Written Testimony of Catherine Glenn Foster, Esq.
President & CEO, Americans United for Life
Opposing S.B. 165, the Controlled Substances to End Patient Life Act
Submitted to the Senate Health and Human Services Committee
February 22, 2019

Dear Chair Hardy and Honorable Members of the Committee:

My name is Catherine Glenn Foster, and I serve as President and CEO of Americans United for Life (AUL). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in bioethics law. In my practice, I specialize in legislation and constitutional law, and in the constitutionality of end-of-life laws specifically. I have written extensively on the end-of-life issue, most recently in *The Human Life Review*.[1] I appreciate the opportunity to submit written testimony against S.B. 165, which would legalize suicide by a doctor's prescription in Nevada.

I have thoroughly reviewed S.B. 165, and it is my opinion that the Act goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable people groups at greater risk, and fails to protect the integrity and ethics of the medical profession.

The Majority of States Affirmatively Prohibit Suicide by Physician

Currently, the overwhelming majority of states—at least 40 states—affirmatively prohibit assisting in a suicide and impose criminal penalties on anyone who helps another person end his or her life. And since Oregon first legalized the practice in 1996, "about 200 assisted-suicide bills have failed in more than half the states."[2] Indeed, a number of states have passed or strengthened laws against assisted suicide in recent years. These include Alabama, Arizona, Georgia, Idaho, Louisiana, Ohio, and, most recently, Nevada's neighbor, Utah. In the nearly 25 years since Oregon legalized assisting in some suicides, only six U.S. jurisdictions have legalized the practice. 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."[3]

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[1] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUMAN LIFE REV. 51 (2018).
[2] *Id.* at 53.
[3] 521 U.S. 702, 710 (1997).

This longstanding consensus among the vast majority of states is unsurprising when one considers, as the Court did, that "opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages."[4] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide in the U.S. Constitution, and instead found 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."[5]

Only by rejecting S.B. 165 can this Committee further Nevada's important state interest in preserving human life and advance the State's duty to protect the lives of its citizens, especially the lives of the most vulnerable members of society.

Suicide by Physician Places Already-Vulnerable Persons at Greater Risk

It is critical for Nevada to protect potentially vulnerable persons—including elder adults and those living in poverty or with disabilities—from abuse, neglect, and coercion. Given the risks posed by assisted suicide to all of us, especially these too-often-disenfranchised individuals, participating in their suicide can be considered neither a compassionate nor an appropriate solution. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in those jurisdictions that have approved suicide by physician, which include a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting individual.[6] Even the most vulnerable among us, such as the poor, the elderly, the terminally ill, the disabled, and the depressed, are worthy of life and of equal protection under the law, and state prohibitions on suicide with the assistance of a physician 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."[7]

Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on enabling suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as the principles articulated in the Hippocratic Oath to "keep the sick from harm and injustice" and to "refrain from giving anybody a deadly

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[4] *Id.* at 711.
[5] *Id.* at 729–30.
[6] J. 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* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (2018), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf (In 2017, 56% of patients who died after ingesting 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.).
[7] *Glucksberg*, 521 U.S. at 731–32.

drug if asked for it, nor make a suggestion to this effect."[8] And today, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of their life. The AMA states that "permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[9] In fact, the AMA emphasizes that physicians must "aggressively respond to the needs of the patients" and "respect patient autonomy [and] provide appropriate comfort care and adequate pain control."[10]

In addition, the U.S. Supreme Court has stated, "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[11] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for physician-assisted suicide, 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.'"[12]

S.B. 165 would further erode the ethics of the medical profession as it forces physicians and advanced practice registered nurses to sign falsified death certificates. This Act requires that the medical certificate of death for an individual who dies from physician-assisted suicide state "the terminal condition with which the patient was diagnosed as the cause of death of the patient." In other words, the medical professional must sign a document that contains information he or she knows to be factually untrue.

The Supposed "Safeguards" Do Not Always Work

Despite the so-called "safeguards," opening the door to suicide with the assistance of a physician also opens the door to real abuse. For "unless we describe, in the law, every possible illness and every possible remedy, what possibility is there that we can ensure safety? The variables are infinite. . . . What the supposed 'safeguards' do well is to protect doctors. They are provided with an immunity from prosecution for homicide or assisting in suicide if they comply with a set of procedures."[13]

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[8] 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, 131–32 (1973).

[9] AMA CODE OF MEDICAL ETHICS OP. 5.7 (Physician-Assisted Suicide), https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf.

[10] *Id.*

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

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

[13] Foster, *supra* note 1, at 58 (quoting Paul Russell, *Should People Be Denied Choices at the End of Life?*, Mercatornet (Jan. 29, 2016), https://www.mercatornet.com/mobile/view/should-people-be-denied-choices-at-the-end-of-life (internal commas and quotation marks added)).

For example, S.B. 165 requires that there be two witnesses to the request for life-ending medication, but only one must be a disinterested party, at least in theory. There is no requirement that the second witness be disinterested, meaning an heir and his best friend would satisfy the two-witness requirement, easily circumventing the alleged safeguard designed to protect the patient from pressure, coercion, or abuse.

One need only look to the Netherlands and Belgium to see how this plays out. A report commissioned by the Dutch government demonstrated that more than half of assisted suicide and euthanasia-related deaths were involuntary in the year studied.[14] At least half of Dutch physicians actively suggest euthanasia to their patients.[15] Another study showed that out of the 1,265 nurses questioned, 120 of them (almost 10 percent) reported that their last patient was involuntarily euthanized.[16] But only four percent of nurses involved in involuntary euthanasia reported that the patient had ever expressed his or her wishes about euthanasia. And most of the patients euthanized without consent were over 80 years old, emphasizing the risks of elder abuse in jurisdictions that have legalized assisted suicide and/or euthanasia.

Another example of the unreliability of these "safeguards" is the requirement for mental health assessments. S.B. 165 only requires the attending physician refer the individual to a psychologist or psychiatrist *if the physician thinks the individual is not "competent."* The psychologist or psychiatrist then meets the patient and makes the decision on whether the individual is "competent." Competency, as defined by S.B. 165, only means the "person has the ability to make, communicate and understand the nature of decisions concerning his or her health care." It does not require any confirmation the individual is not suffering from a psychiatric condition that may be causing impaired judgment or require any treatment. But even such a safeguard would not fully protect the individual. As the most recent statistics show, only five of the 143 patients in Oregon, and only four of the 196 patients in Washington State, who died from ingesting end-of-life drugs in 2017 were ever referred for a psychiatric evaluation.[17] One study from Oregon found 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."[18] But without a requirement the mental health professional see the individual more than once, it is difficult to argue this "safeguard" in S.B. 165 will accurately assess an individual's competency.

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[14] *See* W.J. Smith, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 118–19 (2003) (citing the Dutch government's *Remmelink Report* documenting euthanasia results in the Netherlands).
[15] *See id*. at 119 (citing R. Fenigsen, *Report of the Dutch Government Committee on Euthanasia*, 7 ISSUES LAW & MED. 239 (Nov. 1991); *Special Report from the Netherlands*, N.E.J.M. 1699-711 (1996)).
[16] E. Inghelbrecht et al., *The Role of Nurses in Physician-Assisted Deaths in Belgium*, CAN. MED. ASSN. J. (June 15, 2010).
[17] Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2017 DATA SUMMARY (Feb. 9, 2018) https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf (last visited Feb. 14, 2019); Wash. St. Dept. Health Disease Control and Health Stat. Div., WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT, (Mar. 2018) https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf (last visited Feb. 22, 2019).
[18] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, Am. J. Psychiatry 157:4, 595 (2000) https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.157.4.595.

In conclusion, Nevada should reject physician-assisted suicide and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable persons such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession by rejecting S.B. 165. Thank you.

Sincerely,

Catherine Glenn Foster
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Americans United for Life