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.

---

[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

---

[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

---

[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

---

[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.

---

[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

---

[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.