statutory interpretation argument. As in *Blick*, every court agreed that MAID was encompassed within the state's prohibition of suicide assistance, as a matter of statutory interpretation.

For example, in *Morris*, the New Mexico Supreme Court found that MAID constitutes "deliberately aiding another in the taking of his own life," and thus constitutes suicide assistance under the statute.[252] The court found "compelling" evidence indicating that medical and psychological professionals do not consider MAID to be suicide and that the deaths in cases of MAID are considered to result from the underlying disease, not the taking of the medication. Nevertheless, the legislature had explicitly distinguished "assisted suicide" from withholding and withdrawal elsewhere in New Mexico's statutory scheme. The court held that the practice came within the statutory definition of suicide assistance.[253]

VIII. OTHER MEANS OF LEGALIZING MAID

While only a statute or appellate judgment provides patients and clinicians with clear sufficient ex ante permission to engage in MAID, there are two other means of "legalizing" the practice. First, lawmakers can limit prosecutorial discretion, thus making it unlikely that MAID participants will be arrested or

248. *Cf.* Kathryn L. Tucker, *Aid in Dying*, 142 CHEST. 218, 220 (2012) (noting that MAID is protected in Montana and that "absent a prohibition, the practice . . . can proceed subject to the best practices and an emerging standard of care").

249. *See* Blick v. Office of the Div. of Criminal Justice, No. CV095033392, 2010 Conn. Super. LEXIS 1412, at *21 (2010).

250. *See id.* at *42.

251. *See supra* Sections VI.A & VI.C (including *Morris, Myers, O'Donnell,* and *Brody*).

252. Morris v. Brandenburg, 2016-NMSC-027, ¶ 15, 376 P.3d 836 (2016) (quoting N.M. STAT. ANN. § 30-2-4).

253. *See id.*

prosecuted. Second, even if MAID participants are prosecuted, juries can refuse to convict.

A. Prosecutorial Discretion

The eminent Canadian health law scholar Jocelyn Downie observes that "guidelines for how prosecutorial discretion should be exercised . . . may also be a pathway to a more permissive legal regime."[254] Prosecutors already exercise significant discretion as to which cases to pursue.[255] Downie argues that while MAID would remain illegal, prosecutors could publish guidelines indicating the factors and circumstances under which they would prosecute.

There is substantial track record for this approach outside the United States. For example, before affirmative legalization in 2002, MAID was tolerated for decades in the Netherlands.[256] In Switzerland, MAID is widely practiced, yet still not affirmatively regulated.[257] In the UK, MAID is clearly prohibited by the Suicide Act of 1961.[258] Nevertheless, in 2010, the Crown Prosecution Service introduced guidelines.[259] At least one U.S. jurisdiction has taken a similar approach.[260]

Surprisingly, physicians provide MAID with significant frequency even in those jurisdictions where it remains illegal. Still, there have been few prosecutions. The paucity of reported legal cases is probably attributable primarily to the failure by law enforcement authorities to detect their occurrence. Yet, even when these cases "come to the attention of the authorities, by dint of pervasive discretion in the criminal justice system," prosecutors do not bring indictments.[261] If prosecutors

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254. Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84, 91 (2016); *see also* Ben White & Jocelyn Downie, *Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide: Autonomy, Public Confidence and High Quality Decision-Making,* 36 MELB. U. L. REV. 656 (2012).

255. *See generally* ANGELA J. DAVIS, ARBITRARY JUSTICE (2007).

256. *See* Agnes van der Heide et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 NEW ENG. J. MED. 492 (2017).

257. *See* Samia A. Hurst & Alex Mauron, *Assisted Suicide in Switzerland: Clarifying Liberties and Claims*, 31 BIOETHICS 199, 199 (2017).

258. *See* R (*In re* Purdy) v. Dir. of Pub. Prosecutions [2009] UKHL 45, [2010] 1 AC (HL) 345 (appeal taken from Eng.).

259. THE DIR. OF PUB. PROSECUTIONS, POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ENCOURAGING OR ASSISTING SUICIDE (2010); *see also* R (Nicklinson) v. Ministry of Justice [2013] EWCA (Civ) 961, [2015] AC 657 (Eng.) (involving prosecution after the guidelines were created), *rev'd*, [2014] UKSC 38; Alexandra Mullock, *Compromising on Assisted Suicide: is 'Turning a Blind Eye' Ethical?,* 7 CLINICAL ETHICS 17 (2012) (discussing the effects of the guidelines); *Assisted Suicide*, CROWN PROSECUTION SERV. (Jan. 31, 2018), https://www.cps.gov.uk/publication/assisted-suicide (providing the latest assisted suicide figures).

260. *See Bisbee Taking a Stance on Assisted Suicide*, KVOA.COM (Sept. 4, 2015), http://www.kvoa.com/story/29964343/bisbee-taking-a-stance-on-assisted-suicide (reporting a city council resolution asking the Cochise County Attorney to "deprioritize" prosecuting anyone involved in MAID).

261. *See* THE RIGHT TO DIE, *supra* note 21, § 12.04[D]; *see also* Kenneth A. De Ville, *Physician Assisted Suicide and the States: Short, Medium, and Long Term*, *in* PHYSICIAN ASSISTED SUICIDE: WHAT ARE THE ISSUES? 171, 173–75 (Loretta M. Kopelman & Kenneth A. De Ville eds., 2001). For example, Dr. Rodney Syme was never prosecuted after admitting to assisting the suicide of Steve Guest. *See* Jeff Turnbull, *'Benign Conspiracy' over a Death*, SYDNEY MORNING HERALD (April 21, 2009),

provide ex ante guidance in when they will bring charges, then patients and physicians might have sufficient comfort and clarity to engage in MAID despite its illegality.

B. Jury Nullification

Closely related to prosecutorial discretion is jury nullification. Just as prosecutors can decline to prosecute illegal activity, jurors can decline to convict when there is prosecution. Even when evidence of factual guilt is clear, and the jury believes beyond a reasonable doubt that the defendant engaged in MAID, the jury can still vote the defendant "not guilty."[262] Juries can and do refuse to convict when they think the underlying law is unjust.

Jury nullification is common in MAID cases.[263] For example, Tim Quill wrote in the New England Journal of Medicine that he participated in MAID.[264] This was a very public confession. And MAID is criminally prohibited in New York.[265] Nevertheless, a Rochester grand jury refused to indict Dr. Quill.[266] Similarly, Michigan juries repeatedly refused to convict Jack Kevorkian despite his clear violation of laws in that state.[267] In short, while not the same as decriminalization, jury nullification, like prosecutorial discretion, could help pave a pathway to MAID.[268]

IX. CONCLUSION

The legalization is MAID in the United States is a train that has left the station. It will eventually reach most of the other forty-nine U.S. jurisdictions where it is not yet legal. Yet, policymakers must then grapple with next-generation issues such as the appropriate eligibility criteria and process requirements. The safeguards built into the existing six statutes may unduly restrict access to MAID.[269]

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http://www.smh.com.au//breaking-news-national/benign-conspiracy-over-assisted-death-20090421-adie.html.

262. *See* Morissette v. United States, 342 U.S. 246, 276 (1952) ("[J]uries are not bound by what seems inescapable logic to judges."). *See generally* JEFFREY ABRAMSON, WE, THE JURY 57–97 (1994); CLAY S. CONRAD, JURY NULLIFICATION (Cato Inst. Press 2014).

263. *See generally* Liana C Peter-Hagene & Bette L Bottoms, *Attitudes, Anger, and Nullification Instructions Influence Jurors' Verdicts in Euthanasia Cases*, 23 PSYCHOL., CRIME & L. 983 (2017) (researching the potential for nullification due to MAID attitudes).

264. *See* De Ville, *supra* note 261, at 173.

265. *See* Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. Ct. App. 2017).

266. *See* Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES (July 27, 1991), http://www.nytimes.com/1991/07/27/nyregion/jury-declines-to-indict-a-doctor-who-said-he-aided-in-a-suicide.html.

267. Michigan juries repeatedly acquitted Jack Kevorkian, in trials over the suicide of: Thomas Hyde (May 1994), Ali Khalil and Merian Frederick (March 1996), and Sherry Miller and Marjorie Wantz (May 1996). *See* NEAL NICOL & HARRY WYLIE, BETWEEN THE DYING AND THE DEAD 185–187 (Univ. of Wis. 2006) (2006). Only when Kevorkian moved from assisted suicide to active euthanasia was he convicted of second degree murder in the killing of Thomas Youk. *See Jail Time for Dr. Kevorkian,* N.Y. TIMES (April 15, 1999), http://www.nytimes.com/1999/04/15/opinion/jail-time-for-dr-kevorkian.html.

268. In addition, even when there are convictions, the sentences are often very light.

269. *See* Pope, *supra* note 20.

U.S. Bills Regarding Medical Aid in Dying

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February 17, 2024

This chart summarizes bills before U.S. state legislatures in 2024 regarding medical aid in dying. All these bills are closely modeled on the Oregon model. But some vary especially along four dimensions:

(1) Do they allow only physicians to provide MAID? Or do they also permit other types of clinicians (especially APRN/NP) to provide MAID?

(2) Do they require a traditional 15-day waiting period? Or do they permit a shorter waiting period? Or do they permit waiver/exemption from the waiting period?

(3) Do they limit MAID to only state residents?

(4) Do they require facilities to be open and transparent about whether they participate in MAID – whether by posting policies on their website or by filing standardized forms with the state DOH?

Note that Colorado and New Jersey are amending existing MAID statutes. The remaining states seek to authorize MAID for the first time.

This chart expands and updates Pope, *Medical Aid in Dying: Key Variations among U.S. State Laws,* 14(1) JOURNAL OF HEALTH & LIFE SCIENCES LAW 25-59 (2020).

State	2024 Bills	Provider Types	Waiting Period	Residency	Transparency	Access Score
Arizona	S.B. 1530 H.B. 2878	MD/DO	15 days waivable	Yes	No	1
California	S.B. 1196	*California already has a short waiting period and requires transparency. But CA may further expand access.*				
Colorado	S.B. 68	expand MD/DO to APRN	reduce 15-days to 48-hours	change to No	Yes	4
Delaware	H.B. 140	MD/DO/ APRN	15 days	Yes	No	1
Florida	S.B. 1642 H.B. 561	MD/DO	15 days waivable	Yes	No	1
Illinois	S.B. 3499	MD/DO	5 days waivable	Yes	No	1
Indiana	H.B. 1011	MD/DO/ APRN/PA	15 days waivable	Yes	No	2
	S.C.R. 17 H.C.R. 19	*Opposition and condemnation of MAID.*				
Iowa	H.F. 533 H.F. 612 H.F. 2288 S.F. 2101	MD/DO/ APRN/PA	48 hours waivable	No	No	3
Kansas	H.B. 2076	*Expands criminal assisted suicide.*				
Kentucky	H.B. 285	MD/DO/ APRN/PA	15 days waivable	Yes	No	2
Maryland	H.B. 403 S.B. 443	MD/DO	15 days	Yes	No	0
Massachusetts	S.B. 1331 H.B. 2246	MD/DO	15 days	Yes	No	0
Michigan	S.B. 681	MD/DO	15 days	No	No	1

Minnesota	S.F. 1813 H.F. 1930	MD/DO/ APRN/PA	No	No	No	3
Missouri	H.B. 1903	MD/DO	15 days	Yes	No	0
New Hampshire	H.B. 1283 S.B. 558	MD/DO/ APRN/PA	48 hours waivable	No	No	3
New Jersey	A.B. 1880	MD/DO (in existing statute)	make 15 days waivable	Yes, but being litigated	No	1
New Jersey	A.B. 406	*Enhances penalties for violations of MAID statute.*				
	A.B. 407	*Repeals MAID statute.*				
New York	A.B. 995 S.B. 2445	MD/DO	No	No	No	2
North Carolina	H.B. 877	*Calls for a report by the state Institute of Medicine*				
Pennsylvania	H.B. 543 S.B. 816	MD/DO/ APRN/PA	15 days	Yes	No	1
Rhode Island	H.B. 7100 S.B. 2093	MD/DO	15 days	Yes	No	0
Tennessee	H.B. 1710 S.B. 2258	MD/DO	15 days	Yes	No	0
Virginia	S.B. 280 H.B. 858	MD/DO/ APRN/PA	15 days waivable	Yes	No	2
West Virginia	H.J.R. 68	*Calls for constitutional amendment to prohibit MAID.*				
	H.R. 8	*Rejecting MAID.*				
Wisconsin	A.B. 781 S.B. 739	MD/DO/ APRN/PA	15 days	No	No	2

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Reasons to Oppose Colorado SB24-068
Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation (PCCEF)
Senate Health & Human Services
February 29, 2024

I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation. We advocate for the terminally ill, who often have compromised capacity to choose, making them vulnerable to abuse. I have expertise in pediatric anesthesiology, critical care, and medical ethics. On behalf of our Colorado members, we urge you to oppose SB24-068 which demolishes voter-approved safeguards, violates patient autonomy, and discriminates against those with depression and disabilities who are most likely to pay for these changes with their lives.

- Respect for patients' choices includes ensuring that they have the right to change their minds—this bill denies that option. When a patient says they want to hasten death, this often is a plea for help, not a real desire to kill themselves, and this wish usually abates with supportive care.[1] Lethal drugs are not usually sought for pain but for psychological distress over new onset disabilities. A patient who says they want to die might really mean "I'm afraid I'm a useless burden." Vulnerable patients make rash decisions out of fear, depression, compromised decision-making capacity, embarrassment, subtle pressure by a tired caregiver who makes them feel like a burden, etc. All may go unrecognized by doctors. Given time, palliative care and mental health interventions, patients often change their minds, but this bill allows a bad day to become their last day. Fifteen days may be inadequate to do this but chopping it to 48 hours or eliminating it entirely represents patient abandonment under a guise of "autonomy." It takes two weeks for anti-depressants to begin to work; 48 hours is too short to ensure due diligence has been done.
- Shortening the waiting period has no advantages for patients and will only violate patient autonomy and increase discrimination against the most vulnerable. By not allowing adequate time and sufficient expertise to assess what may be rash requests to hasten death in the midst of fear or depression, this bill not only infringes on patient autonomy by violating patients' rights to change their minds, but it allows injustice and discrimination, because the people most likely to be adversely affected by these changes are those with mental illness and disabilities. There is no scientific data or plausible reason to eliminate the safeguards of time and expertise—the risk of harms for doing so outweigh any benefits.
- The provision to eliminate the waiting period demonstrates reckless disregard for patients. The determination that death is near is difficult and imprecise for experts, and patients typically have loss of both mental capabilities and swallowing function as death nears. By the time one knows a patient is near death the chance of obtaining a valid consent is unlikely, and it is doubtful that the patient could ingest the lethal concoction. Patients must take antiemetics and numb their mouths with popsicles before swallowing substantial amounts of a bitter tasting, sometimes burning cocktail of lethal drugs dissolved in liquid. Risks include painful ingestion, nausea, vomiting, aspiration, prolonged death, and not dying. Patients are more likely to have complications, such as dying from choking on their vomit, when they are close to death. If a patient is already in the process of dying because death is within a few days, lethal drugs are contraindicated. Allowing one practitioner, who could be a non-physician, without specialization and without a second opinion to assess prognosis and decision-making capacity and provide immediate lethal drugs demonstrates reckless disregard for the complexity and dangers of this situation. In addition to the ethical

violations and untenable medical risks inherent in eliminating the waiting period, a patient's autonomy is violated by removing a chance to change his/her mind.

- Lethal drugs are never necessary for pain or symptom management, and shortening or eliminating the waiting period should never be done for reasons of symptom management. Even a physician who advocates for lethal drug prescriptions admits this.[2] Patients rarely seek lethal drugs for inadequate pain control, but usually for psychological distress over new onset disabilities associated with terminal illness. Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. It is unethical to get consent for lethal drugs from patients in severe pain which compromises a person's decision-making capacity.
- Removing the CO residency requirement opens Pandora's box for substandard patient evaluation and care, increased pressure on patients to ingest lethal drugs quickly, insurance fraud, and unclear legal problems.
    - CO practitioners are unlikely to know out-of-state patients and are more likely to miss depression, coercion, and cognitive deficits.
    - Patients traveling to CO are less likely to be accompanied by extended family and/or friends, depriving them of sharing this crucial life experience. Traveling to CO creates pressure on patients to follow through with taking lethal medications to justify the time, effort, and money spent, when they might otherwise have changed their minds and decided not to take the drugs or to wait longer.
    - If a patient does not need to travel to CO, virtual evaluations are substandard with inadequate confirmation of voluntary consent and absence of coercion. Trying to contain controlled substances to prevent their nefarious use would be hampered by interstate mailing of lethal drugs—and the legality of using federal mail service for a federally prohibited practice is questionable.
    - If the patient dies in CO and the death certificate lists the underlying terminal illness rather than the actual cause of death due to lethal drugs, this would be considered insurance fraud in the patient's home state.
    - If the person dies in their home state, legal ramifications are unclear. If it is known how the patient died or if there is an autopsy to discover the cause of death is a lethal overdose, then anyone in the presence of these patients when they died could be guilty of assisting a suicide. Perhaps the prescribing doctor could also be indicted on felony charges. Knowledge of the complications arising for dying in one's own state, this could create undue pressure for a patient to take lethal drugs immediately upon obtaining them in CO.
- The bill adds a potentially conscience-violating provision by requiring an unwilling "health-care provider" to record the individual's request for lethal drugs and the date of this request in the chart. If this recording starts the waiting period, then the recording "provider" is complicit in the act of providing lethal drugs. It also could potentially allow the patient to get same-day lethal drugs if at least 48 hours has elapsed since the request was recorded and the time at which the attending/consulting "providers" are seen.
- Current law requires medical record documentation of participation in this act (Section 25-48-111) and the Department of Public Health and Environment has adopted rules for reporting.[3] Physicians are currently required to submit a list of information within 30 days of writing a lethal prescription and within 10 days of dispensing a lethal prescription. Hundreds of forms are missing that document that the patient was eligible for and voluntarily consented to lethal drugs, including 20% of patient consent forms, 15% of attending physician forms, and 22% of consulting physician forms. (See details in the Table below.) No investigations have been done or sanctions introduced, although noncompliant physicians are potentially guilty of a felony for not following the letter of the law. Why does this bill propose removing safeguards when current safeguards are not being followed and patient safety is in jeopardy?
- This bill violates Medicare hospice regulations, which prohibit nurse practitioners from certifying a patient as terminally ill.[4]

CO Reporting Statistics[5] for Lethal Drug Prescriptions with Missing Forms

	2017	2018	2019	2020	2021	2022	2017-2022 Total (2022 Report)	2017-2022 Missing Forms[iii]
Patients prescribed lethal drugs	72	124	170	188	220	316	1090	
Patients to whom lethal drugs dispensed	56	, 85	137	150	164	246	838	
Patients who died	71	119	165	178	203	243	979	
Attending or prescribing physician form/ missing	63/**9**	108/**16**	146/**24**	160/**28**	188/**32**	260/**56**	925	165 (15%)
Patient's completed written request/ missing	50/**22**	93/**31**	130/**40**	157/**31**	185/**35**	258/**58**	873	217 (20%)
Mental health provider's confirmation	1	0	1	3	0	3	8 (0.7%)	
Consulting physician's written confirmation /missing	30/**42**	89/**35**	130/**40**	156/**32**	185/**35**	259/**57**	852 (849 actual)*	241 (22%)
Medication dispensing form	56	85	137	150	164	247**	839	
Death certificate[i]	71	119	165	178	203	243	979	
Totals Missing[ii]	73 (34%)	82 (22%)	104 (20%)	91 (16%)	102 (15%)	171 (18%)		623 (19%)

Note: Numbers in boxes represent those recorded in the most recent 2022 report from 2017-2022 except for the 2017 column from the 2021 report. Missing forms are in red print. Only 0.7% of all patients who are prescribed lethal drugs have a mental health consultation.

* Adding the final number in this row produces a sum of 849, but 852 is listed in the 2022 Report. Used 849 to calculate percentage of missing forms.

**Unclear why one more form received than patients to whom lethal drugs dispensed

[i]Note that death certificates are not documented for all the patients who received prescriptions for lethal drugs. It is unclear if these patients have not yet died—making their prognosis longer than 6 months in most cases—or if the death certificates have not been received or recorded.

[ii] Calculated using the added number of missing forms in each of three categories (attending, consulting, and patient request forms) divided by three times the number of patients prescribed lethal drugs for that year.

[iii] Calculated using the added number of missing forms in each row divided by 1090 (the number of patients prescribed lethal drugs from 2017-2022).

References

1. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.
2. "[No] patient should take medications to die because they're receiving inadequate symptom management at the end of their life. Hospice care is a way of assuring that patients aren't forced to consider aid in dying because of inadequate end-of-life-treatment." Shavelson, Lonny. Medical Aid in Dying: A Guide for Patients and Their Supporters. American Clinicians Academy on Medical Aid in Dying, 2022. (p. 36)
3. Department of Public Health and Environment Reporting and Collecting Medical Aid-in-Dying Medication Information (https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7163&fileName=6%20CCR%201009-4)
4. "No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill." (Medicare Benefit Policy Manual, Sec. 20.1, p.5; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)
5. See: 2022 Data Summary (https://drive.google.com/file/d/1DLML5hCvII0Udvt0vCalCziN9g9Lhgf9/view?pli=1) and 2021 Report (https://drive.google.com/file/d/1fnWB83wb9nnr0mXlr30t2fFSkJ55Zi-h/view).

SB24-068
Personal testimony of Catherine J. Wheeler, MD
I represent myself
I am asking a “no” vote.

I have had the privilege of caring for both of my parents and my brother, on hospice, at the end of life. At first, I was afraid of what their death would be like. However, on hospice, their pain and discomfort were well-managed, and while hard, getting to care for them until the end of their natural lives was beautiful. They died with peace and dignity.

SB24-068 would expand the medical provider pool to give medications to cause death, I assume because of the rapid increase from 72 deaths to 316 annual deaths, and to accommodate the expansion of the patient pool to non-Colorado residents. This would make Colorado a death-destination state. These patients would not be known by the Colorado medical provider providing prescriptions. How can one accurately assess in as short as 48 hours someone unknown to them, who desires death. Data reveals 40-60% of people seeking assisted suicide suffer depression, yet in Colorado less than 1% of are referred for mental health evaluation. The risk of undetected coercion will also increase.

People who make the effort and expense to come to Colorado for assisted suicide will likely feel more urgency to proceed with ingesting the drugs, and be less free to change their minds.

The definition of “terminal” was changed in this bill to “incurable and irreversible”. This describes most disease processes. Doctors are horrible predictors of when a patient will die. I know many people alive years longer than predicted.

Initially assisted suicide laws were focused on lethally managing intractable pain and suffering, this is no longer the case. In Oregon the top 3 reasons driving assisted suicide were 94%: decreased participation in life; 93% decreased autonomy; 72% decreased dignity

Expansion always comes, in other countries now including mental illness, drug addiction, children under 12 with disabilities, even eating disorders – all treatable conditions.

Expansion normalizes assisted suicide as a reasonable choice for others with similar conditions. I am especially concerned for our youth who are suffering a depression and suicide epidemic.

Expansion puts all of us at risk, because, we will all eventually have incurable, irreversible conditions. May those we love offer us loving care, not death, so we can die with true peace and dignity.

As a physician assistant, I ask you to please oppose SB24-068 ï Medical Aid in Dying.

When the waiting period for assisted suicide is shortened, patients become more susceptible to being coerced to suicide by those who would gain financially. Also, this shortened time infringes upon a patientôs right to have a change of mind.

A high percentage of patients seeking assisted suicide are depressed. There are better solutions for those who are depressed such as giving appropriate care, support and compassion. Compassion literally means "to suffer together." It means journeying with the patient who is suffering, NOT eliminating the patient.

A state sanctioned suicide should not be the approach to clinical depression. Our state Assembly appropriated over 33 million dollars for suicide prevention. It does not make sense to now promote suicide which undermines our state's suicide prevention program. Additionally, we don't want the reputation as the state where people across the country come to die.

If patients are in pain, lethal drugs are never necessary. There are adequate pain management medications.

Suicide is not the best way to die. In states such as Oregon, death by medically assisted suicide can sometimes take hours to days and can be complicated by nausea, vomiting, delirium, and seizures.

It is egregious that this bill will have some physicians falsify death certificates listing the underlying terminal illness as the cause of death, rather than due to lethal drugs. This would be considered insurance fraud. Additionally, this would mean researchers will not have an accurate way to assess the quantity or the quality of the practice of assisted suicide in Colorado.

This bill also violates the Medicare hospice regulations, which prohibits nurse practitioners from certifying a patient as terminally ill. Besides, even experienced health care specialists have been in error of giving a prognosis of less than 6 months to live. In states that have legalized physician-assisted suicide, some patients have lived years beyond the predicted less than 6 months of time of death.

For this and many more reasons, I ask you to please oppose this bill.
Thank you for your consideration.

Respectfully,
Josephine Dennison, MS, PA-C

SB24-068 Medical Aid-in-Dying (MAID), Lloyd Benes opposition, 29feb2024

My Name is Lloyd Benes, and I represent myself. The following 4 reasons for opposing this Bill include citations as shown in the paper copies before you and given in the written testimony I submitted online today (at https://www2.leg.state.co.us/CLICS/CLICS2024A/commsumm.nsf/signIn.xsp).

One: The Hippocratic Oath's principle says, "First, do no harm," reflecting our expectation for medical practitioners to prioritize saving lives. This current Bill endorses increased access to terminating lives of older people, expanding assisted suicide. Colorado data shows 92% of assisted suicides involve ages 55 or older (citation = tinyurl.com/4hsr3fmr). I am a 69-year-old, and I oppose this trend that indisputably focuses on the elderly, so I urge a return to the fundamental principle of "First, do no harm."

Two: "Compassion for those facing extreme pain" is a flawed reason for increased access to assisted suicide. Oregon began assisted suicides 25 years ago & only 28% of Oregon patients listed "inadequate pain control" as an end-of-life concern (citation = tinyurl.com/baum3dy2). The primary worries were diminished ability to enjoy life (90% of patients), loss of autonomy (90% of patients), loss of dignity (72%), and burden on family (48%). Instead of focusing on expanding assisted suicide, our Bill could examine Colorado's current law and require patients to express their end-of-life concerns. And we could take Oregon's data right now and do something positive with it ...

Third: ...like offer mental health assistance to address concerns like diminished abilities, loss of autonomy, and burden on family. In the Colorado study, only 1% had access to mental health provider support (see page 7 of citation = tinyurl.com/4hsr3fmr). Shouldn't we prioritize mental health care to alleviate end-of-life concerns?

Fourth: Insurance companies have begun to deny life-saving drugs in favor of life-ending drugs (citation = tinyurl.com/mvf453n). The Bill's only commendable clauses include Section 19, prevents such insurance benefits denial, and Section 20, prohibits attempts to coerce individuals with terminal illnesses into requesting life-ending drugs.

In summary, please throw out all of this Bill except Sections 19 & 20 that address the insurance concerns. Then modify Section 11 to include the question about end-of-life concerns and insure compliance to filing the questionnaire. Finally provide mental health professional support to address the overwhelming majority of end-of-life concerns. Otherwise, Please vote No on this Bill.

Testimony in Opposition to SB24-068 – Medical Aid in Dying

My name is Tom Perille. I am a physician and President Democrats for Life of Colorado.

The End-of-Life Options Act passed by a large margin in 2016. Voters thought they were choosing to allow assisted suicide (PAS) because of their compassion for patients facing intractable pain and suffering in the course of a terminal illness. They assumed that safeguards would be in place to be sure that patients had a terminal illness, that they were not acting out of clinical depression, that they had the mental capacity to make such a grave decision, and that the physician accommodating their request knew their history and values well.

But now we know that what the voters were choosing, and the reality of assisted suicide in Colorado are two very different things.

In Colorado our process is not transparent. We know nothing about the outcomes/complications of the procedure. Based on data from other jurisdictions that require more robust reporting, we recognize that patients who choose PAS don't have more pain or suffering than those who don't. We know that some who choose PAS can languish for hours or days and die alone. We know that losing autonomy, loss of dignity, and being a burden on family is a much larger driver of the decision than real or anticipated pain. These reasons are an indictment of our medical delivery system and social safety net more than they are an endorsement of PAS.

We know that in Colorado the protocol is so lax that the state doesn't even receive critical documentation such as the Attending Physician form or the Patient Consent form. In contrast to other jurisdictions, there is no mandated peer review process for cases of PAS. Colorado physicians are only held to a "good faith" standard rather than the more appropriate "reasonable medical judgement" standard in their life/death decisions. Even though up to 48% of patients who request PAS are depressed, less than 1% of Colorado patients are referred for mental health consultation. Few patients know the physician before the lethal overdose is prescribed.

SB24-068 expands assisted suicide to nurse practitioners who don't have the training or expertise, it drastically shortens a very important waiting period that is a critical check against the impulsive pursuit of PAS, and it gives non-residents access to PAS. By rapidly expanding access, it normalizes the ableism which defines PAS. It does not address the very significant possibility that expanding access to PAS might increase non-assisted suicide in vulnerable individuals, such as at-risk teens. It does not ensure safe storage of the massive doses of narcotics utilized in PAS. It does not promote or fund a Colorado model of excellence in palliative/hospice care.

Why oppose SB24-068 – Medical Aid in Dying?

1) There are significant problems with the implementation of the End-of-Life Options Act which ***need to be fixed before expanding Assisted Suicide*** in Colorado.
   a) Currently, required forms are not always submitted including the patient consent and attending physician forms. The laxity of compliance needs to be addressed because we don't know that patients are receiving the counseling and care the End-of-Life Options Act promised.
   b) There is no peer review to establish whether the requirements for a 6-month terminal diagnosis and alternative treatment options are being met or that the patients aren't suffering from a clinically significant depression. This kind of best practice is required in some jurisdictions that allow assisted suicide and euthanasia. The bill continues to mandate only a "good faith" effort to comply with the requirements of the End-of-Life Options Act rather than the more robust "reasonable medical judgement".
   c) There is no requirement to document complications from administration of the overdose drugs or the time till unconsciousness and death. This is a best practice mandated in other US jurisdictions.
   d) There are inadequate referrals (<1%) for mental health consultation based on the evidence that a high percentage of patients (up to 48%) seeking assisted suicide are depressed. Shouldn't we require documentation of the performance of simple depression (such as PHQ-9) and mental capacity clinical tools (like MacCAT-T) in the Attending Physician form before we embark on a bill to lower safeguards. None of us want state sanctioned suicide to be an approved approach to clinical depression.
   e) There is no state mandated oversight to ensure that patients seeking assisted suicide aren't being coerced for financial or other reasons. Shouldn't the state have the authority to review random cases where assisted suicide was pursued to be sure there is not a problem.
   f) Since physicians are asked to falsify the death certificate for patients dying from assisted suicide, there is no accurate way to fully assess the quantity or the quality of the practice of assisted suicide in Colorado. We should change this so that we can pursue public health research into assisted suicide and its effects on Colorado.
   g) There has been no public health effort to quantify the impact of assisted suicide on non-assisted suicide rates, especially in high-risk teen populations. In the last 3 legislative sessions alone, the Colorado Assembly appropriated over 33 million dollars for suicide prevention and another $900,000 has already passed one

The Colorado Sun

OPINION: OPINION COLUMNS

Opinion: Colorado needs to stop and rethink possible changes to the medical aid in dying laws

Physician-assisted suicide became Colorado law in 2016, but the latest proposal to loosen restrictions could have serious unintended consequences

Thomas J. Perille, M.D.

Published : 1:30 AM MST on Feb 21, 2024

Compassion for individuals confronting a terminal illness drove the efforts to legalize physician-assisted suicide, or PAS (also known as medical aid in dying), in Colorado in 2016. Compassion is again the motivation behind an attempt by legislators to loosen the requirements and increase access to physician-assisted suicide through **Senate Bill 068**. Despite the admirable intentions, the bill could actually increase suffering and cause serious unintended consequences for vulnerable individuals and communities throughout the state.

When the **End-of-Life Options** ballot initiative was passed, many Coloradans assumed they were voting to give options to patients with intractable pain and suffering — especially for those with terminal cancer. The reality is that fear of pain or actual pain is a minor reason that patients choose PAS in jurisdictions where it is legal. Colorado's law doesn't require physicians to submit the reason why their patients choose PAS, but other states have more robust data collection and safeguards.

In **Oregon**, which has the longest PAS program in the country, only 28% cited inadequate pain control or anticipation of pain as a contributing factor to their decision. In fact, when **assessed prospectively**, the amount of pain and suffering endured by patients who choose PAS is no different than for those who don't pursue PAS.

✱ MORE IN OPINION

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Published : 1:30 AM MST on Feb 28, 2024

Opinion: Coloradans need greater equity to end-of-life care options, and new bill would help

Published : 1:30 AM MST on Feb 27, 2024

Coloradans may be surprised to learn some of the factors which are more commonly cited in the PAS decision. Being a burden on families (48%), loss of dignity (72%), and losing autonomy (90%) all are more important than pain, according to the Oregon report from 2022. These feelings aren't inevitable at the end of life and could be a reflection of the growing ableist mentality in our country. They also highlight the inadequacy of our social safety net.

When I change my 1-year-old grandson's diaper, I never think that he has no value or dignity. Similarly, when I helped my 96-year-old father near the end of his life with personal hygiene tasks, I never thought he was less a man because he had the inability to independently perform some activities of daily living.

Being dependent does not deprive a person of their value and dignity. However, that is exactly the message that is frequently portrayed by PAS advocates and the compliant media. In **public testimonials** to PAS, the term "dignity" is frequently invoked. Choosing PAS is often characterized as "courageous." Equating disabilities and dependency with value and dignity quickly becomes a message that reverberates in vulnerable Coloradans.

By **making access to PAS easier**, we will be promoting this ableist message. Senate Bill 068 expands the universe of people who can prescribe PAS to nurse practitioners. It allows patients from other states to participate in PAS. And it decreases the time that a patient is required to wait to receive their PAS drugs from 15 days to 48 hours or less.

As assisted suicide is normalized, the explicit or implicit message to consider it will increase among vulnerable Coloradans. What starts out as a "right" becomes an obligation nurtured by the medical community and changing public attitudes.

What is often overlooked, if not purposely ignored, is that a significant percentage of people seeking PAS are depressed. The End-of Life Options Act required that PAS participants be "mentally capable." The reality is that **less than 1% of people in Colorado** prescribed PAS drugs have been referred for mental health consultation. Since conservative **estimates** suggest that at least 8% and as many as 47% of patients who request PAS have clinical depression, we are likely treating clinical depression with state-sanctioned suicide. Senate Bill 068 would further exacerbate the problem by ensuring that an impulsive decision to pursue PAS would not be deterred since the waiting period will be abbreviated to a mere 48 hours.

Suicide is a serious problem in Colorado and has been a focus of private and public scrutiny and preventative efforts. Colorado's current public health posture provokes cognitive dissonance. On the one hand, we are doing everything in our power to prevent suicide, especially in vulnerable teens. On the other hand, we are promoting suicide for the sick, elderly and disabled through PAS. And with Senate Bill 068, even when their natural death is imminent.

It is well known that suicide is **contagious.** Our vulnerable teens are listening and watching. Can you imagine the message that they internalize when they see their grandmother extolled for ending her life "on her terms"? They see that suicide is viewed as a rational response to existential and physical suffering. It should come as no surprise that **preliminary work** suggests that PAS is associated with an increase in non-assisted suicide rates.

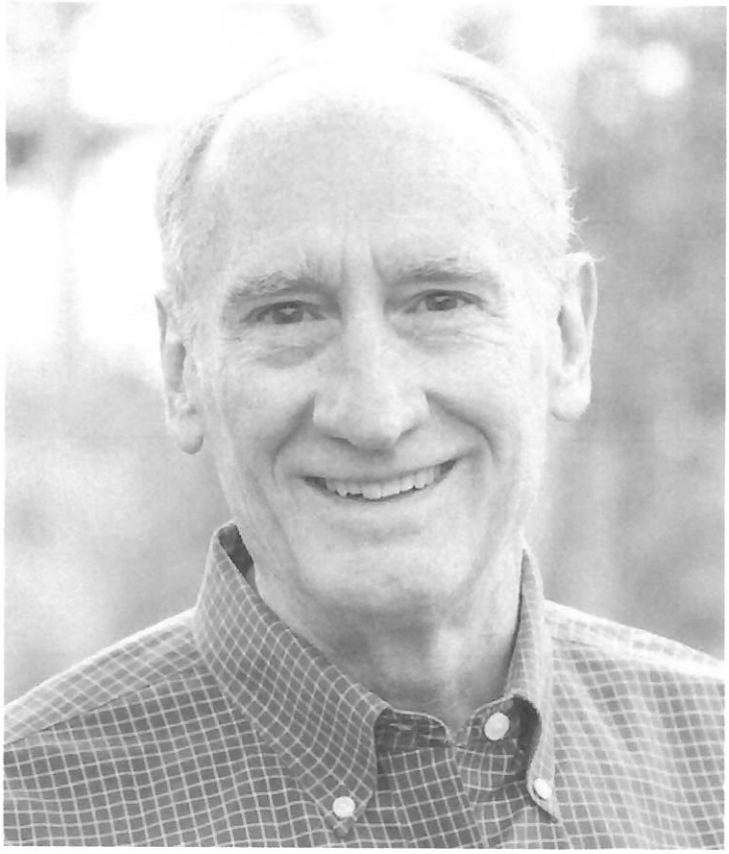
We should redirect our compassion. Senate Bill 068, by promoting PAS, reinforces ableism and diminishes the value and dignity of terminally ill patients. The bill does nothing to address the issue of depression that drives some to pursue PAS. It could increase deaths in vulnerable (non-terminal) populations including at-risk teens. For all these reasons, Coloradans should let their state senators and representatives know that this bill doesn't have a place in Colorado.

Thomas J. Perille lives in Englewood and is a medical doctor and the president of Democrats for Life of Colorado.

https://www.coloradopolitics.com/opinion/vulnerable-coloradans-at-risk-from-assisted-suicide-opinion/article_51ff2d8a-1bb4-11ee-b6e8-a36219becc07.html

Vulnerable Coloradans at risk from assisted suicide | OPINION

By Thomas J. Perille
Jul 6, 2023



Thomas J. Perille

There was little fanfare when the Colorado Department of Public Health and Environment (CDPHE) released the 2022 statistics pertaining to the 2016 Colorado End-of-Life Options Act. This six-year anniversary report deserves meaningful reflection.

Since its inception, there has been a 460% increase in lethal prescriptions. Though the absolute numbers are still small (316), the growth is exponential — consistent with the experience of every other state and country that have legalized physician-assisted suicide (PAS).

PAS has been euphemistically relabeled "medical aid in dying" (MAID) by its proponents. For centuries, physicians have provided curative care when possible and compassionate, palliative care to alleviate suffering when a cure is out of reach. This has been central to our oath as medical professionals dating to the earliest iteration of our ethics articulated by Hippocrates. Prior to the emergence of physician assisted suicide, "medical aid in dying" never encompassed the deliberate prescription of a medication(s) whose expressed purpose was to kill the patient.

Coloradans relish their freedom and idolize the notion of "rugged individualism." It is not hard to see why 65% of the electorate chose to enshrine PAS into state law in 2016. There are few areas in life where people feel more out of control than during the relentless march toward their own death. PAS gives the illusion of control but robs us and our families of precious time together.

The 2022 report highlights the lax drafting and implementation of the law. The required forms are not always submitted. There are no audits of the cases to ensure that the patient wasn't coerced or that their sickness genuinely reflected a terminal illness. And no reasons for PAS are solicited — which means that Colorado has no way to determine where our palliative care and end of life interventions are failing.

Although candidates for PAS are supposed to have a prognosis of six months or less, accurately predicting a person's prognosis is extremely difficult — which me some jurisdictions with longstanding ac nonth" terminal

illness.

There are certain themes that seem to animate the practice of PAS in Colorado. PAS is commonly depicted as "courageous" and critical to maintaining one's "dignity." The underlying assumption is that when we lose cognitive or physical abilities, we also lose our human dignity. This is a very ableist perspective. It undermines the value and dignity of those who are sick or elderly and countless other men and women who live and thrive with their disability.

The reality is that being weak and vulnerable is a feature of our journey as humans and not a flaw. And we become more human when we address the needs of fellow humans facing sickness or disability. No one is totally independent, and rugged individualism is a dangerous myth. Solidarity with our family, friends and community is more integral to society's flourishing than a radical vision of independence and autonomy.

When society equates independence with human value and dignity, the growing dependence that marks a terminal illness will naturally prompt more to choose PAS. And "choice" easily morphs into obligation. In Oregon and Washington, 85% to 86% of patients cite losing autonomy, 62% to 73% cite losing dignity, and 46% to 56% cite becoming a burden on family/caregivers as their end-of-life concern. When we don't cherish the lives of all Coloradans and fail to provide effective end of life support, we perpetuate a cycle of marginalization of the most vulnerable and contribute to what has been aptly called a "throwaway culture."

Besides the sick, elderly and disabled, the other group most susceptible to the negative influences of PAS ideology are adolescents and young adults. They are already experiencing unprecedented levels of suicide. It is well known that suicide can be contagious. There is evidence this applies to publicized cases of PAS and likely to those who only reveal their intentions to a close circle of family and friends. Preliminary research in the U.S. and Europe suggests states that legalize PAS have higher rates of suicide.

Can you imagine the message your child, or grandchild might internalize when they see you choose to pursue suicide because you equate human dignity and quality of life solely with physical attributes and eschew all "suffering?" Your suicide may have unintended ripple effects that can lead to tragic suicides in younger members of your family and community. Suddenly, the prospect of PAS seems less courageous and rather reckless.

Many assume people who choose PAS must have intolerable and disproportionate pain and suffering. The reality is PAS patients have no more pain or suffering than others who choose to die naturally from their disease. Depression and hopelessness are common factors that drives the PAS decision but only 1% of Colorado PAS patients in 2022 were referred to a mental health professional.

I hope Coloradans take this opportunity to soberly consider the implications of our decision to legalize PAS. At the very least, we should tighten the safeguards. And perhaps it is time to study the impact of PAS on our families and communities before we travel further down the proverbial slippery slope. Already more vulnerable Coloradans are at risk. As attitudes change and more qualifications are placed on human value and dignity, nobody will be safe.

Thomas J. Perille, M.D., is president of Democrats for Life of Colorado. He is a fellow of the American College of Physicians and the Society of Hospital Medicine.

These are the precautions from the American Clinicians Academy on Medical Aid in Dying – This requires expertise beyond the training of nurse practitioners.

Red Flag Risk checklist for potentially complicated and/or prolonged AID deaths
(NOTE: This should be checked before prescribing medications, and again close to the aid-in-dying date. Conditions change.)

• Gut issues:

o Severe cachexia and/or prolonged time with no oral nutrition—associated with duodenal villous atrophy and poor med absorption.

o Gastroparesis (delayed gastric emptying)

o Poorly controlled nausea/vomiting = gastroparesis

o Anticholinergic medications (Compazine, Haldol, Benadryl, hyoscyamine, others)

o Severe constipation/obstipation

o Partial or complete bowel obstructions.

o GI disease, including pancreatic cancer, colon cancers, hepatic metastases

o Ascites that is tense (peritoneal mets, and/or portal hypertension with concomitant bowel edema and compression. (For tense ascites, recommend paracentesis the day before aid in dying.)

• Swallowing concerns:

o Too weak to actively swallow

o Oropharyngeal or esophageal obstruction, even if partial

o Intolerance to swallowing bitter or bad-tasting liquids.

• Medication-related concerns:

o Very high opiate or benzo tolerance. (NOTE: This risk factor is improved with the newer aid-in-dying protocols that include phenobarbital.)

• General Factors:

o Obesity

o Extreme exercise history/cardiac fitness, even if remote in time.

Physicians for Compassionate Care Education Foundation (PCCEF)

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Reasons to Oppose Colorado SB24-068
Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation (PCCEF)
Senate Health & Human Services
February 29, 2024

I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation. We advocate for the terminally ill, who often have compromised capacity to choose, making them vulnerable to abuse. I have expertise in pediatric anesthesiology, critical care, and medical ethics. On behalf of our Colorado members, we urge you to oppose SB24-068 which demolishes voter-approved safeguards, violates patient autonomy, and discriminates against those with depression and disabilities who are most likely to pay for these changes with their lives.

- Respect for patients' choices includes ensuring that they have the right to change their minds—this bill denies that option. When a patient says they want to hasten death, this often is a plea for help, not a real desire to kill themselves, and this wish usually abates with supportive care.[1] Lethal drugs are not usually sought for pain but for psychological distress over new onset disabilities. A patient who says they want to die might really mean "I'm afraid I'm a useless burden." Vulnerable patients make rash decisions out of fear, depression, compromised decision-making capacity, embarrassment, subtle pressure by a tired caregiver who makes them feel like a burden, etc. All may go unrecognized by doctors. Given time, palliative care and mental health interventions, patients often change their minds, but this bill allows a bad day to become their last day. Fifteen days may be inadequate to do this but chopping it to 48 hours or eliminating it entirely represents patient abandonment under a guise of "autonomy." It takes two weeks for anti-depressants to begin to work; 48 hours is too short to ensure due diligence has been done.
- Shortening the waiting period has no advantages for patients and will only violate patient autonomy and increase discrimination against the most vulnerable. By not allowing adequate time and sufficient expertise to assess what may be rash requests to hasten death in the midst of fear or depression, this bill not only infringes on patient autonomy by violating patients' rights to change their minds, but it allows injustice and discrimination, because the people most likely to be adversely affected by these changes are those with mental illness and disabilities. There is no scientific data or plausible reason to eliminate the safeguards of time and expertise—the risk of harms for doing so outweigh any benefits.
- The provision to eliminate the waiting period demonstrates reckless disregard for patients. The determination that death is near is difficult and imprecise for experts, and patients typically have loss of both mental capabilities and swallowing function as death nears. By the time one knows a patient is near death the chance of obtaining a valid consent is unlikely, and it is doubtful that the patient could ingest the lethal concoction. Patients must take antiemetics and numb their mouths with popsicles before swallowing substantial amounts of a bitter tasting, sometimes burning cocktail of lethal drugs dissolved in liquid. Risks include painful ingestion, nausea, vomiting, aspiration, prolonged death, and not dying. Patients are more likely to have complications, such as dying from choking on their vomit, when they are close to death. If a patient is already in the process of dying because death is within a few days, lethal drugs are contraindicated. Allowing one practitioner, who could be a non-physician, without specialization and without a second opinion to assess prognosis and decision-making capacity and provide immediate lethal drugs demonstrates reckless disregard for the complexity and dangers of this situation. In addition to the ethical

violations and untenable medical risks inherent in eliminating the waiting period, a patient's autonomy is violated by removing a chance to change his/her mind.

- Lethal drugs are never necessary for pain or symptom management, and shortening or eliminating the waiting period should never be done for reasons of symptom management. Even a physician who advocates for lethal drug prescriptions admits this.[2] Patients rarely seek lethal drugs for inadequate pain control, but usually for psychological distress over new onset disabilities associated with terminal illness. Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. It is unethical to get consent for lethal drugs from patients in severe pain which compromises a person's decision-making capacity.
- Removing the CO residency requirement opens Pandora's box for substandard patient evaluation and care, increased pressure on patients to ingest lethal drugs quickly, insurance fraud, and unclear legal problems.
    - CO practitioners are unlikely to know out-of-state patients and are more likely to miss depression, coercion, and cognitive deficits.
    - Patients traveling to CO are less likely to be accompanied by extended family and/or friends, depriving them of sharing this crucial life experience. Traveling to CO creates pressure on patients to follow through with taking lethal medications to justify the time, effort, and money spent, when they might otherwise have changed their minds and decided not to take the drugs or to wait longer.
    - If a patient does not need to travel to CO, virtual evaluations are substandard with inadequate confirmation of voluntary consent and absence of coercion. Trying to contain controlled substances to prevent their nefarious use would be hampered by interstate mailing of lethal drugs—and the legality of using federal mail service for a federally prohibited practice is questionable.
    - If the patient dies in CO and the death certificate lists the underlying terminal illness rather than the actual cause of death due to lethal drugs, this would be considered insurance fraud in the patient's home state.
    - If the person dies in their home state, legal ramifications are unclear. If it is known how the patient died or if there is an autopsy to discover the cause of death is a lethal overdose, then anyone in the presence of these patients when they died could be guilty of assisting a suicide. Perhaps the prescribing doctor could also be indicted on felony charges. Knowledge of the complications arising for dying in one's own state, this could create undue pressure for a patient to take lethal drugs immediately upon obtaining them in CO.
- The bill adds a potentially conscience-violating provision by requiring an unwilling "health-care provider" to record the individual's request for lethal drugs and the date of this request in the chart. If this recording starts the waiting period, then the recording "provider" is complicit in the act of providing lethal drugs. It also could potentially allow the patient to get same-day lethal drugs if at least 48 hours has elapsed since the request was recorded and the time at which the attending/consulting "providers" are seen.
- Current law requires medical record documentation of participation in this act (Section 25-48-111) and the Department of Public Health and Environment has adopted rules for reporting.[3] Physicians are currently required to submit a list of information within 30 days of writing a lethal prescription and within 10 days of dispensing a lethal prescription. Hundreds of forms are missing that document that the patient was eligible for and voluntarily consented to lethal drugs, including 20% of patient consent forms, 15% of attending physician forms, and 22% of consulting physician forms. (See details in the Table below.) No investigations have been done or sanctions introduced, although noncompliant physicians are potentially guilty of a felony for not following the letter of the law. Why does this bill propose removing safeguards when current safeguards are not being followed and patient safety is in jeopardy?
- This bill violates Medicare hospice regulations, which prohibit nurse practitioners from certifying a patient as terminally ill.[4]

CO Reporting Statistics[5] for Lethal Drug Prescriptions with Missing Forms

	2017	2018	2019	2020	2021	2022	2017-2022 Total (2022 Report)	2017-2022 Missing Forms[iii]
Patients prescribed lethal drugs	72	124	170	188	220	316	1090	
Patients to whom lethal drugs dispensed	56	, 85	137	150	164	246	838	
Patients who died	71	119	165	178	203	243	979	
Attending or prescribing physician form/ missing	63/9	108/16	146/24	160/28	188/32	260/56	925	165 (15%)
Patient's completed written request/ missing	50/22	93/31	130/40	157/31	185/35	258/58	873	217 (20%)
Mental health provider's confirmation	1	0	1	3	0	3	8 (0.7%)	
Consulting physician's written confirmation /missing	30/42	89/35	130/40	156/32	185/35	259/57	852 (849 actual)*	241 (22%)
Medication dispensing form	56	85	137	150	164	247**	839	
Death certificate[i]	71	119	165	178	203	243	979	
Totals Missing[ii]	73 (34%)	82 (22%)	104 (20%)	91 (16%)	102 (15%)	171 (18%)		623 (19%)

Note: Numbers in boxes represent those recorded in the most recent 2022 report from 2017-2022 except for the 2017 column from the 2021 report. Missing forms are in red print. Only 0.7% of all patients who are prescribed lethal drugs have a mental health consultation.

* Adding the final number in this row produces a sum of 849, but 852 is listed in the 2022 Report. Used 849 to calculate percentage of missing forms.

**Unclear why one more form received than patients to whom lethal drugs dispensed

[i] Note that death certificates are not documented for all the patients who received prescriptions for lethal drugs. It is unclear if these patients have not yet died—making their prognosis longer than 6 months in most cases—or if the death certificates have not been received or recorded.

[ii] Calculated using the added number of missing forms in each of three categories (attending, consulting, and patient request forms) divided by three times the number of patients prescribed lethal drugs for that year.

[iii] Calculated using the added number of missing forms in each row divided by 1090 (the number of patients prescribed lethal drugs from 2017-2022).

References

1. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.
2. "[No] patient should take medications to die because they're receiving inadequate symptom management at the end of their life. Hospice care is a way of assuring that patients aren't forced to consider aid in dying because of inadequate end-of-life-treatment." Shavelson, Lonny. Medical Aid in Dying: A Guide for Patients and Their Supporters. American Clinicians Academy on Medical Aid in Dying, 2022. (p. 36)
3. Department of Public Health and Environment Reporting and Collecting Medical Aid-in-Dying Medication Information (https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7163&fileName=6%20CCR%201009-4)
4. "No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill." (Medicare Benefit Policy Manual, Sec. 20.1, p.5; https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)
5. See: 2022 Data Summary (https://drive.google.com/file/d/1DLML5hCvII0Udvt0vCalCziN9g9Lhgf9/view?pli=1) and 2021 Report (https://drive.google.com/file/d/1fnWB83wb9nnr0mXlr30t2fFSkJ55Zi-h/view).

CONCERNED
WOMEN for AMERICA
LEGISLATIVE ACTION COMMITTEE

February 29, 2024
Senate Health and Human Services
Testimony in Opposition to SB24-068

Chairwoman Fields and members of the Committee, I am Dr. Karen Pennington, State Director for Concerned Women for America (CWA) of Colorado. We are the largest grassroots, ~ 500,000 strong, public policy women's organization in the country. I am a nurse and educator, and today, I am testifying for Concerned Women for America Legislative Action Committee in opposition to SB24-068.

As a professional nurse and educator, I taught as well as committed myself to the Nurses Nightingale Pledge in which nurses abstain from knowingly administering any harmful drug. Physicians Hippocratic Oath is similar language to "do no harm"[1]. Medical Aid in Dying (MAID) is, in essence, suicide as defined: intentional taking of one's life[2]. Often presented as end of life "care", I offer there is no "care" in encouraging a person to end life abruptly. I cannot intentionally harm another.

To end life through MAID is the devaluing of human life and a slippery slope leading to a culture of death. If normalized, a progressive increase in suicide and coercion through euthanasia for terminal illnesses, mental health issues, the disabled can be expected. This bill does not protect from coercion and preying on persons with terminal illness.

Consider Canada's most recent legislation expanding MAID to include mental health patients. It was delayed for three years in order to stabilize assisted suicide rates and prepare medical professionals and Canadians for implementation of a moral imperative to end life[3] . Our Declaration of Independence states our Creator endows us with a "right to life," not a "right to die". America was formed on the belief that human life is precious and valued, not disposable. We are not God and have no right to determine an "expiration date" on humans. I have witnessed patients with terminal illnesses live beyond the expectations of physicians, themselves, and family. Additionally, patients need reasonable time to deal with the business of dying: such as saying goodbye to friends, family, finalizing wills, etc., and 48 hours is not long enough. This bill goes far beyond the 2016 Proposition 106 passed by voters and is bad for Colorado.

Concerned Women for America of Colorado urges you to Vote "NO" on SB24-068.

Thank You.

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[1] https://nurseslabs.com/the-nightingale-pledge/
[2] https://www.merriam-webster.com/dictionary/suicide
[3] https://www.cbc.ca/news/politics/mature-minors-advance-requests-mental-illness-maid-assisted-death-1.6021717#:~:text=The%20Senate%20has%20passed%20Bill%20C-7%2C%20which%20expands,with%20Bill%20C-7%2C%20which%20passed%20in%20March%202021.

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COLORADO END-OF-LIFE OPTIONS ACT, 2022 DATA SUMMARY, WITH 2017-2022 TRENDS AND TOTALS

Prepared by:
Center for Health and Environmental Data
Colorado Department of Public Health and Environment

For more information, visit cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying

Introduction

In 2016, Colorado voters approved Proposition 106, "Access to Medical Aid in Dying," which amends Colorado statutes to include the Colorado End-of-Life Options Act, Article 48 of Title 25, Colorado Revised Statutes (C.R.S.). This Act allows an eligible terminally-ill individual with a prognosis of six months or less to live to request and self-administer medical aid-in-dying medication in order to voluntarily end his or her life; authorizes a physician to prescribe medical aid-in-dying medication to a terminally ill individual under certain conditions; and creates criminal penalties for tampering with a person's request for medical aid-in-dying medication or knowingly coercing a person with a terminal illness to request the medication.

This Act requires prescribing physicians and health care professionals dispensing aid-in-dying medication to report to the Colorado Department of Public Health and Environment (CDPHE) specific information outlined by the Act. This information is to be used to ensure documentation requirements outlined in the Act are met, as well as to make available to the public an annual statistical report. Rules for reporting were adopted by the Board of Health in 2017 (6 CCR 1009-4, Reporting and Collecting Medical Aid-in-Dying Medication Information).

This report is the sixth annual statistical report published per this Act, and describes Colorado's participation in End-of-Life Options activities in 2022; incorporates updates to previously-published statistics; and includes summary statistics for the complete six-year period of participation, 2017-2022.

Data Collection and Statistics

Statistics presented in this report reflect patients for whom prescriptions for aid-in-dying medication were written; among those, patients to whom aid-in-dying medications were dispensed; and deaths among patients subsequent to prescription of aid-in-dying medication. Data used for this report are based on required reporting forms and death certificates received by CDPHE. More information about the reporting process and required forms as well as this this annual report are available at: cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying.

It is important to note that the Colorado End-of-Life Options Act does not authorize or require the Colorado Department of Public Health and Environment to follow up with physicians who prescribe aid-in-dying medication, patients, or their families to obtain information about use of aid-in-dying medication. Additionally, the Colorado End-of-Life Options Act requires that the cause of death assigned on a patient's death certificate be the underlying terminal illness.

Table 1. Underlying terminal illnesses/conditions among patients prescribed aid-in-dying medication, 2018-2022 with 2017-2022 totals.

	2018		2019		2020		2021		2022		2017-2022 Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Total number of patients prescribed aid-in-dying medication	124	100	170	100	188	100	220	100	316	100	1,090	100
Malignant neoplasm - Total	79	63.5	103	60.7	126	66.9	137	62.4	184	58.1	676	62.1
Lung and bronchus	9	7.3	15	8.8	19	10.1	22	10	39	12.3	115	10.6
Breast	7	5.6	12	7.1	17	9	12	5.5	19	6	68	6.2
Pancreas	9	7.3	13	7.6	14	7.4	22	10	14	4.4	80	7.3
Colon, rectum and anus	5	4	7	4.1	15	8	11	5	14	4.4	56	5.1
Kidney and urinary tract	2	1.6	2	1.2	2	1.1	8	3.6	10	3.2	24	2.2
Ovary	5	4	4	2.4	3	1.6	4	1.8	9	2.8	27	2.5
Prostate	4	3.2	5	2.9	9	4.8	7	3.2	8	2.5	40	3.7
Multiple myeloma	2	1.6	3	1.8	1	0.5	2	0.9	8	2.5	16	1.5
Central nervous system	4	3.2	8	4.7	10	5.3	12	5.5	7	2.2	42	3.9
Head and neck	5	4	8	4.7	5	2.7	4	1.8	6	1.9	34	3.1
Esophagus	4	3.2	1	0.6	5	2.7	5	2.3	6	1.9	23	2.1
Melanoma	4	3.2	2	1.2	1	0.5	4	1.8	5	1.6	17	1.6
Stomach	1	0.8	3	1.8	1	0.5	2	0.9	5	1.6	12	1.1
Uterus	3	2.4	5	2.9	4	2.1	2	0.9	4	1.3	18	1.7
Bladder	1	0.8	2	1.2	2	1.1	2	0.9	4	1.3	12	1.1
Lymphoma	0	0	2	1.2	0	0	4	1.8	4	1.3	10	0.9
Bile duct	2	1.6	1	0.6	4	2.1	0	0	2	0.6	10	0.9
Leukemia	1	0.8	2	1.2	1	0.5	1	0.5	2	0.6	7	0.6
Cervix	1	0.8	0	0	1	0.5	1	0.5	1	0.3	4	0.4
Other cancers	10	8.1	8	4.7	12	6.4	12	5.5	17	5.4	61	5.6
Progressive neurological or neurodegenerative disorders - Total	27	21.7	34	20	25	13.3	39	17.8	45	14.2	182	16.8
Amyotrophic lateral sclerosis	14	11.3	19	11.2	12	6.4	22	10	23	7.3	99	9.1
Parkinson's disease	4	3.2	5	2.9	3	1.6	6	2.7	10	3.2	29	2.7
Other progressive neurological or neurodegener-ative disorder	2	1.6	7	4.1	5	2.7	6	2.7	6	1.9	26	2.4
Multiple sclerosis	2	1.6	1	0.6	0	0	1	0.5	3	0.9	7	0.6
Progressive supranuclear palsy	5	4	1	0.6	4	2.1	3	1.4	2	0.6	15	1.4
Corticobasal degeneration	0	0	1	0.6	1	0.5	1	0.5	1	0.3	6	0.6
Cardiovascular disease	6	4.8	13	7.6	15	8	13	5.9	24	7.6	78	7.2
Chronic lower respiratory disease	7	5.6	9	5.3	12	6.4	9	4.1	25	7.9	67	6.1
Interstitial lung disease	0	0	4	2.4	1	0.5	6	2.7	9	2.8	21	1.9

Table 3. Summary of patients who died following prescription of aid-in-dying medication, 2018-2022 with 2017-2022 totals.

	2018		2019		2020		2021		2022		2017-2022 Total	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Total number of decedents prescribed aid-in-dying medication	119	100	165	100	178	100	203	100	243	100	979	100
Sex												
Female	61	51.3	79	47.9	93	52.2	94	46.3	134	55.1	493	50.4
Male	58	48.7	86	52.1	85	47.8	109	53.7	109	44.9	486	49.6
Age group												
18-34	1	0.8	2	1.2	0	0.0	2	1	0	0.0	5	0.5
35-44	2	1.7	1	0.6	2	1.1	5	2.5	2	0.8	13	1.3
45-54	12	10.1	14	8.5	10	5.6	12	5.9	8	3.3	58	5.9
55-64	21	17.6	32	19.4	37	20.8	27	13.3	43	17.7	170	17.4
65-74	42	35.3	55	33.3	45	25.3	67	33	70	28.8	302	30.8
75-84	25	21	36	21.8	50	28.1	59	29.1	69	28.4	261	26.7
85+	16	13.4	25	15.2	34	19.1	31	15.3	51	21	170	17.4
Race/ethnicity												
White, non-Hispanic	111	93.3	159	96.4	170	95.5	188	92.6	226	93	921	94.1
White, Hispanic	7	5.9	2	1.2	3	1.7	8	3.9	7	2.9	30	3.1
Black/African American	1	0.8	1	0.6	1	0.6	0	0.0	1	0.4	4	0.4
Asian/Pacific Islander	0	0.0	3	1.8	4	2.2	5	2.5	5	2.1	18	1.8
American Indian/ Alaska Native	0	0.0	0	0.0	0	0.0	0	0.0	1	0.4	1	0.1
Other or not stated	0	0.0	0	0.0	0	0.0	2	1.0	3	1.2	5	0.5
Marital status												
Married	60	50.4	74	44.8	84	47.2	88	43.3	103	42.4	444	45.4
Divorced	24	20.2	55	33.3	44	24.7	59	29.1	59	24.3	260	26.6
Widow/widower	21	17.6	21	12.7	40	22.5	40	19.7	59	24.3	197	20.1
Never been married	14	11.8	15	9.1	9	5.1	13	6.4	21	8.6	73	7.5
Unknown or not stated	0	0.0	0	0.0	1	0.6	3	1.5	1	0.4	5	0.5
Educational attainment												
8th grade or less	1	0.8	2	1.2	4	2.2	1	0.5	1	0.4	10	1.0
9th-12th grade, no diploma or no GED completed	1	0.8	3	1.8	7	3.9	4	2	5	2.1	21	2.1

Monitoring Compliance with Reporting Requirements

To comply with the Colorado End-of-Life Options Act, physicians who prescribe aid-in-dying medication, and those health care providers who dispense such medication, must submit documentation to CDPHE per rules promulgated by the Colorado Board of Health.

Physicians who prescribe aid-in-dying medication must submit:

- ☐ Attending/prescribing physician form
- ☐ Patient's completed written request for medical aid-in-dying medication
- ☐ Written confirmation of mental capacity from a licensed mental health provider (if applicable)
- ☐ Consulting physician's written confirmation of diagnosis and prognosis

Health care providers who dispense aid-in-dying medication must submit:

- ☐ Medication dispensing form

Table 4 contains a summary of documentation received by CDPHE concerning patients who were prescribed aid-in-dying medication. This information is based on reporting forms and supplemental documentation received by CDPHE as of February 20, 2023.

Table 4. Documentation received for patients participating in the Colorado End-of-Life Options Act, 2018-2022 with 2017-2022 totals.

Form/Document	2018 Count	2019 Count	2020 Count	2021 Count	2022 Count	2017-2022 Total Count
Attending/prescribing physician form	108	146	160	188	260	925
Patient's completed written request	93	130	157	185	258	873
Mental health provider's confirmation	0	1	3	0	3	8
Consulting physician's written confirmation	89	130	156	185	259	852
Medication dispensing form	85	137	150	164	247	839
Death certificate	119	165	178	203	243	979

While reporting of the required documentation (including prescribing forms, patients' written requests, consulting physicians' written confirmations, and mental health provider confirmation when applicable) may be incomplete, attending/prescribing forms received contained physicians' signed attestations that all requirements of the Colorado End-of-Life Options Act have been met, and that required documentation is complete and contained in patients' records. Efforts continue to educate physicians and other health care providers about reporting requirements.

Additional instructions for reporting, including specific regulations and forms, and past reports are available on the Colorado Medical Aid in Dying website at https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/medical-aid-in-dying.

Dear Senate Committee on Health and Human Services,

My name is Vanessa Johnston from Littleton, and I am a volunteer with
Compassion & Choices. I am also a death doula trained by the International End-of-Life Doula Association (INELDA) and the American Clinicians Academy on Medical Aid in Dying
(ACAMAID).

I am writing today in support of SB 68, the improvement bill for Medical Aid in Dying.

I own *Denver EOL Doula, LLC* and have been working full-time as an end-of-life doula since 2015. At that time, Medical Aid in Dying was not yet legal in Colorado. My first client died from ALS and I saw the long, slow, debilitating physical decline that is the tragedy of that disease. There was so much suffering before his death and it could have been avoided if Medical Aid in Dying had been a legal option back then.

In 2020, Medical Aid in Dying was an available legal option for another client who was suffering from cancer. However, she was unable to pursue this compassionate solution because her health declined too quickly while going through the eligibility process. While she was awaiting an appointment with a second doctor for approval of Medical Aid in Dying, her disease progressed quite rapidly. Unfortunately, she was no longer able to swallow the medication by the time she was deemed eligible by her doctors. The wait time had made self-administration impossible.

I am also the Vice-President of the nonprofit group Colorado End-of-Life Collaborative. I often hear from folks in rural areas of Colorado who do not have access to prescribing physicians. I know that allowing Nurse Practitioners to evaluate and prescribe for Medical Aid in Dying would be tremendously helpful to those who do not live in the larger metro areas.

The voters of Colorado wanted this humane option to be available to those who qualify without the obstacles that my clients have been encountering. Now is the time to make this empowering and compassionate option more accessible. When someone is dying, we should make it easier for them to find peace, not harder.

I urge you to move the Colorado End-of-Life Options Act quickly and favorably out of committee.

Thank you for taking the time to read my testimony.

Sincerely,

Vanessa Johnston
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Senate Testimony HB24-068

February 29, 2024

Thank you Chair R. Fields, Vice Chair J. Ginal, and members of the committee, for this opportunity to provide some input into the legal process and advance the discussion regarding this quasi-taboo topic: end of life. It's certainly uncomfortable in our culture. In *Secrets of the Talking Jaguar,* Martin Prechtel describes living with Mayan indigenous people who among many differences seem to have an entirely different understanding of death; he describes a scene relating to ancestor worship, digging up ancestors' bones and showing them love. Our societal recoil from this reality—of death itself—appeared to be missing from their culture, though they certainly avoided *dying* as best they could.

My personal cosmovision has been informed by shamanistic traditions and also observations of the natural world, of which we are a part. For example, I've witnessed a wolfdog give himself self-mercy when dying, by way of exposure to the elements. There are stories of wild animals doing the same. They go off alone into the cold. The one I saw, soaked himself with water when there was a bitter-cold wind, and it was spitting snow. He was dying from lymphoma. The Innuits are a commonly-cited example, for at least in the 18th century they sometimes used ice floes to drift off and die from exposure.[i]

One other area that informs my views is that I've witnessed "natural death" and was left with questions about all the "died peacefully at home surrounded by loved ones" news we regularly see. Natural death looks like it can—except for sudden events like cardiac arrest, maybe—be miserable and protracted, with violent spasms, unmanageable pain, and a macabre death rattle (my data points). "Loving families" seem to—on close inspection—be riddled with vitriol, jealousy, and treachery, with some affection that admittedly does come out at surprising times. Maybe most of these people really are "surrounded by loving family" but a lot of people are in my situation—de facto orphans.

I'm rural, in my 60's, and have no family in my life. There's a partner that I see a few times a month, but she is death/illness averse (who blames her?) and likely will not be around for that rough chapter. There is no social safety net for me, in practice, apart from nursing home hospice/palliative care, should the time come. But in between the two—me maintaining my own home and me in a nursing home—there's a lot of distance that has zero coverage. There's a good chance I (and many, maybe you too?) would not survive that trek from here to there (the nursing home). Details to follow.

Further, even euthanasia (which is different from self-administered MAID, by the way) in dogs—as I have seen, repeatedly—is a solid three days of torture. That's my fault, because I give them three days to "rebound" or change their minds. They never do, though. The last time, the dog more mercifully went after two days because I changed the protocol.

This brings me to Colorado's existing laws. Consider that the current law requires a prognosis of less than 6 months to live; two doctors have to agree on this. This is problematic in multiple ways. Example: I've had a chronic, progressive, debilitating neurological disease since 1991. Guess how many specialists I have seen, and how many of them agree on a prognosis, treatment, or even specific diagnoses…? Each specialist has their own syntax and a different name for the piece of the elephant that they are touching. Some can be coerced to agree that Name X = Name Y (more or less). Prognosis: N*obody Knows.* Since cardiac involvement became a chronic thing back in September of 2022, there's a non-trivial chance that any day I could die. Not hyperbole. I was on a walk on February 5th, and a combination of SVT's and AV Block made it impossible for my Apple Watch to even count my heart beats: it had the pulse rate *greyed out.* I could feel the frenetic and irregular mamba dance on my throat pulse and had to creep home. If a cardiac event causes brain damage, for example, I'm confident it would be impossible to get two doctors to agree on a prognosis of less than six months, though that certainly could turn out to be the case.

Another thing about that six months…? You're not allowed to even fill the Rx until after a fifteen-day waiting period (the human equivalent of my "three day period"). Well, it turns out that time goes really, really slowly when you are being tortured. Gross debilitating injuries, and fast-moving diseases…can have you dead within that. Stats I have seen, is that some 24% of the time in Colorado MAID cases, the people do not make it past the fifteen days. I believe aggressive forms of lymphoma and other cancers can do that. It took the wolfdog in three

painful weeks. His attempted self-mercy was around two weeks, and he would not have been able to self-administer at that time (as a human) as he was too nauseous. It was torture after that.

Canada's laws seem excellent. As I understand it, the single guiding premise is: "Tenable Life." If your life becomes untenable, then you can—***if you choose***—pursue a claim for self-mercy. If people don't want you to leave this world, then perhaps they can prop up your life and keep it…*tenable*. Otherwise, they should shut up and let you make your decision, even be supportive. That's my belief.

What government *shouldn't do,* is funnel people toward MAID. Currently, our federal and state governments provide the worst of both worlds: they funnel people toward MAID but do not provide it as an option. The only way out of the *torture* is to endure it or do the equivalent of a "back-alley coat hanger procedure." You see, people who commit gruesome acts of self-mercy likely (in my opinion) were enduring worse or facing enduring worse.

This is not only a traumatic transition for the person, but also for First Responders, friends, and family. But, on the plus side, it permits governmental deniability or splash-back. The government can't be accused of funneling people toward MAID if they do not allow MAID, right? However, they *can* be accused of contributing toward making life *untenable* and then de facto torturing people to death, all legal like.

Hyperbola? Well, maybe. In my case, here's what track I'm on. After owning a house plus this land for 25 years, I'm on track to default on the mortgage *this year.* My crime: the disease progressed and I had to early retire from my livelihood in September of 2022, barely of age to collect Social Security. However, Social Security is currently about $1,000 short to sustain my life. It won't pay the mortgage, the property taxes, house maintenance, gasoline to enjoy socialization with others, etc. Land around here saw a 50% increase in appraised value a few years ago; another 25%-30% jump in property taxes is being discussed for this year. Total overall inflation for last three years' I've seen estimated as high as 40%. Meanwhile, Social Security's COLA increase to cover the huge inflation of last few years, not counting property taxes: ~$60/month. I'm losing ground and my life is becoming: untenable.

What happens when I (or others) lose the house? Well, I'm homeless, with a debilitating disease. I'm doing that long trek to the nursing home, but not yet eligible to get in there. The *pricey* infusions I take three times per week have bulky IV supplies that must be kept sanitary and refrigerated. So, those infusions go away—a major medical support. Of note, if I *could* drop those infusions to twice a week, the savings of product would be somewhere between $17,000 and $34,000 *per month,* enough money to pay off my mortgage *in a few months.* I'm grateful for the infusions and unfortunately, at the lower dosage it would be out of the therapeutic range for me—but my point is that it amazes me how much is being spent on my health (MUCH GRATITUDE), but keeping a home *is not considered essential for health*. This is how government funnels toward MAID: "Social Security" is anything but.

I've been homeless before, and don't want to do that again. I can't survive it. Further, I can't do the stress of living in a crime-infested apartment complex that perhaps the government would provide—though the wait here in Colorado for government housing is 1-4 years. (By then, I would be long gone—but good luck getting two doctors to agree on that.) It would have to be *fully* subsidized, too, for my tiny Social Security to be enough to keep me in the tenable category. Likely, I would be paying same or more as my subsidized mortgage, so I would *still be unable to afford it*. If I endured the torture of homelessness long enough, maybe I would arrive at the nursing home for a meaningless stay I would never choose for myself. No, I would choose self-mercy, *given the option.* That is what *funneling* looks like. What would you do? Because, you or loved ones may be called upon to decide that one day.

Another example. My beloved neighbor. She was older than I and actually grew up living next door to our family ranch near Hayden. Her family and mine go way back. I considered her extended family. Her family ranch is also still there to this day. Her health diminished and the day finally—begrudgingly—came when she had to go into assisted living, as that was *the only option she had.* She was a proud rancher and when her husband died in early 2000's, she continued to *run her neighboring ranch on her own,* a recognized pioneer of women in ranching, in that regard. She loved that land. I can't speak for her, but I did talk to her shortly before she went into assisted living in town. She did not want to go, but had no options. She was dead within a few months. Would she have chosen MAID if she could have? I don't know. But, I would have been honored to be at her side through that process if she did so choose. Bonus: It was during the height of Covid; once she was in assisted living, there was no leaving. She could not visit her land nor could she be visited. She died in confinement, which I suspect was

psychological torture for her. In talking with her on the phone, her day consisted of staying in her room and she did not like it. “But what can you do?” or words to that effect was what she told me, once. I have no idea how that sacred event of her passing presented itself in the facility, but I would have wished for her peace and dignity…and mercy…on the land she loved, truly surrounded with friendship and family…if that was an option.

How else does government funnel us? Well, I saw that $450B+ is being spent on illegal aliens or possibly that is only on housing for illegals, it was not clear. Our state leadership in Denver is in alignment with that policy. Ditto for the hundreds of billions going to Ukraine and other countries. Then, there is the push to take away full-agonist opioids for the treatment of chronic pain. You see, it is the removal of all supports: *that is how* you funnel people to MAID, all legal-like. Take away homes, take away pain management, take away a person’s ~~reason~~ *ability* to live. But don’t make MAID accessible, or the optics will be bad. In fact, charge people $850 for the Rx, and don’t permit insurance to pay that. That way, you can get the last cash they might have—that’s right, extort $850 out of them, as a parting tribute, but claim clean hands: “We’ll stop torturing you…for eight-fitty. You did this. Neither we nor the insurance agencies had anything to do with it.” Well, that’s not entirely true: *funneling.*

If my tone sounds “spicey,” please appreciate it’s merely meant to be assertive and not euphemistic, to shine light on the absurdity of how seniors/veterans/disabled are treated in contrast to illegal aliens and other countries and political ambitions. These are horrible policies that have deeply impacted the entire nation. I believe rural Colorado shares my opinion towards self-serving, short-sighted, governmental policies. We *all* should be angry at what is happening to the nation and world, and this debate is only a tiny part of the larger.

For example, that money spent on welcoming and supporting illegals…could go a long ways towards ***housing for seniors/vets/disabled***. We could be fully exempt from paying property taxes, too. Incentives for employers to hire seniors/vets/disabled could be enhanced. But there is no political hay to be stacked in those fields. Those groups have little political upside, it seems. They’re a burden. That political narcissism is the ugliness rural Colorado (in my opinion) would have me underline in passing, without politely “churching it up.”

Look, I can only speak of my experience. But…from all the Facebook groups and Twitter (X) people…? There are *a lot* of people in the same boat, with neurological/autoimmune/autonomic diseases alone. A lot. Covid arguably has greatly amplified those numbers. As a group, it’s hard for us to contribute. Hard, but largely not impossible. For a good portion, it’s impossible. I can contribute. Here I am, writing this to you folks *for free.* People tend to expect our stuff to be free, which is problematic, for one thing. I can do software work but require a lot of flexibility and low hours. I can write. I can research. But no one will hire on the terms I need. It sucks, also, that our GDP-based society would demand seniors work until they die—no leeway given to illness and disability.

It’s the types of accommodations we need. They simply do not mix with the predatory/competitive corporate culture we have. Our economic engine literally forces us to be part of someone’s wealth funnel to have permission to live. [Unrelated, there is another economic engine available, but no one wants to hear about it.]

What I, and (I suspect) this larger group in general need: “Low-stress, meaningful work, mentorship to get you up-to-speed in three-to-six months. Friendly environment, flexible hours, 10-15hrs/week, remote work valued, where our people are valued for who they are. Growth in responsibilities and duties as your skills naturally grow. We are a *no striving zone*.” In other words, there are high-level contributions I could still make…but that scenario simply does not exist in my industry, the computer industry. My productivity is being wasted. Government could stop the funneling plus focus on providing what we need to be effective, to stay in the *tenable zone*. Then, government can truly say “We had nothing to do with this,” when people choose self-mercy.

Opposing Arguments: People will abuse the system and unlive themselves unnecessarily. Well, ok, but they do that already—again, using the “back-alley coat hanger approach.” If someone does this, isn’t it fair to say they in general—unless an impromptu act of passion (which the proposed 48hr waiting period would prevent)—must have had a good reason? My experience with beloved dogs, is that they *always* know when it is their time. If anything, they hang in there too long, for the benefit of their humans. My suggestion would be to not make it gruesome to bail out, but instead—this is crazy talk, I know—for government to actually seek the well-being of the planet and humanity over their bottomless lust for wealth and influence. You know, make the world a non-toxic place to live and thrive. I remember the days when everyone in town could leave their homes unlocked, day or night. Oh, there was gossip, adultery, drama, bigotry, negative human nature, sure. But fact remains: doors unlocked day and night. We’ve gone the wrong direction.

Fun Fact: If you all live long enough, all these issues will apply to you and those you love. We all will eventually be left to contemplate the terms for how we leave this world; be careful what world you help co-create for yourself, those you love, and your constituents. This bill is a step in the right direction.

Regards,

Richard Warner

Bio: Colorado 4th Generation Native. Family ranch in Hayden area was de facto "Ponderosa-sized" back in the day. Patent App for underlying tech enabling augmented reality & VR goggles, etc., (was first to reduce Intangible Reality to practice, aka invented it). Writer who has published eight books plus articles in MacTech, Radio-Electronics, Far Cry Literary Magazine, South American Explorer, and Ibn Qirtaiba (now-defunct literary website for Australian Mensa Society). Attended Rose-Hulman I.T., University of Montana, and Colorado State University. Ecologist and computer scientist by training. Former GS-13 Computer Scientist for federal government, plus contractor to Hewlett-Packard, EDS, and Bureau of Census. Developed concept of Hope Now Project for incentivized conception control to reduce global poverty and overpopulation at the same time, plus a different economic engine (based on per capita GDP instead of GDP) that can grow personal prosperity economy in down-trending population. Developed five simple things that if everyone globally and en masse did them, could halt biospheric destruction (fossil fuels and meat did *not* make the Top 5, as they are dealing with secondary issues rather than root or primary ones). Has traveled substantially in Latin America and South Pacific. Lives in rural Larimer County.

[i] https://www.straightdope.com/21343302/did-eskimos-put-their-elderly-on-ice-floes-to-die

Dear Members of the Senate Committee on Health and Human Services,

We are Devin and Shannon Hibbard, sisters from Colorado, and we are writing to urge you to vote yes on the Colorado End-of-Life Options Act, SB24-068, which would enable more Coloradans who are eligible to access Medical Aid in Dying. For us, this is a subject we are very familiar with. In April of 2021, our father, Dr. David Hibbard, used Medical Aid in Dying to have a peaceful and dignified death. To be able to support our father's choice to end his severe suffering was one of the most profound ways we could show our love for his decision.

Our father lived life to the fullest. He was one of the first Peace Corps volunteers in 1961, he was a mountain biking enthusiast, and he loved his career as a medical doctor, being one of the last docs on the Front Range to make house calls. When he was diagnosed with Parkinson's in 2007, he wondered what the last few months of his life would be like. He was a staunch supporter of palliative care and finding ways to make the last stages of life easier. Not only was my father a doctor, but towards the end of his career, he served as the Medical Director for Hospice in Boulder, Colorado.

Given his work with hospice, our dad was familiar with the pain and suffering many people experienced in their last months of life and became a strong advocate for Medical Aid in Dying legislation around the country. When he was diagnosed with Parkinson's, he knew what likely awaited, which gave him great fear about what his last months and days would be like. Prior to legislation being introduced that would enable Medical Aid in Dying, he considered alternate means to end his life if his suffering became unbearable. Those conversations were gut wrenching to have, leaving us feeling hopeless. Thankfully it did not come to that, as our father became one of the lead medical activists to pass the Colorado legislation in 2016.

The last few months of our father's life were extraordinary, both in how much we cherished our time with him and in how much we saw him suffer. He was taking narcotics every two hours, yet the pain he was experiencing would often cause him to go white as a sheet.

When two doctors independently agreed that our father had less than six months to live, instead of continuing through months of unrelenting pain, our father was able to take control of his life to use Medical Aid in Dying medication to pass into the next world. He died peacefully, in his home of 50 years, surrounded his family who told him it was okay to go, that we loved him and supported his decision.

Every person should have this choice available, should they meet the requirements to use Medical Aid in Dying. We encourage you to support this expansion of access to Medical Aid in Dying, which will extend access to more Coloradans, while protecting medically vulnerable people. Please let us know if you have any questions. We would be happy to share our father's experience with you or any of your colleagues.

Devin and Shannon Hibbard

Please pass SB24-068. My father, aged 78 with stage 3 kidney failure and late stage Parkinson's with Dementia passed on Friday, February 2nd, 2024. He lay in bed at home, unable to speak but thrashing violently for 10 days. When I told him about Colorado's MAID Law in 2019, he told my mother, his best friend and his twin of his plans to come to Colorado and do MAID.

However, as his disease progressed he didn't bring it up again. When I traveled there to have the conversation again in August 2022, he said he still wanted to do it but that he had thought he needed to have two terminal illnesses.

I don't know when this miscommunication happened but I regret I did not make it clearer.

I told him that due to his oncoming dementia, he had to choose his death date and make plans now.

Unfortunately, due to the requirements that he needed to take the solution and either rent a hotel or do it at our Colorado home, my mother told him it would cause irreparable harm to my then 8 year old son. I, being unaware, continued to travel back and forth to IL and help him whenever I could.

He went on hospice at home in January 2023. His dementia meant he was violent to his wife of 49 years. His last month (January 2024) was spent crawling as my Mom refused to put him in a facility after a 5 day respite stay had, in her view, made him worse off. However, he was increasingly agitated but she didn't want to restrain him. The result was 2 black eyes.Finally, his body was so weak he became bedridden on January 23rd and spent the last 10 days of his life in a state he NEVER wished to be in.

With no food for nine days and no water for seven, he finally passed on 2.2.24. I had his end of life wishes in a Compassion and Choices document he filled out in August of 2022. But had I not been there to oversee him doing VSED - Voluntary Stopping Eating and Drinking, my mother, who had never accepted what was happening, would have done either nothing as she refused to give him morphine, or would have fed him water until he passed from malnutrition.

Reducing the waiting time between the oral request is also important because there is a chance that something could happen, an accident or stroke, in that 15 days which would render the person unable to complete MAID. I only wished I could have helped my father avoid an agonizing last 10 days and this bill could have helped him immensely. It has the power to help others who live in states who, unlike Colorado, haven't legalized MAID.

Dear Madam Chair Fields, Vice Chair Ginal and Members of the Committee,

Thank you for the opportunity to provide written testimony. I support SB24-068. I am a long-term resident of Colorado, a retired social worker, and I have enjoyed supporting my community as a volunteer for Compassion & Choices since 2016. I collected and delivered signatures for our ballot measure, and I was present the day Proposition 106 passed with a 65 percent of Colorado voters saying yes. In 2017, I began providing education about the Medical Aid in Dying law and end-of-life options to Hospices, community groups and organizations as well as to individuals and their families. I also provide general information about end-of-life support and options to Coloradans at educational events in my community.

As a volunteer, I have had the honor of meeting with Coloradans who are exploring their end-of-life options, and they often want to share their stories. What is shared in my community is that it is difficult for individuals to find a physician willing to write a prescription for medical aid in dying. It can sometimes take weeks or months and when they finally find the physicians, they have to wait another 15 days before they are eligible to receive the medication. They may not survive that waiting period. For patients and their families, this has caused additional physical and/or mental suffering. Changing the waiting period from 15 days to 7 days, with the option of waving the waiting period if the patient is not expected to live through it, would help to eliminate additional suffering. As Coloradans, we have the option to request medication to take control at the end of our lives if we meet the criteria, but it's difficult.

I had the opportunity to discuss medical aid in dying and end-of-life care to a group of people in Basalt, Colorado, along with another volunteer. For that group, as well as many rural locations in Colorado, they have limited access to physicians. Allowing APRN's to prescribe medications would increase access for those in rural Colorado.

Whenever I provide educational presentations I always tell my audience I'm not sure if I would use Medical Aid in Dying but I'm glad I live in a state that allows me to make that choice.

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Senate Health & Human Services
02/29/2024 01:30 PM
SB24-068 Medical Aid-in-Dying
Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Michael Dennis Against themself	I am Michael Dennis, and I am a citizen of this state. I wanted to comment on my opposition to Senate Bill 24-068, entitled “Medical Aid-In-Dying”. Colorado has had this bill in place since 2016. I’ve not experienced a situation where I would face an end-of-life decision but feel it unfortunate that now Colorado wishes to make amendments to this bill which on its merits is anything but death with dignity. How will taking doctors out of the suicide, allowing people from other states to procure suicide, or adding language to flawed legislation forcing federal rules to be inoperative make this better? Worse yet, the Colorado legislature wants dying people to have a "fast lane" to suicide when palliative care could render the dignity they deserve. Representing physician assisted suicide as dignified or a choice is the largest fallacy this state government has ever enshrined. Stop forcing the idea that life or death is the right of a government to legislate. Stay out of this decision and develop palliative care as dignity for a dying person. Thanks!
Michael Glugla Against themself	I would like to thank the people and lawmakers of Colorado who have entrusted me and my fellow nurse practitioners to provide for their health care needs. Over the past forty years, I have been privileged to assist my patients during some of the most joyful and difficult periods of their lives. The State is now on the cusp of providing me with additional privileges that I wish to decline. SB24-068 expands the current law to allow medically assisted suicide to anyone with minimal delay. I cannot in good conscience use this privilege to prescribe life ending medications to someone I have just seen and who wants to end their life with a 48 hour waiting period. Yes, there are safeguards in this bill, but this is only sugar coating over a very flawed bill. Will our legislature in the future allow medically assisted suicide based on a mental health diagnosis or a failed transgender transition? If this bill passes, I see a crack in an already opened door that will be flung open in the future and for what reason? Are we to become the Switzerland or Netherlands of the Americas? Yes, voters approved medically assisted suicide in the past, however I wonder if they realized that our legislature would want to amend the law so shortly in order to make it easier and more convenient to end ones life. This is not health care but a tragic slippery slope. The direction we should take is one of acceptance, assistance and compassion and not self-termination.
Barak Wolff For	As a founding member of End of Life Options New Mexico, the amendments in SB24-068 are changes that we incorporated into our NM

themself	law in 2021. Each has contributed to increasing access to medical aid in dying, particularly in our vast rural areas. We have APNs and PAs assessing patients and providing end of life care and our 48 hour waiting period has been critical to enhancing access for fragile, dying patients who wish to hasten their death and end their suffering. These are sound and patient-centered changes that will be a godsend to many Colorado elders and others with life ending conditions. Thanks for this opportunity to share our experience here in New Mexico.
Valerie Lovelace For Maine Death with Dignity	Dear Senator Fields and esteemed members of the Senate Committee on Health and Human Services, I am writing to voice my strong support for SB24-068. Colorado's End-of-Life Options law has served to give many the peaceful , self-directed dying circumstances they wanted to end their terminal suffering. SB24-068 will make access for available to those who qualify by allowing qualified APRNs to serve their patients without having to refer them away, and by eliminating unnecessary waiting periods. Aid-in-dying is not a decision that people arrive at lightly. Once they arrive at it, though, it shouldn't be a process made more difficult by having to find a different provider because one's own PCP cannot prescribe even if qualified to do so. It is already well known that the waiting periods are an unnecessary delay, given that patients spend an average of 50 to 60 days in the process of qualifying. The waiting periods create an administrative burden for providers and a period of increased anxiety for patients who are qualifying. I urge you to look to the experience in New Mexico, where APRNs are practicing successfully, and where there is no requirement for multiple requests separated by extended waiting periods. In my experience working with patients and families in Maine, the process to qualify is complicated and exhausting, which is made worse by the additioonal waiting periods. Please do the right thing. Send this bill to the floor with your recommendations for passage. It's the right thing to do for the Colorado folks with terminal disease who want this option. Dropping the residency requirements additionally providers others an opportunity to die in a meaningful way when they cannot do so in their home state. It's a travesty to think that a person who is dying has to go to another state to get the healthcare they wish to have, but that's the reality of healthcare these days.

	I am happy to answer any questions the committee may have regarding how things have been working in Maine. Sincerely, Rev. Val Lovelace Executive Director Maine Death with Dignity
Mark Kaplan For themself	My sister, niece and family, and friends are Colorado residents. I am sending in this note of support because medical aid in dying access is important to them. Please pass this bill.
Jessica Koerner For themself	Dear Chair Senator Fields, Vice Chair Senator Ginal, and members of the Health and Human Services Committee: My name is Jessie Koerner from Denver, and I am a death doula writing in support of SB 24-068. This bill will vastly improve access to medical aid in dying in Colorado. As a doula, I help empower people to envision and enact their end of life wishes. I love working in Colorado, where I can tell those I work with they have the option of medical aid in dying… most of the time. When my client, "Jane", began having strokes that would eventually cause her death, she decided she wanted to access the End of Life Option Act. The race against the clock began. The agony of finding doctors who would support her decision, and waiting, waiting, waiting for the 15 days to pass so she could be deemed mentally capable again was the most nerve-racking part of her whole death experience. The relief in the family once the medication was in hand was palpable. Reducing the waiting period is one way to reduce barriers to access to this medication, and reduce distress in those who are already facing death. This option should not just be available to Colorado residents, either. As we become a haven for those without choice elsewhere in our nation, death should not be an exception to the freedoms we share in our state. Proving residency has not had any safety implications, it only serves to block access. SB 24-068 will make Colorado a national leader in end of life options. We should make every effort to embrace policy that makes dying according to our own values possible.
Jeany Rush Against themself	TO: SENATE HEALTH & HUMAN SERVICES COMMITTEE RE: SB24-068 END OF LIFE OPTIONS FOR AN INVIDUAL WITH A TERMINAL ILLNESS

	FROM: JEANY RUSH CONCERNED CONSTITUENT COLORADO SPRINGS 2-26-24 NO WAY NO WAY IS THIS RIGHT While I was not even aware of this bill, I certainly totally object to the contents of this bill in which you, all, Play God! If it is already a law, as it appears, it should not be done with anyone but the doctor, licensed, and legal entity in America. Further, this is such a huge huge decision for anyone, no matter what the circumstances, this is not to be watered down to other people making the act official. THE OVERREACH OF ACTIVITIES THAT COULD ALSO BE MISHANDLED IS WORSE. The idiocy, of this type of legislation, and the many ways in which this could go wrong, are epic. Isn't it bad enough that this state allows a newborn to be killed even after coming out of the womb. ??? How much more morbid narrative are you going to add to the gene pool of shameful bills already existing. I AM APPALLED BY ALL OF THIS. WOW MY MIND IS BLOWN!
Jeany Rush Against themself	TO: SENATE HEALTH & HUMAN SERVICES COMMITTEE RE: SB24-068 END OF LIFE OPTIONS FOR AN INVIDUAL WITH A TERMINAL ILLNESS FROM: JEANY RUSH CONCERNED CONSTITUENT COLORADO SPRINGS 2-26-24 NO WAY NO WAY IS THIS RIGHT While I was not even aware of this bill, I certainly totally object to the contents of this bill in which you, all, Play God! If it is already a law, as it appears, it should not be done with anyone but the doctor, licensed, and legal entity in America. Further, this is such a huge huge decision for anyone, no matter what the circumstances, this is not to be watered down to other people making the act official. THE OVERREACH OF ACTIVITIES THAT COULD ALSO BE MISHANDLED IS WORSE. The idiocy, of this type of legislation, and the many ways in which this could go wrong, are epic. Isn't it bad enough that this state allows a newborn to be killed even after coming out of the womb. ??? How much more morbid narrative are you going to add to the gene pool of shameful bills already existing. I AM APPALLED BY ALL OF THIS. WOW MY MIND IS BLOWN!
Raymond Hockedy For themself	I am the life partner of a woman, Carol, who just died from a blood cancer and she, at age 80, used Medical Aid in Dying (MAiD). Carol and received excellent treatment by a specialist in blood diseases for seven years and this was truly a gift of life. However, in 2023 the treatment options ran out and her cancer took over her life and toward the end became the cause of suffering. The last two weeks were the worst and this was because of the waiting period required in the law for MAiD. I picked up her MAiD prescription on the afternoon of January 24 and she used it the very next morning in the presence of some loved ones. This was a great relief for her and provided a quick, peaceful passing. If

	she had had the MAiD medication without the waiting period she would have suffered less. Please change the law to remove this waiting period for MAiD patients so they can obtain relief from extended suffering. It's the compassionate thing to do.
Kendra Stokes For themself	Competent, Adult individuals should have the opportunity to make their own choices, such as having access to a peaceful to end terminal suffering. I support this bill as Medical aid in dying is an important end-of-life care option that everyone should have access to--it's a human right. Thank you, Kendra S., LMSW
Susie Klee For themself	As a resident of Colorado, I want to share my support for SB024-068, which I believe will make a big difference for terminally ill individuals in Colorado. I believe everyone deserves the right to make their own choices about their health, especially in such difficult circumstances. SB24-068 will help ensure that terminally ill Coloradans have the support and options they need. I hope you'll support SB24-068. It's a small but important step toward providing dignity and compassion to those who need it most. Thank you for your time and consideration.
Ardis Westwood For themself	My name is Ardis Westwood and I live in Denver, Colorado. I am in favor of these changes in the Medical Aid in Dying Law, based on my experiences and my own wishes. When my husband died in 2018 he had been under hospice care for about two weeks. When he was in pain or agitated, I just had to call the hospice and they led me through the steps to administer morphine to relieve the pain or anxiety. When he died, someone came from hospice and took care of his body and let family members visit him individually. The hospice nurse then neutralized the morphine as we watched. We called the mortuary we had chosen and they came and took his body away. I know, though, that other's deaths do not go as well. A friend had had COVID, which left him very debilitated. He decided to stop eating and drinking (VSED). It was not hard to stop eating, but to stop drinking was more difficult. Because his mouth was dry, he would take a sip of water and swish it around in his mouth and spit it out. Two or three

	friends took turns sitting with him around the clock. Some friends visited or sent emails. It took him nine days to die. I know that in Colorado hospice facility can give as much medication as necessary to relieve pain, even if it causes death, if the motive is to relieve pain. So that is important. But I do believe that a competent person with a terminal illness should be able to request medication to hasten death without waiting 15 long days. Peace of mind and choice is a right we should all have.
Katelyn Van Valkenburg For themself	My name is Katie Sue Van Valkenburg, constituent of Senate District 4/Rep District 13 in Bailey, Colorado. I wish to express my support of SB24-068, an amended bill for the Colorado End of Life Options Act. I am an end of life social worker, having worked professionally with dying Coloradans since 2016- ironically, the same year this initial bill passed in Colorado. Today, I am the program coordinator for a centralized Medical Aid in Dying program, speaking daily with people from across the country interested in learning more about this option. At this time, our program is considered the gold standard of Medical Aid in Dying care. We consist of a team of physicians & a social worker who spend great care in reviewing each case. We field between many calls each day & each caller is offered a full assessment while also being evaluated for access to appropriate resources. Our program regularly connects people with not only hospice & palliative services, but also general needs like financial support, emotional counseling, or access to basic safety needs like food & shelter. Once someone is deemed eligible to have met the criteria, we work to make the process as smooth as possible. If a patient has symptoms of imminent death, we often schedule their visit for the same day to ensure they wait only the minimum amount of time of 15 days. But even in these cases, we are often unable to prescribe the medication before a patient dies. Within our program, we have found that 1 in 4 people die before their second consultant visits. 1 in 4. Recently, our program was scheduled to see 7 patients for their second visit. Of those 7, 4 died and they all died between day 10-15 of their mandatory 15 day waiting period. Had the waiting period been shorter, all of those humans could have accessed this option instead of having to experience anguish over the lack of bodily autonomy they had in their own dying process. In the days since the patients died, I have personally fielded emotional calls from their loved ones, saying they 'feel like they failed their loved one'. The 15 day waiting period is unnecessary suffering for humans who have already suffered enough.

	While it is a gift that Colorado has access to medical aid in dying, the current law NEEDS to change. The initial bill was a great start, but after 7 years with the law in action, there are opportunities to improve so that we don't continue to fail our terminally ill neighbors with unnecessary barriers to care.
JoAnne Jolly For themself	Hello Health and Human Services Committee Members: My name is JoAnne Jolly, from Senate District 32 and Representative District 9 in Denver, Colorado. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. I am 89 years old with multiple morbidities. At this point in my life, I want to make sure I have access to all of my options as I approach the end. Even if I never use the option, it makes me feel better knowing that this option is already legal; however, it seems that there are quite a few roadblocks to easy access. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Lindalee Lawrence For themself	Dear Health and Human Services Committee Members: My name is Lindalee Lawrence, from Boulder. I'm writing to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I strongly support the End of Life Options Act. However, necessary changes would better support our terminally ill partners, family and loved ones. Having worked within the current Act, I support changing it to reduce the waiting period between the two verbal requests, remove the residency requirement, and include APRNs as eligible prescribing practitioners. Thank you.
Ben Rappold For themself	Hello Health and Human Services Committee Members: My name is Ben Rappold, from senate district 4 and rep district 13. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. I am a firm believer that everyone has the right to bodily autonomy, especially in regards to the death and dying process. It is unfair that legislators are the ones deciding that people must wait 15 days to make a conscientious decision regarding their own dying process. The wait time should be shortened to better support people going through the hardest time of their lives.

	As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Cassie Palmer For themself	Hello Health and Human Services Committee Members: My name is Dr. Cassie Palmer, from Senate district 31 and Rep district 9. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. I am a hospice social worker and a tireless advocate for bodily autonomy. Continuing to advance patient right to death with dignity is not only ethical but beneficent. Thank you for your consideration.
Samantha Stein For themself	Hello Health and Human Services Committee Members: My name is Samantha Stein, from District 1. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident and hospice social worker in the state of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. I have witnessed patients of mine be denied access to MAiD for lack of residency - I hope to never have to tell one of my dying patients they do not qualify to take suffering into their own hands. Thank you for your consideration, I am eager to see the improvements we are able to make for the people of Colorado when it comes to suffering at end of life.
Richard Smith For themself	Hello to the Health and Human Services Committee Members: My name is Richard Smith, from Boulder County and I am writing to lend my very strong support for bill SB24-068, the amended bill for the Colorado End of Life Options Act.

	As a resident of Colorado, a citizen of this state and a person who has worked with people at the end of life for more than 30 years, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. My experience with patients and families who have taken advantage of this program has been very uplifting, comforting and humbling to watch patients and families come together to help their loved one leave this world in a dignified, peaceful and non-painful way by following the patient's expressed wishes to avail themselves to the option. While certainly a sad parting indeed, it has allowed the person to die with his/her dignity, pain-free and support of family and friends. And the family's grieving is greatly eased and helped knowing that they were able to fulfill the wishes of their loved one. But in working with patients with terminal illnesses and their families who are there to support them, there are situations which are not so desired. There are quite a few times when the person wanted to access the Colorado End of Life Options Act, but could not complete the process due to extended time during the interviews, lack of available prescribers and other road blocks. These situations tend to be more often than desired. It is heartbreaking to hear a family say, "We wish we could have helped to move the process along so she/he would not have had to go through this." A terminal illness does not always respect timelines and many can lose this option due to the waiting period being longer than the illness' untimely progression. Thank you for your consideration.
Linda Wallace For Retired Teachers of Summit	Hello Health and Human Services Committee Members: My name is Linda Wallace, from Senate district 17, rep district 12. I strongly support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Because my partner chose to use Medical Aid in Dying last year, I am acutely aware of the importance of these changes. It is imperative that

	we offer more compassionate choices for folks at the end of life. These changes will go a long way in providing that. Thank you for your consideration. Linda Wallace
Rachel Zuber For themself	Hello Health and Human Services Committee Members: My name is Rachel Zuber, from Arapahoe County. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Jacci Bencomo For themself	The Colorado End of Life Options Act is critical. My brother, Rick Mahlke was able to access this option for the end of his life. A little family history: we grew up on a small family farm in North Dakota. Our Dad died of a heart attack at 40 when Rick was 12, our Mom died of lung cancer at 40 when Rick was 18. We watched our Mom die a tortuous death in the hospital, before hospice was a thing. When Rick found out his colon cancer was no longer in remission, and there were no other treatment options, he was living in a small town in Nebraska with no nearby hospitals or hospice care. I mentioned that Colorado had this option, and we began to research it. The residency requirement was a huge hurdle. He had lived in Colorado for the previous 20 years, and had just moved to Nebraska because he was disabled and couldn't afford to live here. He'd only been in NE for less than a year. Knowing he was sick, not knowing how much time he had, he put his house on the market, and reestablished a relationship with his former oncologist. He had to get a Colorado driver's license, and move in with me, even though he wasn't quite ready. Residency established, getting an appointment, then another appointment 15 days later, was so rushed and stressful. We just wanted this time to spend time together, share memories, say our goodbyes. The things this bill does, 1)remove the residency requirement 2)reduce the waiting period between the two visits and 3)include APRNs as eligible prescribing practitioners, remove the barriers that make the process of death more difficult. Make no mistake, these decisions come with much thought, discussion, contemplation and consideration. This bill allows terminally ill people the ability to choose the time and place when they have suffered enough. They are going to die. This gives them some control, and in our family situation, time and peace. Was it easy? No. Am I glad we went through it? After watching our Mom die a slow, miserable death,

	intubated and suctioned hourly for 2 months, yes. I will do whatever I can to help people have the dignified death of their choice. Making this process a little easier for an outcome that is certified by a medical professional, is a gift for families who are helping their loved ones go through a period we will face one day. I strongly support passage of this bill and am willing to answer any questions about my family's experience. Please vote yes to pass.
Jack Williamson For themself	To: Health and Human Services Committee Members: I am Jack Williamson, a retiree from Boulder County. I am writing to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, while I am professionally and personally grateful that our current End of Life Options Act exists, however, there are changes that can better support our terminally ill. I concur and support the following three changes: reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. I recently had the unique privilege of being present with a dear friend who was granted access to ending/completing her life journey at the time and means of her choosing with the MAID option. However, I must add that the waiting process of getting approval was both painfully stressful and frustrating for this suffering yet determined patient. This patient's death was the most beautiful and peaceful passing in my memory, after over 50 years of ministry as a pastor. In addition to many years in civilian ministry, I also served for twenty-five years as an Air Force Chaplain (Colonel, USAF, Retired) of pastoral experience supporting many wounded and permanently incapacitated service warriors. I applaud our elected Colorado representatives for enacting the original Colorado End of Life Options Act and will salute you as you advocate for and pass this bill SB24-068 to amend the original bill. Thank you for your courage and wisdom. Jack Williamson, Chaplain, Colonel (Ret.) USAF
Janessa Schueler For themself	Hello Health and Human Services Committee Members: My name is Janessa Schueler from Denver County. I am writing to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am also a social worker by profession. I used to serve terminally ill clients for many year as a hospice social worker. I am passionate about the current End of Life Options Act and so thankful that those in need have access to support for end of life options.

	However, there are necessary changes that need to be made to better support our terminally ill community members. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration. Janessa Schueler
Ptarmigan Emery For themself	Hello Committee Members: My name is Ptarmigan Emery, from District 4. I'm writing to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, and a hospice nurse, as well as a daughter whose father did MAID in 2020, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. I understand that these steps are there to protect people but they become unduly burdensome when people are in situations they have no control over and with no positive ending. My father went thru MAID and he didn't waiver from day 1. He had Parkinson's and the day he was diagnosed he stated that when he became fully dependent on someone else to do all his cares was the day he no longer wanted to live. His 2 favorite things were golf and gin rummy. He got to the point where he couldn't play golf and then, because of his Lewy Body dementia, he developed an intermittent blindness. So now he couldn't play golf, he couldn't even watch golf, and he couldn't see his cards to play gin rummy. Maid was his only hope for peace. I have had many patients go thru the process and although some of them never used the medications, I never had one, nor their family, express regret that they did it. I've never heard any complaints that it was too easy or that the person hadn't thought things thru. When someone has a terminal diagnosis, and is miserable, with no possibility of a positive outcome, why would we try to keep them from utilizing this option? Why would we make it so hard that it stops many people from even getting started? Do we WANT them to suffer? Have we no mercy? When our pets are at the end of their life, we have them humanely put down. Because we think it's unfair to make them live in pain and be miserable. Why would we not show the same consideration for our fellow humans? As it is, now, we treat our pets better than we treat our people…. But passing this bill will enable more people to take back some control over their lives, have a say in how they go out, and peace of mind that they will not have to suffer needlessly and endlessly. Thank you, Ptarmigan Emery

Jennifer Movish For themself	My name is Jennifer Movish, from District nine. I write to support SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End O Life Option Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing residency requirements, and including APRNs as eligible prescribing practitioners. As an EOL life nurse, I believe it is important for EOL Patients to maintain control through out their journey as they are slowly losing control of so much as their disease progresses. Our patients should be able to maintain control of their journeys. Thank You for your consideration.
MICHELE STEFFENS For themself	Hello Health and Human Services Committee Members: My name is Michele Steffens, from Senate District 26. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, an end-of-life educator, bereavement support specialist, and hospice worker, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. These neighbors include my family and my friends. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Lisa Chattin For themself	Hello Health and Human Services Committee Members: My name is Lisa Chattin. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Katrina Niemisto For themself	your details: Hello Health and Human Services Committee Members: My name is Katrina, from district 10. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that

	need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Clark Bencomo For themself	My name is Clark Bencomo. I have personal experience with medical aid in dying. My brother-in-law died of cancer in 2022 in my house with the mercy of Medical Aid in Dying. I remember meeting with his doctor in Nebraska where we were informed that Rick's cancer had returned and spread to other organs and that he was terminally ill. As we discussed his cancer with the doctor and nurse, we were informed that he had about 6 months to live. Rick new this was a possibility, and was somewhat prepared with a response. He had watched his mother die of cancer years before. He recalled her anguish and painful suffering as she neared the end. He was determined not to go through that as in her final weeks there was no quality of life, only the misery. He told the doctor he would buy a large bottle of whiskey and drink it all when things got bad. The doctor told him that people who had tried this in the past often survived and were in even more misery. His sister, my wife, was present and brought up medical aid in dying in Colorado. We are from Colorado and Rick had lived here before moving to Nebraska. The doctor mentioned that hospice nurses were spread thin in Nebraska. As time passed Rick's condition became worse, so together we decided he would move to our house where we could take care of him. We began the process of jumping through the many hoops of qualifying him to receive medical aid in dying. It was a lengthy process causing much stress at a time when we needed to be focused on his care and on saying goodbye, Rick developed a tumor which grew, tearing through the skin of his abdomen. The tumor was large and portruded outside his abdomen. It had to be cleaned and cared for daily. Rick knew when he could no longer bear the misery of his condition. He determined that the next day he wanted to be at peace and finished with this anguish. We were all so grateful that he had qualified for Aid in Dying and could make this decision in a dignified manner providing a humane way for him to finalize his life on his own terms. Not everyone has the kind of family support we could give Rick. He would not have been able to get medical aid in dying by himself or without access to our great state. Anything that can be done to simplify acquisition of this humane, merciful, and dignified action would be deeply appreciated by people who are faced with these tragic circumstances.
Jessica Munson For themself	Hello Health and Human Services Committee Members: My name is Jessica Munson, from District 8. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that

	need to be made to better support our terminally ill neighbors in my community. Specifically, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Having watched my mom go through this process in her fragile medical state, I personally witnessed the impact these barriers can pose on the terminally ill. My mom moved from out of state to be close to me near the end of her life. As her health deteriorated, I watched as she endured unnecessary pain and suffering while trying to establish residency in order to apply for this program. As a current practitioner in our health care system, I also know that there are so many other stories and voices that have experienced similar burden with attempting to access Medical Assistance in Dying. I am grateful that I have this opportunity to speak on my mom's behalf. Thank you for your time and consideration. Jessica Munson
Melinda Pilliterri For themself	Thank you to the Chair and Committee Members of the Legislature for the opportunity to provide testimony in support of the passage of SB24-068/Colorado End-of-Life Options Act. Of all the ways I have contributed to my beloved State of Colorado over nearly five decades, this letter is the most personal and the most essential I have ever written. My husband, Les Pillitteri, chose to end his life via medical aid in dying. It was the most profound decision of his life—and our life—and we did not take it lightly; we did take it with great intention and gratitude, despite the waiting and the essential hurdles to ensure such a choice is made with discernment. The difficulty in waiting for approval is that time is not always on our side—especially as life becomes a matter of breath-to-breath, with no guarantees that tomorrow will not bring another crisis. I'm a writer and I cannot find the words to encapsulate how much changed in our lives and how we tried so hard to remember the time before Les was ill. Through it all, we found joy and purpose and the opportunity to form deeper relationships with ourselves, our faith, and our friends and extended-family. As his primary caregiver and life advocate, I knew Les and I were always just walking each other home. He left with the same grace with which he lived-that was because the gift of choice was restored to us with medical aid in dying. Les died at age 66 of end-stage Parkinson's Disease. He left this life in our home, in our bedroom, in his favorite hat. I stayed next to him until I knew he was free of his body. It was private and profound and exactly as we wished it to be-no other means but medical aid in dying would have given us that final gift together. It's not an easy choice and it's been lonely on the other side, but I take great comfort in knowing his final wishes were honored. To further remove impediments such as waiting time via legislation is a natural, and necessary, next step so that more individuals and their

	people can avail themselves of this humane choice. Passage of this Bill will enable more to choose with dignity the way in which they pass. I am so grateful this legislation is on the floor and I urge all of you to support it—in doing so, you support the life Les and I created with each other and the legacy of love and light that remains. I wish you all good health and beautiful Colorado skies. They will be brighter because of the passage of SB24-068. Thank you.
Ellen Keckler For themself	I am offering testimony in support of SB24-068. As a retired social worker, I regularly encountered situations involving death and dying. As an individual, I have had direct experience with loved ones in the final stages of life. Based on both my professional and personal experiences, I strongly believe in human dignity as a crucial component in the death and dying process. One way of providing compassion and promoting the inherent value of human dignity is to allow people to retain some sense of control regarding the process of their own death in situations which meet the criteria for medical aid in dying. I have been with loved ones who have passed peacefully at home through voluntary stopping eating and drinking, and others who ran out of time to exercise free choice and passed amidst the chaos and flurry of a hospital emergency room. The contrast between the two is stark, and I believe to retain our dignity as human beings, we need to value and honor requests for medical aid in dying, allowing all people the right of self determination when it comes to this final stage of life. I applaud Colorado for being an early adopter of medical aid in dying, and at this time I support removing some of the barriers involved in accessing that opportunity. When someone already knows they are dying, why wouldn't we support that person in more easily accessing medical aid in dying if that is their choice? Medical aid in dying isn't the right choice for everyone, but for those who understand the process and are opting to follow through with medical aid in dying, we owe them the chance to access it without undue burden in initiating their choice. People who choose medical aid in dying deserve the right to exercise their judgment to proceed with medical aid in dying in a timely manner. There are already enough hoops through which dying patients need to jump including the time delays built into the current system. I strongly urge you to support this bill on behalf of all Coloradoans and their families who are counting on the right to choose medical aid in dying as a viable end of life option. Thank you.
Katie Knepler For themself	Hello Health and Human Services Committee Members, My name is Katie Knepler. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing

	the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration.
Cory Carroll For Compassion and Choices	Madam Chair and committee members, thank you for allowing me to testify. My name is Dr. Cory Carroll, and I am a board-certified family physician who for 33 years has been and continues to practice medicine in Fort Collins. I am also a part-time medical director for Compassion and Choices. I am here to speak in favor of the changes offered in SB 24-068 to the Colorado End of Life Options Act. Regarding medical aid in dying, since the law passed in 2016, I have been the attending physician for twenty-two patients and written prescriptions for nineteen. I have been at the bedside for all but one patient who consumed MAiD and can tell you with certainty, those patients had good deaths. Opponents speculate about all the problems that can occur, but the reality is that MAiD is a wonderful option for those patients that choose it. About half of the patients who sought my care were new to my practice. This was because their primary care provider chose not to or weren't allowed to participate. This bill will allow Advance Practice RNs to participate, if they choose, and will expand access, especially in rural communities. The wait period is another unnecessary barrier. A 2018 study done by Kaiser Permanente in California showed that 21% of patients who requested to use the End-of-Life Option act died during the 15-day waiting period. Shortening the waiting period and allowing the provider to waive the wait is a critical improvement. Lastly, I take care of patients who are residents of Wyoming. To restrict my ability to provide legal medical services to these patients has actually been struck down in legal cases in Vermont and Oregon in the last few years. Do not limit my ability to provide care for all patients who seek my care, resident or not. I urge this committee and the CO legislature to support SB 24-068. I would be happy to answer any questions. Cory D. Carroll, MD, Foothills Family Care, LLC 3213 Nelson Lane, Fort Collins Colorado 80525 cdc@drcorycarroll.com office: (970) 221-5858, cell: (970) 2140787
Rebecca Doyle For	Hello Health and Human Services Committee Members:

themself	My name is Rebecca Doyle, from District 8. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. My mother was one of the first individuals to utilize Medical Aid in Dying (MAiD) in Colorado. She was a world-renowned mental health professional, outstanding member of the community, and an avid supporter of MAiD. We watched the trial of Dr. Jack Kevorkian when I was young. She gently explained to me that, "that man is not a bad guy, he is a good guy that people don't understand." She was endlessly grateful for, 'the good guys' that made it possible for her to die with dignity when cancer had other plans. I had to navigate the new law alone, facing judgment and criticism at every step in the process. I was my mother's caregiver; exhausted and anticipating being an orphan. I was in no state to carry the weight of the world, but she meant the world to me so it had to be done. I spent 60 hours a week calling providers; rejected by all but a few that did what was kind; and just. I toted her withering body across the state for the appointments. My mom who, just six months prior, would never be caught without heels and her favorite accessory was now sitting in a crowded waiting room, holding her leaking colostomy bag. "What a pity," someone said. But she was not to be pitied, she had a tenacity to be reckoned with. The strength this took her is something we can't comprehend until it is us. She wanted peace in those weeks, not to be a spectacle, nor to sacrifice her time with me. She didn't deserve to be pitied, but to be celebrated for paving the way for others. I didn't really get to say my goodbye. Though, I never really had to. She is with me in memory and heart as I write this, and I do so for her. She would be proud to share her story, as I am. I am a graduate counseling student at Regis University, a Jesuit Catholic Institution. I plan to center my counseling career around this issue, as I understand the gift it provides. My greatest hope is that others can be with their loved ones in a way I could not, which starts with a better process and more help. I say with the utmost confidence that Kevorkian stood on the right side of history, and, that my Mother made it. I ask that you do the same by supporting this bill; for daughters like me, and families like yours. We share great pride in our state, and SB24-068 would add to the many reasons we have to be proud. Thank you.
Teresa Baird Against themself	SB24-068 does a disservice to health care professionals who have a duty to safeguard human life, especially the most vulnerable among us: the sick, elderly, disabled, poor, minorities and those that are marginalized. SB24-068 puts Colorado health professionals directly against the relationships that we have built to protect those that cannot protect themselves. As a nurse myself, assisting those who are dying with compassion and support is what our profession is built on and intentionally harming someone is the antithesis of the nursing profession. Please defeat this proposed bill.
Kati Van Sicklen For	To Whom it May Concern,

themself	My is Kati Van Sicklen, and I want to express my support for SB24-068. My father, Kirk Arnold, utilized the Medical Aid in Dying (MAiD) program on January 18th, 2023, after battling a rare neurological disease called PSP for six years. The loss of my once lively, energetic, outdoorsy father at the age of 71 has been an unimaginable challenge for our family. Initially, my father was an active man who relished spending time with his five children, numerous grandchildren, and enjoying outdoor activities. However, this changed dramatically when PSP affected his balance, robbing him of his favorite hobby, golf. Subsequently, his ability to walk was compromised, stealing away his joy in outdoor pursuits, and eventually, his executive functioning. PSP stripped my father of the things he loved and lived for, including any control over his body and life. Living in Nebraska, my father's situation became more complicated due to my stepmother's battle with cancer. We had to relocate him to Colorado, where, under the care of my brother, his disease progressed rapidly. Faced with limited options, my father had to choose between waiting for death from asphyxiated pneumonia or participating in the Medical Aid in Dying program. Fortunately, we could secure his residency approval due to his living arrangements. However, many people with terminal illnesses in neighboring states face challenges due to residency requirements. Medical Aid in Dying provided my father with the one thing he could control—choosing not to suffer anymore. It was the last act of autonomy he could exercise in the face of a disease that had already taken so much from him. While the decision to participate in the MAID program is never taken lightly, it unquestionably granted my father the dignity he deserved. As my siblings and I held his hand during his passing, I reflected on how, without MAiD, we might have had to say our goodbyes in a sterile hospital room surrounded by machines. I implore you to consider passing SB24-068, not just for me and my father but for countless others whose lives have been prematurely shortened by terminal illnesses. Eliminating the residency requirement would mean that individuals like my father, without the privilege of having family in Colorado, could still experience a dignified end to their suffering. Thank you for your time and consideration. Sincerely, Kati Van Sicklen
Barbara Klaus	I am a healthy senior and a retired nurse practitioner.

For themself	I would like to ask you to support Senate Bill 068. The proposed changes in the Death and Dying law are sensible and will make it possible for those with six months or less to live to receive more appropriate care than the current regulations allow.
David Kehn For themself	My partner of 13 years, Susanne Baity, suffered from End Stage Renal Disease for 20+ years, and endured 10 hours of peritoneal diaylysis every night of her last 10 years of life in order to maintain a quality life. After suffering a slipped disc in 2020, she was no longer able to conduct her daily routines, including dialysis, without excruciating pain. After her decision to take advantage of Colorado's MAID statutes, it took 5 long months for her to obtain the medication necessary to end her life successfully on March 25, 2021. I strongly support and encourage the effort to update the MAID statues to allow qualified requestors to obtain the assistance they need in a more reasonable time frame and with fewer restrictions to access in order to reduce their unnecessary suffering. Thank you.
Kay Roesch For themself	In November of 2020 my husband was diagnosed with stage 4 esophageal cancer. Treatable but not curable. In November of 2021 he was given the “get your affairs in order” speech and sent home to die. He asked to be considered for a clinical trial. In May of 2021 he was released from the trial and sent home to die. They offered radiation to relieve his shoulder pain from the cancer. When he was finally ‘treatment free’ he signed up for the dignity to die. Because the process too SO long, he died without it. In the end, he begged me to give him the drug which we were still a few weeks away as we hadn’t had the 2nd doctor sign off yet. We had 6 dogs in our married life that never had to suffer in the end the way that he did. To watch his suffering, knowing there was no other outcome but death and not be able to expedite it was cruel and inhumane. Please make this an easier and less painful process.
Curtis Mitchell For themself	I strongly support medical aid in dying.
Pamela Moore For themself	I support simplification of the Medical Aid in Dying regulations. When my mother suffering a stroke, her living will and oft-expressed wishes made it clear she did not want to be attached to life support, and we let her go. But when my father was finally accurately diagnosed with Lewy Body Dementia (a notoriously difficult diagnosis to make early on) we could not offer him the same respect for his wishes. He suffered horribly, not from simple forgetfulness, but from near-constant, terrifying hallucinations and delusions, shaking in fear of his caregivers, convinced his loved ones were being tortured, that all his hard-won savings were stolen. In a single month, he fell over 20 times, breaking ribs and neck bones, in desperate efforts to "save" himself. I believe now he was throwing himself on the floor in part to get out of his living conditions; a horrible way to have to commit suicide. I wish we could have respected wishes he made before his diagnosis, as we did for my mother. Patient-made, written wishes documented before

	diagnosis should be respected after dementia/mental diagnoses, just as for physical maladies. If a person makes those decisions in advance, ethical concerns that the family is pushing their own wishes are mitigated. The demand that patients "pass" multiple checks are no more needed than they are if a patient decided in advance not to be tied to life support.
Shelby Marcuse For themself	Hello Health and Human Services Committee Members: My name is Shelby Marcuse, from District 12 in Colorado Springs (zip code 80918). I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. My Mom, Vyki Bishop, utilized Medical Aid in Dying in late October 2023 after suffering from terminal stage IV Bile Duct Cancer. The challenges of finding a doctor to prescribe (which required contacting more than 10 doctors offices in Colorado Springs and Denver Metro), getting appointments after finally locating a doctor, and traveling 1 1/2 hours to achieve the two appointments while she was in such poor health were a huge challenge. Additionally my mom was terrified she would be too sick to wait the 15 day waiting period. We did overcome the challenges and my Mom was able to fulfill her final wish, surrounded by her family and loved ones. It was the most peaceful passing I can imagine and we are eternally grateful that she had this freedom in Colorado. Others should have easier access and face less challenges than we did to fulfill this wish. Please support this bill. Thank you for your consideration. Shelby Marcuse
MARTIN MARCUSE For themself	Hello Health and Human Services Committee Members: My name is INSERT YOUR NAME, from INSERT DISTRICT. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. I have personally seen the complicated hoops and that a loved one has gone through to make a compassionate choice for herself, and the anxiety and confusion the current system creates with numerous

	hurdles. Safely reducing wait times and expanding provider access may one day alleviate the issues we faced in giving our loved ones her compassionate choice. Thank you for your consideration.
Natalie Macy For themself	Hello Health and Human Services Committee Members: My name is Natalie Macy, from District 12. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. This is especially critical to those terminally ill persons who are in rural or underserved communities. Thank you for your consideration.
Elizabeth Tovado Against themself	Argument against SB24-068 Medical Aid in Dying I am writing to share my opposition to SB24-068 Medical Aid in dying. As a Registered Nurse with 40 years of experience working with sick and dying individuals, I will state that we can control a person's pain and provide symptom relief from things like nausea, constipation, urinary retention etc.at the end of life with palliative and hospice care. Hospice care starts with a visit from the hospice RN who works in conjunction with the Hospice physician. Support items and medications are brought to the individual and much of the care can be done with guidance over the phone and by changing prescriptions at a local pharmacy. Patients can be admitted to an inpatient hospice for symptom management if unable to manage at home. Loved ones and support people can have peace of mind knowing that they assisted the dying person in their end of life journey. Removing the safeguards of a 15 day waiting period, allowing nurse practitioners to prescribe the end of life medications, which is not covered by Medicare, reducing the evaluation of the individual from 2 practitioners to only 1 and welcoming those from out of state to get their suicide medication here opens the door for more nefarious possibilities. My brother in law recently died at home under hospice care. His pain and symptoms were managed with excellent care virtually from the hospice team. The hospice RN came to his home one time to assist with a symptom that my sister was unable to manage. He was lucid and was able to interact with family and friends until the last few days. He was happy knowing that he could adjust his pain medicine as desired for visit with family etc. Hospitalized patients who want to stop any curative treatment are treated compassionately and comprehensively in their final days and hours. This law is not necessary and further erodes the relationship between patient and provider.

	Liz Tovado RN
Thalia Oster For League of Women Voters of Colorado	SB24-068 Medical Aid-in-Dying ~ LWVCO Supports this bill February 29, 2024 Senate Health and Human Services Committee Madam Chair and members of the Committee, Thank you for the opportunity to testify in support of SB24-068. My name is Thalia Oster, and I am a volunteer lobbyist for the Colorado League of Women Voters' Legislative Action Committee. For 103 years, The League of Women Voters has been a nonpartisan organization with the mission of encouraging informed and active participation in government and influencing public policy through education and advocacy. The League supports any measure that lessens or eliminates barriers to a patient's health care decisions, and an individual's right to have their personal medical decisions honored. This bill concerns end-of-life options for individuals with a terminal illness and would modify our current aid-in-dying laws to do the following: • Provide advanced practice registered nurses (NPs) with the same authority as an individual's attending physician to prescribe medication necessary to hasten an individual's death, • Removes the requirement that the individual be a resident of Colorado, • Reduces the waiting period between the oral request from 15 days to 48 hours to receive the medication, • Prohibits insurers form denying or altering healthcare or life insurance benefits otherwise available , and • Prohibits insurers from attempting to coerce an individual with a terminal illness to request medical aid-in-dying. The League of Women Voters strongly supports a patient's right to face death honorably, peacefully, and without undue administrative burdens, and would thus ask this committee to support passage of this bill. Thank you, Thalia Oster, Volunteer lobbyist for the League of Women Voters of Colorado LWVCO Healthcare Task Force Chair

Kathryn Waterman For themself	Dear Health & Human Services Committee Chair/ Committee My name is Kathryn Waterman and I am very much in support of Bill #SB24-068 and Colorado End of Life Options Act. My mother was critically ill with pulmonary hypertension, acute on-chronic kidney disease. Her lungs were failing, on the maximum oxygen allowed, her heart was failing, filling with fluid, and her kidneys were failing due to the strong diuretics. She got to where standing from wheelchair to toilet was a huge undertaking. She was losing quality of life and she knew it. Years before we all watched as my mother-in-law lay dying very slowly in extreme pain over 9 months, on a ventilator from pulmonary edema. It was horrible. I hope you never have to watch a family member who cognitively knows what is happening to their body and their quality of life and watch them suffer until the body finally fails because the medicines and machines can longer save them. We prayed daily for God to take her. My mother did not want this fate. I do not want this fate. As Coloradans, we the family, gladly voted for the right to die. My aunt lives in WA another right to die state. They gladly voted for the right to die. My mother met with endless doctors, spiritual church clergy, hospice, palliative care teams, and of course she met with the family about her choice and wishes, she was at peace. When the MAiD RTD doctors asked did she understand what would happen to her this was her response MOM: I will take the medicine and then I will go to sleep. DOCTOR: Go to sleep? MOM: Yes like when I go to surgery, count backwards and fall asleep. DOCTOR: With surgery you wake up in a recovery room, what then? MOM: I will wake up in a different recovery room, up in heaven with loved ones. Mother was at peace, she was happy and almost excited to take the medicine. She had a small sheer bag with precious mementos from her husband, mother-in-law, mother, grandmother, and children. She went to sleep thinking of them and how they would be there when she woke up in heaven. It comes down to the Right to Die SUFFERING HORRIBLY AND PAINFUL surrounded by family or the Right to Die PEACEFULLY, COMFORTABE and with DIGNITY surrounded by family. What would you choose? The family and friends surrounding mother had a celebration for and with her as she went Peaceful and Quietly. Having a controlled situation

	to end your life is a personal decision and I don't believe anyone should deny us the right to die WITH DIGNITY.
Annie Zeiler Against themself	My name is Annie and I worked as a Physician Assistant in several Denver and Boulder area nursing homes in 2018-2021. I accompanied several people at end of life with a terminal disease or other insurmountable debility. I was called by staff in spring 2019 to talk to a terminal patient who had been asking for suicide medication. Let's call her Nancy. When I got to Nancy's bedside, I allowed her to lead the conversation. She was clinically depressed and fret with grief, elaborating on how she was widowed and her daughter had also died, and how afraid she was of the loneliness of her future, of dying alone. I kept waiting for her to bring up the suicide pill, but she never did. I kept looking for my turn to interject with her options, but the best medicine I could give her in that moment was a listening ear as she very clearly just wanted to be heard. She never asked for suicide pills again. She took a turn for the worse a few days later and died within the week, feeling reconciled and surrounded by the loved ones she did have left. I still am humbled by how real and raw she made herself to me, and I am all the more a proponent of limiting access to a medication that a patient—and their loved ones—may regret after it's too late. Even if there were perfect use of physician-assisted suicide practice with no potential pit-falls, there is something too definite and inflexible with suicide that makes it a dangerous practice. Not only would people like Nancy be unable to achieve the natural passing they desire, reconciled with their fears, they would have no voice to share their story and speak out after the fact. There is nothing wrong with wanting to wish a peaceful death for ourselves and others, but limits and scrutiny are the only way to handle something as intricate and tricky as physician-assisted suicide.
David Van Sicklen For themself	Hello Health and Human Services Committee Members: My name is David Van Sicklen, from 28. I write to support bill SB24-068, the amended bill for the Colorado End of Life Options Act. As a resident of Colorado, I am passionate that while it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. Thank you for your consideration. David Van Sicklen
Lloyd Benes Against	SB24-068, Lloyd Benes opposes the Bill

themself	The following 4 reasons for opposing this Bill include citations as substantiation. One: The Hippocratic Oath's principle says, "First, do no harm," reflecting our expectation for medical people to prioritize saving lives. Instead, we condone terminating embryonic human life, even though the AMA has affirmed that human life begins at fertilization since1859 (citation = tinyurl.com/4kf7p4jr). This current Bill now endorses increased access to terminating lives of old people, expanding assisted suicide. Colorado data shows 92% of assisted suicides involve ages 55 or older (citation = tinyurl.com/4hsr3fmr). I am a 69-year-old, and I oppose this trend of targeting older individuals as well as permitting abortion up to the day of birth, so I urge a return to the fundamental principle of "First, do no harm." Two: "Compassion for those facing extreme pain" is a flawed reason for increased access to assisted suicide. Only 28% of Oregon patients listed “inadequate pain control” as an end-of-life concern (citation = tinyurl.com/baum3dy2). The primary worries were diminished ability to enjoy life (90% of patients), loss of autonomy (90% of patients), loss of dignity (72%), and burden on family (48%). Instead of focusing on expanding assisted suicide, our Bill could examine Colorado's current law and require patients to express their end-of-life concerns. And we could take Oregon’s data right now and do something positive with it … Third: …like offer mental health assistance to address concerns like diminished abilities, loss of autonomy, and burden on family. In the Colorado study, only 1% had access to mental health provider support (see page 7 of citation = tinyurl.com/4hsr3fmr). Shouldn’t we prioritize mental health care to alleviate end-of-life concerns? Fourth: Insurance companies have begun to deny life-saving drugs in favor of life-ending drugs (citation = tinyurl.com/mvf453n). The Bill's only commendable clauses include Section 19, prevents such insurance benefits denial, and Section 20, prohibits attempts to coerce individuals with terminal illnesses into requesting life-ending drugs. In summary, please throw out all of this Bill except Sections 19 & 20 that address the insurance concerns. Then modify Section 11 to include the question about end-of-life concerns. Finally provide mental health professional support to address the overwhelming majority of end-of-life concerns. Otherwise, Please vote No on this Bill.
Brenden Macy For themself	Esteemed Committee Members - I write today from my home in Colorado Springs in support bill SB24-068, the amended bill for the Colorado End of Life Options Act. While it is a gift that our current End of Life Options Act exists, there are necessary changes that need to be made to better support our terminally ill neighbors. Namely, reducing the waiting period between the two verbal requests, removing the residency requirement, and including APRNs as eligible prescribing practitioners. These measures will allow

	those truly in need to access the care they deserve, without undue delay and without additional pain and suffering attributable to such delays. In some of Colorado's most recognizably Coloradan communities, often in very remote or sparsely populated locations, care of all types is difficult to access at best, and impossible to access at worst, including the kind of palliative, compassionate care provided by the existing End of Life Options Act. This effectively means that not all of our neighbors have the same level of access to care as you and I, and this inequality is especially heartbreaking when it comes to those in desperate need of relief. I urge you to support your neighbors, support those most Coloradan communities, and tear down barriers of access by supporting bill SB24-068.
Sandra Marriott For themself	MY DEAR FRIEND CHOSE TO MOVE TO COLORADO IN ORDER TO TRANSITION ON HER OWN TERMS AND NOT SUFFER IN PAIN AND HAVE OTHERS EXPERIENE EXTENDED PAIN N TAKNG CARE OF HER DEBILITATED CONDITION. iT TOOK HER 6 MONTHS TO EXTABLISH RESIDENCY AND FIND A DR TO SUPPLY HER WITH THE MEDICATIONS AND LEARN ABOUT WHAT THE EXPERIENCE WOULD BE GENERALLY BE LIKE. sHE THOUGHT LONG AND HARD ABOUT HOW SHE WANTED THE LAST AMOUNT OF TIME SHE HAD ON THIS PLANE TO GO, AND THE SPIRITUAL TRANSITION SHE SHARED SHE WANTED TO INCLUDE IN THIS WAS POWERFUL. WE WHO SHE SHARED THIS WITH ALL WERE CONFIDENT AND AT PEACE WITH HER CHOICE AND IT HAS HELPED US TO GRIEVE HER PASSING ON MANY LEVELS. i BELIEVE IT COULD BE LESS STRESSFUL AND MORE PERSONABE IF DOULAS AND NURSE PRACTIONERS OR OTHER TRAINED PERSONNEL COULD FACILITATE THE PROCESS. MY FRIEND HAD TO JUMP THROUGH MANY HOOPS FOR THE LAST FEW MONTHS SHE HAD TO GET ALL THIS IN PLACE THAT SHE DIDN'T GET TO GET ALL OF HER AFFAIRS IN ORDER AND NOW THAT PAINFUL PROCESS IS IN HER DAUGHTER'S HANDS, WHICH SHE WOULDN'T HAVE CHOSEN