Written Testimony of Catherine Glenn Foster, Esq.
President & CEO, Americans United for Life
Against H.B. 140
Submitted to the House Health and Human Development Committee
May 8, 2019

Dear Chair Bentz and Members of the Committee:

I serve as President and CEO of Americans United for Life (AUL), America's original and most active organization advocating for life-affirming support and protections for the most vulnerable members of our communities. Established in 1971, AUL has dedicated nearly 50 years to advocating for everyone to be welcomed in life and protected in law. In my practice I specialize in life- and health-related legislation, and am testifying as an expert in constitutional law generally and in the constitutionality of end of life-related laws specifically. I have also written extensively on the end-of-life issue, most recently in *The Human Life Review*. I appreciate the opportunity to provide written testimony against H.B. 140, which would legalize suicide by medical means in Delaware.

I have thoroughly reviewed H.B. 140, and it is my opinion that the Act places already-vulnerable persons at even greater risk, fails to protect the integrity and ethics of the medical profession, and goes against the prevailing consensus that states have a duty to protect life.

Suicide by Physician Places Already-Vulnerable Persons at Greater Risk

Delaware has a responsibility to protect vulnerable persons—including people living in poverty, elder adults, and those living with disabilities—from abuse, neglect, and coercion. Considering the risk posed to these vulnerable individuals, legalizing suicide can be considered neither a "compassionate" nor an appropriate solution for those who may suffer depression or loss of hope at the end of life.

Indeed, contrary to the prevailing cultural narrative, the reason why people consider seeking assistance in their suicide is neither pain nor fear of pain. In the last 15 years, pain and fear of pain have never been in the top five reasons cited by those seeking assisted suicide in Oregon;[1] the latest data from

[1] Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY (Feb. 15, 2019) [hereinafter Oregon 2018 Data Summary], https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf.

Washington State reveal the same concerns.[2] As bioethicist Ezekiel Emanuel has noted, "the main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . . . In this light, assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."[3]

Emanuel is not alone. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved prescription suicide, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[4] The most vulnerable among us, such as the poor, the elderly, the terminally ill, the disabled, and the depressed, are equally worthy of life and even more in need of equal protection under the law, and state prohibitions on promoting or enabling 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."[5] Speaking to this disparate treatment, Dr. Kevin Fitzpatrick wrote, "When non-disabled people say they despair of their future, suicide prevention is the default service we must provide. Disabled people, by contrast, feel the seductive, easy arm of the few, supposedly trusted medical professionals, around their shoulder; someone who says 'Well, you've done enough. No-one could blame you.'"[6]

There has been discussion of a "suicide contagion," or the Werther Effect.[7] Empirical evidence shows media coverage of suicide inspires others to commit suicide as well.[8] One study, which incorporated assisted-suicide statistics, demonstrated that legalizing assisted suicide in certain states has led to a rise in overall suicide rates—assisted and unassisted—in those states.[9] The study's key findings show that after

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[2] Wash. State Dept. of Health Disease Control and Health Statistics Div., WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (Mar. 2018) [hereinafter Washington 2017 Report], https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf.

[3] Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, N.Y. Times (Oct. 27, 2012), https://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/.

[4] 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* Washington 2017 Report, *supra* note 2 (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.).

[5] *Glucksberg*, 521 U.S. at 731–32.

[6] Kevin Fitzpatrick, *Assisted Suicide for Disabled People – Democracy in Britain?*, Euthanasia Prevention Coalition blog, June 23, 2015, available at http://alexschadenberg.blogspot.com/2015/06/assisted-suicide-for-disabled-people.html.

[7] *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/.

[8] *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).

[9] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015) https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf.

accounting for demographic, socioeconomic, and other state-specific factors, physician-assisted suicide is associated with a 6.3% increase in overall suicide rates.[10] These effects are even greater for individuals older than 65 years of age—14% increase.[11] And so suicide prevention experts have criticized assisted-suicide advertising campaigns, writing that a billboard proclaiming "My Life My Death My Choice," which provided a website address, was "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal."[12]

The Supposed Safeguards Are Ineffective in Practice

Despite the so-called "safeguards," opening the door for suicide via prescriptive means also opens the door to real abuse. For example, H.B. 140's mental health assessment requirement is woefully inadequate. The Act merely requires the physician ensure the individual has "decision-making capacity," and refer the patient to a mental health professional if he or she "believes the individual may not have decision-making capacity."

This safeguard is ineffective for two reasons. First, H.B. 140 defines "decision-making capacity" as the ability to "understand and appreciate the nature and consequences of a particular health-care decision, including the benefits and risks of that decision and alternatives to any proposed health care, and to reach an informed health-care decision." Act § 2508B(8). This does not require any confirmation the individual is not suffering from a psychiatric condition that could influence his or her decision to choose to end his or her life. Even if the individual were found to suffer from such a condition, that does not preclude the psychiatrist or psychologist from determining the individual can understand the nature and consequences of his or her decision to end his life. And so a person suffering from depression might never receive treatment, but rather be deemed capable of understanding the decision to request assistance in suicide, and be prescribed the lethal drugs.

Second, if the physician does decide to refer the individual—which he is not required to do—there is no requirement that the referred psychiatrist or psychologist meet with the individual more than once. As the most recent statistics from Oregon show, only 3 of the 168 patients who died from ingesting end-of-life drugs in 2018 were ever referred for a psychiatric evaluation.[13] Similarly, in Washington, only 4 of the 196 individuals who died in 2017 were referred for a psychiatric evaluation.[14] 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

[10] *Id.*
[11] *Id*.
[12] *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/.
[13] Oregon 2018 Data Summary, *supra* note 1.
[14] Washington 2017 Report, *supra* note 2.

suicide."[15] For these reasons, it is difficult to argue this "safeguard" in H.B. 140 will take into account or accurately assess an individual's mental health.

Another example of the unreliability of these "safeguards" is the requirement there be at least two witnesses to the request for life-ending medication—but only one must be a disinterested party, at least in theory. The Act explicitly allows one of the parties to be a relative, beneficiary, or other interested party, easily circumventing the alleged safeguard designed to protect the person from pressure, coercion, or abuse.

In addition, the Act assumes the physicians are able to make the correct diagnosis that a patient is has an incurable and irreversible disease which will "result in death within 6 months." But this fails as a safeguard as terminality is not easy to predict. Current studies have shown "experts put the [misdiagnosis] rate at around 40%,"[16] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[17] 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.[18] Nicholas Christakis, a Harvard profess or sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care,"[19] and Arthur Caplan, the director of the Center for Bioethics at the University of Pennsylvania, considers a six month requirement arbitrary.[20] 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."[21]

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

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

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[15] 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.
[16] 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
[17] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, The Local, published Apr. 24, 2014 (reporting the docto was not held accountable for his negligence).
[18] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[19] *See id.*
[20] *See id.*
[21] 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.

deadly drug if asked for it, nor make a suggestion to this effect."[22] Likewise, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of 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."[23] In fact, the AMA states the physician must "aggressively respond to the needs of the patients" and "respect patient autonomy [and] provide appropriate comfort care and adequate pain control."[24]

Furthermore, the Act threatens the integrity of the medical profession and the conscience rights of healthcare professionals. It requires that "attending physicians *must* provide sufficient information to an individual with a terminal illness regarding *all* available treatment options, and the alternatives and the foreseeable risks and benefits of each." Act § 2503B(b) (emphasis added). It also states that the failure to inform or refer the individual "who requests additional information about available end-of-life treatments, including medication to end their life" is considered a "failure to obtain informed consent for subsequent medical treatment." Act § 2503B(c). While the terms "available treatment options" and "alternatives" are ambiguous and undefined in subsection (b), they would most likely be interpreted to include assisted suicide as an "available treatment option" or "alternative treatment option," since subsection (c) includes "medication to end [] life" explicitly as an "available end-of-life treatment[]." Act § 2503B(c). Thus, physicians would be required to discuss physician-assisted suicide and explain its supposed benefits or refer a patient to another physician who can provide that information.

This Act harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. It opens the door for physicians to be forced to violate medical ethics, such as the Hippocratic Oath to "do no harm," as well as their moral convictions or religious beliefs against taking one's own life or assisting another to end her life. If passed, physicians who object to physician-assisted suicide for ethical, religious, or moral reasons will be forced to choose between violating their conscience or violating the law and potentially losing their medical license. This Act increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with assisted suicide as a viable treatment option along with its alleged benefits. Additionally, a physician is prohibited from proceeding with any life-affirming care even for a terminally ill patient *until* that patient has given informed consent, which under the Act, *must* include information about physician-assisted suicide.

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[22] 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).

[23] 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.

[24] *Id.*

The U.S. Supreme Court has stated "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[25] 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.'"[26]

The Majority of States Affirmatively Prohibit Medicalized Suicide

Currently, the overwhelming majority of states—at least 39 states—affirmatively prohibit assisted 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," and more states have moved to ban the practice than have decided it was worth the risk.[27] In *Washington v. Glucksberg*, the United States 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."[28]

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."[29] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide 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."[30]

Thus, Delaware should reject H.B. 140 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable individuals such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession. Thank you.

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[25] *Glucksberg*, 521 U.S. at 731.
[26] *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).
[27] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUMAN LIFE REV. 51, 53 (2018).
[28] 521 U.S. 702, 710 (1997).
[29] *Id.* at 711.
[30] *Id.* at 729–30.

Sincerely,

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