Bill as Introduced
HOUSE BILL 339

AN ACT relative to death with dignity for certain persons suffering from a terminal condition.


COMMITTEE: Judiciary and Family Law

ANALYSIS

This bill allows a mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal condition by the patient’s attending physician and a consulting physician to request a prescription for medication which will enable the patient to control the time, place and manner of such patient’s death.

Under this bill, the request is witnessed and signed in essentially the same manner as a living will. The bill requires the division of public health services, department of health and human services, to collect certain information and compile a statistical analysis of such information.

EXPLANATION: Matter added to current law appears in bold italics.
Matter removed from current law appears in [brackets].
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.
HB 339

STATE OF NEW HAMPSHIRE

In the year of Our Lord
One Thousand Nine Hundred and Ninety-Five

AN ACT

relative to death with dignity for certain persons
suffering from a terminal condition.

Be it Enacted by the Senate and House of Representatives
in General Court convened:

1 New Chapter; Death with Dignity for Certain Persons Suffering Terminal Illnesses. Amend RSA by inserting after 137-J the following new chapter:

CHAPTER 137-K

DEATH WITH DIGNITY ACT

137-K:1 Statement of Purpose. The state of New Hampshire recognizes that persons have a right, founded in the autonomy of the person, to control the decisions relating to the rendering of their own medical care. The state of New Hampshire further recognizes that medical care for terminally ill patients who are capable of making informed decisions during the time of their illness includes the right, with assistance from their physicians, to decide how they die with dignity. Many terminally ill patients experience severe, unrelenting suffering. To remedy these situations the state of New Hampshire hereby declares that the laws of the state shall permit a licensed physician, upon written request of a terminally ill patient in a condition of severe, unrelenting suffering, to provide such patient with a prescription for lethal medication which will allow the patient, if the patient chooses to do so, to self-administer and thus control the time, place, and manner of death.

137-K:2 Definitions. In this chapter:

I. “Adult” means an individual who is 18 years of age or older.

II. “Attending physician” means the physician who has primary responsibility for treatment and care of the patient’s terminal disease.

III. “Capable” means that, in the opinion of a court or in the opinion of the patient’s attending physician or consulting physician, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient’s manner of communicating if those persons are available.

IV. “Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient’s disease.

V. “Counseling” means a consultation between a licensed psychiatrist or certified psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, depression, or any physical disorder causing impaired judgment.
IV. "Division" means the division of public health services, department of health and human services.

VII. "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.

VIII. "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end the patient's life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of the:

(a) Medical diagnosis.
(b) Prognosis.
(c) Potential risks associated with taking the medication to be prescribed.
(d) Probable result of taking the medication to be prescribed.
(e) Feasible alternatives, including, but not limited to, comfort care, hospice care, palliative treatment, and pain control.

IX. "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

X. "Patient" means a person who is under the care of a physician.

XI. "Physician" means a person licensed by this state to practice medicine or osteopathy.

XII. "Qualified patient" means a capable adult who is a resident of New Hampshire or is a patient regularly treated in a New Hampshire health care facility and who has satisfied the requirements of this chapter in order to obtain a prescription for medication to end the patient's life in a humane and dignified manner.

XIII. "Terminal condition" means an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.

137-K:3 Initiating a Written Request for Medication. An adult who is capable and a resident of New Hampshire, or who is a patient regularly treated in a New Hampshire health care facility, and who has been determined by the attending physician and consulting physician to be in a condition of severe, unrelenting suffering from a terminal disease, and who has voluntarily expressed a wish to die, may make a written request for medication for the purpose of ending such person's life in a humane and dignified manner in accordance with this chapter.

137-K:4 Form of the Written Request.
I. A valid request for medication under this chapter shall be in substantially the form described in paragraph V of this section, signed and dated by the patient and witnessed by at least 2 individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

II. One of the witnesses shall be a person who is not:
   (a) A relative of the patient by blood, marriage or adoption;
   (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
   (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

III. The patient's attending physician at the time the request is signed shall not be a witness.

IV. If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the division.

V.

REQUEST FOR MEDICATION

I,.................................., am an adult of sound mind.

I am in a condition of severe, unrelenting suffering from .................................., which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, palliative treatment, and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

- I have informed my family of my decision and taken their opinions into consideration.
- I have decided not to inform my family of my decision.
- I have no family to inform of my decision.
I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: ............................................................

Dated: ............................................................

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

............................................................ Witness 1/Date

............................................................ Witness 2/Date

Note: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person’s estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

137-K.5 Attending Physician Responsibilities. The attending physician shall:

I. Make the initial determination of whether a patient has a terminal disease and is in a condition of severe, unrelenting suffering; is capable; and has made the request voluntarily.

II. Inform the patient of the:

(a) Medical diagnosis.

(b) Prognosis.

(c) Potential risks associated with taking the medication to be prescribed.

(d) Probable result of taking the medication to be prescribed.

(e) Feasible alternatives, including, but not limited to, comfort care, hospice care, palliative treatment, and pain control.

III. Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily.
IV. Refer the patient for counseling if appropriate pursuant to RSA 137-K:7

V. Request that the patient notify next of kin.

VI. Inform the patient that the patient has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period pursuant to RSA 137-K:9.

VII. Verify, immediately prior to writing the prescription for medication under this chapter, that the patient is making an informed decision.

VIII. Fulfill the medical record documentation requirements of RSA 137-K:10.

IX. Ensure that all appropriate steps are carried out in accordance with this chapter prior to writing a prescription for medication to enable a qualified patient to end the patient's life in a humane and dignified manner.

137-K:6 Consulting Physician Confirmation. Before a patient is qualified under the chapter, a consulting physician shall examine the patient and the patient's relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is in a condition of severe, unrelenting suffering from a terminal disease and verify that the patient is capable, is acting voluntarily, and has made an informed decision.

137-K:7 Counseling Referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression or any physical disorder causing impaired judgment.

137-K:8 Informed Decision; Family Notification.

I. No person shall receive a prescription for medication to end such person's life in a humane and dignified manner unless such person has made an informed decision as defined in RSA 137-K:2, VIII. Immediately prior to writing a prescription for medication under this chapter, the attending physician shall verify that the patient is making an informed decision.

II. The attending physician shall ask the patient to notify next of kin of the patient's request for medication pursuant to this chapter. A patient who declines or is unable to notify next of kin shall not have the patient's request denied for that reason.

137-K:9 Written and Oral Requests; Rescinding a Request; Waiting Periods.

I. In order to receive a prescription for medication to end a patient's life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to the patient's attending physician no fewer than 15 days after making the initial
oral request. At the time the qualified patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

II. A patient may rescind such patient's request at any time and in any manner without regard to the patient's mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

III. No fewer than 15 days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter. No fewer than 48 hours shall elapse between the patient's written request and the writing of a prescription under this chapter.

137-K:10 Medical Record Documentation Requirements. The following shall be documented or filed in the patient's medical record:

I. All oral requests by a patient for medication to end such patient's life in a humane and dignified manner.

II. All written requests by a patient for medication to end such patient's life in a humane and dignified manner.

III. The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily, and has made an informed decision.

IV. The consulting physician's diagnosis, prognosis, and verification that the patient is capable, acting voluntarily, and has made an informed decision.

V. A report of the outcome and determinations made during counseling, if performed.

VI. The attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request pursuant to RSA 137-K:9.

VII. A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

137-K:11 Applicability. This chapter shall apply only to requests made by New Hampshire residents or requests by patients regularly treated in a New Hampshire health care facility.

137-K:12 Reporting; Rulemaking.

I. The division shall adopt rules relative to the collection of information required under this chapter and relative to the qualifications of witnesses under RSA 137-K:4, IV. The information collected shall not be a public record under RSA 91-A and shall not be made available for inspection by the public.

II. The division shall annually review a sample of records maintained pursuant to this chapter and shall generate and make available to the public an annual statistical report of the information.
137-K:13 Exceptions.

I. No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, shall be valid.

II. No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end such person's life in a humane and dignified manner.

III. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end the person's life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end such patient's life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

IV. Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

137-K:14 Immunities. Except as provided in RSA 137-K:15:

I. No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end the patient's life in a humane and dignified manner.

II. No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter.

III. No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this chapter shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

IV. No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end the patient's life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers such patient's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.
137-K:15 Liabilities.

I. A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a class A felony.

II. A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life or to destroy a rescission of such a request, shall be guilty of a class A felony.

III. Nothing in this chapter limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

IV. The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this chapter.

137-K:16 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

2 Effective Date. This act shall take effect January 1, 1996.
Amendments
Amendment to HB 339

Amend RSA 137-K:2 as inserted by section 1 of the bill by inserting after paragraph XII the following and renumbering the original paragraph XIII to read as XIV:

XIII. "Suffering" means a state of severe distress, sense of personal loss, lack of hope, loss of control, and impaired quality of life.
HB 306, establishing a children, youth and families council to address the efficient delivery of services to children and families.

HB 521-FN, creating interagency family assistance teams for at-risk youth.

HB 538-FN, relative to DCYF enforcement of financial liability of responsible parties, authorizing DCYF to pay for ancillary services without a court order, and removing the requirement that advisory board consult in rate setting.

HB 545-FN, relative to child support collection and related rulemaking authority of the director of human services.

HB 557-FN, relative to the procedures of the central registry under the division for children, youth, and families.

HB 594, requiring employers to report to the department of employment security the names of individuals hired or rehired, which information is used by the division of human services in child support enforcement.

HB 586-FN, suspending the salary and benefits of any judge suspended by the supreme court for misconduct.

HB 612-FN, requiring the attorney general to bring suit against the United States Government for violating the United States Constitution and the New Hampshire constitution by enacting a military firearms ban.

HB 620-FN, relative to mandatory prelitigation screening and mediation panels for professional negligence claims.
Speakers
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HB 339 (pink cards)

SPEAKING — SUPPORTING

Peter Devere, Melvin Village, NH
Ted Capran, MD, 34 Main St., Belmont, NH
Robert Nace, 20 Mt. View Dr., Peterborough
Thomas Bugley, P.O. Box 401, Franklin
Allen Mayville, Lane Rd., Chichester
Doug Hall, Lane Road, Chichester
G. Kenneth DeHart, Jr., MD, Rte. 107, Belmont
Rev. Lawrence D. Rupp, RR #2, Box 415, New London
Luis A. Gallup, P.O. Box 35, Franconia, N.H. Hemlock Society
Rev. Charles Stephens, 123 Mountain Rd., Concord, Concord Unitarian Universalist Church
Phillipe Citron, Mt View Apts., #33, Laconia, NH
Rep. Robert Guest, Hanover
Rep. O. Alan Thulander, 1 Main St., Franconia
Cynthia A. McGovern, Portsmouth

SPEAKING — OPPOSING

Robert Forsing, 12 Green Rd., Raymond
Ellen Kolb, 5 Sharon Ave., Merrimack
Kathleen Souza, N.H. Right to Life, Merrimack
Patricia F. Prescott, Fairview Rod, P.O. Box 205, Pittsfield
Marie Kinn, 477 Old Street Road, Peterborough, NH Hospice Organization
Judith Delisle, 251 Ash St., Manchester, Dr. C. Everett Koop
Bradford T. Cook, representing Monsignor Francis Christian, 15 Ash St., Manchester, Roman Catholic Diocese of Manchester
Aggie Dowd, 15 Maple Rd., N. Hampton, Women Offering Life
Richard B. Friedman, 2334 Elm St., Manchester, N.H. Medical Society
Lucius Hill, MD, Saltonstall Bldg. 9 Buzell Ave., Exeter, NH
Richard Johnson, MD, 31 Holt Rd., Amherst, NH

TESTIFYING — NEITHER SUPPORTING NOR OPPOSING

Paul Arnstein, 12 Oxalis Way, Concord, N.H. Cancer Pain Initiative
Hearing Minutes
HOUSE COMMITTEE ON JUDICIARY AND FAMILY LAW

PUBLIC HEARING on HB 339

BILL TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: 2/16/95

LOB ROOM: 208 Time Public Hearing Called to Order: 11:15 a.m.

Time Adjourned:

(please circle if present)


Bill Sponsors: Reps. Guest, Copenhaver, McGovern, Thulander

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Guest – sponsor – supporting


Philip Citron, Laconia, N.H. Hemlock Society
-terminally ill, believes right to die should not be public matter
-no institution should have no right to determine how or when one should die
-wants to carry out last willful act while he still has mental powers to do so
-wants state to recognize this is solely a matter between him and his physician
-this is a decision he did not come to lightly

Rep. Peter Wells
-opposed

Rep. Goddard
-opposed
Dr. Richard Friedman – President of N.H. Medical Society
- opposed
- numerous conventions, caucuses, surveys – concludes the issue opposed by N.H. physicians
- moral, ethical arguments against legislation is flawed
- physician's role to promote health and relieve suffering
- HB 339 sanctions death
- HB 339 makes physician active provider for death
- HB 339 intrudes in patient-doctor relationship
- how will depressed or undecided person deal with this?
- feels the need for continuing education on pain management
- doctors should strive to make patients' last days as comfortable as possible
- this bill allows for abuse and doctors who won't perform according to required standards
- safeguards in bill are superficial
- pressures elderly to accelerate death for financial reasons
- poor will find costs for care will lead to having to make death decision
- "capable" and "terminal illness" = terms that are ambiguous
- this is a slippery slope of euthanasia and potential for abuse
- makes it easy for society to dispose of patients

QUESTION – REP. JACOBSON
- "abuse in Netherlands" stated – but aren't there abuses in every law?
  ANSWER – Yes

QUESTION – REP. HALLYBURTON
- don't physicians take Hippocratic oath?
  ANSWER – some schools use that, some use another, but they all take oaths

QUESTION – REP. HART
- this committee is concerned about pain control, isn't there an accelerated education program for pain control?
  ANSWER – there are now doctors who specialize in pain control

QUESTION – REP. KENNEDY
- will doctors be making ethical choices they don't want to make?
  ANSWER – doctors should not have right to decide to kill or violate, his choice is to how patients should be treated

QUESTON – REP. McMAHON
- any studies on young people traumatized and easy suicides?

QUESTION – REP. JACOBSON
- what if patient is incapable of making decision?
  ANSWER – with advance directives physician can be guided; we let them, also by family know choices patient made
Dr. Lucius Hill - opposed
-people fear abandonment and loss of dignity as well as fear
-palliative care has grown as a specialty in Canada and United Kingdom
-hospice care multidisciplinary with social workers, nurses, CNA's, doctors, chaplains to deal with distress
-pain management is central to this issue
-90% of cancer pain can be managed relatively easily
-only 1 or 2 in 10 years with overwhelming pain
-much more skilled in dealing with other physical symptoms
-they help patient "live until they die"
-American College of Surgeons promotes program and surveys of hospice care and their work with doctors.
-New Hampshire has almost universal hospice care, but some don't use it
-extremely rare for hospice patients to ask for assisted suicide, though some may want to
-hospice care is an alternative to this bill
-he is in total agreement with Dr. Friedman

Dr. Richard Johnson - surgeon - opposed
-agrees with Dr. Hill and Dr. Friedman
-he rarely has patients with unrelieved pain
-pain mediation often causes drowsiness and impaired mental capacities
-would the paralyzed, depressed, or those with Alzheimer's become victims?
-in 1991 Dutch Government report showed a large number of involuntary deaths due to deliberate over doeses without patients knowledge due to others' choices
-equal protection of 14th Amendment - persons could be deprived of treatments by others decisions
-there are sometimes fine lines of interpretation in medicine
-wise setting of limits on use of power-
-Hippocratic Oath - 1. no breach of confidence
-2. no sexual relations with patients
-3. no dispensing of deadly drugs with intent to kill
-patients are vulnerable
-primary function of physicians is to heal the sick

HEARING TO BE CONTINUED ON 3/2/95, 10:00 a.m.

Respectfully submitted,

Rep. Irene Pratt, Acting Clerk
H.B. 339–

Rep. Guest – supports

"McGovern -


Terminally ill – believes it to die should not be a public matter, no institution should have no right to determine how or when one should die.

Wants to carry out last willful act while he still has mental powers to do so.

Wants State to recognize this is solely a matter between his physician and he.

This is a decision he did not come to lightly.

Rep. Peter Welter – opposed

Rep. Goddard –

Dr. Richard Friedman – Pres. of N.H. Med. Soc. – opposed

In numerous conventions, caucuses, surveys, concludes the issue opposed by N.H. physicists.

Moral, ethical arguments against.

Leg. is flawed.

Phys. role to promote health and relieve suffering.

H.B. 339 sanctions death.

‘‘make phys. active provider for death.

Introduces in patient – dr. relationship.

How will depressed or undecided person deal with this?

Feels need for continuing ed. on pain management.

Dr. should strive to make patients’ last days as comfortable as possible.

This bill allows for abuse, this who want perform according to required standards – safeguards in still are superficial.
pressures elderly to accelerate death for financial reasons. Poor will find costs for care will lead to having to make death decision.

"Capable" + "Terminal illness" = terms that are ambiguous. This is a slippery slope of euthanasia + potential for abuse makes it easy for society to dispose of patients. Jacobson: Ques. = "abuse in Netherlands" stated - but aren't these abuses in every law?

Ans. = Yes

Hollywood: don't phys. take Hypocritic Oath?

Ans. = some schools use that, some use another, but they all take oaths

Hart: Ques. = this committee is concerned about pain control isn't there an accelerated ed. program for pain control?

Ans. = yes there are now, also do who are specialists in pain care

Kennedy: Ques. = will this in making ethical choices. Why don't want to make?

Ans. = do should not have it to decide to kill or violate his choice as to how patient should be treated

Mc Mahon: Ques. = any studies on young people traumatized + easy suicide?

Ans. =

Gardstein: What if patient is incapable of making decisions?

Ans. w/ advance directives, phys. can be guided, also by family

we let them know choices patient made

Lucius Hill = opposed people fear abandonment + lost of dignity as well as fear palliative care grown as specialty in Canada + United Kingdom hospice care multidisciplinary w/soc. worker, nurse, CNA's, diet, chaplains to deal w/ distress
Pain management central to this issue
90% cancer pain can be managed relatively easily

only 1.2 la 10 yrs w/overwhelming pain

much more skilled in dealing w/other physical symp

they help patient "live until they die"

Am. College of Surgeons promotes program + surveys of hospice care + their work w/dea.

NH has almost universal hospice care, but some don't use extremely rare for hospice patients to ask for assisted suicide though some may want

hospice care is an alternative to this bill—
totally agrees w/Dr. Friedman

Dr. Richard Johnson—opposed—surgeon—

agrees w/Dr. Hill + Dr. Friedman

he rarely has patients w/unrelieved pain.
pain causes drowsiness + imparing mental capacities

would the paralyzed, depressed, or those w/alhzheimer become victims?

1991 Dutch govt report showed a large # of suicides involving deliberate early deaths due to overdoses w/out patient's knowledge due to others' choices

equal protection of 14th Amendment—persons could be deprived of treatments by others' decisions

there are sometimes fine lines of interpretation in medicine

wise setting of limits to use of power—

Hypocrite

1. no breach of confidence

2. sexual rel w/patients

dispensing of lethal drugs w/intent to kill
Patients are vulnerable.

Primary function of physicians is to heal the sick.
HOUSE COMMITTEE ON JUDICIARY AND FAMILY LAW

PUBLIC HEARING on HB 339

BILL TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: 3/2/95

LOB ROOM: 208 Time Public Hearing Called to Order: 10:00 A.M.

Time Adjourned:

(please circle if present)


Bill Sponsors: Rep. Robert Guest

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Robert Guest - sponsor - supporting
    -will try to be brief, please read packet that was mailed with the many letters, particularly from the physicians
    -we are talking about terminal patients of sound mind requesting only the prescription for drugs
    -it appears some people who have testified against this bill have not read it; particularly Dr. Friedman.

Rep. Thulander - co-sponsor
    -this is not a moral issue, not a religious issue, it's a personal issue

Rep. Cynthia McGovern - co-sponsor - supporting
    -this issue is not simply pain control - particularly if it means the patient is stupified

Rep. W. Goddard - opposing

*Aggie Dowd - opposing
Brad Cook, representing Manchester Diocese
- there is no bill that could be written which the Diocese of Manchester
will support on the issue of actively ending life

*Judith DeLise - opposing - representative of Dr. E. Koop

Marie Kirn - opposing - N.H. Hospice

Luis Gallop, supporting - N.H. Hemlock Society

*Patricia Prescott - opposing -- immoral, unnecessary

Kathleen Souza, N.H. Right to Life - opposing

Rev. D. Rupp Lawrence, - Episcopal Minister
- Hemlock Society member
- believes that 14th amendment insures right to hasten death

Kenneth DeHart, M.D. - supporting
- durable power of attorney and do not resuscitate irony if patient changes
mind - this allows the patient choice
- support hospice but must leave choice in hand of patient
- N.H. Medical Society 1/2 of total doctors in state belong, 44% responded
45% in favor, 25% oppose

Doug Hall, supporting
- former representative
- experienced father's death, believes mother assisted, but if children
were aware of this they would become accomplices

Allen Mayville, supporting, Matter of Choice

*Thomas Bugely, Franklin, NH, supporting
- mother is cancer patient, has metastasized to brain
- lived 28 days without food or water (controlled physical pain but not
emotional)
- assured by doctor it would be only 7-10 days
- after 15 days she said this has gone on too long

*Robert Nace - supporting

Ellen Kolb - opposing
- believes bill will reduce palliative care

*Paul Arnstein, N.H. Cancer Pain Initiative
- even so still 400 and 1% of cancer patients which cannot be helped
- would support amendment to require pain management specialist
Robert Forsing, Raymond, opposing

Ted Capran, M.D., supporting
- member of Medical Society
- 45% of membership in favor
- today with patients and families making decisions daily whether life is
  work continuing - solutions withhold medications

Peter DeVere - supporting
- terminal melanoma
- gone through regimen of chemotherapy
- bill offers choice if condition worsens
- has living will
- is amazed hospice does not support this bill

*Chas. Stevens - supporting
- Concord Unitarian Universalist Church

Respectfully submitted,

Rep. Sandra B. Kean, Clerk
PUBLIC HEARING on HB 339 (cont)

BILL TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: 3/2/95

LOB ROOM: 208 Time Public Hearing Called to Order: 10:00

Time Adjourned:

(please circle if present)


Bill Sponsors: Reps. Guest, Copenhaver, McGovern, Thulander

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.
Rep. Rob S. Guest, sponsor: Try to be brief but please read the packet that was mailed out. Many letters particularly the physicians. We are talking about terminal payments of sound mind requesting only the prescription for drugs. It appears some people who have testified against this bill have not read it, particularly Dr. Friedman.

Rep. Thulander, co-sponsor: This is not a moral issue, not a religious issue. It’s a personal issue.

Rep. Cynthia McGovern, co-sponsor: The issue is not simply pain control—particularly if it means the patient is suffocated.


* Angie Dowd’s opposition:

Brad Cook Bishop: There is no bill that could be written which the Diocese of Manchester will support on the issue of actively ending life.

* Judith Desuse, opposition.

Rep. Dr. E. Koop

Marie Kiran, opposition. NH Hospice.

Leslie Gallop, NH Hemlock Support.

* Patricia Prescott, opposition. Immoral, unnecessary.

Kathleen Souza, NH Right to Life.
Rev. D. Rupp Lawrence Ordained Episcopal Minister Hemlock
Society Member Believe That 14th Amendment Insures Right To Hasten Death.

Kenneth De Hart MD Support: Durable Power of Attty &
Do Not Resuscitate Order If Change Mind - This Allows The Patient Choice. Support Hospice But
Must Leave Choice In Hand of PAti
NAMED SOC. 1/2 of Total In State Began 44% Responded
$ 45% In Favor 25% Oppose

Doug Hail Support Former Rep. Experience of Father's
Death Believes Mother Assisted But To Become
Aware Of This Would Make Children Accomplices.

Allen Mayville Support Matter of Choice
Franklin, NH Mother

Thomas Bugely Support Self Cancer Patient Metastasis
To Brain. Lived 27 Days With Food or Water [Controlled
Physical Pain But Not Emotional] Assured By Doctor
It Would Be Only 7-10 Days After 15 Days She
Said This Has Gone On Too Long.

Rob Nace Support

Ellen Kolb Oppose Believes Will Reduce Palliative Care

Paul Arinstein NH Cancer Pain Initiative
Even So Still 400+ Patients Which Can Not Be Helped.
Would Support Amendment To Require Pain Management
20 Specialist.
Raymond Root, Oppose

Ted Capran, MD, Bioethics Comm at Lakes Region Hospital
Member of Med Soc. 45% favor
Today with patients & families make decisions daily
whether life is worth continuing - solutions withheld
medication.

Peter Devere, support terminal melanoma (blood)
gone thru regimen of chemotherapy. Bill
offers choice if condition worsens. Has living will
Amazed Hospice does not support.

Chas. Stephens, support Concord Unitarian Unitarian Church,
Sub-Committee Minutes
Jacobsen Speech 9/13/95
Richardson, Allison, Kennedy, Lottman, Hart, Keans

Alf Jacobsen - poll taken by University
62% favor
23% opposed
15% unsure.

Oregon voters passed 51% to 49% Right to life and Catholic Church brought in special lawyer to appeal - Judge Hogan took 108 days to stay law. 9th Circuit Court meets in San Francisco in October.

Also in Oregon - "Compassion Case" Doctors complained that physicians were being prevented from treating patients as they see fit. Appealed to 9th. Voted for rehearing.

New York - also compassion case in appeal thru the court system.

Lisa Carpenter, Institute of Ethics at Franklin Pierce generally support patients' rights vulnerable population must be protected.

Lawrence, Episcopal Priest highly supportive worked for 20 years in health care.

Judith Delisle, Roman Catholic Church will never go for anything of this nature.
KEANS moves OTP and wall

JACOBSEN, if any person does not agree with provisions, they just don't have to participate. Boils down to a choice.
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<th>Yeas</th>
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<td>Lockwood, Robert A., Chairman</td>
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<td>Hess, David W., V Chairman</td>
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<td>Battles, Marjorie H.</td>
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<td>Hart, Nick</td>
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<td>Keans, Sandra Balomenos, Clerk</td>
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<td>Richardson, Barbara Hull</td>
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**TOTAL VOTE**

7-1

Appeared in Favor

Appeared in Opposition
Sept 13, 1995
HB 339 -
NAME ADDRESS - For or Against

Luis A. Gallop Francesstown 03455
Thoreau Raymond Havenwood Concord, NH
Mary Thorne Barnstead 03218
Leah K. Carpenter Institute for Health, Law & Ethics

Rep. Robert Guest Haven

Emma Clark Smith Havenwood, Concord
Deborah McPhail Sugar Hill,
Lawrence Rupp New London

Rep. Cynthia A. McGowan Portsmouth
Patricia B. Havumaki Northfield

Robert Longabaugh Alton Bay, 03810
Mary Bee Longabaugh Alton Bay

Nolan T. Jones

Sandra Kallman Jeffrey 03452

Minat King Wilton 03086

Natalie Smith Concord 03301

J. الدينة Die. of Manchester, Manchester
Hb 339
Subcommittee 7-1 OTP
Jacobson OTP 2nd Brown
Most calls against arguments were that against God's Law & Natural Law. Jefferson argued that God's Law gave us freedom to make individual decisions. As to Natural Law people are very selective. God's Law subject in thousands of interpretation. No individual must do it if they do not want to - ultimate choice & will of individual.

Brown - overwhelming letters from individuals who thought their families could better have been served.

Walt Amendment 3919 2nd Kearns
Feels this will be a clarification that will be valuable
14-5 pass

Kennedy cannot prevent individual from departing. This allows a more general method.

Hawbury: Bill incorrectly drafted this allows that the doctor cannot be prosecuted, concern to 137 & 2 III including commun... available. "pg 5 "one witness shall be "

Bill
no documentation of rescinding.

I - being present immunity - slippery slope

III guardian conservator

Johnson page 7 last line "I request that..." opposed.

Mayhew
Barry Peaceful opportunity

Mayhew terrible message to youth
people will take advantage for financial reasons
defeer. - catholic which says we have free will
was - not perfectly written, but does respond to
people in need. Doctors to know definition
of "lethal" Dr O’Connell says there are
good people for whom pain management does not work

Kemps - support

Lockwood - will support if needed - need to remove
statute for penalty of assisted suicide

Ness - Netherlands has gone too far and no
reason to think this can be corrected here.
Believes major flaw is suffering definition

Battles support

Hart - patient self-administers - choice
STREETER—ULTIMATE FREEDOM OF END
RICHARDSON—NO ONE NEEDS TO TAKE ADVANTAGE OF ANY
LEGEND—LONG SUPPORTER OF INDIVIDUAL CHOICE
ALLISON—PER PERSUADED BY LOCAL HOSPITALS
MCCARTHY—ALLfläche IN DRAFTING—CONCUR
with AMA
Testimony
HOUSE BILL 339 "DYING with DIGNITY"
Continued Hearing, Thursday, March 2 10AM LOB 208
Persons Testifying in Favor by Mail or in Person (partial list)

Dr. Kenneth DeHart MD, chief of staff, Lakes Region General Hospital (267-7017)
Dr. Ted Capron MD, family practitioner, Leconia, (528-1500)
Dr. Peter Mason, medical director, Community Care Center, Lebanon, Alice Peck Day Hospital (448-3122)
Dr. Carleton Chapman MD, former president, American Heart Association and dean,
Dartmouth Medical School (643-1234)
Dr. Stuart Russell MD, former president, New Hampshire Medical Society (643-3305)
Dr. Henry Brown MD(ret.) family practitioner, Canaan Enfield Lebanon (632-4306)
Dr. Thomas P. Almy MD(ret.), head, community and family medicine, Dartmouth-Hitchcock Medical center
Dr. Dr. Orie Jane Sahler MD, board of directors, Choice in Dying, (603-433-9016)
Dr. Warren Goldburgh MD, past president, Thomas Jefferson University Hospital, and Lyme resident (353-4277)
Dr. Timothy E. Quill MD, assoc. chief of medicine, principle medical advisor to HB339 Genesee Hospital, Rochester (716-336-3890)
Dr. Milton Heifetz MD and JD, prof. neurosurgery, USC, medical and legal advisor (HB339), author, Right to Die
Dr. Robert A. McKinley MD Psychiatrist(ret.) terminally ill (cancer), Hanover (643-8857)
Rev. Dr. Fred Berthold PhD, professor of religion emeritus, Dartmouth, (646-2386)
Rev. Robert K. Nace DD, former moderator, General Synod, United Church of Christ,
Peterborough (924-9320)
Former Rep. Douglas Hall, Chichester, (796-5028)
Former Rep. Arthur B. Corte, Dover, co-sponsor, original HB1275 (749-4366)
Luis Gallop, founder and chairman, New Hampshire Hemlock Society and board of directors,
World Federation of Right to Die Societies 547-3474 FAX 547-6868
Natalie P. Smith, AARP, Concord, (228-0296)
Mr. Philip Citron, terminally ill cancer patient
Mr. Eugene Beard, reported on case of brother undergoing long and painful death, (643-2581)
Ms. Janet Ward, head, The Scientists Humanist Project, Contoocook, (746-4991)
Irwin and Audrey Bierhans, journalists, experience in issues of dying, Claremont (543-1489)

Sponsors HB 339
Robert H. Guest, prime sponsor, 8 Barrett Road, Hanover, 03755 643-3517
Marion L. Copenhaver, Woodcock Lane, Etna, NH 03750 643-5617
O. Alan Thulander, Box 240, Francestown, 03043, (547-2929)
Cynthia A. McGovern, 41 Salters St. Portsmouth 03801
Hearing: Thursday, February 16th, Judiciary 208 LOB

New Hampshire House Bill 339 – Death with Dignity Act

Explanatory Statement

This act, a revision of the Oregon Measure No. 16, which was voted in by popular referendum November 8, would allow an informed and capable adult resident of New Hampshire, who is terminally ill and in a condition of severe unrelenting suffering, to voluntarily request a prescription for medication to take his or her life. The physician and others may be present if the medication is taken.

The process begins when the patient makes his or her request of his or her physician, who shall:

-- Determine if the patient is terminally ill, is capable of making an informed decision, and has made the request voluntarily.

-- Inform the patient of his or her diagnosis and prognosis; the risks and results of taking the medication; and alternatives, including comfort care, hospice care, palliative care and pain control.

-- Ask the patient to notify next of kin, but not deny the request if the patient declines or is unable to notify next of kin.

-- Inform the patient that he or she has an opportunity to rescind the request at any time.

-- Refer the patient for professional counseling, if appropriate.

A consulting physician, who is qualified by specialty or experience, must confirm the diagnosis and determine that the patient is acting voluntarily.

If either physician believes that the patient may be suffering from a psychiatric or psychological disorder, or from depression causing impaired judgement, the physician must refer the patient to a licensed psychiatrist or psychologist for counseling. The psychiatrist or psychologist must determine that the patient does not suffer from such a disorder before medication may be prescribed.

The measure requires two oral and one written requests. The written request requires two witnesses attesting that the patient is acting voluntarily. At least one witness must not be a relative or heir of the patient.

(continued on reverse side)
At least fifteen days must pass from the time of the initial oral request and 48 hours must pass from the time of the written request before the prescription may be written.

Before writing the prescription, the attending physician must verify the patient is making a voluntary and informed request, and offer the patient the opportunity to rescind the request.

Additional provisions are:

- Participating physicians must be licensed in New Hampshire.

- The physician must document in the patient's medical record that all requirements have been met. The state Division of Health must review samples of those records and make statistical reports available to the public.

- Those who comply with the requirements of the measure are protected from prosecution and professional discipline.

- Any physician or health care provider may decline to participate.

- The measure does not authorize lethal injection, mercy killing or active euthanasia. Actions taken in accord with this measure shall not constitute suicide, assisted suicide, mercy killing or homicide, under the law.

- Anyone exerting undue influence on a patient to request medication, or altering or forging a request for medication, is guilty of a Class A felony.

Prime sponsor: Representative Robert H. Guest PhD Grafton Co. Dist. 10
8 Barrett Road, Hanover NH 03755  (603) 643-3517

Cosponsors:  Rep. Marion Copenhaver, Grafton, District #10
14 Woodcock Lane, Etna, NH 03750
Rep. Cynthia McGovern, Rockingham, District #35
41 Salters Street, Portsmouth, NH 03801
Rep. O. Alan Thulander, Hillsborough, District #6
Box 240, Francistown, NH 03043
HB339 - "Dignity in Dying" bill Hearing Thursday 3/2/95 10AM LOB 208
As prime sponsor of HB339, and because of the tight schedule for
testifying, I am sending you in advance this information on our position.
Attached is a summary of the bill.

Many people do not seem to realize that virtually all segments of society -
physicians, other health care personnel, patients, voters, the courts and
many religious denominations clearly favor this kind of legislation. The
hierarchy of the Catholic Church, fundamentalists and the AMA hierarchy
strongly oppose.

HOW THE GENERAL PUBLIC VIEWS THE ISSUE

All national polls in the last 4 years have shown that the
general public favors legislation allowing a physician to
prescribe lethal medication to a mentally competent terminally
ill patient. This support ranges from 60% to 74%.

Two New Hampshire public opinion polls conducted by the
highly reliable University of New Hampshire survey research
center showed overwhelming support for the issues set forward
in HB339.

62% “Support”  23% “Oppose”  15% “Unsure”
(Note: 56% of Catholic respondents “supported” - 26% were “opposed”)

The use by the public of living wills and durable power of
attorney documents has grown enormously in the last three
years. Such documents, filed long before a person becomes
afflicted by a terminal illness or accident, do not cover persons
who are conscious and wholly capable of making an informed
decision about how they wish to have life terminated. HB339,
crafted primarily by physicians and dying patients, is designed
to meet this need not covered by advance directives.

HOW DOCTORS VIEW THE ISSUE

Doctors in two recent anonymous physician polls conducted by
the medical societies of New Hampshire and Massachusetts were
asked whether under certain circumstances they would honor a
terminally ill patient's request for a lethal medication
prescription if it were made legal. The results in both were
almost identical.

52% said “Yes”  28% said “No”  20% “No Answer”
(Over)
THE COURT'S VIEW

In spite of the fact that assistance in dying by a physician is illegal in most states, no physician, patient or other health care person has been convicted of a crime by a jury during the past several years. Nevertheless, fear of prosecution is always present. HB339 has full protection for physicians and patients.

In May 1994 the first decision on the issue ever made by a United States federal court was handed down by a Seattle district court judge. The judge struck down a law, almost identical to New Hampshire's law against physician assisted suicide, on the grounds that the statute was unconstitutional and in violation of the liberty provision of the 14th Amendment. In overturning it the judge declared: The liberty interest protected by the Fourteenth Amendment is freedom to make choices about those matters which are essential to a personal autonomy and basic human dignity. There is no more profoundly personal decision, nor one which is closer to the heart of personal dignity, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death. Using the same reasoning incorporated in HB339 the judge went on to say: "From a constitutional perspective, the court does not believe that a distinction can be made between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."

VOTERS VIEW THE ISSUE

In the early 90's a referendum in both Washington and California allowing a physician to prescribe medication to a mentally competent terminally ill person was narrowly defeated. However, on November 8, 1994, the voters in Oregon passed such a law by popular referendum. A challenge to the results has been filed in court. Our bill, HB339, is patterned after the Oregon law.

Rep. Robert Guest PhD  Hanover/Lyme
8 Barrett Road  Hanover  03755  Tel: 643-3517
February 14, 1995

Hon. Robert A. Lockwood, Chairman
House Judiciary and Family Law Committee
Concerning: Dignity in Dying Bill, HB_339.

Dear Mr. Lockwood:

I write in deep commitment to the substance of HB 339 from longtime conviction that such a measure is immensely humane and in the public interest.

I am a retired physician, consultant cardiologist for 30 years, then Dean of Dartmouth Medical School. I graduated MD from Harvard Medical School in 1941.

Probably the most harrowing and grievous aspect of medical practice in my time was the inability of the physician to work with others - usually family members - in alleviating suffering of hopelessly ill patients.

I recognized then and still that some aspects of public opinion, and certain religious tenets, appear to be in opposition to the substance of HB 339 but am convinced that some such stands, including that of the Roman Catholic Church, are not absolute. More binding is the dire need for legal means of preventing abuse of the intent of HB 339, should it one day become law, as I am confident it will.

I respectfully plead that your committee pass the Dignity in Dying measure up the legislative ladder so that practical and effective means of protecting the patient from abuse may be developed as promptly as possible. I do not, please note, question the dire need for the measure. In my considered opinion, based on years of experience at the bedside, the central principle has long since ceased to be at issue.

Respectfully submitted,

Carleton B. Chapman, MD, MPA

cc: Robert Guest, Esq.
February 14, 1995

To: Hon. Robert A. Lockwood, Chairman
    House Committee, Judiciary and Family Law
From: Stuart Russell MD (ret.)
Subject: House Bill 339 "Dying with Dignity"

As former president of the New Hampshire Medical Society, I strongly support HB 339. I consider it to be an important piece of enabling legislation which physicians, patients and society at large have needed for a long time. This legislation gives patients the right to decide on their own, with assistance from their caring physician, how they control their lives when terminally ill and in a condition of severe unremitting suffering.

I know the issues in this legislation having also served for 15 years on the New Hampshire Board of Registration in Medicine, the state licensing body which also is involved in issues of professional medical conduct.

The recent anonymous poll by the Society showed that a majority of members who responded said that they would honor a patient's request for lethal medication if it were made legal. This should be convincing proof to you and your committee members of the real feelings of physicians and not those of the traditional hierarchy.

Many suffering patients now and in the future will thank you for giving them another option on the way they choose to die.

Stuart Russell MD (ret.)
Kendal of Hanover 88 Lyme Road Hanover NH 03755

Hitchcock Clinic staff physician
Past President, New Hampshire Medical Society
Past member and president, NH Board of Registration in Medicine
February 12, 1995

Dear Bob:

Here is your letter,

Pat and I believe strongly in the purpose of your bill, and we admire you for your persistence in keeping the subject of dignity in dying before the legislature. I hope that this time there will be enough of your colleagues who are compassionate and caring about others to get your bill passed.

With all good wishes,

Henry
Hon. Robert A. Lockwood, Chairman,
Judiciary and Family Law Committee,
House of Representatives, State of New Hampshire,
Concord, New Hampshire

Dear Mr. Lockwood:

I write to support strongly your consideration of N.H. House Bill 339, the Death with Dignity Act. I am familiar with its content, and have followed with interest previous consideration of this proposal by the House in 1991 and 1993, as well as legislation for the same purpose in the State of Oregon.

Like every other physician, my life has been committed, as an advocate for those who have come to me as patients, to two purposes—to sustain life by curing or preventing disease, and to relieve human suffering. House Bill 339 recognizes the anguish of a physician when these purposes cannot be reconciled with each other, and would allow him or her to act only in accordance with the clearly and repeatedly expressed request of a mentally competent patient. The Bill would not require a physician to take action contrary to his or her own moral principles.

The safeguards the Bill provides against abuse of the principle of death with dignity are essential, are wisely formulated, and should be fully effective. They will be further ensured if the consultants and the ethics committees that might endorse the proposed action by the attending physician would pay special attention to the duration and the depth of the preceding relationship between the physician and the patient. The prolonged and conscientious examination of the patient’s values and intention, as modelled by Dr. Timothy Quill in his widely published account, must become the rule if both the public and the private good are to be served in actions of this kind.

Sincerely yours,

Thomas P. Almy, M.D.
February 10, 1995

TO: Hon. Robert A. Lockwood, Chairman
House Judiciary and Family Law Committee

Over the course of the month of January 1995, I had the opportunity to review the Bill, HB 339, "Dignity in Dying", sponsored by Representative Robert Guest and would like to make some comments about this proposed legislation.

By way of introduction, I am currently Adjunct Professor of Pediatrics at the University of Rochester School of Medicine and Dentistry, Rochester, New York. My interest in the relationship between physicians and dying patients began in the late 1960's and my research on this topic has continued over the years.

In addition, from 1978 to 1994, I was a member of the national board of directors of Concern for Dying--An Educational Council, situated in New York City, which just recently merged with the Society for the Right to Die to form Choice in Dying, Inc.--The National Council for the Right to Die. For the years 1990-1992, I was president of the Rochester (NY) Affiliate Chapter of Choice in Dying. The major purpose of these organizations, regardless of specific name, is public education about and distribution of advance directives; for almost 30 years, the Living Will; more recently, the Durable Power of Attorney for Health Care. My activities, as a pediatrician, in promulgating the Living Will stem primarily from my subspecialty interest in Adolescent Medicine which has now extended the sphere of influence of pediatrics into early adulthood. As a result, many pediatricians now provide health care to competent young adults. The recent case of Nancy Cruzan and the deaths of thousands of relatively young AIDS victims each year are poignant reminders that legislation regarding end-of-life decision-making by the individual who is terminally ill does not affect and potentially empower only the old.

Although I have discussed the opinions I am expressing with many lay people and health care professionals, these opinions are entirely my own and do not in any way necessarily reflect the views of the University of Rochester School of Medicine and Dentistry nor of Choice in Dying, Inc.

I urge you to support passage of HB 339 for several reasons:

First and foremost, we must acknowledge that unrelenting suffering does exist. Increasingly sophisticated medical technology has made it possible to prolong life almost indefinitely; unfortunately, control of pain and maintenance of functional ability cannot be promised with the same degree of certainty. The result, for some individuals, is chronic unmitigated pain that is tantamount to true physical suffering and/or loss of capacity to fulfill a role that is meaningful to the patient that is tantamount to true mental anguish.

Second, by providing patients with a sense of control over their own destiny, we are actually in a position to enhance their tolerance of pain and frustration. If, as has been suggested by others, about 3% of terminally ill patients will request a physician's assistance in securing a prescription that provides sufficient medication for a lethal overdose to be taken when and where the patient desires, I doubt (although there are no data to support or refute that doubt) that more than a small fraction of such patients will actually exercise that prerogative. Many, many studies in the psychologic literature have demonstrated, in both animal and human research, that tolerance for aversive stimuli is greatly enhanced when the subject is given the power to control the duration or intensity of the stimulus. Thus, having a prescription on hand, if needed, may bring such a sense of relief that actually using the medication often may become unnecessary.

601 Elmwood Avenue, Box 777
Rochester, New York 14642
Page two - February 10, 1995
Hon. Robert A. Lockwood, Chairman

Third, the Death and Dignity Act seems, to me, to be a logical extension of such other prior directives as the Living Will, which has been widely endorsed. As a society, we have already accepted the notions of non-administration and withdrawal of treatment as viable options for those individuals who do not wish to have life prolonged. In some instances, patients are so dependent on external supportive care, that death occurs within minutes of cessation of active treatment. For the vast majority of people, however, death occurs over hours, days, or weeks (occasionally even months) and may be accompanied by excruciating pain despite massive doses of analgesics or psychologic treatment. Thus, by not providing the means for swift inevitable death, current laws mandate slow inevitable death for many of our best citizens—the kind of death that we would not even consider inflicting on a single one of our worst criminals in states where the death penalty is permitted.

The proposed Act permits consenting adults to enter into an agreement entirely on the initiative of the terminally-ill patient; there is no requirement for action on the part of the physician unless he or she feels that fulfilling the patient’s request lies within the boundaries of his or her moral principles; and safeguards such as second opinions regarding the terminal nature of the disease, repeated requests over time, and oversight by an impartial Ethic Committee have been included to protect against coercion, the most feared "slippery slope" of assisted suicide. Given that no system, of any kind, is fallible, there is no humanly possible way to ensure that even these multiple points of checks and balances will fully protect any given individual. However, an open system which mandates these safeguards is far better than a closed system without any safeguards, such as that which currently exists. That is, it is absurd to believe that the Quill case (New Engl J Med, March 5, 1991) is unique and, indeed, I am personally aware of several instances in which physicians have given patients prescriptions for medication knowing the most likely use to which they would be put, if used at all. That Dr. Quill was not indicted by the Grand Jury before which his case was presented is, for me, a compelling affirmation of the humanitarianism of his actions as perceived by a body of his peers. The Bill before you would make it unnecessary for another Dr. Quill and his patient and family to have to endure the public scrutiny that invaded their personal privacy and nearly destroyed the quiet, painless, and whole-heartedly desired nature of his death with dignity that they sought.

I fully realize that some, perhaps many, physicians cannot and will not participate in physician-assisted suicide even when it is regulated and overseen as in this proposed Bill. However, that fact that there is no obligation for the physician to act in opposition to his or her moral values should, I believe, serve to relieve the physician by explicitly permitting non-participation rather than to impose burden.

Continued public education about the differences between physician-assisted suicide (perhaps, better termed, physician aid-in-dying) as advocated for in HB 339 and active euthanasia (with which physician-assisted suicide sometimes is confused) is essential and will serve to clarify the rights, responsibilities, and obligations both of the patient and of the physician in this extremely important junction in their relationship.

[Signature]
Olle Jane Z. Sahler, M.D.
January 25, 1995

To: Hon. Robert A. Lockwood, Chairman
House Judiciary and Family Law Committee

Dear Sir:

I am writing to support H.B. 339. I believe that this bill serves the needs of a growing segment of our population. H. B. 339 provides for the voluntary termination of undue suffering in terminal states without any mandates except for provisions to prevent abuse.

Modern medicine is increasingly able to prolong the duration of life without the ability to improve or even maintain the quality of life in many instances. This may inadvertently increase the intensity and duration of suffering. This bill provides an additional tool for the care of the terminally ill but in no way replaces measures already established such as adequate pain relief, good outpatient Community Nursing and Hospice programs.

There is a positive aspect to this bill. There are many patients who decline statistically favorable curative or life saving measures because they fear potential failure with the risk of increased suffering and further impairment. Many of these unfortunate patients might alter their choice if such a bill were enacted.

In the 37 years from my graduation from the Medical College of Thomas Jefferson University until my retirement in 1989, I saw many patients who would have benefited from a bill such as H. B. 339.

I strongly support H. B. 339 and urge its adoption.

Sincerely,

Warren P. Goldburgh, M.D.
Emeritus Clinical Professor of Medicine - T.J.U. Past President of Staff - T.J.U. Hospital Adjunct Professor of Medicine - Dartmouth Med. School
January 24, 1995

Chairperson
House Judiciary Committee
New Hampshire Legislature

Dear Chairperson:

RE: HB339 "Dying with Dignity" Bill

I am the author of "Death with Dignity: A Case of Individualized Decision Making" which was published in the New England Journal of Medicine (NEJM) in March of 1991. In that article, I outlined how I indirectly assisted a patient who was dying of acute leukemia to take her life at the end of her illness, when only suffering and indignity remained. I have also authored several articles in the NEJM which have outlined safeguards and strategies for regulation. I am writing in support of the "Death with Dignity" Bill #HB339, which meets or exceeds all of the safeguards that I and others were recommending.

It is my opinion that many patients have a desire to control the end phases of their life, often after a heroic struggle against their disease. Sometimes these struggles go on for long periods of time and culminate in a person's physically and personally falling apart prior to death. When death is the only outcome at the end stage of such a long process, it seems to me that we should allow people much more control and more humane options than we currently do. Your Death with Dignity Bill would allow such options. Currently such practices between doctors and patients must occur in secret because of laws prohibiting open discussion and practice in this domain. The secretive nature of the practice makes it much more open to idiosyncratic physician and patient behavior. I believe your Bill would minimize this kind of idiosyncracy, and help ensure that the option would only be exercised when other avenues have been exhausted.

I want to emphasize several important safeguards that are included in the Bill:

1) The patient must be confirmed to be both terminally ill and competent.
2) Witnesses to the patient's written request must not be in a position to benefit from the patient's death.
3) A second opinion is required by an experienced physician who must actually see the patient, and confirm the terminal diagnosis, the awareness of alternatives, and the patient's competence to make decisions.
4) The primary physician and the consulting physician must express their judgements and findings in writing.
5) There is a 15 day waiting period between the initial oral request and the written request, and another 48 hour wait before the prescription is written.
6) The death will not be considered a suicide for medical/legal or insurance purposes.
7) The physicians are free to participate or not to participate in assisting suicide when their patient request help from them.

It seems to me that this is a substantial and adequate list of safeguards that would prevent the practice from being abused. In particular, it would prevent its use for people who are not competent to request it, not terminally ill, or for who there is any question about the voluntariness of the request.

I hope that you are seriously considering passing the Bill. There is a crying need expressed by patients and families who have witnessed end-of-life suffering and who wish to exercise a more controlled, dignified end to their life. The possibility of a controlled death may be almost as important as its actual availability, since many people are very fearful about end-of-life suffering, but never actually experience it in a severe form. Your Bill would guarantee people of a possible out should their suffering become too extreme.

If you would like to discuss any of this further, please let me know.

Sincerely,

Timothy E. Quill, M.D.
Fellow, American College of Physicians
Professor of Medicine and Psychiatry
University of Rochester
School of Medicine and Dentistry
Robert A. McKinley M.D.
80 Lyme Road Apt. 265
Hanover, N. H., 03755

January 29, 1995

The Hon. Robert A. Lockwood, Chairman
House Judiciary and Family Law Committee
House of Representatives
Concord, N. H.

Dear Chairman Lockwood:-

I was engaged in the practice of medicine for nearly 40 years with a specialty in psychiatry. I write in strong support of HB 339. I have seen a number of individuals with terminal conditions which caused life to be unbearable. Some have committed suicide, much to the distress of their families and I assume to themselves. Others have just endured a life which had lost all meaning, although they worried considerably over the trouble and expense of keeping them alive was causing others. These people need the relief that a bill like HB 339 would give. In fact, since I have cancer, I have given some thought to the circumstances of my own death. Should such a law not be in existence at that time and if I would be suffering unbearably I would starve myself to death (would take about 10 days if I did not drink water) or take a quantity of sleeping pills and tie a large plastic bag around my neck—a technique which permits the sleeping pills to take effect before all the oxygen is used up. I know that my family would not interfere with this. It is shocking that I should have to be planning in this way.

I feel, as a psychiatrist, that it is not difficult to judge competency under these circumstances. The bill seems to me to have adequate safeguards. I hope the legislature will pass this bill soon so that there can be an end to useless and painful suffering.

Sincerely,

[Signature]

Robert A. McKinley
23 January 1995

Honorable Robert A. Lockwood, Chair
House Judiciary and Family Law Committee
House of Representatives
State of New Hampshire

Dear Mr. Lockwood:

I want to record my complete and earnest support for N.H. House Bill #339 ("Death with Dignity Act").

It is morally proper that the greatest weight in matters of life and death should be given to the individual person whose life or death is at issue, assuming that that person is mentally competent to understand the alternatives involved. N.H. House Bill #339 will support that view. I would, incidentally, hope that all who are concerned with these issues (legislators, physicians, clergy, etc.) would encourage everyone to compose, sign and have notarized, "advanced directives on health care"--and, of equal importance, discuss these documents and issues openly with all of their close kin. My view on these issues has been reached after 45 years of scholarship and teaching in the field of theology and religious ethics, and after years of discussion within Dartmouth's Institute of Applied and Professional Ethics, of which I was a founding member.

My view has in more recent years been influenced by residence in Kendal at Hanover. Here my wife and I have a close up and personal relationship with many people who desperately seek some way to end their lives with dignity. We are also becoming acquainted with the anguish of care-givers (most often a loving spouse, or a child) who are torn between the desires of the one who wants to die and the various traditions, and laws, which make them fearful of taking any action. Action, yes! Many would like to take action; but it is important that any action be thoughtful, informed, deliberate and protected by safeguards against irresponsibility. The bill under discussion provides for guidance and safeguards.

I hope that this bill will receive serious consideration and will win approval.

Sincerely yours,

(Reverend) Fred Berthold
Kelsey Professor of Religion Emeritus
February 16, 1995

To: The Judiciary and Family Law Committee
    the New Hampshire House of Representatives
    Robert A. Lockwood, Chairman

From: The Rev. Robert K. Nace, D.D.

In Re: Support of The New Hampshire Death With Dignity Law - HB 339

May I begin by saying thank you for the opportunity to speak in support of the Death With Dignity Bill which is before you.

My name is Robert Nace. I am a retired Pastor of the United Church of Christ (Congregational) living in Peterborough. I was at one time the Moderator of the General Synod of the United Church of Christ and the Chairman of the Publications Committee of the A.D. Magazine. But I speak to you primarily as a member of the clergy with 46 years of experience as a parish Pastor.

Over those years I have stood with countless individuals who have been in the "death time" of their lives or the lives of their loved ones. Many times I have been asked to pray that the individual will be given God's gift of death. Many times after a visit at a nursing home I left saying: "No one did this person a favor by keeping them alive so long." In fact, their life is finished and they want to die.

I have been preaching on this subject for more than thirty years. The first time the sermon title was "Thinking the Unthinkable about Life and Death." The thrust of the sermon has been to allow the individual to say: "My life is over. Help me die." I have preached this sermon in Pennsylvania, Arizona, Massachusetts, Vermont and New Hampshire. Without exception the overwhelming response from the congregations has been "I agree with you" or "I feel the same way." Nurses, who are on the front line of the dying process in our society, have been most vigorous in their support.

Popular support for "Death with Dignity" has increased over the past two decades as we have increasingly seen the consequences of medicines success in keeping our bodies alive beyond the biblical "three score ten, or if by reason of strength four score." (Psalm 90:10) Of course, all of us can cite individuals in their 80's and 90's for whom life is full and rich, but they are the exception, not the rule. I am equally confident that all of us can give many illustrations of individuals for whom the fullness of life is over, yet death has not come.
May I make two caveats to this bill as currently constructed.

(1) I regret that it is limited to those who are “terminally ill,” which is usually construed as death within six months. Unfortunately this leaves unanswered the tragic question of Alzheimer’s Disease which is even now taking away the dignity of our beloved former President Reagan. I read that an intimate of President Reagan wrote: “When I visited him three months ago he didn’t know who I was. On my last visit he didn’t know who he was.”

(2) I regret that it is limited to those with “severe unrelenting suffering” which leaves out many like a parishioner of mine - 91 years old - limited in speech and movement by a stroke - confined in a nursing home - with her husband and only son dead - who, though not in pain, repeatedly asked: “Why can’t I die?”

Grant me a few more moments to address the most common objections I hear to “Death With Dignity.”

(1) - Some say “It is playing God.” God created us and has “determined allotted periods and the boundaries of our habitation.” (Acts 17 26). Yes we do not choose to be born, and we can not choose not to die. This is the paradox of dependence with freedom and responsibility. I believe to ask a Doctor “help me die” is in the same moral category as asking the Doctor “keep me from dying.” Both ask for human intervention concerning the time and manner of our death.

(2) - Some say “Death With Dignity” is a slippery slope that could lead to children encouraging the death of parents in order to get the estate, or eventually it could lead to the state killing the less productive members of society - “another holocaust.” All forward steps are potentially “slippery slopes” (particularly in New Hampshire, in February), but it is the challenge of legislation to anticipate and restrict potential risk and abuse. My reading of House Bill 339 suggests it has an abundance of protective measures.

(3) - Others say “what if” some take their lives in a moment of depression or when they misread the signals of death.” The story is told of a father who gave his son a bottle of vintage brandy as he went off to war, with the instruction to drink it on the worst day of battle. When the son returned home he brought back the brandy with the observation: “I always thought another day could be worse.” So may it be with the availability of death with dignity.

As a Pastor I have conducted more that 1200 funerals. The final prayer of each funeral is a prayer for the living. Its a classic prayer. Perhaps you know it and have prayed it.

O Lord, support us all the day long - until the shadows lengthen, the busy world is hushed, the fever of life is over, and our work is done. Then, of Thy tender mercy, grant us a safe lodging, a holy rest and peace at the last.

I believe it is toward the fulfillment of this prayer that the legislation you are considering is directed.
MARCH 2, 1995

MR. CHAIR, MEMBERS OF THE COMMITTEE: I AM NATALIE SMITH, CHAIR OF THE NEW HAMPSHIRE STATE LEGISLATIVE COMMITTEE OF AARP. AARP HAS STUDIED THE ISSUE OF PHYSICIAN ASSISTED DEATH AND THEIR POSITION IS AS Follows: AARP MEMBERS' VIEWS ABOUT THE RIGHT TO DIE, ABOUT ASSISTED SUICIDE AND ABOUT OTHER ISSUES RELATED TO END-OF-LIFE MEDICAL TREATMENT ARE VARIED AND STRONGLY HELD. THE LARGE MAJORITY FAVOR ALLOWING PATIENTS AND THEIR FAMILIES A RANGE OF OPTIONS, INCLUDING ASSISTED SUICIDE, TO END THE LIFE OF A PERSON SUFFERING WITH A TERMINAL DISEASE WHO HAS NO HOPE OF RECOVERY. A MINORITY OF MEMBERS, HOWEVER, STRONGLY OPPOSES SUCH END-OF-LIFE DECISIONS. MEMBERS ON BOTH SIDES VIEW THESE ISSUES AS MORAL AND PERSONAL DECISIONS, AND SEE NO ADVOCATE'S ROLE FOR AARP IN THE PUBLIC DEBATE. HOWEVER, THEY AGREE THAT AARP CAN PLAY AN IMPORTANT ROLE IN DISSEMINATING INFORMATION ABOUT THESE ISSUES TO MEMBERS. AS AARP DOES NOT HAVE AN OFFICIAL POSITION ON THIS ISSUES, I CANNOT SPEAK TODAY AS A REPRESENTATIVE OF THE ASSOCIATION. I AM SPEAKING AS A PRIVATE CITIZEN, EXPRESSING ONLY MY OWN VIEWS.

IN PREVIOUS HEARINGS ON THIS ISSUE, A NUMBER OF PERSONS STATED THAT THIS BILL IS IN VIOLATION OF THE HIPPOCRATIC OATH. I NOTICED THAT THE PERSONS WHO RAISED THE ISSUE OF THE HIPPOCRATIC OATH WERE ALL LAY PEOPLE. THE PHYSICIANS WHO TESTIFIED ON THIS SUBJECT DID NOT MENTION THE OATH. SO I DECIDED TO DO SOME RESEARCH ON THE HIPPOCRATIC OATH.

THE OATH BEGINS "I SWEAR BY APOLLO THE PHYSICIAN, BY AESCULAPIUS (AS-KEL-PIOS), HYGEIA AND PANACEA, AND I TAKE TO WITNESS ALL THE GODS, ALL THE GODDESSES, TO KEEP ACCORDING TO MY ABILITY AND MY JUDGMENT, THE FOLLOWING OATH." FEW, IF ANY PHYSICIANS IN THE UNITED STATES TODAY ARE DEVOTEES OF THE ANCIENT GREEK PANTEHEON. THERE MAY BE SOME WHO ARE OUTDOORS AT DAWN, HAILING APOLLO AS HE PULLS THE SUN ACROSS THE SKY, BUT I FEEL SURE THEIR NUMBERS ARE FEW. TO MANY PHYSICIANS WHO ARE OF THE CHRISTIAN OR JEWISH FAITH, THIS WOULD BE SACRILEGE.
I was curious about the oath and its meaning to present day physicians. I asked four physicians about the oath (a small sample, I agree). The answers I received were very interesting. Two young men (age 40 or younger) grinned and said "we recited it at graduation. It's a tradition." A third man had graduated in the 1970's and stated "it was very controversial. Some of us said it and some didn't." He laughed and wouldn't say which side he was on. Then I spoke with a retired physician - a man about my own age. He was emphatic, saying "we took the oath." I questioned - a vow to Apollo, Aesculapius, Hygeia and Panacea? He replied he remembered Apollo but he was firm in that he took the oath. So the importance of the Hippocratic Oath would appear to vary depending on the age of the physicians involved.

Hippocrates wrote the Oath 2500 years ago and if he were alive today and could see the medical technology controlling our life functions, he would probably word it differently. The oath was written to deal with its time -- not medicine as it is practised on the eve of the 21st century.

Helping a dying patient to avoid the agony and pain of a terminal disease is not harm. It is mercy.

I am in the final decades of my life, perhaps not even decades, maybe only a few years or months. None of us know. But I do know that I am the only surviving member of my generation in my family. My sister died at the age of 36 and my two cousins are both deceased. I alone survive. And I have watched my family die slow, agonizing deaths. My sister died of kidney disease at a time when kidney transplants were just beginning and were performed only on identical twins. We were sisters, not twins, and her doctors refused to consider transplanting one of my kidneys, saying the methodology had not been developed. And so my only sister died a slow painful death.

Five years later, my father died of heart disease -- again, a long, painful death.
BUT THE MOST DIFFICULT WAS MY MOTHER'S DEATH. A PROUD, ELEGANT WOMAN WHO WAS BROUGHT DOWN WITH CANCER OF THE RECTUM. I HAD TO STAND BY, HELPLESS TO EASE HER SUFFERING, AND WATCH MY STRONG, COURAGEOUS MOTHER IN EXCRUCIATING PAIN, BEGGING TO DIE.

I DON'T WANT THAT TO HAPPEN TO ME. I HAVE TAKEN ALL THE PRECAUTIONS WHICH ARE AVAILABLE TO ME AT THIS TIME. I HAVE A LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE. I HAVE INSTRUCTED MY CHILDREN AND MY PHYSICIAN -- NO CPR, NO REVIVAL METHODS OF ANY KIND. IF MY HEART STOPS BEATING -- THAT'S IT. I'VE HAD A LONG LIFE AND A GOOD LIFE. I'M NOT AFRAID TO TRAVEL ON. BUT I AM AFRAID OF Dying. I WANT THE PROTECTION OF THIS LEGISLATION SO THAT THE OPTION IS AVAILABLE TO ME WHEN THE PAIN BECOMES UNBEARABLE. I URGE YOU TO PASS THIS LEGISLATION.

THANK YOU.

Natalie R. Smith

Natalie R. Smith
33 Highridge Trail, Concord, New Hampshire 03301-5202
Telephone 603-228-0296
80 Lyme Road Apt. 367
Hanover, NH 03755
Jan, 30 1995

Hon. Robert A. Lockwood, Chairman
House Judiciary and Family Law Committee
State of New Hampshire
House of Representatives

Dear Mr. Lockwood,

I saw my brother die a few years ago. He was paralyzed from a heart attack. He was in his late eighties. He could not speak. He did not recognize me. He had to be fed through tubes. He just laid there in bed for several months in a vegetative state.

It cost a lot of money to prolong his dying. Why do we do this to old people, who are terminally ill with no chance of recovering, and whose quality of life is poor? We don’t treat our pets like this!

Please do what you can to allow representative Guest’s "Dignity in Dying" bill to be voted on this year.

Sincerely,

Eugene Beard
In regard to HB 339 relative to death with dignity for certain persons.

March 2 1995

Judiciary and Family Law Committee
Testimony in support of HB 339:

To the Chair and members of the Committee:

My name is A.D. Copestakes, I am a resident of Concord and am testifying on behalf of myself.

HB 339 involves the quality of life issue. When the quality of life has deteriorated through illness, especially many forms of cancer, to the point where the expectancy and hope of recovery or improvement is nil, the urge for a speedier release from the torment, pain and indignities is welcomed. In these circumstances Death is not a dark angel of doom but the pardoner giving release from the prison of the pain wracked body.

Modern medical science has done many things to lengthen the period of occupancy we may have in these bodies, but when the shell and structure has worn-out, betrayed us or just is no longer habitable, then it should be our prerogative to vacate the premises and move on to whatever awaits us.

HB 339 has many safe guards build in to the proposed law to be certain that it is the wishes of the person. Especially the provision of being mentally competent and multiple specialist checks. It is not a procedure that can be gone into lightly. It permits death to be a time of passing, a transition, perhaps with friends either related or otherwise.

I urge you to report this bill out as Ought to Pass. Thank you.

A.D. Copestakes
To members of the Committee on Judiciary and Family Law

I am Marion Copenhaver of Shafter, CA. I am proud to be a sponsor of #6337, Rep. Robert Guest. I have done a monumental job in researching this issue and have consulted with most of the experts in medical ethics across the country. This bill has been before the committee twice but because of the controversial nature of the bill it has yet to become law. I know of no other bill that has been given such extensive study and such careful scrutiny. It is imperative that this bill be debated on its merit.

The bill has any number of built-in protections to prevent abuse, i.e., the patient must be capable of making an informed decision, a second opinion by a physician trained in that discipline, a psychiatric review, plus safeguards to protect physicians and health facilities from legal action.

I won't go into detail because Rep. Guest can take you through the bill and clarify issues as they arise. I urge the committee to clear their minds of preconceived ideas or impressions and to listen carefully to the facts as presented. The advances in medical technology have reached the point that
patients can be kept alive tormented by extreme pain long after that life has any meaning or dignity. And there but God, if God go anyone of us

Mason L. Copenhaver
March 2, 1995

To the N.H. House Committee on Judiciary and Family Law,

I come today to urge the passage of House Bill 339 relative to death with dignity for certain persons suffering from a terminal condition.

I come as an ordained minister who has served a variety of congregations for the past twenty years. I have sat with a great many people during the last hours and days of their life and tried to comfort their family members.

It is often clear to the person with a terminal condition and to her/his family members that the suffering is only going to get worse before she/he dies. I have been asked numerous times by people facing a slow painful death: "Why are we more compassionate to animals that we are to human beings?" Or other people pray that their God will speed their death. The irony is that they should be praying to the state, in our case to you the Representatives of New Hampshire for compassion.

A mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal condition by the patient's attending physician and another consulting physician ought to be able to obtain a prescription for medication that would enable the patient to control the time, place and manner of his or her death.

For the sake of many suffering terminally ill patients I urge you to support and pass House Bill 339. Not all terminally patients will want this, but those who do ought to be given permission and enabled to do so.

As a minister who has spent countless hours with terminally ill patients I am convinced that this is the moral and right thing to do. This is the compassionate thing to allow an individual to select how to die if they face a terminal death.

Sincerely,

Rev. Charles J. Stephens
Charles J. Stephens, minister
603-224-0291
The Unitarian Universalist Church of Concord
274 Pleasant St.
Concord, NH 03301

-Elderly person who starved herself in Nursing home - she had a slow terminal form of Cancer. Nursing home tried to force her to eat

-Mother-in-law died slowly of Cancer. My wife her sisters & their father watched her die a slow painful death, she would not have wanted this sort of death.

-Scott Nearing couldn't have done what he did if he had stayed in the Nursing home. I know I did a memorial Service for him and talked with his wife Helen about this.
David C. Allison
Rural Route #2  Box 889
Cornish, New Hampshire 03745
telephone: 603 543 3481

Re: HB 339   Death with Dignity Act

Dear Colleagues,

Here are two short pieces from Anna Quindlen's new book "Thinking Out Loud" that I believe you may find interesting:

"Seeking a Sense of Control" and "A Time to Die"


David Allison

March 7, 1995
Many years ago I took a stroll around the block with the mother of a friend. As we walked she made sudden noises, like shots from a gun. But when I listened carefully it seemed that the sounds were orphaned bits of words, as though her conversation were a tape and most of it had been erased, leaving only stray fricatives and glottal stops. Perhaps the sounds were the remaining shreds of her personality, which had been taken into some dark place by a then little-known ailment called Alzheimer’s disease.

This may have been the sort of life Janet Adkins feared when she lay in a Volkswagen van and pressed the button that released lethal drugs into her body. Mrs. Adkins’s doctor believed she had years to go before her self disappeared into the degenerative swamp of Alzheimer’s. But anyone who has ever encountered the disease knows its Catch-22; by the time you might want to die, you’re too far gone to do anything about it. Mrs. Adkins, a former English teacher, looked into the future and committed suicide.

If she had done so alone, her story would be a small one. But she went to Jack Kevorkian, a euthanasia entrepreneur who constructed a suicide machine at home. Mrs. Adkins used it to go quietly into that good night. And Dr. Kevorkian was charged with first-degree murder.

This is the sort of case prosecutors characterize as “sending a message,” as though we were unruly schoolchildren waiting to throw rocks through the windows of the law. Mrs. Adkins could have accomplished what she sought with a handgun or a tall building. But she went to Dr. Kevorkian because she wanted a gentle death, the kind we offer now even for some of those we execute.

There is a message in this case, but it is not the one prosecutors send. It illustrates how desperate we have become to retain some modicum of control in the face not only of horrible illness but of medical protocols that lengthen degeneration and dying. There are probably few Americans who, like Mrs. Adkins, want to end their lives while they are still unmarred by illness. And only one country, the Netherlands, permits physician-assisted suicide. But there are thousands of people who find that after the chemotherapy and the surgeries and the progression of disease they have become a macabre mockery of their former selves, keeping their lives but losing their dignity.

Once a friend told me that her mother, who was suffering from ovarian cancer, had a superb oncologist. He was kind and considerate and explained all procedures thoroughly. But she blurted out what was his great virtue: “He told me how many of my mother’s painkillers constituted a lethal dose.”

There are doctors like that, who go quietly about the business of tempering science with mercy. A pneumonia goes untreated; a new course of chemo is not tried. The American Hospital Association says 70 percent of the deaths that occur in this country include some negotiated agreement not to use life-prolonging technology.

The case of Nancy Cruzan may end soon, although her parents
believe her life ended years ago. The State of Missouri, after fighting all the way to the Supreme Court, has withdrawn its opposition to having the thirty-two-year-old woman’s feeding tube removed. The cases of Nancy Cruzan, who has been in a persistent vegetative state for seven years, and Janet Adkins, who discussed her planned suicide with her family, are worlds apart. And yet both the Cruzan family and Mrs. Adkins yearned for the same thing: a sense of control.

Hard cases make bad law, my lawyer says, and this is one. Dr. Kevorkian, an assisted-suicide zealot who has been a guest on Donahue, had a vested interest in Mrs. Adkins’s decision to end her life. But hard cases sometimes illuminate hard issues. The medical profession must continue to find ways to balance its capabilities and their human costs. The people must demand laws that allow them to participate in that balancing, laws that embody the facts of their lives.

The question of how and when we die, in an age of respirators and antibiotics and feed tubes, has become one of the great “who decides?” issues of modern time. When Nancy Cruzan’s case was being heard, people with medical war stories said: “Wheel her into the courtroom. Then they’ll understand.” Perhaps that is what Janet Adkins did: placed the evidence before the judge she believed knew best, saw herself incontinent, incompetent, incapable of knowing the difference between Tom and Jerry and War and Peace. And then pronounced sentence.

A TIME TO DIE

June 3, 1990

When she visits her husband in the nursing home, she apologizes to him. Ann is a nurse, and her husband was a carpenter, and when they came home from work in the old days, before the accident, she would tell him about the people on machines, the respirators, and the feeding tubes. And he would say, “If that ever happens to me, I want you to shoot me.”

As his eyes stare out into some middle distance from his hospital bed, his feeding tube a small stigma in his side, she tells him she is sorry she cannot do what he asked.

The American Academy of Neurology defines a persistent vegetative state thus: “A form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiologic sleep/wake cycles, but at no time is the patient aware of himself or his environment.” There may be as many as ten thousand people in this condition in the United States. Ann’s husband has been one of them since the night before Thanksgiving in 1986, when his car didn’t make the curve.
He is thirty.
She is twenty-nine.
She feels as if her husband died three years ago and she's waiting for the funeral. Three times she has asked to have the feeding tube removed. The hospital said no. The nursing home said no.

The lawyer said, "Wait for Cruzan."

There are many stories like this one in America, but the one we know best now is the story of thirty-two-year-old Nancy Cruzan. She once told a friend she would never want to be kept alive as a vegetable. Her parents have spent eight years arguing that that is important, arguing that she would not want to continue life in a persistent vegetative state, arguing that her feeding tube should be removed. Any day now the Supreme Court will decide whether this can be done, whether there is a constitutional right to discontinue unwanted life-sustaining treatment.

Right now there is a patchwork of state regulation and case law on this matter. In some places you can remove a respirator but not a feeding tube. In some places you can remove a feeding tube if a patient left written instructions, but not if he simply said he wouldn't want one.

In most places people who are spending their lives staring at the contorted, withered shell of someone they love dearly must go to court to do what they think best. Many of them never make it. There are the legal costs. A retainer of $10,000 is not exorbitant, given the amount of time spent on a case like this, but for most Americans, it might as well be $10 million.

And there is the holier-than-thou factor. One family in Oregon, whose son was drowned at age six and died at age nineteen, never went to court to have his feeding tube removed because, his mother said, they didn't want problems with right-to-life zealots. In New York State, a bill that would allow people to designate someone to make medical decisions if they were incapacitated has been kicking around the Legislature for a year, supported by groups ranging from the Lutherans to the Gay Men's Health Crisis Center. The state Right to Life Committee has been vehement in its opposition. That sort of reaction is why Ann's last name does not appear here. She is afraid of the right-to-life types, of the hate mail and the publicity they bring. "Yes, I am," she says.

She doesn't go to see her husband much. Most of the time she believes she is looking at a shell. Sometimes she thinks there is a spark inside. I don't know which is worse: a body being kept alive while no one is home or a bit of a man trapped, like a fly in a bottle, unable to talk, to see, to touch—just like a ghost.

The Supreme Court may not see fit to provide constitutional salvation for these people. But just as the Webster decision has galvanized those who want abortion to remain legal, perhaps Cruzan will remind us that we must demand reasonable regulations to help people whose husbands, fathers, daughters have become the living dead. Someday we could be beside the bed, or in it.

There must be some reasonable way to allow someone to speak for us when we cannot speak for ourselves, some reasonable way to make the distinction between real life and the mirage modern medicine can create. A way that does not include years of court appearances and bedside vigils.

He asked her to shoot him.

I'm betting that if you stopped ten people on the street and asked them who should make this decision for that man, they would say his wife should.

"If he could talk," Ann said, "he'd be really angry at me for not doing what he asked."
Gently Guiding
The Gravely Ill
To the End of Life

Death has been called the undiscovered country. At its border, hospice programs are gaining ground as people strive to deal gracefully with the end of life.

Of the 10 million Americans who die each year, about 20% end their lives in hospitals. For some—the very young, the suddenly stricken or accident victims—that can't be helped. But the other 80% of the population die at home under hospice care last year, about double the number a decade ago.

"Hospice care, like home care, has blossomed as hospitals have gotten so expensive," says Constance Borden of the nonprofit Hospice by the Bay in San Francisco.

Neither euthanasia nor hand-holding, hospice care is a cluster of special services for dying patients. It blends medical, spiritual, legal and financial services. People usually enter hospice care following referral by their doctor, nurse, social worker or health plan, but individuals can also contact hospice directly. When necessary, hospice care includes medical, dietary, and emotional counseling.

Comfort is the main goal, says Richard Brett, director of hospice care at Kaiser Permanente Medical Center in Hayward, Calif. "This is the myth of the perfect death," he says. "Though few people are accorded a perfect death, most can be free of pain and terror, with less of the isolation and chaos replaced by calm and control."

"Over the years, I've asked 1,000 people: Are you afraid of dying?" says Mr. Brett. "My favorite answer came from a 55-year-old gentleman who said: I'm afraid of the unknown, and if I had my druthers, I'd rather not do it."

Hospice tries to unite grieving or fractious families around the dying person, says Mr. Brett. It also helps put a client's estate in order, so he or she can rest easy.

One woman on her deathbed, he recalls, confided that she feared "her husband was going to marry the woman across the street, and her kids wouldn't get their rightful inheritance." The hospice called a family conference, where the husband expressed his love and loyalty, easing her terror of disappointment.

In another case, Mr. Brett recalls: "A devout man said: I have something important to tell you. I thought something big and emotional was coming. He said: Tell my daughter to pay the dentist. He needed to take care of all his business, so he could see his wife again in heaven."

Death is so much a mystery of nature that, at birth, "People ask the same questions about dying that they ask about having a baby: How long is it going to take, and is it going to hurt?" says Mr. Brett. Some hospice nurses begin their careers in the maternity ward.

One nurse is Theresa Stephanie of Kaiser who has ushered patients in and out of life for 20 years. Far from being hand-holding, she insists, "There's real skill in titrating medications for pain and symptom control." Hospice palliation is an art, she says, unfettered by fear of addiction when comfort, not cure, is the goal.

But hospices aren't out to hasten death. Indeed, the National Hospice Organization, an advocacy group based in Arlington, Va., opposes assisted suicide.

"We should have a national debate about care, not killing," says Kathleen Foley, chief of pain-control services at Memorial Sloan-Kettering Cancer Center in New York. "We don't like to talk about death," she says. "We don't handle it well. Otherwise, people wouldn't be riding to Jack Kerouac."

Dr. Foley, now studying care for the dying, says San Francisco, conversion planner Barbara Capua knows the value of such specialized care. Last year, her husband, Dick, was diagnosed with terminal throat cancer. A firefighter, Mr. Capua resisted the idea of dying until a hospice nurse, Sister Margaret Glynn, R.N., arrived.

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Tamar Seder, says Mrs. Capua, When Sister Maggie found a drug regimen that eased his pain, Mr. Capua vowed to take her dancing. They never made it, but in her eulogy, the nurse vowed to hold him to his promise in the afterlife. Without hospice care, says his widow, "I wouldn't have made it.

Nearly every hospice provides bereavement counseling for survivors for one year after a death, says Hospice by the Bay director Ms. Borden. It's often free and portable anywhere in the country. With modern families often dispersed, dying at a funeral and then flying home, this benefit can be a boon. Carol Crawford, a public-relations executive, lost her mother in Reno, Nev., but got counseling at her local hospice in San Francisco.

Nationally, patients enter hospice care when they have only six months to live. Of course, such prognosis isn't an exact science and some patients defy the doctor's prediction. When a patient lingers longer than expected, they can be transferred back into long-term nursing or hospital care. For such patients, hospice care may not be appropriate. But as Kaiser's Mr. Brett says only a "lousy program" would end hospice benefits without offering medical or nursing care in its place.

Memorial's Dr. Foley warns that hospice care's economic appeal has led some health plans to cut benefits at $2,000 – or 20 days of care. While hospice care can indeed be cost-effective, imposing a fiscal deadline on the dying violates its principles of comfort and dignity.

"The economics of death and dying are driving the discussion, and it's scary people," she says. Care for the dying should be recognized as a specialty with its own reimbursement category, she says, "so people don't feel there's a time clock on their bed."
NEW HAMPSHIRE MEDICAL SOCIETY

END - OF - LIFE ISSUES
SURVEY RESULTS
INTRODUCTION

In response to the growing public debate surrounding euthanasia and physician assisted suicide, the New Hampshire Medical Society recently conducted a survey of its members to determine physicians' attitudes towards these end of life issues. Surveys conducted in other states regarding physicians' views on euthanasia and physician assisted suicide have commonly been plagued by low response rates and ambiguous results. This survey was designed to determine whether physicians believe assisted suicide and euthanasia are ethical, whether they believe either or both practices should be legalized and whether they have or are willing to participate in these practices personally.

METHODOLOGY

The New Hampshire Medical Society sent questionnaires to all 1350 in-state active member physicians. (There are over 3000 New Hampshire licensed physicians -- surveys were mailed only to NHMS members in active practice.) No limitations or considerations were made as to area of practice or years in practice. 597 physicians responded to the survey, representing 44% of the 1350 physicians who received a questionnaire. The survey was modeled after an earlier one conducted by the Massachusetts Medical Society and the Boston Globe in April of 1993. The survey consisted of 21 questions relating to the demographic characteristics of the respondents, their attitudes towards euthanasia and physician assisted suicide and their willingness to participate in these practices. Additionally, the physicians were asked if they had in the past or were currently practicing euthanasia or assisted suicide.

RESULTS

First and foremost, the results of this survey cannot be generalized to New Hampshire physicians because of the low response rate of 44% and the fact that only NHMS members were polled. (Such a low response rate is considered unpublishable in professional circles.)

270 or 45% of respondents felt that a physician should have the legal right, upon a patient's request, to give that patient a prescription for a lethal dose of medication to be self-administered as opposed to 191 or 32% who felt physicians should not have the right (21% answered "Don't know."). As shown in Table 1, 44% of the group of physicians in favor of having the legal right to prescribe lethal doses of medication to be self administered were Protestant and 17.6% were Catholic. Of the group opposed to physicians having the legal right, 40.3% were Catholic and 34.3% were Protestant.
118 (44%) of the physicians in favor of that legal right were 35-44 years of age, while in the same age group 72 (38.1%) were opposed.

The survey indicated less support for physicians administering a lethal injection to a mentally competent, terminally ill patient upon the patient’s request, with 180 physicians in favor and 241 against. As shown in Table 2, religious beliefs of these two groups were not significant; however, of the group in favor, 50% were between 35-44 years of age, while this same age group represented 35% of the group not in favor of legalizing physician administered lethal injections.

310 physician respondents agreed that there were circumstances under which they would honor a terminally ill patient’s request for aid in dying by administering or prescribing a lethal dose of medication if it were legal, while 113 said they would in spite of current legal constraints. 113 respondents reported having received a patient request for a prescription for a lethal dose of medication to be self administered and 22 physicians reported honoring that request. Interestingly, 99 physicians reported receiving requests for lethal injections of medications and 11 physicians reportedly complied with the request. It is interesting and remarkable that respondents did admit to honoring such a request.

The survey results, although not scientific, indicate that physicians are more likely to comply with a request for a lethal dose of medication to be self-administered than they are a request for a lethal injection to be performed by the physician. It also appears that many more physicians would be willing to engage in the practice of assisted suicide if it were legal. In addition, there is a small minority of doctors engaging in assisted suicide in spite of the current legal constraints.

Perhaps the most significant results of the survey came in response to a question addressing physicians' awareness of a patient's pain and suffering. 72% reported pain as the single most important reason that physicians feel patients seek aid in dying. This result directly contradicts the notion that physicians are unaware or insensitive to their patient's pain. On the other hand, the physicians who claimed to have engaged in the practice of assisted suicide said that 89% of the time they did it because the family agreed with the patient's wishes and because no further medical treatment would improve the patient's condition; while 78% of the time they did it because they didn't want to see their patient suffer any longer and because they believed their patient had a right to self-determination. Once again, these results reflect a concern for the liability of assisted suicide and the physician's concern with having both patient and family consent before complying with a patient's wishes for aid in dying.

Even though euthanasia and assisted suicide are not openly practiced by any significant number of New Hampshire physicians, the survey indicated that most physicians take other measures that are legally sanctioned to assist their patients with dying when necessary. Fifty-one percent reported that they initiate DNR orders and agree not to use a ventilator upon patient request. Additionally, approximately 45% of
respondents report that they withhold other medical treatment related to the patient's condition and other measures that would not extend a patient's life. Results seem to indicate a willingness on the part of physicians to assist their patients in managing their own deaths in ways that are currently legally permissible, an awareness of a patient's pain and suffering and a desire to comply with patient wishes whenever possible.

Forty-three percent of the physicians responding to the survey said that if they found themselves to be suffering from a terminal illness, they would likely take steps so that they could administer a lethal dose of medication to themselves. These results indicate that there are physicians who would do for themselves what they wouldn't consider doing for their patients, but this disparity appears to be due primarily to legal as opposed to ethical considerations.

Miscellaneous Statistics

In your care of terminally ill patients, do you initiate any of the following measures upon a patient's request?
- Issue a DNR order..........................50.8%
- Agree not to use a ventilator or similar equipment........51.3%
- Withhold other medical treatment..................46.4%
- Other measures that would not extend life............44.6%

What is the single most important reason you think that terminally ill patients seek aid in dying?
- Do not wish to be kept alive on tubes and machines.....12.9%
- Concerned about cost of medical care................2.3%
- Do not wish to face increased pain and suffering.......70%
- Do not wish to be a burden on their families...........14.4%
Let's take the case of a mentally competent, terminally ill patient who requests aid in dying from the physician. Should a physician have a legal right, upon the patient's request, to give that patient a prescription for a lethal dose of medication to be self-administered?

<table>
<thead>
<tr>
<th>Response</th>
<th>Catholic</th>
<th>Protestant</th>
<th>Jewish</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should have legal right</td>
<td>17.6%</td>
<td>44%</td>
<td>18.2%</td>
<td>20.2%</td>
</tr>
<tr>
<td>Age under 35</td>
<td>4.4%</td>
<td>44%</td>
<td>33%</td>
<td>13.2%</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Should not have legal right</td>
<td>40.3%</td>
<td>34.3%</td>
<td>9%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Age under 35</td>
<td>6.2%</td>
<td>38.1%</td>
<td>26.2%</td>
<td>20%</td>
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TABLE 2

Should a physician have the legal right to give a mentally competent, terminally ill patient a lethal injection upon a patient's request?

<table>
<thead>
<tr>
<th>Category</th>
<th>Catholic</th>
<th>Protestant</th>
<th>Jewish</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should have legal right</td>
<td>20.9%</td>
<td>38.2%</td>
<td>20.9%</td>
<td>20.2%</td>
</tr>
<tr>
<td>Age under 35</td>
<td>2.6%</td>
<td>50%</td>
<td>31%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Should not have legal right</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age under 35</td>
<td>7.5%</td>
<td>35.2%</td>
<td>29.5%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Don't know/Refused</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
February 27, 1995

Hon. Robert Lockwood
Chairman, House Judiciary Committee
Legislative Office Building
Concord NH

Dear Representative Lockwood:

As I was unable to testify on the 16th and am unable to appear on March 2nd, I am writing to express my support for Bob Guest's bill legalizing assisted suicide. As you may remember I was one of the prime sponsors of a similar bill while a member of the house in 1992. The current bill has the advantage of closely following the language of the referendum approved by the voters of Oregon and I support it completely.

I should simply like to add the observation that American attitudes to death and dying are undergoing a transformation, as exemplified by the actions of two former residents of the White House, Richard Nixon and Jackie Onassis. Both, while clearly able to command the maximum that modern medicine has to offer, chose to avoid heroic measures to keep them "alive", recognizing that at some point one's life is effectively over and their time has come.

The close votes in Washington and California and the victory in Oregon on referendums dealing with control over one's death demonstrate the depth of these attitudinal changes, as the opposition greatly outspent the supporters on TV ads. We are as a society coming to grips with the fact that medical science has created an ethical dilemma by keeping people "alive" but not really living. I hope the Committee will recognize this dilemma by voting HB 339 "ought to pass".

Sincerely

[Signature]
March 2, 1995

Chairman, Judiciary Committee
Subject: HB 339
"Dignity in Dying" Bill

I have been a practicing family physician for twenty years, the last thirteen in the State of New Hampshire. I care for patients throughout the life cycle: delivering their babies, providing care and advice about illness and prevention, and attending them and their families at the time of their deaths. Throughout my practice I strive to empower people to make informed decisions about their health care. Often the most difficult decisions involve patients’ refusal of measures that will prolong physical and emotional suffering that I am powerless to significantly mitigate.

This bill meets a very real need. It provides physicians like myself the opportunity to assist those suffering individuals who have carefully and rationally decided that a peaceful death is far preferable to continued pain and distress. Most impressive in its language are the built-in safeguards against capricious or malicious abuse. I commend the authors on the sensitivity and compassion which underlay its conception and applaud the practical procedures it proposes. I strongly urge its passage.

[Signature]

Peter A. Mason, M.D.
Medical Director, Community Care Center
Past President, Medical Staff
Alice Peck Day Memorial Hospital
Lebanon, N.H.
Assistant Professor of Clinical Community
and Family Medicine
Dartmouth Medical School

Note: Titles provided for identification purposes and do not imply endorsement by the institutions of the above opinions
PHILIPPE CITRON, RE: HB 339, THE NEW HAMPSHIRE DEATH WITH DIGNITY LAW

When I accepted the New Hampshire Hemlock Society's invitation to testify before this hearing, I did so with a good deal of trepidation. What could I, a private citizen, without medical credentials or expertise, add to the much debated issue concerning a terminally ill patient's ethical and legal right to decide for himself to terminate his life, once the pain and incapacitation inflicted by his illness sapped his life of all dignity, independence and any remaining will to live? What could I say to you, a body of lawmakers, that you haven't heard from prominent advocates for or against the right to die—or read about from the much publicized events in different parts of the country?

But more troubling than my having to articulate my layman's position on this matter was the fact that I would need to do so from the very personal standpoint of one who is afflicted with a terminal illness and who is confronted with making such a decision for himself. Being a private person, I am uncomfortable using my physical condition as an argument for the right to die. I would have much preferred for it to remain a matter between my immediate family and I—and between my personal physician and I. Indeed, I firmly believe that one's right to die should not be a public matter or a political issue to be debated, licensed or prohibited by the state. How much physical pain and debilitation a man can endure should not be a matter of law, and I dare say cannot be. For how can any
law truly prevent a terminally ill man from acting upon what his tortured state of existence compels him to do?

One's right to die, to decide for himself when his body has turned the gift of life into an insufferably, degrading existence is a profoundly private matter, different for everyone whose physical condition forces him to confront the issue. It is the most profound and intimate, soul-searching question a man must resolve for himself. No one can decide it for him. And no institution should have the right to force a dying man to suffer the needless agony and degradation of a few extra days or weeks of dehumanizing existence?

Thankfully, my illness has not yet ravaged me. I don't know when and if it will. Maybe never? Maybe the terminal cancer that I am afflicted with will prove more benevolent in its lethal work. But if not—if my cancer should become as brutally debilitating as I have seen it be to others--I would like to think that the state would not impose its impersonal will upon me and seek to prevent me from carrying out my last willful act, while I still retain the mental powers to carry it out. I would like to think that the state would not make me a prisoner to a life that has ceased to be useful to me, to others, or to the state. And I would like to think that the state would not dictate to the medical profession what measures they may or may not take in respecting my wishes when and if my disease should reduce me to nothing more than its helpless, suffering servant. I would like to think that the state recognizes that this should be
solely a matter between myself and the attending physician who is most intimately aware of my condition.

I have made my decision regarding what I would do should my disease become so all consuming that I could no longer suffer its relentless pain and indignity. Should that time come, I intend to ease my way out of the non-life left me by my disease. I've shared my decision with my immediate family and intimate friends, all of who understand that it is a decision I did not come to lightly. And, I'm pleased to say, no one has questioned my right to so act, when and if I find it necessary.

My decision, as I said before, is very private and personal. I think we would do well to respect a man's most private and agonized decision to terminate his life under the circumstances I've described.

In saying so, I believe, I speak for many other facing what I face.

Thank you for giving me the opportunity to speak at this hearing.
STATEMENT TO NH HOUSE COMMITTEE ON JUDICIARY & FAMILY LAW

BY LUIS A. GALLOP, CHAIRMAN, NH HEMLOCK SOCIETY

March 2, 1995

RE: HB 339

The New Hampshire Hemlock Society, a part of the 50,000 member Hemlock, U.S.A. complex believes it is time for New Hampshire to undertake to satisfy approximately 70% of the people of New Hampshire who have indicated in polls on a number of occasions that they believe in Death with Dignity for the terminally ill.

If this bill is passed, lethal drugs will not be available to most terminal patients. A patient has to be able to self-administer the drugs that will end his or her life. Most terminally ill persons, in the last days of their lives, do not have the strength to self-administer the lethal medicines. If patients, anticipating what the end of their lives would be like, asked for the drugs when they were strong enough to self administer and hold them down, they would be told that they were not yet sufficiently terminal to be given the drugs. There is a catch-22 built into this bill, but we regard it as a beginning.

Do not be misled by those who would tell you that allowing people to die on request is immoral. What is immoral is the suffering and dismay in the lives of these patients and in the lives of those who care for them. Do not be misled by those who would tell you that we are denying families an opportunity to be together during the final days of their loved ones. My family and I were with my wife during her final suffering and we were, fortunately, able to help heed her wish to die when the suffering became too great for her to bear.

Presently, the law of this state says that it is illegal to help another person commit suicide. The right to die is not a privilege to be dispensed by others. It belongs to all of us. However, many of us do not have the physical means to act on that right, and we need to be assisted to end our lives with grace. Unfortunately, physicians, because only they have the right to prescribe pain-killing drugs or drugs that can produce a peaceful death, are caught up in a loop where they do not belong. Their medical advice, and that of family, friends, lawyers or the clergy, is invaluable. But they cannot be the arbiters of lives. My mission, and that of the right-to-die organizations to which I belong, is to legalise each person's right to exercise the right to die.

We beg you to report favourably on HB 339.

Thank you.

Luis A. Gallop, Chairman
NH Hemlock
POB 162
Francoestown NH 03043
(603) 547-3474
READINGS RELEVANT TO HB 339 (RELATIVE TO DEATH WITH DIGNITY)
2/16/95

Excerpt from Letter to the Editor, Valley News, 1/23/94, by Joanne Lynn, M.D., Senior Associate and Professor, Dartmouth-Hitchcock Medical Center.

... The kind of case that Guest portrays, that of a dying patient in terrible pain, need never exist. We can always induce anesthesia, even if there is no better option. And that is already legal. In point of fact, even cancer patients with severe pain can almost always be kept comfortable and awake with modern palliative care. When we do not provide this care, it reflects a failure of the care system, not the law. The errors that do occur that allow such suffering need to be addressed through education and quality assurance, and those need to be high priorities. While it may seem appealing to bypass these difficult and time-consuming endeavors by simply allowing certain kinds of killing, a reasonable citizen should be alarmed that we would consider legalizing killing in order to respond to shortcomings in our current palliative care. Unless we can develop a care system that can handle giving adequate narcotics for pain, we should be terrified about allowing such an inadequate system to take on giving lethal potions on demand.


Abstract. We propose that chronically-ill and terminally-ill patients who wish to die more quickly may voluntarily refuse life-sustaining hydration and nutrition. Physicians have moral and legal duties to respect treatment refusals, including the refusal of hydration and nutrition, when they are rational decisions made by competent patients. Physicians should educate terminally-ill patients that dying by cessation of hydration and nutrition can be accomplished comfortably in most instances. Patient refusal of hydration and nutrition is a preferable public policy to legalizing voluntary active euthanasia or physician-assisted suicide because it avoids the host of moral, social and professional problems resulting from the latter.

... The most pressing need is to dispel the myths about suffering caused by dehydration and to publicize as widely as possible to both physicians and their terminally-ill patients the availability of PRHN (Patient Refusal of Hydration and Nutrition) as a means of shortening the dying process. Educational efforts should be directed to physicians who are often ill-informed on this matter as well as to the general public. The emphasis on research and education on symptomatic treatments to relieve suffering during dying is fully compatible with the traditional and appropriate role of the physician as caregiver and comforter.

Abstract. The publication of *Final Exit* resulted in a public response that was exuberant, largely sympathetic and, to many within hospice, disquieting. The book and the public response it engendered can not be understood without exploring the Hemlock Society and the political agenda which both the Society and the book advance.

Hospice must begin a response to this book, and any discussion with Hemlock supporters, from a basis of consensus. Hospice must acknowledge that those within the euthanasia/assisted suicide movement believe as deeply as we in hospice in the need to address the suffering of people enduring the effects of terminal illness. We must further acknowledge that there remain unmet needs in the care of the dying which for primarily socio-political reasons hospice has been unable to resolve.

There are several compelling reasons for hospice as an organized movement to oppose the political initiatives of the Hemlock Society - at least in their present form and within the current social context. These reasons involve core ethical issues and issues of direct social consequence, each of which seems sufficient to reject the current proposals.

Hospice programs and personnel must enter this debate in earnest. Before serious consideration is accorded to legalization of euthanasia/assisted suicide, we must insist that genuine access to comprehensive hospice/palliative care becomes a reality for all dying patients and their families.

Within the medical community, and even within hospice circles, there are caring providers who can envision situations in which suffering is so profound and life so apparently devoid of meaning that assisted suicide would seem acceptable. But in seeking to find our own level of consensus, we as hospice personnel must take care not to confuse a natural tolerance for the actions of those in extraordinary circumstances with a presumed need for social legislation. The current legal situation with regard to mercy killing in this country is one in which prosecutors find it difficult to obtain a conviction. In fact there is a growing reluctance to indict at all. The implications of moving assisted suicide beyond the status of a non-indictable exception to that of an acceptable public policy must be examined very closely . . .

. . . A central flaw, then, in the political theory of the Hemlock Society and in the resultant structure of its legal initiatives is the legislated involvement of physicians. Physicians are not trained in killing . . . I maintain that the legislation of the inclusion of euthanasia/assisted suicide into medical practice is a change so critical and so profound as to compromise the very foundations of the profession.
My name is Marie Kirn. I am Executive Director of New Hampshire Hospice Organization, representing the thirty-two hospice agencies in the state. We support dying persons and their families in finding comfort, dignity and quality time together through a natural time of dying. We are deeply involved in the many issues raised by HB 339. We do not think that these issues belong in legislation. I will address five points:
- This legislation is too controversial to be put into law today.
- We have natural alternatives to suicide when we are ready to die.
- The right to palliative care is widely supported today throughout the medical community, but is not well enough known to the public.
- The time of dying often offers powerful experiences of personal and spiritual growth for the dying person and for friends and family.
- While acceptable as an act elected now by many people of good will, physician-assisted suicide is not acceptable as social policy.

I have said that HB339 is too controversial to be put into law in this state today. No legislation with such heavy implications should be undertaken in the present climate of fear, distrust and anger. We cannot allow control of our dying, the most universal and mysterious human experience, to be caught up in the chaos of animosity and politics.

Suicide is not our only choice if we are really ready to die. We can refuse unwanted medical intervention. Many are so open to death, and so in tune with body, mind and spirit, that death actually comes when they want it - after the holiday, when the children arrive, when a project is complete, when a loved one has also become ready to let go. We can refuse unnecessary nourishment, turning to juice and then to water, as Scott Nearing did; his conscious and comfortable death is described eloquently by his wife who held him as he died. "‘All...right,’ he breathed, seeming to testify to the all-rightness of everything, and was gone." As the body declines, from illness or from age, it does not need the chicken soup we would feed it. We can learn to honor the body's natural process of dying if we are truly accepting of death. We need neither the legislation nor the lethal medication. We do need education of the medical community as well as the public.

The extraordinary world-wide movement that we call hospice knows that it is possible for all but a very few to die in comfort and with dignity today. Hospice physicians speak of controlling 90 to 100% of pain. Hospice offers medication, care and support which enable families to experience together completion, resolution, peace and even joy as they share in the transition from this life. When trust and control replace fear and denial, we can live with quality until we are ready and able to let go of this life. Again, it is a matter of education and choice rather than legislation.
The revolution in childbirth happened in this country in about a dozen years; we turned from anesthetizing ourselves against the pain to sharing with loved ones this miraculous experience of a lifetime. The pressure for physician-assisted suicide suggests that people do not know the extent to which we can take charge of our natural dying, just as we did with natural childbirth. Hospice must spread the word. We must see that palliative care is available to every NH resident. We must develop in our hospices and hospitals the greatest expertise in pain and symptom management that is possible. You and we must support this final event of a lifetime, not spend legislative, judicial and clinical resources to avoid it.

Dr. Ira Byock, a prominent hospice Medical Director, reminds us that personal and spiritual growth is a lifetime process. "Dying is not simply suffering to be avoided. It really is an opportunity to be fulfilled. There is real value in dying... a full range of the potential of personal experience still exists at the end of life."#

Dr. Byock speaks of a young woman brought into his Emergency Room by a quarreling and troubled family. No one, including the patient, was ready for her impending death. Byock spent one hour with this woman and her family, easing her pain while listening to their fears and to their differences about this loss. The family was able to get in touch with the love they shared, for the dying woman and for each other. She died at the end of that hour. As they left the hospital, family members expressed their gratitude and their new understanding that with death can come relief for the loved one and a new awareness of life's joys and relationships. One hour - even the very final hour - can change the experience, not only of one death but of many lifetimes.

Daily in our hospice work we see patients and families and, often, friends, grow remarkably in the last weeks, days, even hours of life. We have witnessed too many surprises at the very end of life to believe that we can know when to end it. We cannot know what we - or our loved ones - will miss.

Finally, we believe that this fundamentally personal matter does not belong in the legislature or in the courts. Choices around our dying and our death - and those choices will come to every one of us in this room - arouse in us the deepest spiritual, interpersonal and social questions. How can we reduce such a question to a Yeh or Nay vote? We must each face our death out of our own spiritual beliefs, in the intimacy of our family and friends, and in a trusting relationship with our physician whose role is to offer expertise and to care. Our own dying will be as personal, powerful and vulnerable a time as we will know; it is not a matter for legislated procedures, whatever they are.

* Helen Nearing, *Loving and Leaving the Good Life*  
TESTIMONY ON HB 339

Diocese of Manchester urge NO vote on Assisted Suicide Bill

I am Msgr. Francis J. Christian, Chancellor of the Roman Catholic Diocese of Manchester. On behalf of Bishop Leo E. O'Neil I wish to express in the strongest terms possible the opposition of the Catholic Church to House Bill 339. While our opposition is grounded in our religious faith, it is also based on a number of public policy considerations which I believe the vast majority of people who are concerned with human dignity accept as reason for rejecting this sort of legislation.

The doctrines of Christianity, Judaism, and Islam all proclaim that human life is a gift from God over which we have stewardship but not absolute dominion. Such an understanding about the dignity of the human person leads to the understanding that the taking of human life can only be done in self-defense and when such killing is a last resort. We can never directly kill or intend to kill ourselves or another person outside of these very narrow limits because life and the human person belong to God.

Doctrinal issues aside, however, I am convinced that there are weighty public policy issues which convincingly speak against any law permitting assisted suicide. Let me discuss the four most important of these. In so doing I will make reference on several occasions to the experience with assisted suicide that has been in place for nearly twenty years in Holland. While Dutch law forbids both physician-assisted suicide and active euthanasia, it exempts doctors from prosecution from either crime if they follow government guidelines. A 1991 government survey has revealed some important findings to which I will refer in what follows.

I. The Denial of Our Human Dignity
Suicide is a direct contradiction of the preciousness of human life. It is a stark denial that life is good, and each human person is uniquely valuable. Social acceptance of suicide would teach that life is only valuable under some circumstances, and should be ended when those circumstances are less than desirable. The fact that a suicide would be assisted — even for motives that seem compassionate — simply corroborates the judgment that someone is making about him or herself, and magnifies the problem. When killing is accepted as a solution to the problems of life — no matter how difficult they might be — society in fact has relativized human life, and no longer has any bedrock on which to build and to judge what is good. Assisted suicide should be rejected for this reason alone.

II. The Extension of Such Laws
House Bill 339 — and, in fact, all such bills — inevitably will be further extended in unacceptable ways. Before enumerating them, it is important to understand why such extensions cannot be prevented in law. The main reason why we should not start down the "slippery slope" or allow the "nose of the camel under the tent" is that in the initial decision itself we are adopting a principle that cannot logically be limited. Contrary to what proponents of such legislation maintain, once we have accepted in principle that an individual has autonomy over the decision when and how to die, the circumstances permitting the use...
of that autonomy become arbitrary and cannot be limited in law. Why is a terminal condition more onerous than living in a radically limited way, e.g., living with the results of a severe stroke that leaves one crippled and not able to speak, or living as a quadriplegic? To suggest that a person has to be terminal, that is, in the process of dying, to exercise the choice to die simply begs the question. It is not the fact that a person is dying that is the issue. Rather, the issue is that a person finds no value in continuing to live in a particular set of circumstances. It is that person’s perception of what makes life worthwhile which is the controlling issue. As a result if the law gives a person the right to kill oneself when the process of dying makes that person’s life qualitatively unacceptable, then in principle the same autonomy logically must be granted in other circumstances that an individual judges make life no longer worthwhile. Some of the inevitable extensions of such a law will occur in the following fashions.

A. In regard to terminal patients themselves.

1. If I am in a mentally lucid condition but because of my physical condition cannot issue a written request, as Bill 339 stipulates, it will be required that exceptions be made for such circumstances. In other words, it will be judged illogical and unkind to deny someone the choice to die simply because a given physical condition does not permit a signature in a written request.

2. If I am in a terminal condition but am not experiencing “severe, unrelenting suffering” in a physical sense, but I am experiencing significant emotional pain, why should I not be able to end my life? This emotional pain need not be due to a serious psychological problem or depression but the result of the strain of prolonging the dying process or the dismay at seeing much of my savings used up in this fashion.

In Holland a doctor who assisted an emotionally distraught woman to commit suicide on her third attempt was acquitted by the courts, which argued that if suicide was permitted for a physical pain it must be permitted for emotional pain as well. Here is an example of the extension of the principle of autonomy in practice.

B. In regard to non-terminal patients but people who find their life burdensome.

1. While it may not be the direct intention of the local framers of Bill 339, there is no doubt that the principal supporters of such legislation nationwide see this as a first step to creating a social climate in which other burdened people can legally take their lives. Derek Humphrey, the president of the Hemlock Society, openly speaks about permitting quadriplegics to kill themselves, and talks as well about people afflicted with “terminal old age”. As stated earlier, since the controlling principle in such matters is when and under what conditions an individual judges life to be worth living, any law that permits suicide in terminal conditions would logically need to extend that to other burdensome conditions as well.
C. The move from assisted suicide to active euthanasia.
There will also be an inevitable extension from assisted suicide to active euthanasia. This will occur principally for two reasons.

1. If a person has followed all of the requirements of the law and has received the prescribed medications, but then is unable to self-administer those medications, the logic of the autonomy given to that patient will require that someone else be permitted to follow the wishes of the patient and administer the medication. In other words, a person’s desire to end his or her life in a “humane and dignified manner” will logically need to be extended to another person’s action when self-administration of such drugs is no longer possible. We will then have moved from assisted suicide to euthanasia driven by the logic of the autonomy the law extends.

2. The self-administration of the supposed lethal drugs will often not lead to the desired results. Dr. Peter Admiral, one of Holland’s foremost practitioners of euthanasia, reports that his four-year study of assisted suicide in that country shows that about 25% of the time patients who have self-administered lethal drugs linger for hours or even days in an unconscious state. Admiral realizes that such a result is not acceptable, and indicates that once assisted suicide is accepted direct mercy killing must be acceptable too in order to dispatch the person who is lingering. Derek Humphrey corroborates that judgment, and he says that assisted suicide “will only work if in every instance a doctor is standing by to administer the ‘coup de grace’ if necessary.” Once again, then, assisted suicide will require active euthanasia. For 2,400 years patients in western societies have had the assurance that doctors will try to cure them. Any connection between doctors and the causing of death will seriously erode faith in the medical profession as a healing profession.

III. The Social Climate Created by Such Laws

A. House Bill 339 exerts unacceptable social pressure and expectations on the people of our society. The so-called right to die quickly becomes the duty to die. This is true because civil law is perceived by the great majority of the people of our society as prescribing what is to be pursued or avoided. In other words, law is understood to hold up what is good for our imitation. Passing a law on assisted suicide places the state in a position of at least implicitly encouraging its citizens to consider suicide (and, inevitably, euthanasia) when confronted with circumstances that make life burdensome. People with terminal conditions who want to continue living and others, as the right to suicide or euthanasia is inevitably extended to other groups, will surely feel internal and external pressure to choose to die because it is expected of them. The fact that people value themselves less and are seen by others as of less value when they begin to require significant care is surely one of the most tragic consequences of this sort of legislation. Once this social mentality is in place, economic conditions will certainly exert themselves. The American Medical Association last December strongly opposed all assisted suicide laws precisely for this reason.
Once again the Dutch experience is frighteningly enlightening. The government survey conducted anonymously among the Dutch doctors revealed that more than 1,000 people have been killed in the last twenty years by doctors with no request of the patient. The doctors defended what they did on the grounds that it was what the patient or family would have wanted. How did they know that? Because that is what many in their society were choosing to do. Furthermore, the Dutch Pediatric Association is now developing instructions on active euthanasia for certain babies who face chronic illnesses even though they are not terminal. In other words, society has come to demand a certain quality of life from its citizens.

IV. The Constitutional and Legal Questions Surrounding Such Laws
There are also significant constitutional and legal problems with such legislation.

A. In the first place the types of drugs that would be prescribed for lethal purposes are likely to be those that are regulated under the Federal Controlled Substance Act. This act requires all drugs to be issued for a “legitimate medical purpose”. It is unclear under federal law that prescribing drugs to permit a patient to commit suicide would constitute a legitimate medical purpose.

B. The U. S. District Court in Oregon has issued a temporary restraining order against implementation of a referendum which approved assisted suicide. The Court ruled in this fashion to allow a full study of federal and constitution claims on the merits.

C. In December of 1994 the Michigan Senate overwhelmingly approved a new law against assisted suicide, rejecting a substitute bill modeled on the Oregon law. Six days later the Michigan Supreme Court upheld an earlier ban and declared there is no constitutional right to suicide or assisted suicide.

D. In December of 1994 a federal judge in New York upheld an existing state ban against assisted suicide, and ruled that a right must be “implicit in the conception of ordered liberty” or “deeply rooted in the nation’s history and traditions”. He concluded that a right to suicide fulfills neither standard.

It would be exceedingly unwise for the State of New Hampshire to enact such a law in a legal climate that probably will ultimately end up in the U. S. Supreme Court.

V. Other Questions

A. The question of pain. Much of the testimony in favor of assisted suicide is based on the perceived need to relieve people from intractable suffering. Obviously, relieving pain must be a primary concern, and is an emotionally persuasive argument. It would seem, however, that there is a great deal of misunderstanding regarding the ability to control pain that makes its way into the arguments on assisted suicide. Many people who die in pain do so simply because they are under-medicated or improperly medicated. In opposing an assisted suicide bill in the State of Washington, the Washington State Medical Association stated, “Pain control is available for virtually everybody. There is no medical reason for anyone to die in pain. A patient who is dying in pain
needs to find a doctor who knows how to give compassionate effective pain control.” Raising the issue of pain in support of assisted suicide may well be a question of bad medicine, which then makes for terrible law.

B. The legal ambiguities in Bill 339.
There are a number of unanswered questions of a technical nature in this proposed bill.

1. Could doctors be sued if their patients took a suicide medication and did not die, or did not quickly and painlessly die?
2. In spite of the immunity granted to a good faith action, what does good faith mean from a legal point of view? Is it not true that nothing can really prevent a law suit?
3. How is coercion or undue influence, as described in 137:K:15 to be defined or proved? Is even the raising of the issue with someone not exercising some kind of influence?
4. What is the sense of the permission to rescind a request in 137:K:9II? Why should a request need to be rescinded at all if the patient remains free not to take prescription drugs?
5. The use of the term “terminal condition” in 137:K:2III seems very ambiguous. For example, is not old age an irreversible condition which has an end state for which there is no known treatment?

In conclusion, I would propose that we, as a society, are badly served by assisted suicide legislation. We already have well established legal and moral tradition which allow us to withhold or withdraw medical treatment that is no longer beneficial to a person, thus permitting that person to die his or her own natural death from an underlying illness. We should emphasize those rights and educate about them. We should encourage patients and doctors to withhold or withdraw treatment that simply prolongs the process of dying. But we should not adopt laws through which death occurs not because of illness but because of direct human intervention and human agency. When we permit killing for reasons other than self defense and see killing as a solution to the problems of life, we have moved indeed into a legal and moral position that contradicts social life founded on the dignity of the human person. I urge you to reject HB 339.
TO: House Judiciary & Family Law Committee
FROM: Ellen Kolb, 5 Sharon Ave, Merrimack 03054
RE: HB 339
DATE: 3/2/95

If I ask you for your prescription medication so that I can kill myself, and you oblige me, you are party to a homicide.

Take the same suicidal person, make the abetter a physician, and throw in the buzzwords "rights," "autonomy," and "dignity," and you have HB 339, which would give assisted suicide the legislature's seal of approval.

While the sponsors want assisted suicide to be legal, they recognize that the word "suicide" carries a lot of baggage. HB 339 therefore states that an act which is manifestly assisted suicide shall not be called by that name (see page 7 of the bill).

HB 339 removes one of the strongest incentives for patients and health care providers to find better methods of pain control and palliative care during terminal illness. No
Longer would there be a barrier between physician-as-killer and physician-as-healer. Instead, when care becomes a challenge, New Hampshire law would effectively say to both patient and physician, "The option of killing is available - why not use it?"

Some supporters of euthanasia are forthright in their belief that assisted suicide bills are useful chiefly as trial balloons for active euthanasia. Oregon voters recently passed an assisted-suicide measure, very similar to HB 339. Derek Humphry, co-founder of the Hemlock Society, has written, "The new Oregon way to die will only work if in every instance a doctor is standing by to administer the coup de grace if necessary" (New York Times, 12/3/94). If New Hampshire legislators are unwilling to open that door, there's no reason to blunder down the alley leading to it.

I am appending to this
testimony a letter from Thomas J. Manzen of the National Legal Center for the Medically Dependent and Disabled, Inc. to Rep. Warren Goddard of Portsmouth. (Rep. Goddard has given me permission to submit the letter to you.) Mr. Manzen, an attorney, addresses many of the concerns I have with HB 339, and I invite you to consider his points carefully.

According to Mr. Manzen, among HB 339’s myriad defects are conflicts with the Federal Americans with Disabilities Act and Religious Freedom Restoration Act. The bill also invites equal protection challenges based on age or health status.

Please don’t throw sick, suicidal people to the wolves. You or I could be in that position someday. Decide now that you can see the difference between killing & caring. Reject HB 339.

APPENDICES: Letter from atty. Manzen
Oregon injunction
JUST STOP THE PAIN
Submitted by Paul Arinstein RN.CS.NP-C. MSN 3/2/95
On behalf of the New Hampshire Cancer Pain Initiative

Cancer Pain in New Hampshire?
This year more than 5,000 people in New Hampshire will be diagnosed with cancer. There are an estimated 40,000 citizens now living in our State who have been diagnosed with cancer in past years. Although not all people with cancer have pain, the majority who do describe their pain as moderate to severe in intensity at some time during their illness. Many citizens and professionals report that cancer pain is not satisfactorily relieved. The growing interest and demand for physician assisted suicide in our State is another symptom of our failure to effectively manage people's pain and suffering. This unrelieved pain destroys the quality of life for the individual, their family and friends, and is tragic in light of the knowledge of what could be done.

What is the Initiative?
Many professionals and citizens of New Hampshire are appalled by the presence of unrelieved cancer pain despite knowing it can be prevented and relieved in almost all cases. Since volumes of research and expert consensus opinion have failed to eradicate needless suffering, an "Initiative" was formed in 1990 to influence change on the grass-roots level, through education, research and advisory activities. New Hampshire was the 27th State to develop a Cancer Pain Initiative and is now joined by 47 other States and 43 Countries to solve this world-wide public health problem.

Why Do They Suffer?
Conflicting research makes one ponder, why do 70% of people with advanced cancer suffer when 90% can have pain satisfactorily prevented or relieved by oral medication. Even more can have pain relieved by newly refined procedures if the pills don't work. The fear of using the available medicines, and trouble talking about pain are common obstacles to relief.

What has been done?
The federal government has released guidelines for effective management of pain that are freely available to professionals and citizens by calling (800) 4-CANCER. Last year Governor Merrill issued a Proclamation authorizing the Initiative to "urge health care providers to become expert in pain management and offer hope to all New Hampshire citizens".

The New Hampshire Cancer Pain Initiative has been able to influence some changes through educational programs for Doctors, Nurses, Pharmacists and has facilitated curricula changes at Medical and Nursing Schools across the State. Improvements in assessing and documenting pain as well as Quality Assessment methods of ensuring relief have been put in place in Hospitals, Nursing Homes, Hospices and Doctors Offices.
Tim Ahles PhD, Director of Psycho-Oncology at Dartmouth Medical School, led a research program that surveyed the knowledge and attitudes of health professionals in New Hampshire. Unfortunately, we do not have data available at this time, however with over 800 responses to decipher, I am convinced there will be many gaps in knowledge and attitudes among the practicing professionals in our State. The Cancer Pain Initiative is well positioned to meet those needs once they are identified.

Response To House Bill 339

The people representing the New Hampshire Cancer Pain Initiative have mixed feelings about this Physician Assisted Suicide Bill. Many with a position are for it, some against, but most are yet undecided. What we can all agree on is that we have to do all that is possible to alleviate the pain. Since we believe that many requests for Physician Assisted Suicide result from a failure to manage pain, why not include the presence of unrelieved pain in the second opinion?

Further, since there is a provision for those with possible mental illness to receive treatment from appropriate specialist prior to making the decision, why no add a provision that "In the event of unrelieved pain, a specialist in the field of pain management will be consulted with..." This can be generally stated or you may wish to specify "Board Certified Pain Management Specialist" or "at a recognized multi-disciplinary pain program".

We appreciate the opportunity to present our viewpoint on this important topic, and can be reached by mail at: NHCPPI, Box 1703 Concord, NH 03302-1703; phone 228-4646; or fax 226-0016. Remember, individuals with cancer have a right to have their pain believed and relieved. Stopping the needless pain is an endeavor worthy of your consideration and effort!

Respectfully Submitted,

Paul Arnstein
THANK YOU MR. CHAIRMAN; MEMBERS OF THE COMMITTEE FOR THIS OPPORTUNITY TO SPEAK IN SUPPORT OF HB 339, DEATH WITH DIGNITY.

I AM HERE TODAY TO CONVEY THE STRONG FEELINGS OF A WOMAN I KNEW INTIMATELY FOR OVER FIFTY YEARS.

PICTURE IF YOU WILL, A LIVELY AND VIBRANT WOMAN; ONE ACTIVELY INVOLVED WITH FAMILY AND COMMUNITY; A COMPASSIONATE AND CARING PERSON WHO LOVED AND LIVED EVERY DAY OF HER LIFE TO THE FULLEST.

WHEN STRICKEN WITH INOPERABLE CANCER AND KNOWING HER REMAINING WEEKS WOULD BE FILLED WITH EXCRUCIATING PAIN AND SUFFERING; HER FERVANT WISH WAS TO END HER LIFE. SHE ASKED HER DOCTOR TO HELP HER, BUT HE WAS AFRAID; SHE ASKED HER ONLY SON TO FREE HER FROM THIS FATE, BUT HE, THOUGH WILLING, COULD NOT!

SHE ATTEMPTED TO SHORTEN HER SUFFERING BY FORCEFULLY RIPPING THE INTRAVENOUS TUBING FROM HER BODY. SHE SUFFERED TERRIBLY AND NEEDLESSLY FOR THE REMAINDER OF HER LIFE STRAPPED TO A HOSPITAL BED TO PREVENT HER FROM FURTHER ATTEMPTS OF SUICIDE.

THIS IS NOT A MORAL ISSUE!

THIS IS NOT A RELIGIOUS ISSUE!

THIS IS A PERSONAL ISSUE!

THIS WONDERFULLY STRONG WOMAN WAS MY MOTHER. I URGE YOU TO VOTE IN SUPPORT OF AN END TO THIS NEEDLESS DISREGARD OF AN INDIVIDUAL’S RIGHT TO SELF-DETERMINATION.

THANK YOU, MR. CHAIRMAN.
Bar pays clients defrauded by judge

No Fairbanks victims get all they lost

By BEN SCHMITT
Monitor staff

Thirteen victims of the late Judge John Fairbanks will be getting a piece of a $90,000 refund from the state Bar Association.

The money comes out of a client indemnity fund set up in 1960 by the Bar Association to pay back victims of corrupt lawyers.

Fairbanks, of Newport, was indicted on Dec. 27, 1989 for billing more than $1.8 million from his clients. In all, about 25 former clients filed more than $4 million in claims against Fairbanks in U.S. Bankruptcy Court in Manchester.

Instead of facing the criminal charges, Fairbanks skipped town the day after his indictment came down. He was pronounced dead last year in a Las Vegas hotel room. Authorities said he committed suicide by suffocating himself with a plastic bag. He was 70.

Fairbanks's professional conduct files have remained sealed.

John Tweedy, 68, of Washington, said he received a letter Friday stating he would be receiving a little more than $5,000 back from the Bar Association.

"We regret that we were unable to fully compensate for your loss," the letter read. "We hope that you are able to put this unhappy experience behind you, and we wish you well in the future."

After receiving money from a bond and bankruptcy court, Tweedy said he has now recovered about half of the $103,000 he said Fairbanks stole from his mentally incapacitated brother, Richard.

"Yeah, I'm happy about it. I have no complaints," said Tweedy in response to the notice of payment from the indemnity fund. "This is a responsibility of the Bar Association and the courts."

Jack Crisp Jr., president of the New Hampshire Bar Association, said the amount each victim received was based upon the total amount of their claims and the money available.

"We would have loved to have had enough money to make everybody whole," said Crisp. "Unfortunately, that's just not the reality."

Crisp said lawyers voluntarily donate to the client indemnity fund and have been doing so long before Fairbanks was an issue.

"At the time it was established, no one ever foresaw that we would have some kind of situation as we had with Fairbanks," he said. "Nobody really anticipated claims of this magnitude. If so, we probably would have dealt with the contribution process differently."

In 1992, members of the Bar Association voted down a proposal to impose mandatory contributions to the fund.

Michael Shklar, who represented Tweedy in his claim, said the general consensus was that lawyers did not want to have to pay for the mistakes of crooked colleagues.

"The money set up in the fund was in the six figures," he said. "Then came John Fairbanks in 1989, and claims into seven figures. Claims against him clearly would have broken the bank."

Claremont lawyer Charles Spanos represented Kaarle Lehtinen, 103, who now lives in Florida. Lehtinen, formerly of Newport, filed the first suit against Fairbanks. He claimed the former judge and lawyer bilked him out of $279,000.

After the money he received from bankruptcy court, Lehtinen is getting about $7,000 from the Bar Association.

"You can't look at a gift horse in the mouth," said Spanos. "I guess the Bar does it for the purpose of keeping up an image that they are trying to be helpful."

Spanos said he would like a further explanation of how the Bar Association arrived at who would receive what.

The letter to Tweedy read: "The Bar Association allocated the available monies among the several Fairbanks claimants in the fashion the association felt was most equitable in the circumstances. No Fairbanks claimant was paid in full."

Martin Murray, public information coordinator for the Bar Association, said five victims who asked for money were denied. Some of the reasons for rejection included not filing a timely claim.

Crisp said the fund is almost gone now.

"There's some money left, but not a lot," he said.

The association also is considering setting up trust accounts to reimburse victims of lawyer misconduct.

He also pointed out that he knows of no other profession with a fund like this.

Spanos said the money helps but it won't wipe away the memory of Fairbanks's crimes.

"I think it's sort of a value-neutral situation," Spanos said. "Obviously that's what the money is there for, but I don't think it's going to repair the damage Fairbanks did."

"On the other hand, I don't know if there is any way of repairing the damage."

See FAIRBANKS – Page A-6

FAIRBANKS

Continued from Page A-1
The Honorable Robert Lockwood, Chairman
House Judiciary Committee

Feb. 15, 1995

Many who advocate physician-assisted suicide describe a horror story of a loved one dying in agony with untreated pain and spiritual or emotional anguish. This is a truly tragic turn of events. However, this is preventable and unnecessary misery. Energy would be better spent in making available palliative care programs to provide pain relief and support with the dying process. It is ironic that, in a time when their has never been greater knowledge of how to alleviate the pain of terminal illness, that some conclude that doctors start knocking-off their "terminally-ill" patients at request. It is misguided to promote the practice and availability of physician-assisted suicide without first educating the public (and uniformed doctors) about the benefits of appropriate hospice care. The advocacy of appropriate palliative care programs would benefit many more patients and their families than a hollow bill that claims "death with dignity" but offers only suicide.

I am a practicing physician who all too often needs to attend to a patient dying of an incurable illness. In actuality, the process of dying is rarely easy. However, I and my colleagues have fortunately seen the vast majority of patients die with their dignity preserved, their pain eased, and their spiritual needs attended to. This is the reality throughout the country where dedicated nurses, pastors and doctors assist patients and their families with well-trained hospice programs. It is simply untrue that "many terminally ill patients experience severe, unrelenting suffering." When such suffering does develop, it must be considered a failure of palliative care, and this is rare when nursing/medical staff is adequately trained. (It is important to note, by the way, that it is accepted practice to provide sufficient narcotic analgesia to allow a terminally-ill person with great pain to have relief of their agony, even if this results in shortening the patient's life, and this is not exceptional.) Respect for patient autonomy and self-determination is an integral part of all medical care, including care towards the end of life. However, the need to ensure patient self-determination in medical decision-making must be distinguished from the impulse to assure physician complicity in personal decision-making. If we embrace the right to have one's doctor kill them at one's request, our society will be drastically altered. The State's first responsibility, that of protecting innocent life, and the State's monopoly on the legal use of lethal force, will also be compromised.

Throughout the eons, during periods when access to pain relief and palliation was often quite limited, doctors have grappled with the ethics of assisting in suicide. The traditional prohibition against physicians killing (or aiding in the death) of their patients has been based on the commitment of the doctor to alleviate suffering and also protect the patient from harm. (Many also hold the spiritual conviction that man's life is a trust from God, which is a separate issue) The selective use of death as a tool of the physician will likely have numerous unplanned consequences in our
pressurized, often paranoid society. The integral relationship between patient and physician will be altered to include other allegiances rather than that of healing and alleviating suffering. Patients with financial hardship (with or without adequate insurance) may have legitimized their impulse to commit suicide so as to spare the family monetary burden. Invariably, patients with readily treatable depression will be knocked-off. The 137-K7 counselling referral contingency is fairly ridiculous: patients who seek death will select M.D.s who are supportive of their decision, and it is clear that it is often uncertain as to whether depression is present in a patient who "rationally" decides to commit suicide. The most commonly cited medical disorder associated with suicide, whether or not there is a "terminal illness" is depression. A major feature of depression is hopelessness, which is transient and likely to respond to treatment. Whether one recognizes depression or not may have as much to do with the philosophy of the practitioner (i.e. Dr. Kvorkian?) as much as the condition of the patient.

In addition, health care providers may become reluctant to invest their efforts to achieve appropriate palliation when a "quick and easy" death can be offered to their patients. It is taxing for health personnel to care for dying persons, and subtle pressures can be conveyed. The ongoing drive to reduce health care costs would certainly not discourage insurers from offering "option D" to their customers with "incurable and irreversible conditions." Lastly, there is the logical implication of expanding physician-assisted suicide into voluntary euthanasia, which, after all, is nearly identical in its ethical construction. (It's interesting that proposition 161 in California was most vigorously voted down by poor, less powerful people, such as minority women. This suggests that this group feels itself at most risk from insufficient protections from physicians' final interventions.)

Do I personally believe that assisted suicide is ever ethically justified? In fact, I personally do believe that there are extraordinary instances when such circumstances can be justified, but they are exceptional. The formerly fiercely independent factory worker, lucid but quadriplegic from a degenerative neurological illness, who no longer wants to linger in a helpless, dependent state, may require assistance in his efforts to end his life. However, it should be recognized that this can be accomplished in many ways, including simply the refusal to receive food. (A recent medical article describes a physicians' mother doing just this, etc.) And, to date, there has never been a successful prosecution of a doctor or lay-person who has assisted in such an exceptional situation when one acted compassionately and competently. I don't believe that these exceptional cases should generate radical legislation which would serve to design wholesale legitimization of physician-assisted suicide.

In the remarkably homogeneous society of the Netherlands, there has been growing concern of the inappropriate use and extension of this final, active intervention. In 1973, the Royal Dutch Medical Society recommended the following: 1. euthanasia should be restricted to cases of terminal illness, 2. euthanasia be reserved only to the attending physician 3. euthanasia remains legally a crime and 4. assisted suicide be seen as a separate issue. By 1992, all of these recommendations have been abandoned for broader practise recommendations. Although the Dutch laws simply codify that physicians will not be prosecuted for voluntary euthanasia, already guidelines have been proposed for terminating the lives of severely defective
newborns, comatose patients, the demented elderly and the severely mentally handicapped, all groups which are incompetent to make decisions. (The ethical distinctions between voluntary euthanasia and physician-assisted suicide are minimal.) Concerns about the "slippery slope" are valid and borne-out in the Dutch experience. In this society, at a time when basic medical care is often unaffordable and fragmented, and when health-care policy is more volatile than ever, it seems unwise to travel a course which would further complicate the more pressing disparities at hand.

Respectfully,

Kenneth Dolkart M.D.

Co-Chairman
Southern New Hampshire Regional Medical Center
Robert A. Lockwood  
Chairman, Judiciary & Family Law Committee  
New Hampshire House of Representatives  

Dear Mr. Lockwood,

I am writing to speak against House Bill 339, Physician-Assisted Suicide. I speak as a resident of New Hampshire and a member of the faculty of Dartmouth Medical School.

I oppose legal physician-assisted suicide. As a geriatrician, I have cared for innumerable patients at the end of their life. I believe that, with rare exception, death can occur peacefully and without significant suffering.

The topic of physician assisted suicide has been hotly debated. In Holland, the reasons for requesting physician-assisted suicide center around patient fears of decline in condition or decline in function, suffocation, pain, suffering and the desire to not be further dependent on or burden other. While the issues of financial and physical burden and dependency ordinarily cannot be resolved by health care providers, good palliative care could substantially reduce the other fears commonly identified, and may obviate the demand for suicide.

Hospice and palliative care have developed in the United States over the past twenty years in response to the need for symptom management and comfort care in terminally ill patients. In the past two decades medical, nursing, and social disciplines have made substantial progress in the knowledge base of palliative care, particularly in the management of pain, and the recognition of other symptoms.

The public perception seems to be that dying is a protracted, painful process. however we are capable of controlling the majority of pain with medications or other interventions, making it rare for patients to need to suffer.

At Dartmouth Medical School, the White River Junction VA Medical Center, the Mount Ascutney Hospital, and Dartmouth Hitchcock Medical Center, we have embarked on an effort to improve the care of dying cancer patients, while simultaneously teaching medical students how to provide optimal care to dying patients. We aim to develop a patient and family-focused process of delivering care, which minimizes suffering and optimizes the quality of the end of life.
I believe our efforts should be focused on improving the dying experience, rather than legalizing euthanasia. Thank you for your attention.

Sincerely,

Sarah J. Goodlin, M.D.
Associate Chief of Staff for Geriatrics and Extended Care, White River Junction VAMC
Assistant Professor of Medicine, Dartmouth Medical School
Christian Action Council  
of Western New Hampshire  
Glen Road Plaza Box 11 • W. Lebanon, NH 03784

February 13, 1995

House Judiciary Committee  
Room 208, LOB  
Concord, NH 03301

Re: HB 339

To the members of the Committee:

Guess what? Not everyone who ingests a medicine dies from it! EMTs are called to scenes all the time with people who are unconscious, but not dead, from an overdose. What provision does this bill make from EMTs called to help a person who has vomited (a common occurrence) some or all of the prescription or who is alive but unresponsive? How is the Emergency Department or hospital to handle this patient? What if the patient survives but has, for example, nervous system or brain damage because of it? Who is responsible?

Scenarios like this can certainly occur - HB 339 does not require anyone to be notified of the patient's intentions.

Here is more foolishness disguised as legislation: 137-K:13,IV says that "actions taken in accordance with this chapter shall not, for any purpose, constitute suicide ... under the law." Incredible! Suicide is defined as "the act or instance of intentionally killing oneself." If ingesting a medicine with the full expectation and desire that death will result (137-K:4,V) isn't suicide, what is it?

Finally, an insurance company I talked with said it was standard procedure not to cover suicide during the first two years of a policy. Does 137-K:13,III, saying that ingesting medication to end one's life shall not "have an effect upon a life, health, or accident insurance or annuity policy," attempt to override insurance procedure and dictate insurance company policy?

HB 339 is a flawed bill. Please vote it inexpedient to legislate.

Sincerely,

Margaret M. Drye  
for the Christian Action Council
February 13, 1995

Hon Robert Lockwood, Chairman
House Judiciary Committee, Room 208
Legislative Office Building
Concord, NH 03301

re: hearing on HB 339 - Physician Assisted Suicide on Feb. 16, 1995

Dear Rep Lockwood:

I first addressed this committee three years ago on this subject. In all that time, we have not seen any real effort to delineate this problem any better, or to implement efforts to improve the care of dying persons.

Your committee will find that there are good reasons to think that the government ought to stay neutral and allow physicians to cause deaths. Certainly, there are persons who feel that doing otherwise impinges upon their ability to run their lives as they see fit. Furthermore, there certainly are people who endure substantial suffering before they die and who might want to cut it short rather than live it out.

But your committee will also find that there are powerful reasons to think that serious harms will result from liberalizing physician involvement in killing patients. Persons facing isolation, bankruptcy, or institutionalization are likely to seek to be killed rather than endure these hardships. Persons with pain that could be relieved might well encounter such inadequate treatment that they seek to be dead rather than in pain. Killing people rather than relieving pain and suffering or in order to avoid destitution or disgrace should be very troubling.

Obviously, the relative rates of these occurances and their likely outcomes if the laws were changes are very important elements. No legislator should have to decide these issues without some reliable descriptions of the problems. But none are available.

Once again, your committee will be asked to legislate on the basis of a few anecdotes. We could do better.

Some established observations:

1. No one need die in terrible pain. This is irrefutably true. For the roughly 1% of dying persons whose pain cannot be relieved with conventional narcotic administration, we could induce anesthesia. We can put anyone into a coma. Again NO ONE NEED DIE IN PAIN. Anyone who tells you otherwise is misled. There may well be a trade-off of alertness and comfort, but there is no pain that cannot be stopped if the physician and nurses are astute and aggressive in pain management.
2. Many people do in fact die with serious pain. We have a care system in which pain specialists are rare, and more rarely paid. Home support for pain relief is not generally well-paid and few practitioners are skilled. The solution would seem to lie more in demanding that the pain relief that we know how to do would be applied, rather than in killing the sufferer. We could demand this of our care system through incentives and disincentives.

3. We do not know the rate at which persons are now inadequately supported, the rate of requests for physician assistance in suicide, the likely rates with changes in the law, or who would be most affected. These are things we could know, we just have to ask. In a chart review in two New England hospitals, we have found that the rates of coma in terminally ill persons near death are nearly half, that nearly three quarters of patients are receiving morphine, and that nearly all patients are allowed to die without a try at resuscitation. These are reassuring figures for those who would contend that we face a terrible and technological dying. You could mandate that we come to know the rates in New Hampshire.

5. The image that we have in mind as we discuss physician assisted suicide is that of a relatively articulate and capable adult, secure in the bosom of a loving family, and confronting a tragic course of physical suffering. Such a person is "just" asking for some pills. We must confront the fact that most of us die while old, progressively disabled, and increasingly dependent. The image for public debate changes when one considers physician assisted suicide for a 90 year old woman who would ask for death because she cannot get what she really needs -- human companionship and supportive care, continuity and confidence. Such a person is "just" asking for the humane behavior of a community of caring, being denied, and seeking to be dead rather than face the consequences of our community failure. We should be very slow to respond with the means of killing without seeing the obvious call to redress the service inadequacy.

6. The proposed legislation does not provide adequate safeguards to prevent killing persons with treatable depression or unduly coercive social situations.

7. Patients can tell their physician most anything, secure that the physician will not hurt them. They can say that they would rather be dead as a mode of testing whether caregivers and family will respond. They can say such things to hurt their physician with their anger. But they can now be secure that the physician will not act upon these words. We do not really know the effect upon patients of changing the rules, or the degree to which patients will come to understand the change.

8. A physician to a dying person who wants to be killed rather than cause financial burdens to family or live in terrible conditions is caught in a hopelessly tragic situation. That physician can certainly become an activist in the cause of community responsibility to support people facing catastrophic health problems, but that will not help in the short run. Are we to kill those whom society has chosen to abandon, conveniently eliminating the sufferer so that we need not redress the sources of the suffering?

I will close with recommendations. The courageous and worthy course is not to de-criminalize physician-assisted suicide at this time. Instead, you should require measures of pain and suffering among the dying across the state, and assessment of the sources of that suffering, perhaps through a study administered by the Department of Health and Human Services. You should insist that care systems show that they are doing a good job in caring for the dying patient, perhaps as a condition of participation in Medicaid. You should insist that physicians, pharmacists, and home care nurses evidence high standards of pain relief, perhaps through payment, licensure, or supervision.
requirements. You should monitor this problem on a regular basis to ensure that gains made are secured.

But you should not authorize physician assisted suicide. We don't know how to control it, who to apply it to, and what harms will ensue to persons who could have lived well. And we know that we can arrange systems of care so that we die well without it, if we only resolve to do so.

Sincerely,

Joanne Lynn, M.D., M.A.
Women Affirming Life
New Hampshire Chapter

Regarding HB 339

My name is Aggie Dowd, and I am director of the New Hampshire chapter of Women Affirming Life, Inc. (WALI). We are a group of women, spanning several generations, involved in many professions, single and married, working in the home and outside the home, active in the community, and retired. At the time of our inaugural in the Granite State, we had 10 members; today, not even four months later, we have over 100 members, and new members continue to join each week as word of our group spreads.

I am here today because WALI is concerned about the increasing tendency of our society to solve problems with violence. HB 339 is the most recent example. It says, when life becomes burdensome, do away with the life. We have heard that refrain all too often in this country. We were told 23 years ago that we must legalize abortion because of the problem of unwanted children being born into the world. So the solution proposed to solve that problem – eliminate the unwanted, unborn children.

HB 339 is proposed as the solution for the problem of lingering or painful "terminal conditions." Never mind that as mortals, we are all in a terminal condition. What does HB 339 propose as the solution? – elimination of the person experiencing the "terminal condition."

Can we as a society do no better than this? Where is respect for the dignity of a human person in a message that says, because you are a burden to yourself and your family, your life is no longer worthwhile. Ask any mother about suffering and temporary mood swings. When a person is depressed and suffering, what is called for is compassion and caring., not the cruelty of

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killing. As for pain, it is part of the human condition. Ask any mother. About the pain of birth, and scraped knees, burned fingers, broken hearts, the discomfit of discipline, the rigors of athletic training. Pain is a growth aid. Nonetheless, medical technology today has the ability to relieve pain in almost all cases, so using pain as the justification for assisted suicide is not logical.

WALI believes that violence is never the answer to individual or social problems, and the lessons of history have shown the dangers of such an approach. If this bill becomes law, our dehumanization of our society accelerates significantly. In 1972, we were told that we must legally allow abortion because of the problems of rape and incest. Today, we have 1.5 million abortions annually, with only 1-3% of them, the hard cases of rape and incest. The slippery slope gets steeper.

Just about a month ago, in the state of Oregon (which in November passed a referendum allowing doctor-assisted suicide), there was a rare instance of honesty concerning this slippery slope. Dr. Pieter Admiral, who has pioneered the practice of euthanasia in the Netherlands, wrote in a column that 25% of assisted suicide cases fail to cause death, or else cause a long and what he termed, "troubling," process of dying. Because of this, Admiral wrote, Oregon must be prepared for "Phase Two," -- not only doctor-assisted, but doctor-administered suicide. Derek Humphry, founder of the Hemlock Society, a day earlier cited that 25 percent statistic, and agreed with Admiral.

Indeed, giving doctors the power of life and death over their patients is already a reality in the Netherlands where voluntary euthanasia has been allowed since 1973. This fact came to light in 1991, when an official Dutch government survey revealed that 61 percent of the cases
of doctor-administered euthanasia were given without the patient's request. Are we really ready to give such power to doctors?

In yesterday's Portsmouth Herald, one of the sponsors of HB 339, Rep. Cynthia McGovern (D-Portsmouth), was quoted as saying the bill is needed because, "We suspect doctors are already doing it--supplying patients with medications in quantities or prescriptions sufficient to kill them." It is gravely flawed logic to say we must legalize something bad because some people are practicing it.

Before we pass HB339, we had better be sure we know the answers to the following questions: Why is society responding to the most vexing problems with killing? Why are we teaching our children that when the going gets tough, violence is the answer. Why are we making the elderly and disabled feel that because they are a burden, their lives are no longer worth living and so they have a responsibility to exterminate themselves?

The world religions of Judaism, Christianity and Islam oppose suicide because they view human life as God's gift. Albert Camus concluded that, "Even if one does not believe in God, suicide is not legitimate." And Victor Frankl, the famous concentration camp doctor, stated his belief that "the so-called life not worth living does not exist."

The health of a human person is much broader than simply the state of his body. There is a good beyond pure physical flourishing, such as spiritual and emotional health. We must return to a society that is more humane. We must affirm life, not take it. We must solve our problems with compassion, not violence. Please reject HB 339.

The End
February 14, 1995

The Honorable Sandra Balomenos Keans  
Judiciary & Family Law Committee  
Legislative Office Building  
Concord, NH 03301

Dear Representative Keans:

Enclosed please find a written copy of the testimony I will offer in summary form in regard to HB 339. I hope this will enable you to better deliberate the serious issues surrounding this proposed legislation.

Sincerely yours,

(Msgr.) Francis J. Christian  
Secretary  
Chancellor

Enclosure
MY NOTES IN OPPOSITION TO H.B. 339, THE ASSISTED SUICIDE BILL

Good Morning (or afternoon). My name is Mrs. Patricia F. Prescott. I'm a concerned citizen, mother, grandmother and a retired registered nurse. I would like to speak in opposition to HB 339, the assisted suicide bill, because I believe it is illegal, immoral, and unnecessary.

I believe assisted suicide is illegal because only in grave cases does law give us the right to kill. These exceptions would include self defense, wartime, and the execution of murderers and traitors. Another exception has been granted in allowing abortion, where many people like myself believe a terrible error has been made. Perhaps this was the beginning of the slippery slope. Our own Declaration of Independence states that we are endowed by our Creator with the right to life, liberty, and the pursuit of happiness. This great Declaration also recognizes that there is a law in nature from nature's God.

That leads me to the second reason I am against this assisted suicide bill....it is immoral. I think most of you Committee members and the people you represent are people of faith and have your own religious beliefs. Our Creator has commanded us: "Thou shalt not kill". All major religions ...Catholic, most Protestant, Jewish, Greek and Russian Orthodox, and Islam...oppose assisted suicide and euthanasia. The Eastern Religions don't give scriptural guidelines here, but assisted suicide and euthanasia would interfere with the working -out of karmic patterns.

I believe HB339 is unnecessary because modern medical practice is competent to treat the terminally ill. Even those with cancer and A.I.D.S. can live in more or less relative comfort and dignity till death. This treatment includes proper use of pain medication, competent care...as by hospice workers, visits by religious ministers, and the love we ourselves can bring as friends, neighbors, and family.

I can speak from personal experience here as I have lost seven members of my family in the past five years -- one brother, three sisters, and three brothers-in-law. Mercifully, one brother-in-law died in his sleep. But all the others had good care, pain medication, encouragement and love to ease them in their last illness and dying.

sources of material:
The Declaration of Independence
"Euthanasia Is Not The Answer", by Dr. David Cuniff, M.D. Humana Press Totana, N.J. 1992
HB 339

AN ACT relative to death with dignity for certain persons suffering from a terminal condition.

Statement for the House Judiciary Committee - February 16, 1995
by Richard B. Friedman, M.D., President

Members of the New Hampshire Medical Society have spent considerable time and effort in consideration of physician assisted suicide. Serious in-depth discussions on the issue presented by HB 339 have occurred within the Council on Health Services, the Medical Society Executive Committee, the full House of Delegates and at numerous formal and informal gatherings, conventions and educational conferences over the past four years. Last year we conducted a survey of our active members which reaffirmed our position against physician assisted suicide. The issue in HB 339 is not new to New Hampshire physicians.

The New Hampshire Medical Society once again speaks out in opposition to HB 339 and to physician assisted suicide consistent with its prior position. The Medical Society opposes this proposed legislation on several levels. Not only are there moral and ethical arguments against physician assisted suicide that will be detailed in later testimony, but there are obvious flaws in the structure of the proposed legislation. The Medical Society stands firm in its commitment to the public and the profession of medicine. It is a fundamental principle of medical ethics that a physician's role is to promote health and relieve suffering. HB 339 debases this basic tenet of the medical profession and challenges one of society's basic beliefs, that it is wrong to kill innocent human beings. If we accept this belief how can we now morally accept physician assisted suicide. HB 339 eliminates respect for human life by sanctioning death. While HB 339 addresses an area of genuine concern and legitimate fears, however, the answer is not to make doctors a participant in a patient's suicide. Doctors do not have a right or an obligation to willfully permit a patient to take their own life. Physicians cannot be perceived as the givers of death. HB 339 makes the physician the active public provider of death. The problem goes beyond the rights and wrongs of suicide. The heart of the problem is placing the physician in the position of actively aiding a patient in ending their life. Legislation mandating or condoning physicians' participation in suicide is inappropriate and fraught with inherent dangers.

The first of these dangers is an intrusion into the doctor/patient relationship. Patient trust and hope in the physician will be undermined. Patients look to their physician for guidance in determining treatment decisions. If a doctor is sympathetic to Physician Assisted Suicide the impression conveyed to the patient may be that suicide is a desirable option. How will a depressed or undecided patient deal with this impression? HB 339 can provide no protection against the pressure such a patient will be under.
The New Hampshire Medical Society feels strongly that the public is being given the wrong perception of this issue by the proponents of HB 339. The choice is not to die or to suffer. The choices are much broader for all patients and include viable alternatives to Physician Assisted Suicide. Pain management has been recognized as an area that should be at the forefront of continuing medical education. The AMA, like the New Hampshire Medical Society, focuses on making educational material and programs on advanced pain management techniques available to physicians within New Hampshire. Citizens within New Hampshire now have available to them physicians who specialize in the treatment of pain and the use of advanced pain management techniques.

Contrary to the current understanding and definition of euthanasia, the original concept of euthanasia had a different meaning. It developed prior to the discovery of lethal chemicals that could be used to kill a patient. It initially referred to the attempt of the physician to prepare their patient for a peaceful death by relieving the psychological distress that accompanied the dying process. Experts in the psychiatric aspects of terminal illness are able to alleviate the emotional suffering that causes patients to consider Physician Assisted Suicide. New Hampshire physicians feel strongly that patients should not be driven by despair nor fear of intolerable suffering to ask their physician to help them kill themselves. Instead, physicians must first regard such a request as a sign that efforts should be redoubled and medical treatment regimes modified to provide the necessary palliative care. Physicians should strive to make their patients' last days as comfortable as possible, not help to kill them.

The second of the dangers inherent in HB 339 is the possibility of abuse. HB 339 places killing the terminally ill within the realm of socially acceptable behavior. HB 339 will spawn hurried pressured decisions leading to untimely deaths. Abuse of Physician Assisted Suicide would be nearly impossible to monitor. Studies conducted in the Netherlands, a country with universal health care, where euthanasia and physician assisted suicide are essentially legally tolerated, consistently show abuse; • there are doctors who routinely fail to observe required standards and obtain a patient's formal approval prior to the use of lethal injection; • there is evidence of newborns and infants being involuntarily subject to euthanasia; • almost 25% of all deaths in the Netherlands associated with active intervention did not have the patient's documented or explicit request; • often no second opinion is sought; • there are doctors who fail to record the event; and • no one checks the facts even if the event is recorded.

Thus, in reality, the practice is unregulated. The invisible intimidation placed on patients to consider this option in our country, where financial concerns and pressures are very real, would be extreme.

There is no assurance, nor can any be plausibly offered, that the mandates of HB 339 would not likewise be abused. Safeguards offered by HB 339 are superficial and only cosmetic legal cover for people helping to kill other people. The reporting requirements of HB 339 are minimal, no follow up investigation is required and there is no safeguard for a physician who is ignorant or
insensitive to a patient's mood swings that might be the underlying cause of a decision to opt for physician assisted suicide. Depressed patients in severe pain are vulnerable to medical and or family persuasion. The potential for abuse inherent in HB 339 is endless.

The third of the dangers in HB 339 is discrimination. HB 339 is poorly drafted so as to create pressures for certain groups within our state. HB 339 discriminates against:

1. **The elderly**, who would inevitably feel pressure to opt for Physician Assisted Suicide so they wouldn't be a financial or emotional burden to their families. Arguments for accelerated death would become those of expediency and convenience.
2. **The poor**, who cannot obtain the health care they need currently, will see the increasing cost of caring for the terminally ill will become the unspoken rationale for their death. Our society will turn toward physician assisted suicide rather than creating systems that allow for better medical access and coverage of the poor to treat the terminally ill.
3. **The family members**, who are given no voice in the decision to end a patient's life, but will exert unspoken pressure on patients because of the family stresses that inevitably develop during serious illness.
4. **Minors**, for whom HB 339 makes no provision.
5. **Non terminally ill patients**, who meet all the other suggested criteria. Is their pain not worthy of relief via Physician Assisted Suicide simply because of the nature of their illness?
6. **Incompetent patients**, whose suffering is impliedly less unbearable than a competent patient.

These dangerous discriminations are inescapable and fatally flaw HB 339 as a viable method of dealing with death.

Also inherent in HB 339 is the ambiguity of the terms "capable" and "terminal illness." The definitions of these terms are too loose to be used in legislation of the magnitude proposed by this bill. Use of the term "capable" unacceptably glosses over the issue of competency. The legislative and legal systems are not equipped to deal with the ambiguity of both the issue in HB 339 and the language. Keep physician assisted suicide from becoming a legislative mandate. Society should not be in the position of deciding whose suffering is unbearable and whose is not, which is an inescapable result of HB 339.

HB 339 places us on the slippery slope to euthanasia, a prophecy not denied by proponents of the bill. HB 339 is the proverbial "foot in the door" and if people are deemed to have a basic right to Physician Assisted Suicide, it will be impossible for the courts to constitutionally deny this right to everyone including the poor, the elderly, the disabled and the vulnerable where the potential for abuse is greatest. HB 339 complicates existing law. Patients can already achieve death with dignity via advance directives such as living wills and powers of attorney. Many physicians now provide advanced pain relief as the result of a private doctor/patient decision and not because of the legal grounds or because a corporation is seeking to save money and maximize profits, but because physicians share in their patients' pain. The recent survey conducted by the New Hampshire Medical Society strongly supports the assertion that physicians in New Hampshire are
Acutely aware of their patients' pain and recognize that their fear and sense of loss of control need to be addressed.

In conclusion, the New Hampshire Medical Society reiterates its opposition to HB 339. Physician assisted suicide does not help society meet its obligations, it merely makes it easier to dispose of them. Although the intent of HB 339 is humane, the chances for abuse are unacceptably high which may lead to inhumane results. End of life decisions are best left within the realm of the doctor/patient relationship. The bill is so lacking in safeguards that even though it appears to give a humanitarian choice, it in fact achieves just the opposite. Death is irreversible and mistakes cannot be corrected. HB 339 does not grant equal access to physician assisted suicide and offer physicians protection. It does, however, establish a public policy in favor of physician assisted suicide with all the inherent dangers. Given the present unstable environment of health care, it would be unwise for New Hampshire to take the unprecedented step of legalizing physician assisted suicide by passing HB 339.

I would like to end with a quote from Aristotle that should guide our decision, "An act becomes a habit, which becomes a character, which becomes a destiny."

Thank you.

REFERENCES:
The debate over

Across the nation, euthanasia is the medical topic of the moment.

Should physicians ever help patients end their lives?

By Sherwin Nuland, M.D.

57 percent of Americans now approve of some form of doctor-assisted suicide. Nuland, 64, a Yale surgery professor and the author of the 1994 National Book Award winner How We Die, proposes one solution to the moral dilemma.

Not long ago, a leading U.S. medical school held a conference on the subject of death. The most hotly debated topic was the role of physicians when life nears an end. Late on the morning of the first day, as arguments moved back and forth, an audience member made a stunning declaration.

In the unemotional manner he might use to describe a clinical report, a respected oncologist who had treated thousands of late-stage cancer patients announced that he had kept count of the patients who had asked him to help them die. “There were 127 men and women, and I saw to it that 25 of them got their wish.”

Later, as the audience members filed out for lunch, some were overheard praising the oncologist for what they called his courage in helping his patients, as well as his courage in declaring it publicly. Others were scathingly critical, saying the doctor had disgraced the medical profession by murdering 25 patients — then having the gall to speak about it.

My response was simple and direct: this oncologist was known to me as a nurturing physician of high ethics. If this skilled, thoughtful colleague had followed such a course of action, it is within my own moral code to accept it. And yet there remains a troubling uncertainty in any easy acceptance of my colleague’s actions — and even of my own, on the far fewer occasions when I have done exactly as he has. The oncologist and I, as well as the thousands upon thousands of other doctors who quietly have helped patients die, have done it within the sanctity of the privileged doctor-patient partnership. We have done it for people we know well, whose desperation for the relief only death can bring seemed entirely appropriate.

What troubles me is the very privateness of that decision. Usually, there are plenty of undiscussed issues when only a doctor and patient know such an irrevocable step is to be taken. Some doctors feel personal morality and a long empathetic relationship are sufficient bulwark against error. I no longer believe that, although I remain committed to the concept of euthanasia. Other doctors — thankfully very few — feel it is proper to provide the means for any suffering patient to die, even if the patient was previously unknown to the provider. Those doctors (I refer here to such as Jack Kevorkian) seem to lack the clinical, and perhaps even the moral, judgment to fully comprehend the implications of what they are doing.

Some of these issues have been
addressed by legislation. In the Netherlands, the Dutch Medical Association and the government have set guidelines under which euthanasia is permissible. Recently, Oregon voters passed the so-called Death With Dignity Act, permitting physicians to prescribe lethal drugs for terminally ill patients. As in the Netherlands, consultation with another doctor is required.

In neither case, in my view, are there proper safeguards against abuse, including inadvertent abuse by well-intentioned physicians, patients and families. Not surprisingly, a U.S. District Court judge has issued a temporary restraining order against the Oregon measure until its constitutionality can be determined. There is far more to a legislative decision to end life than Oregonians seem to have considered.

Three terms are commonly used in this debate: “Active euthanasia” is taking a specific action to end a patient’s life, such as injecting a lethal drug. “Passive euthanasia” is withholding life support, such as feeding tubes for the comatose. In “assisted suicide,” a patient is provided the means to take his or her own life. Writing a lethal prescription, as the Oregon measure would allow, is an example.

It is over active euthanasia and assisted suicide that the battle rages. Some opponents feel either practice undermines respect for, and ultimately the value of, life. Some fear doctors will use active euthanasia or assisted suicide as an “easy way out” instead of vigorously seeking other ways to relieve suffering. Others fear widespread use would lead to laxness in other areas of medical ethics and lessen faith in the medical profession.

Most difficult to argue against are
I WANT THE OPTION

On Nov. 8, Nancy Dorr, who has breast cancer, voted for Oregon's Measure 16, the so-called Death With Dignity Act. The next day, she learned her tumor had grown 20-30 percent. When the measure passed, the Portland resident was relieved to know she wouldn't have to suffer long if her illness became terminal. "You can't believe how freeing that is," says Dorr (right, with her cat, Sylvester). "It gave people with terminal illnesses control over their lives. When the quality of life isn't there, [you] should have the option not to suffer."

(On Dec. 27, a U.S. District Court judge issued a temporary restraining order against Measure 16 so its constitutionality could be reviewed.)

objections based on personal morality. As much as we would like to think otherwise, euthanasia is killing. There is no way to avoid that grim reality.

But killing and murder are different. Sometimes helping someone die is an act of mercy. Let me describe the situation of a patient I know well.

A patient I'll call "Henry Clarke" was a man in his 70s who had reached the terminal stages of leukemia after a battle of several years. His spleen had grown huge and overactive, compromising his immune system. It had become impossible to follow the last-ditch course of near-experimental chemotherapy. Understanding the great risk, Clarke agreed to surgery to remove the spleen, in the hope he might then undergo drug treatment.

Despite antibiotics and meticulous surgery, however, Clarke developed an abdominal abscess. It was necessary to operate again to drain it. A week later, the problem recurred. Again Clarke had surgery; again the abscess returned. As the physicians and consultants were coming to the conclusion that controlling the infections would be impossible, Clarke began to go in and out of unconsciousness. It was clear that he might go on for weeks racked by pain.

Clarke's wife and family could not bear watching the torment and loss of dignity of a man who often had told them he wanted to die peacefully when all hope was gone. There seemed to be no solution until Clarke's physician brother-in-law took the surgeon aside and suggested active euthanasia. The surgeon felt his duty was clear: He injected a lethal dose of morphine into Clarke's intravenous tubing.

If asked, the surgeon would say his decision was based on his idea of a physician's primary obligation. There are physicians who believe their most basic obligation is to fight disease and prolong life; there are physicians who believe their most basic obligation is to relieve suffering. Clarke's surgeon was one of the latter. He would point out that there are situations — fortunately rare — in which the two obligations are inconsistent with each other, when disease no longer can be fought and both patient and doctor are left with only suffering. In the surgeon's view, if determined efforts to relieve the patient's pain fail, the physician should, if asked, end the suffering as humanely as possible. I am in complete agreement with this view.

But even in a situation as apparently clear as Clarke's, there are problems. Here again I am not troubled by my support of the surgeon's decision. I worry about the "slippery slope": Once we permit active euthanasia,
An attempt to set clear, universally acceptable criteria for euthanasia certainly will have many opponents. Nevertheless, the growing complexity of medicine and the intense involvement in the debate by so much of our citizenry demands some solution. I propose a series of steps that I believe are responsive to the many criticisms of euthanasia:

- A request by a patient or family member to end life must be defensible. Patients who ask for death must be challenged to be certain that they have examined all the alternatives, and that they are not in a state of depression treatable by psychotherapy or antidepressant drugs. Commonly, an outlook of unreasoning despair is transformed into a realistic appraisal of what can be faced.

- If after a reasonable challenge the doctor is convinced that a request for death is appropriate, another specialist in treating the patient’s disease should be consulted. Any other physician who has special skills in relieving the patient’s distress, especially experts in the field of palliative care (comfort care), also should be consulted. For many patients, spiritual counseling is a necessity.

- If after these consultations it is generally agreed that the patient’s suffering cannot be relieved, one final step should be taken. I suggest a final step because the decision to end one’s life does not occur in a vacuum. Even if my life has ceased to have meaning for me, it still has meaning for others — particularly for those who love me, but also for society. I take issue with those who say, “It’s my life; I can do what I want with it.” Each

Continued to Page 6
a 'council of sages' to judge a person's request to die.

Noland proposes a 'council of sages, lawyers or lay people. A series of consultations and the coming of a council of sages could be carried out in a matter of days.'
Euthanasia promises Marcus Welby, but gives us Jack Kevorkian

Proponents of physician-assisted suicide envision a heartwarming scenario. The reality would be subtle pressure on the patient to die.

By Eric M. Chevlen, M.D.

I used to believe in informed consent. After discussing the treatment possibilities with the patient and answering all questions, a doctor must let the patient make an unpressured decision. To do less is to deny the autonomy of the patient.

To which I now say: Baloney!

I still go through the same exercise with patients, mind you; the words are no different. But I now know that, regardless of informed consent, it's doctors who make patients' decisions for them—often life-or-death ones. Proponents of legalized euthanasia fail to realize that.

Take the 58-year-old man who arrived in our emergency room one Saturday morning when I was practicing in California. He was cachectic and dyspneic. He'd been traveling home from a cancer clinic across the border in Mexico, he told us, when he'd grown short of breath and pulled into our hospital. In Mexico, he had been receiving what he described as "natural" therapy. I describe it as quackery. He had large bilateral pleural effusions due to advanced lymphoma and multiple large palpable nodes.

I told him that I wanted to remove the fluid from his chest so that he could breathe more easily, and I explained the risk of pneumothorax from the procedure. Between gasps he consented to a thoracentesis: "Okay... remove the... fluid... but... no chemotherapy."

The next day, he was breathing easily. I had established my credentials with him by relieving his dyspnea. Since he'd never received chemotherapy for his lymphoma, I knew he could benefit from it. Otherwise he would die. He told me he opposed chemotherapy because it wasn't "natural." So I suggested that I treat him with "natural chemotherapy."

"I can treat you with a medicine that works fundamentally like an extract from the adrenal gland," I explained. "I can give you another medicine that's derived from the periwinkle plant." I told him that the names of these "natural agents" are prednisone and vincristine. I informed him of the risks of the treatment and the potential benefit.

Because the treatment was "natural," he consented. Later, he let me add another "natural" agent, one originally extracted from fungi growing along the Adriatic Sea. It's called Adriamycin.

I didn't deceive this patient. Everything I told him was true. But it was my interpretation of the facts that persuaded him to take the treatment. A simple recitation
of the facts about chemotherapy would have been a disservice. His own fears and misconceptions would have prevented him from understanding and accepting the treatment.

He did well on chemotherapy, achieving an almost complete remission. He was able to return to work and never resumed the Mexican “therapy.” Years later, his disease progressed and he died. But there’s no question that the chemotherapy added many years to his life.

In situations where it’s clear that patients won’t be helped by chemotherapy, I present the treatment in a different light. I explain that chemotherapy can occasionally help people with their type of cancer, but that their advanced disease or debility makes it unlikely that they would benefit from it. And I explain that even though we have better antiemetics now, some patients still have uncontrolled vomiting. I add that while kidney damage is a rare side effect, it still can happen even when we take precautions. In this way, I steer them away from the therapy.

I take these different approaches, based on patients’ conditions, because I’ve come to realize that most people can’t really give informed consent. It’s impossible for a doctor to adequately inform them of every conceivable outcome. Even if they could understand everything that might occur, they can’t foresee their own reactions, physical or mental.

Moreover, patients aren’t truly free to decide: They are beset by fears and false hopes. Their illnesses leave them too emotionally overwrought to properly weigh their choices and make decisions in their own best interests. As they often say, “I’m not myself these days.”

Yet in the end they must decide. They must say Yes or No.

I’m not arguing against obtaining informed consent, but stressing that consent is neither as informed nor as freely given as we would like to believe. So patients make a leap of faith. Explicitly or implicitly, they say, “Whatever you say, Doc.”

Informed consent is then a sham, behind which doctors may hide the awful fact that it is really they who make the life-and-death decisions for their patients. I take no pleasure in this. I accept it as simply part of the job. So does every doctor who reflects on the matter.

All this rumination on informed consent would be only so much woolgathering were it not for a political development of life-threatening proportions. In November, Oregon became the first state to pass a law allowing physicians to aid suicide. Similar proposals are pending in other states. The politically correct term for this killing of the dying is “physician-assisted suicide.”

All the proposals explicitly limit euthanasia, at least initially, to patients with terminal illnesses who give informed consent for the procedure.

Proponents of these measures describe the final exit of those dying by euthanasia in pastel hues. The patient will be surrounded by those he loves. The doctor will gently place his hand on the patient’s arm, asking one final time if this is really what he wants.

“Yes, Doctor,” says the patient. “And I want to thank you for letting me die in dignity.” A final kiss, a prayer, perhaps, or a poem. Then the doctor will inject the barbiturate, and the patient will slip away from this life as smoothly as a hair being drawn from a glass of milk.

The reality would be quite different from that rosy scenario. The euthanasists promise us Marcus Welby. What they’ll deliver is Jack Kevorkian.
Were euthanasia legalized, every dying patient would live in a society that had cast him in the role of expendable flesh. The dying would be assailed by the sentiment, "You may live if you want to, but we see no reason why you must."

Recognizing the burden they were placing on their families, or merely wanting to cut short their families' anguish over their dying, dying patients would feel societal pressure to accept euthanasia. The right to die would soon become a duty to do so.

Beset by the pressures of the mass media and perhaps doubting the sincerity of his family's protestations, the patient would discuss euthanasia with his doctor. Even if the patient didn't raise the subject, the doctor would, because euthanasia would now be one of the "treatment options" and would have to be presented before the patient could give informed consent to any therapy. If the patient declined euthanasia, the doctor would add, "Remember, you can always ask for it later," since to be fully informed, the patient must also be told that.

If euthanasia is defined as a component of health-care rights, it will be subject to the same expansive interpretation as other rights have been in the last few decades. What if Grandpa has a stroke and can't say that he wants euthanasia? Surely his right cannot be denied due to his disability. What if Jimmy is born retarded and cannot realize that his life is but one long indignity? Surely society must appoint an ombudsman to make sure that his right to euthanasia is not arbitrarily denied. What of teenage Sarah, who wants to die because she's depressed? Her suffering is no less real than that of a patient suffering from a visible disease.

Anyone who doubts the inevitable push for judicial expansion of euthanasia should note this: Just days after Oregon passed its referendum, euthanasia advocates were in court, claiming that the new law violated the Americans With Disabilities Act. They want the law to allow assisted suicide for the disabled, too.

The dying, the disabled, and the depressed are among the most vulnerable in our society. A just society takes extra care to protect such people from potential predators. Far from protecting them, legalized euthanasia gives strength to those who would relegate them to a place beneath that of the legally protected spotted owl.

Legalized euthanasia does not do away with burdensome medical treatment; it does away with burdensome people. Legalized euthanasia is not freedom to choose; it is not even freedom to die. It is freedom to be killed.
Euthanasia bill a loser
Oregon law no model

Checks on assisted suicide haven't worked elsewhere. New Hampshire should again reject the idea.

By MITCHELL M. SIMON
For the Monitor

Again this year, the Legislature will consider physician-assisted suicide, with hearings likely early this month. Having studied the developments in this area over the last year, I remain convinced legislators should not adopt the law.

On the national level, proponents of physician-assisted suicide had their first victory on Nov. 8 when Oregon voters, by a 52-46 percent margin, made their state the first in the United States to legalize physician-assisted suicide. The Oregon initiative differed from earlier measures that were defeated in California and Washington states in that it added several safeguards, ostensibly to ensure only competent people will be eligible to receive lethal medicine.

Specifically, the Oregon law authorizes a doctor to prescribe a lethal dose of drugs to a person with six months or less to live. The patient must have his or her diagnosis confirmed by two doctors, must have asked the doctor to prescribe the drugs at least three times, the last time in writing, and must wait 15 days before filling the prescription. In addition, the law mandates that if either doctor believes the patient to be suffering from depression, the patient must be referred for counseling. The physician may be present when the drugs are taken but may not administer the lethal does.

The bill proposed in New Hampshire this session is virtually identical to the Oregon law.

See SUICIDE — Page D-3
While the law seems designed to have a limited application, that is not its supporters' intention. Questioned about why incompetent people with physical disabilities preventing self-administration are not provided the "service," supporters in both states candidly admit that the limits are in their view unwise. The choice not to extend access to physician-assisted suicide to incompetent people is practical and political. It is not based on the belief that the foundation for physician-assisted suicide is solely personal autonomy. I do not mean to cast aspersions on the supporters. There is a powerful argument that physician-assisted suicide is justified not only on the basis of personal choice but also to relieve unnecessary suffering. If this is true, supporters argue, it should be "offered" to all in need, not just to those able to self-administer drugs and who made their request before becoming incompetent.

We have no information on how the Oregon initiative is working because advocates for people with disabilities and right-to-life groups have succeeded in getting a court to enjoinder implementation. The federal judge in Oregon, while not ruling on the legal claims, stated that, "the balancing of the important factors in this case merits postponement of the implementation of the legislation until the constitutional concerns are fully heard and analyzed."

The Dutch example
In light of this court action, we only can evaluate how the practice is working by looking to the Netherlands, where for years doctors have been performing euthanasia and assisted suicide.

The authority for the doctor's actions comes from court cases and from a statute that bars prosecution of doctors who comply with guidelines covering voluntariness, the degree of suffering and consultation. A physician who provides either lethal medication or an injection to a competent person suffering unbearable pain and who gets approval of the decision from at least one colleague is protected from prosecution. While the doctor may not be prosecuted, the act is not technically legal.

The key point is that the system in the Netherlands, as are the Oregon and New Hampshire models, is supposed to be based on several important protections. It is often said in the Netherlands that involuntary euthanasia is an oxymoron. Also, the Dutch are clear that the patient must have unbearable suffering. Despite this, recent evidence shows that these restrictions are not constraining the practice as the proponents had promised. This has important implications for New Hampshire.

One recent court case demonstrates how fragile the procedural wall designed to ensure voluntary choice soon becomes. Last spring the Dutch courts dramatically expanded the definition of unbearable suffering. The court acquitted a doctor who had assisted in the suicide of one of his patients, a physically healthy 55-year-old woman who had lost her two sons and was recently divorced. The court found that she could not overcome her emotional suffering, thereby authorizing assistance with suicide.

More important, a recent government study of euthanasia in the Netherlands shows that in more than 1,000 cases doctors admitted actively causing the death of a patient without patient consent. The reasons ranged from the most prevalent — impossibility of relieving pain — to "low quality of life" and "a therapy was withdrawn and the patient didn't die."

In the one laboratory we have, the limits official to the enactment of physician-assisted suicide did not act as constraints on the practice for any significant period. The crossing of the line between actively hastening and allowing death is a significant act.

Would it happen here?
Some of you may be wondering whether the Dutch experience has anything to teach us in light of our different cultures. In answer to this concern, I would like to paraphrase a recent article by Dr. Herbert Hendin, a psychiatrist at New York Medical College. Dr. Hendin, after studying the Dutch system, pointed out that we are more, not less likely, to abuse the practice since we:

- Do not have comprehensive health care for disadvantaged people, which may make death the only viable option for many poor people.
- Do not have a pervasive culture of the family doctor, the core of medical practice in the Netherlands and a major source of protection in their system.
- Do have an increasingly competitive system of health care that puts economic pressures on the major players in the system, doctors, hospitals and insurers.
- Having discussed and debated this issue with its supporters for several years, I know them to be concerned individuals, many of whom have reached their position after watching a loved one die. However, when invoking public policy we also need to look at the impact on all members of our society. We need to be mindful of the vulnerability of people with disabilities, the frail elderly and children with birth defects.

The developments of the last year do not give us any reason to adopt physician-assisted suicide at this time. We have an emerging system of hospice that is effectively and humanely caring for terminally ill people. More important, the death of universal coverage in Congress last year and the lack of any real possibility of such coverage during the session do not present a climate in which the choice of care for uninsured people can ever effectively be voluntary.

For these reasons, the Legislature should kill the physician-assisted suicide bill this session.

(Mitchell M. Simon is a law professor and co-director of the Institute for Health Law and Ethics at Franklin Pierce Law Center. He lives in Contoocook and is a member of the Monitor's board of contributors.)
Federal Judge Says Ban on Suicide Assistance Is Unconstitutional

Continued From Page A1

said it would begin operating more openly and freely.

The group, Compassion in Dying, is the only organization of its kind in the United States. In two years, it has assisted a number of people who wanted to commit suicide, offering guidance and suggestions on how to end a life. Members of the group say they do not administer lethal drugs, but refer patients to doctors for prescriptions that taken in sufficient doses can be fatal.

"We expect a tremendous increase in the number of patients coming to us for help," said Ralph Mero, the Unitarian minister who is the group's executive director. "Today, every time I pick up the phone, there are three more people on voice mail asking for help."

About 30 states have laws prohibiting doctors or others from helping people kill themselves.

In her ruling Tuesday, Judge Rothstein said the United States Supreme Court had drawn what amounts to a legal road map with its past rulings on the right to an abortion. She quoted from the High Court's 1992 abortion-rights case Planned Parenthood v. Casey, which said states could regulate abortion within a reason but which reaffirmed women's fundamental right to an abortion.

Ulcer Bacteria Linked to Risk Of Brain Cancer

"Like the abortion decision, the decision of a terminally ill person to end his or her life involves the most intimate and personal choices a person can make in a lifetime, and constitutes a 'choice central to personal dignity and autonomy,'" Judge Rothstein wrote.

She held that the 14th Amendment, which says the state cannot deprive people of life, liberty or property without due process of law, protects a terminally ill person seeking help to die.

The Seattle case involved a challenge to the Washington State law by Compassion in Dying, three terminal-ly ill patients and five doctors. The patients had asked the court to allow them to seek help from doctors in ending their lives. One of the patients, a 69-year-old cancer patient, has already died. The others are now free to commit suicide, Mr. Mero said. Their names did not appear in the lawsuit.

The state argued that the law against assisted suicide protected vulnerable people from the influence of others who might not have their best interests in mind and that there was a significant difference between hastening death and opting not to prolong life artificially.

The people who brought the suit conceded that the state had a right to try to prevent suicide but that such a ban should not apply to mentally competent, terminally ill adults who choose to end their lives.

Judge Rothstein agreed. "Obviously, the state has a strong, legitimate interest in deterring suicide by young people and others with a significant natural life span ahead of them," she wrote. "But this case is not about people for whom suicide would abruptly cut life short."

Never Prosecuted

The Washington law has been on the books in some form since 1854, but was seldom enforced. Even Compassion in Dying, while operating in the shadows of the law, had never been threatened with prosecution.

With Tuesday's ruling, Mr. Mero said his group was free to accept more patients and be less cautious in promoting its purpose. "This has the de facto effect of protecting physicians from prosecution," he said.

"This does not give physicians the authority to kill their patients," said Mr. Mero, referring to the decision. "But it will allow them to prescribe medication if they are asked by a terminally ill patient."

Three years ago, Washington voters turned down an initiative that would have allowed doctors to assist terminally ill patients who wanted to commit suicide.

Bill Williams, the Washington Assistant Attorney General who argued the case, said the state had not yet decided whether to appeal.

While the decision was hailed as a watershed for so-called right-to-die groups, many religious leaders were appalled.

"Assisted suicide crosses the line by using lethal means to actively and intentionally end a life," said a statement today by the Roman Catholic Bishops of Washington State. "It undermines the moral integrity of the medical profession whose duty is to heal and comfort, not kill. It tramples on our conviction that life, no matter how feeble or impaired, is a sacred gift from God."

The Right to Hasten Inevitable Death

Let me now briefly summarize the constitutional argument on the specific issue that is presented in the ACLU challenge to Michigan's ban on assisted suicide. The first part of the argument is that the "liberty" protected by the Fourteenth Amendment's due process clause embraces the right of a terminally ill person to hasten inevitable death. Here we argue that the essence of the "liberty" protected by the due process clause is personal autonomy. This means that a person has the right to bodily integrity, to control his or her own body, and to define his or her own existence. As the Supreme Court recently stated in Casey:

It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. . . . It is settled now that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity. . . . At the heart of liberty is the right to define one's own concept of existence, of [the] meaning of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

A person's entitlement to bodily integrity and control over one's own body protects a person's right to refuse unwanted medical treatment, including the right of a competent adult to make the personal decision to discontinue lifesaving medical treatment. It protects the right of a woman to have an abortion and the right of all persons to use contraception to prevent pregnancy. For the same reasons as people have a right to refuse unwanted medical treatment, to have an abortion, and to use contraception, we contend that a terminally ill person's right to control over that person's own body must include the right to make decisions about the voluntary termination of that person's life. Thus, we contend that the decision of a terminally ill person to hasten inevitable death involves an important liberty interest that is protected by the Fourteenth Amendment's due process clause.

The second part of the argument is that an absolute ban on the use of physician-prescribed medications imposes an undue burden on the right of a terminally ill person to hasten inevitable death. This part of the argument is likewise based on the Casey decision, where the Supreme Court held that the state may not impose an undue burden on the exercise of a person's fundamental right to bodily integrity and control over his or her own body. In that case, the Court held that a law imposes an undue burden on the exercise of a woman's right to have an abortion when it places a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. Thus the government may not prohibit a woman from having an abortion prior to viability. Nor may it require notification to a married woman's husband of her intention to have an abortion, since the threat that her husband may commit an act of violence against her would effectively prevent a small number of women from making the decision to have an abortion.
February 14, 1995

The Honorable Warren Goddard
House of Representatives
State of New Hampshire
Legislative Office Building
33 North State Street
Concord, New Hampshire 03301

Dear Mr. Goddard:

We have received and reviewed your request of February 8, 1995, for our legal analysis of New Hampshire House Bill 339, known as the "Death with Dignity Act", in anticipation of a public hearing on the bill on Wednesday, February 15, 1995. The following is a summary of our review and analysis.

The language and design of H.B. 339 is quite similar in most respects to a referendum measure which recently passed in Oregon, known as Proposition 16, and which is currently under injunction pursuant to a constitutionally based court challenge. Lee v. Oregon, Civ. No. 94-6467-HO (D. Oreg. Dec. 27, 1994) (order granting preliminary injunction) (attached). Thus, many of the potential constitutional infirmities of Oregon's measure are also present in H.B. 339. Moreover, H.B. 339 also conflicts with other federal law and contains internal inconsistencies and problems that warrant serious concern.

**Constitutional Considerations**

1. **Equal Protection of Law**
   
a. **Disability-Based Classification**

New Hampshire currently has an unqualified interest in suicide prevention regardless of the condition or status of the person wishing to commit suicide. This strong public policy is reflected in the following provisions in New Hampshire Law:


* New Hampshire law recognizes neither the consent of the victim as a defense to a charge of homicide nor alleged benevolent motive as an excuse to homicide.

New Hampshire law provides for the involuntary civil commitment of individuals who, as a result of mental illness, may harm themselves. N.H. Rev. Stat. Ann. § 135-C:27.

H.B. 339 seeks to create an exception to these provisions that would render persons with "terminal conditions" substantially unprotected by them in potential violation of such persons' right to equal protection of law.

Like other states, New Hampshire's unqualified interest in suicide prevention and treatment rests on the presumption that the desire to commit suicide is an irrational impulse -- the product of mental or emotional disturbance that represents a plea for help and that justifies state or private therapeutic intervention. The exception H.B. 339 seeks to create necessarily derives from: 1) the conclusion that the desire to commit suicide by persons with "terminal" disabilities is a presumptively "rational" response to life with a disability, 2) the conclusion that the State has no proper interest in preventing the suicides of such persons, or 3) both.

The first conclusion is unjustified because, like other suicidal individuals, suicidal persons with terminal conditions are usually suffering from a treatable mental condition, most commonly depression. See Herbert Hendin & Gerald Klerman, Physician-Assisted Suicide: The Dangers of Legalization, 150 Am. J. Psychiatry 143, 143 (1993). In this regard, the desire to commit suicide by a person with a terminal condition is no more "rational" than the suicidal desires of any other person. Moreover, suicidal persons with terminal conditions can benefit from suicide intervention and treatment just as readily as suicidal persons without terminal conditions.

The second conclusion, that the State has no proper interest in preventing the suicides of persons with terminal conditions, creates a classification concerning the State's interest in homicide prevention between those who have terminal conditions and those who do not. The discrimination implicit in this scheme is plainly subject to constitutional attack on two bases. First, persons who experience severe, unrelenting suffering but do not have terminal conditions might justly claim that they are being irrationally and arbitrarily denied the "benefit" of self-killing that the scheme provides to those with terminal conditions. (This accommodation, however, would force the exception to swallow the rule and render the State's interest in protecting life and preventing suicide moot). Second, those with terminal conditions might justly claim that they are being denied equal protection of
the State's homicide laws (which includes its suicide laws) based on their condition, much as African Americans or females might bring an equal protection challenge against a law that permitted suicide assistance for them but forbade suicide assistance for whites or males.

The latter claim is given additional weight by the federal Americans with Disabilities Act. 42 U.S.C. §§ 12101-12213. Because a "terminal condition" is an impairment which substantially limits one or more major life activities of a person, persons with terminal conditions are clearly protected under the Act. Moreover, because the Act recognizes persons with disabilities as a suspect class, the classification created by H.B. 339 constitutes invidious discrimination and would be subject to heightened scrutiny.

We note, moreover, that if the State has no interest in preventing assisted suicides of those with terminal conditions, then it might be argued that the State cannot easily and consistently assert that it retains an interest in preventing homicide of such persons. From this perspective, those who commit homicide-by-consent of those with "terminal conditions" might claim a denial of equal protection if they could not raise the defense of consent of the victim.

b. Age-Based Classification

Under H.B. 339, only an "adult" -- i.e., individual who is 18 years of age or older -- may exercise the rights created under the statute. See §137-K:2(I). While this restriction attempts to account for legal competency to render informed consent, it could be challenged on equal protection grounds as violative of the rights of mature minors.

The Act's Statement of Purpose (§ 137-K:1) establishes that the right created under the act derives from autonomy rights and the right of persons with terminal conditions to decide how they will die with dignity. Both rights are stated in unqualified terms. The Statement of Purpose offers no legitimate basis for denying exercise of these same rights to minors, or for denying their parents or guardians the ability to assert these rights on their behalf. Precedent establishing that minors have a right to refuse treatment, even life-sustaining treatment, which may be exercised by their parents or guardians would provide a basis for interpreting the right to request a lethal prescription as extending to minors. In the alternative, like parental consent/notice abortion statutes that do not provide a judicial bypass procedure for mature or emancipated minors, this statute could be found unconstitutional for similar reasons.
2. Due Process of Law

a. Substantive Due Process

H.B. 339 does not adequately protect persons with "terminal conditions" in the exercise of their fundamental right to live and liberty interest in receiving medical care, and at the same time, it does not adequately protect against erroneous waiver of these rights by such persons.

H.B. 339 is illegitimate as not rationally related to its stated purpose. Its asserted justification is "to remedy the[] situations" of "terminally ill patients [who] experience severe, unrelenting suffering." H.B. 339, § 137-K:1 (Statement of Purpose). However, H.B. 339 is not narrowly tailored to achieve this purpose and does not constitute the least restrictive means of achieving it. H.B. 339 does not require exhaustion of pain management remedies. It does not even require that any pain management techniques be attempted prior to issuing a lethal drug prescription. Where the suffering is psychological and directly related to facing "death with a deadline," the Act does not require exhaustion of counselling measures for coping with a terminal illness.

b. Procedural Due Process

H.B. 339 provides no mandatory assurances that the person requesting suicide assistance is not acting as a result of duress, undue influence, or emotional/mental illness. Section 137-K:2 (III) provides only that the patient be deemed to have the "ability to make and communicate health care decisions" solely "in the opinion of the patient's "attending physician or consulting physician." Thus, even when the attending physician and the consulting physician disagree about whether the patient is capable to request a lethal prescription, that patient can nevertheless be deemed "capable."

Moreover, like other states, while New Hampshire law presumes that suicidal persons are a danger to themselves and warrant mandatory psychiatric evaluation (see N.H. Rev. Stat. Ann. § 135-C:27), § 137-K:7 of H.B. 339 (Counseling Referral) provides discretionary authority to the attending or consulting physician regarding suicidal persons with terminal conditions: The physician must refer the patient for "counselling" (defined to mean a one-time diagnostic consultation) if the physician is of the "opinion" that the patient "may be suffering from a psychiatric or psychological disorder." In other words, despite the fact that the DSM-III, the psychiatric field, and New Hampshire law uniformly recognize that suicidal persons necessarily suffer from psychiatric or psychological disorder by definition, H.B. 339
provides a mechanism for the attending or consulting physician -- neither of whom are required to have experience/training in the psychological/psychiatric field -- to circumvent these legal and medical presumptions when the suicidal person has a terminal condition. Because H.B. 339 provides good faith or subjective immunity (§§ 137-K:14 (I & II)), the physician who fails to refer, and the psychologist or psychiatrist who erroneously finds that the patient does not suffer a psychiatric or psychological disorder, could not be subjected to civil or criminal liability even if their actions violated objective standards of reasonable medical practice.

As such, H.B. 339 raises serious constitutional issues for failure to provide sufficient due process protections for the patient's right to live analogous to the failure to provide sufficient assurance for the due process rights of one subject to the death penalty. In the latter case, mandatory assurance of competence and absence of duress in accord with objective standards are required before accepting a voluntary plea of guilty from a capital defendant.

The lack of due process protection in H.B. 339 is further underscored by its failure to provide for mandatory family notification (§ 137-K:8 (II)), and by its failure to provide for statutory compliance oversight and/or review by any public authority. Consequently, H.B. 339 provides no assurance that any actions taken pursuant to it will be in compliance with its requirements, either before or after the suicide is completed.

c. Vagueness

Certain key aspects of H.B. 339 are subject to attack as being unconstitutionally vague, i.e., that the conduct permitted and the conduct prohibited under H.B. 339 is so unclearly defined that "persons of common intelligence must necessarily guess at its meaning and differ as to its application." Connally v. General Construction Co., 269 U.S. 385 (1926). H.B. 339 does not provide fair notice of the conduct permitted or forbidden under its provisions either to the public or to authorities charged with enforcing the law.

The elements which are vague are discussed below under Internal Inconsistencies and Problems and include ambiguous, undefined, and/or ill-defined terms and phrases such as: a "resident" of New Hampshire; "a patient regularly treated" in a New Hampshire facility; "an appreciation of the relevant facts"; "terminal condition"; "premature death"; "humane and dignified"; "severe, unremitting" suffering; "suffering"; "impaired judgment"; "medication for the purpose of ending . . . life"; "coerce"; and "undue influence".

Section 137-K:14 (Immunities) provides that, "No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter." (Emphasis added).

As such, H.B. 339 would make it impossible for "health care providers" (including, e.g., hospitals, nursing homes, or home health providers under § 137-K:2 (III)) to subject any employee or agent to any discipline for assisting in the suicide of patients in their care even if the provider has a stated religiously based policy opposed to assisted suicide. Thus, for example, a religious hospital with stated opposition to assisted suicide could not terminate or penalize in any way a resident physician who prescribed a lethal overdose for a patient, the pharmacist who filled the prescription, or the nurse who provided it to a patient.

Obviously, this provision would make it impossible for any religious provider to sustain the moral integrity of its mission. It plainly renders H.B. 339 subject to attack as violative of free exercise of religion. H.B. 339 is analogous to hypothetical laws that, for example, would render unenforceable institutional policies that forbade performance of abortion in Catholic hospitals or distribution of blasphemous material in a Christian schools.


Even in the absence of a religiously based claim, in this regard H.B. 339 creates serious burdens on the associational freedom rights of health care providers. Thus, for example, a hospice provider might wish to forbid assisted suicide in its practice because it is perceived to be in conflict with its secular mission of providing non-invasive palliative care for those with terminal conditions. Yet it could not, consistent with H.B. 339, discipline in any way its agents or employees who would subvert this policy by providing suicide assistance.
Federal Statutory Law

1. The Americans with Disabilities Act (ADA)

The ADA prohibits public entities, such as the State of New Hampshire, from promoting discrimination, or otherwise denying services or benefits, on the basis of disability. 42 U.S.C. § 12132. Under the ADA, as well as other state and federal civil rights laws, "disability" means: "a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment." 42 U.S.C. § 12102(2).

Thus, under the ADA and civil rights laws, "persons with disabilities" includes persons with terminal conditions because terminal conditions constitute impairments which, by their very nature, substantially limit such persons' major life functions or activities.

New Hampshire currently assures equal protection of law by maintaining unqualified bans on assisting suicide (N.H. Rev. Stat. Ann. § 630:4) and consensual homicide (N.H. Rev. Stat. Ann. §§ 629 to 630). Contrary to the ADA, however, § 137-K:3 of the proposed law would single out and remove "qualified" persons who purportedly have a "terminal condition" from New Hampshire's blanket ban against assisted suicide. H.B. 339 would sanction the exposure of persons with terminal conditions to anti-therapeutic health care practices, and the unmonitored distribution and administration of lethal substances to them, precisely on the basis of their medical disability. As such, H.B. 339 is subject to challenge as violative of the ADA's anti-discrimination prohibitions.

2. The Controlled Substances Act

Barbiturates, sedatives, depressants, opiates, and their analogues are controlled substances under the federal Controlled Substances Act (21 U.S.C. § 801 et seq.; see particularly 21 U.S.C. § 802 and corresponding regulations (21 C.F.R. pt. 1308) (definitions). Therefore, because the "drugs of choice" for causing assisted suicide typically fall into these stated categories, the federal Act would apply as a matter of course were New Hampshire to legalize prescription drug overdose for the purpose allowing self-administration by "qualified" terminally ill persons.

H.B. 339 appears to conflict with the federal Act, because the Act only permits persons to monitored consumption of controlled substances for therapeutic benefit. Distribution of controlled substances for the purpose of intending death would be construed as non-therapeutic or contra-therapeutic, and therefore would run contrary to the Act: "[T]he drugs included within this title have a useful and legitimate medical purpose and are necessary to
maintain the health and general welfare of the American people." 21 U.S.C. § 801(1). As the discussion on "FDA enforcement activities" below makes clear, federal law presumes that "legitimate use" refers to beneficent or life-preserving care only; the federal standard for "legitimate use" may not countenance uses intended primarily for promoting death.

Additionally, the federal Act, without distinguishing between intrastate and interstate drug manufacture/distribution systems, requires certified registrations of manufacturers and distributors of controlled substances. 21 U.S.C. § 822 et seq. Thus, once federal Act registrants or attempt to participate in the activities proposed in H.B. 339, they would immediately fall out of compliance with the terms of their mandatory registrations and thereby cause themselves to be subject to federal civil and criminal charges. 21 U.S.C. §§ 822-824 (provisions concerning "scope and extent" limitations on registrants and mechanisms for suspension, revocation, and other disciplinary action for violation of these limitations).

Finally, the federal Act requires that a patient may only self-administer a controlled substance "at the direction and in the presence of the practitioner" (21 U.S.C. § 802(2)(B)). Consequently, because H.B. 339 would permit "qualified" patients to self-administer a controlled substance without medical supervision, it is subject to challenge as a violation of federal law.

3. FDA Regulation in General

By virtue of the FDA’s powers as stated under the federal Controlled Substances Act and the Federal Food, Drug and Cosmetic Act, the activities proposed in H.B. 339 would be subject to FDA controls, regulation and enforcement. "In implementing the statutory scheme, the FDA has never made exception for drugs used by the terminally ill." U.S. v. Rutherford, 442 U.S. 544, 553-54 (1979). "For the terminally ill, as for anyone else, a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit." Id. at 555-56. Thus, under the applicable FDA statutes, a drug is only effective if it prolongs life, improves physical condition, or reduces pain; human consumption of regulated drugs attempted for other purposes would be deemed presumptively illicit and outside the ambit of legitimate medical practice. Rutherford at 555 (construing in particular the proposed regulation now codified in substantially the same form as 21 C.F.R. § 1306.04); see generally Rutherford at 554-556.

Rutherford and other federal law deem suicide assistance as contrary to the practice of sound, effective, and legitimate medicine or health care. H.B. 339, if enacted into state law, would run diametrically counter to the clearly stated policies of federal law, particularly 21 U.S.C. § 801(1) (quoted before) and
21 C.F.R. § 1306.04: "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. . . . An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. § 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances."

**Internal Inconsistencies and Other Problems**

1. **Who can exercise the right created under the Act?**

   Only a "qualified patient" may exercise the right to self-administer a lethal prescription under H.B. 339. Pursuant to § 137-K:2(XII), a "qualified patient" means:

   * a capable adult;
   * who is a resident of New Hampshire or
     a patient regularly treated in a New Hampshire health care facility;
   * who has satisfied the requirements of this chapter:
     * be in a "terminal condition", i.e., one that is:
       * incurable,
       * irreversible,
       * for which there is no known treatment that can reverse its terminality,
       * which, in the opinion of the attending or consulting physician, will result in premature death;
     * be experiencing severe, unrelenting suffering;
     * be voluntarily expressing a wish to die;
     * be making an informed decision;
     * has had an attending physician and a consulting physician confirm all the above;
     * has not been precluded from obtaining a lethal prescription as a result of a counselling referral by the attending or consulting physician in which it is determined that s/he is suffering from a psychiatric or psychological disorder causing impaired judgment.

   **Capable adult**

   H.B. 339 uses the term "capable" as opposed to "competent". In so doing, it establishes a physical capacity requirement without a psychological capacity requirement for this critical threshold determination. Thus, as long as a patient has the mere "ability" to make and communicate health care decisions, the manner in
which the patient arrives at such decisions, and the objective irrationality of that process or of the decisions are irrelevant. Moreover, H.B. 339's informed consent provision requires only that the patient have "an appreciation" of the relevant facts (it is unclear whether this requires full understanding or merely awareness) and be fully informed about these facts.

In addition, a determination that a patient is "capable" need only be made by the attending physician or the consulting physician. As long as one of the two deem the patient capable, the patient may be considered "capable" for the purpose of the statute. Inexplicably, neither the attending physician nor the consulting physician is required to be "qualified by specialty or experience to make a professional diagnosis" regarding the patient's mental state even though the statute does require them to be so qualified regarding the patient's physical state. This, despite the fact that it is the patient's mental state which is most directly at issue in the decision to exercise the decisive and fatal right to end his/her life.

As discussed earlier, the requirement that the patient be an adult 18 years of age or older is also subject to constitutional attack as violative of the equal protection rights of mature or emancipated minors pursuant to "right to die" and abortion caselaw precedents.

Resident of N.H. or a patient regularly treated in a N.H. health care facility

H.B. 339 does not define residency for the purposes of the Act. Nor does it define what constitutes being "regularly treated." Moreover, the use of the term "health care provider" in the context of H.B. 339 has implications for what legally constitutes health care.

H.B. 339 defines "health care provider" as "a person licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility." § 137-K:2(VII). This definition impliedly redefines health care to include the provision of lethal prescriptions although lethal prescriptions do not promote "health." Such a construction of "health care" might require health insurance companies to cover payment for lethal prescriptions and the State to cover payment for lethal prescriptions under its medicaid and medicare programs.

Terminal condition

H.B. 339 defines "terminal condition" as "an incurable and irreversible condition, for the end stage of which there is no known treatment which will alter its course to death, and which,
in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death." § 137-K:2(XIII).

The most problematic aspect of the definition is the use of the term "premature death." This phrase implies that there is some ideal time of death that can be reliably estimated for a particular individual such that a physician can predict whether actual death will be prior to that time, "on time," or belated. The concept suggests the use of actuarial tables such as are used by life insurance companies. If "premature" intends to account for a shortening of some objective healthy lifespan, even the most minor impairment of health could be considered as leading to a "premature death" -- hence, qualifying the affected person for assisted suicide.

The definition is so expansive that the aging process itself would be a "terminal condition" because it is both incurable and irreversible. Any condition that cannot be cured or reversed but can be wholly and comfortably managed over the course of a lifetime would be terminal -- including, for example, diabetes, kidney disease, heart disease, even Down's Syndrome (because persons with such condition tend to die at a relatively early age).

Severe, unrelenting suffering

By declining to define what is meant by "severe, unrelenting suffering," the Act includes any type of suffering -- physical, psychological, emotional, spiritual, financial, or otherwise.

In addition, "suffering" is not a medically quantifiable characteristic or symptom. It cannot be objectively measured; indeed, it is an inherently subjective experience. How is a physician to confirm the subjective "suffering" of another human being? Is there a scientifically reliable way to distinguish, for example, between true subjective suffering and mere acting?

In addition, § 137-K:3 (Initiating a Written Request for Medication), which attempts to summarize the eligibility requirements for a "qualified patient," creates ambiguity and confusion regarding the requirement of suffering. This section specifies that the patient must "be in a condition of severe, unrelenting suffering from a terminal disease." Such phrasing mandates that the suffering experienced must derive directly from the terminal illness itself. Thus, it seems to imply that if the patient's suffering came from a condition other than the terminal one, such a person would not be a "qualified patient."
Voluntarily expressing a wish to die

That this requirement is unqualified is especially peculiar in light of the expressed intent of the statute. If H.B. 339 is specifically designed to enable a patient to be relieved of the suffering connected to his/her terminal condition, then why are the patient’s reason(s) for wanting to die irrelevant under it? According to its present construction, H.B. 339 permits a person with a terminal condition to request a lethal prescription for any suicidal reason. Thus, although H.B. 339 creates a distinct classification for suicidal persons with terminal conditions, the irrelevance of their suicidal motive undermines the legitimacy of the classification. Indeed, if their reasons are irrelevant under H.B. 339, then the reason for treating such persons differently can only be either that the State has no interest in preventing the suicides of such persons, or that the State has no interest in protecting or enhancing the lives of such persons.

Not precluded from obtaining a lethal prescription as a result of a counselling referral

Section 137-K:6 requires that if the attending or consulting physician is "of the opinion" that the patient may be suffering from a psychiatric or psychological disorder causing impaired judgment, then said physician must refer the patient for "counselling" before any lethal prescription is scripted.

As noted earlier, H.B. 339 does not require either physician to be qualified to render such a psychiatric/psychological assessment. Moreover, not only is the critically dispositive term ("impaired judgment") left undefined, but either physician is within his/her discretion to find that the patient indeed suffers from a psychiatric or psychological disorder, but may nevertheless conclude that such condition does not "cause" the patient’s judgment to be "impaired" -- or that such condition affects the patient’s judgment, but not to such an extent as to be "impaired" according to the physician’s subjective interpretation of the term.

In addition, the "counselling referral" provision is highly misleading and medically incoherent. The plain meaning of "counselling" stands in stark contrast to the way it is defined in the Act. H.B. 339 defines "counselling" as "a consultation between a licensed psychiatrist or certified psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder causing impaired judgment." § 137-K:2(V). While the plain meaning of the term "counseling" denotes a dynamic exchange with a therapeutic goal, the Act’s definition refers rather to a static, one-time ("a consultation") diagnostic ("for the purpose of determining") assessment without any therapeutic goal(s).
The definition is also incoherent insofar as a referral of any suicidal person to a licensed psychiatrist or certified psycholog-
ist would necessarily lead to diagnosis of a psychiatric disor-
der of some sort which, by definition, would be considered to impair judgment if such psychiatrist or psychologist was properly guided by the DSM-III, which is the diagnostic and statistical manual of mental disorders. For such psychiatrist or psycholog-
ist to find otherwise would be a clear departure from accepted standard medical practice in that field.

2. What "right" does the Act create?

The "right" which a qualified patient may exercise under H.B. 339 is the right to:

* obtain a prescription for medication to end the patient's life,
* in a humane and dignified manner.

Prescription for medication to end a patient's life

Aside from conflicts with federal statutory law governing con-
trolled substances discussed before, there remain additional problems with this provision. H.B. 339 does not define what would constitute an "appropriate" lethal prescription. Does the term "medication" place a limitation on the types of substances which could be prescribed? For example, could a Kevorkian "prescribe" a lethal dose of carbon monoxide, instructing the patient how to do so in the privacy of his/her own garage, even though carbon monoxide is not a recognized "medicine" and has no known medicinal purpose? Or would this violate the requirement that the method result in a "dignified" death? Would H.B. 339 preclude the lethal prescription of a drug that has not already been approved for medical, therapeutic purposes, e.g., cyanide? Similarly, would H.B. 339 preclude the lethal prescription of an illegal drug such as heroin? Under H.B. 339, are patients entitled to the drug overdose of their choice, or must they accept whatever drug the physician prescribes?

Humane and dignified manner

These terms are not defined under the statute. As queried before, would a lethal prescription of carbon monoxide be consid-
ered "undignified"? Would a lethal prescription that, although it was fast-acting, involved great pain, be considered "inhu-
mane"? Would a lethal prescription that, although it was fast-
acting, involved an unsightly result be considered "undignified." Would a lethal prescription that, although it was the least painless method, involved the risk of an incomplete suicide be considered "inhumane"? Is what constitutes "dignified" deter-
mined according to the subjective views of the patient, the
subjective views of on-lookers, an objective standard of society, or some combination of these views?

In addition, the statute provides no assurance that the suicide will not be "botched" and result in serious physical/mental damage but not death. Would a cause of action for "wrongful living" lie? What if that patient was not killed but rendered incapable of thereafter requesting a lethal overdose or of self-administering the overdose? Plainly, H.B. 339 would generate a multitude of issues for civil and criminal law if it were to be enacted.

Conclusions

In sum, H.B. 339 raises serious constitutional difficulties, serious questions under federal statutory law, and contains numerous inconsistencies and vageries. As such, it suggests the prospect of confusion, extreme potential abuse, and lengthy litigation if enacted in its present form.

Thank you for your attention. Please contact us for further information or assistance.

Sincerely,

Thomas J. Marzen
General Counsel

/jb
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

GARY LEE, et al., }  
} Plaintiffs, } Civil No. 94-6467-HO

v. } PRELIMINARY INJUNCTION

STATE OF OREGON, et al., }  
} Defendants. }

The court, having reviewed the plaintiffs' motion for a
preliminary injunction, and being duly advised in the premises,
hereby grants said motion.

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that:

(1) the defendant Attorney General and the defendant district
attorney are preliminarily enjoined from recognizing the exception
from the homicide laws created by Oregon Ballot Measure 16 in the
conduct of their criminal enforcement duties;

(2) defendant members of the State Board of Medical Examiners
are preliminarily enjoined from recognizing the exception from the
1 PRELIMINARY INJUNCTION
standard of professional conduct created by Oregon Ballot Measure 16 in the conduct of their duties involving licensure, quality control, continuing education, and discipline of physicians;

(3) the defendant Oregon Health Sciences University Hospital is preliminarily enjoined from allowing assisted suicides to be performed in its facilities;

(4) defendants are preliminarily enjoined from bringing any criminal, civil, or regulatory enforcement action based on Ballot Measure 16 against any plaintiff for refusing, on the basis of religious objection, to (a) advise a person with the disability of a terminal illness of his or her option to choose assisted suicide, either upon admission to a health care facility or in any informed consent to treatment dialogue; (b) transfer patient records to another physician or facility who intends to assist a patient in suicide; (c) provide or be a witness to the oral or written consent of a person to assisted suicide; (d) allow counseling regarding assisted suicide; (e) receive and record written and oral requests for assistance in suicide pursuant to Measure 16; (f) assist any physician with a patient suicide; and,

(5) defendants are preliminarily enjoined from recognizing the constitutionality of recently enacted Oregon Ballot Measure 16.

Pursuant to Fed. R. Civ. P. 65(c), nominal security is set in this matter in the amount of $1.00, to be posted in the form of cash or bond with the clerk of this court.

Pursuant to Fed. R. Civ. P. 65(d), this preliminary injunction is binding upon named defendants, their agents, servants,
employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of this order by personal service or otherwise.

IT IS SO ORDERED.

DATED this 27th day of December, 1994.

[Signature]

[Signature]

UNITED STATES DISTRICT JUDGE
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF OREGON

GARY LEE, et al.,

Plaintiffs.  

v.

STATE OF OREGON, et al.,

Defendants.

Civil No. 94-6467-HO

OPINION

Before the court is Measure 16, passed by Oregon voters on November 8, 1994. This law, for the first time in the history of this country, authorizes physician assisted suicide for the terminally ill. The law invokes profound questions of constitutional dimension. The narrow issue presented at this juncture is whether those questions justify a brief delay in the implementation of this law. For the reasons set forth below, I find that the balancing of the important factors in this case merits a postponement of the implementation of the legislation

1 - OPINION
until the constitutional concerns are fully heard and analyzed, which will be scheduled as soon as practicable.

Plaintiffs are two physicians, four terminally ill or potentially terminally ill patients, a residential care facility, and individual operators of residential care facilities. Plaintiffs claim Measure 16 violates the Equal Protection and Due Process Clauses of the Fourteenth Amendment, the First Amendment rights of freedom to exercise religion and to associate, and the Americans with Disabilities Act. I granted plaintiffs' motion for a temporary restraining order (#39) on December 7, 1994. I heard oral arguments and took evidence on plaintiffs' motion for a preliminary injunction (#21) on December 19, 1994. The following are my findings of fact and conclusions of law concerning that motion, in accordance with Fed. R. Civ. P. 52(a).

Standing

Defendants argue that plaintiffs are not entitled to a preliminary injunction because they lack standing. A threshold question in every federal case is whether a plaintiff has sufficiently alleged a "case or controversy" within Article III of the United States Constitution. Warth v. Seldin, 422 U.S. 490 (1975). Standing does not depend on a determination of the merits of a claim, rather on the nature and source of the claim. The question is whether a statutory provision on which the claim
rests can be understood to allow the plaintiffs a right to seek relief.

A plaintiff invoking federal court jurisdiction must establish, at an irreducible constitutional minimum that: (1) they have suffered an "injury in fact" or an invasion of a legally-protected interest which is concrete and particularized and "actual or imminent," (2) there is a causal connection between the injury and the challenged conduct, and (3) it must be likely that the injury will be "redressed by a favorable decision." *Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130, 2136 (1992). The United States Supreme Court has recognized that "imminence" is an elastic concept, but one which must be limited so that an alleged injury is not too speculative. *Lujan v. Defenders of Wildlife*, 112 S.Ct. 2130, 2138-39 at n. 2 (alleged injury to occur at some indefinite future time is not sufficient). The injury must proceed with a "high degree of immediacy, so as to reduce the possibility of deciding a case in which no injury would have occurred at all." *Id.*

Plaintiff Weinkauf is a diabetic who argues that diabetes may fit within the definition of "terminal disease" under Measure 16, if he ceases taking insulin. It is undisputed that plaintiffs Dutson, Elsner, and Stotler have terminal illnesses. All claim that they would not choose assisted suicide while exercising sound judgment. The record does not reveal whether any have contemplated suicide in the past. The gist of their
claims is that they may, at some future time, request physician assisted suicide due to undue influence caused by judgment-impairing depression, or other inappropriate influence.

Hopefully, these plaintiffs will never experience the severe, judgment-impairing, undiagnosed depression which concerns them. If they do not, they will not benefit from a ruling in their favor. However, I must consider the unique facts presented by this action. Interpreting the "imminence" requirement too strictly may lead to claims becoming moot on account of plaintiffs' deaths. One may ask, if a terminal patient does not have standing, who does? However, because this court finds that both the physician and residential care provider plaintiffs have standing (see below), it is not necessary to decide at this time whether these plaintiffs have standing.

Aside from this minimum constitutional mandate, the Supreme Court has recognized a prudential limit on the class of persons who may invoke the court's powers. There is a general rule that a plaintiff may not claim standing to pursue the constitutional rights of a third party. However, this general rule has not been applied where its underlying justifications are absent.

There are three criteria for determining third-party standing: (1) the litigant must have suffered an "injury-in-fact" giving them a sufficiently concrete interest, (2) the litigant must have a close relationship to the third party, and
(3) there must exist some hindrance to the third party’s ability to assert their own right. Powers v. Ohio, 499 U.S. 400 (1991); Singleton v. Wulff, 428 U.S. 106, 114 (1976). As to the first element, the Supreme Court has held that two physicians had standing to challenge the constitutionality of a Missouri statute excluding abortions that are not "medically indicated" from medicaid coverage. Id. The Court found that there was a sufficient injury in fact because, if they prevailed, they would benefit by receiving payment for the abortions. As to the second element, if the enjoyment of the third party’s right is "inextricably bound up" with the activity the litigant wishes to pursue, the court is assured that its construction of the right will be necessary, rather than simply advisory. Id. at 114-115. The relationship between the litigant and the third party may be such that the former is as effective a proponent of the right as the latter. The doctor-patient relationship has been found to be a sufficiently close relationship to support third party standing. Singleton v. Wulff, 428 U.S. 106, 115 (1976). Even where the relationship is close, the reasons for requiring persons to assert their own rights still apply, unless there is some genuine obstacle to this assertion. Id. at 116. Protection of privacy and imminent mootness have been recognized as sufficient obstacles. Id. at 117.

Defendants argue that the two physician plaintiffs lack standing to assert claims on behalf of their patients. Both
Drs. Lee and Petty state for purposes of standing only, that if one of their patients commits suicide, they will no longer receive payment for services. Affidavits #36, #23. The physician plaintiffs have met their burden to show a direct financial impact on their practices and an injury-in-fact if Measure 16 goes into effect. See Diamond v. Charles, 476 U.S. 54 (1986), and Singleton v. Wulff, supra.

Plaintiff Dr. Lee specializes in oncology and hematology, and is a medical director of the Sacred Heart Hospital Hospice. Affidavit of Plaintiff Gary L. Lee #36. Plaintiff Dr. Petty specializes in gynecologic oncology. Affidavit of Plaintiff William Petty #23. A majority of their caseloads are cancer patients who are expected to die. Dr. Lee states that some of his patients fall into such severe depression that they become dysfunctional. Affidavit #36. Several have approached him requesting assistance in ending their lives. Id. He claims that almost no one chooses suicide if their physical, emotional, social, and spiritual needs are met. Id. He states that he does not have specialized training in identifying debilitating depression or suicidal tendencies. Id. Both physician plaintiffs state that significant numbers of their patients will seek physician assistance in ending their lives prematurely due to severe depression or undue influence, if Measure 16 takes effect. Affidavits #23, #36.

The physician plaintiffs have demonstrated sufficiently
close relationships with their patients, including those with severe depression and suicidal thoughts. Some terminally ill patients have willingly set aside their personal privacy interests to join this litigation, on both sides. However, the greatest obstacle to terminal patients asserting constitutional rights they may have to challenge Measure 16 is the possibility of claims becoming moot due to death prior to a final resolution. The physician plaintiffs have sufficiently demonstrated standing to protect constitutional rights of their patients.

Defendants argue that the residential care plaintiffs, Fritz and June Beck, Sister Geraldine Bernards, and Maryville Nursing Home, lack standing because they are not required to participate in implementing Measure 16. Section 4 of the Measure provides, in relevant part:

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life. . . .

First Amended Complaint #17, Exhibit A. The gist of these plaintiffs' claims is that: (1) some "participation" under the Measure is unavoidable and would violate their First Amendment right to free exercise of religion, unless (2) they choose to transfer a patient to another facility, but that forcing such a choice violates their First Amendment right to free association.

First Amended Complaint #17, Count Five; Affidavit of Plaintiffs
Fritz and June Beck #52; Supplemental Affidavit of Fritz and June Beck #53; Affidavit of Plaintiff Geraldine Bernards #63. In addition, plaintiff Bernards states that Oregon Administrative Rules, Chapter 411, Division 88, prohibits a nursing home from involuntarily transferring patients under many circumstances. Affidavit #63.

Again, standing does not depend on a determination of the merits of these claims, rather on the nature and source of the claims and plaintiffs' connection to them. The residential care plaintiffs have sufficiently demonstrated a legally-protected interest, a possible invasion of which is imminent if Measure 16 takes effect, a causal connection, and a likelihood their injury, if proven, will be redressed by a favorable decision. The physician plaintiffs have also demonstrated sufficient standing to assert First Amendment claims on their own behalf.

Intervenors Goodwin, Lee, and Sinnard argue that plaintiffs' claims are not ripe. However, the physician and residential care plaintiffs have presented sufficient evidence that they currently have patients whose interests will be affected if Measure 16 takes effect.

The attorney for these intervenors also raised potential jurisdictional issues related to other state defendants at oral argument. It may also be appropriate for the constitutionality of Measure 16 to be tested in state court under state constitutional jurisprudence before review under the United
States Constitution. The court will address these issues when they have been formally raised and properly briefed.

**Standards for Preliminary Injunction**

A party seeking preliminary injunctive relief must meet one of two tests. Under the first, a court must find that:

1. the [moving party] will suffer irreparable injury if injunctive relief is not granted,
2. the [moving party] will probably prevail on the merits,
3. in balancing the equities, the [non-moving party] will not be harmed more than [the moving party] is helped by the injunction, and
4. granting the injunction is in the public interest.

*Stanley v. University of Southern California*, 13 F.3d 1313, 1319 (9th Cir. 1994) (citation omitted). Alternatively, a court may issue a preliminary injunction if the moving party demonstrates either a combination of probable success on the merits and the possibility of irreparable injury or that serious questions are raised and the balance of hardships tips sharply in its favor. The formulations under the alternative tests "represent two points on a sliding scale in which the required degree of irreparable harm increases as the probability of success decreases." *Miller v. California Pacific Medical Center*, 19 F.3d 449, 456 (9th Cir. 1994), quoting *United States v. Odessa Union Warehouse Co-op*, 833 F.2d 172, 174 (9th Cir. 1987). If the balance of harm tips decidedly toward the plaintiff, then the plaintiff need not show as robust a likelihood of success on the merits as when the balance tips less decidedly. *Benda v. Grand Lodge of Int'l Ass'n of Machinists & Aerospace Workers*,

9 - OPINION
584 F.2d 308, 315 (9th Cir. 1978), cert. dismissed, 441 U.S. 937 (1979).

Serious questions are "substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberative investigation." *Gilder v. PGA Tour, Inc.*, 936 F.2d 417, 422 (9th Cir. 1991) (citation omitted). "Serious questions need not promise a certainty of success, nor even present a probability of success, but must involve a 'fair chance of success on the merits.'" *Id.* (citation omitted); see also, *State of Alaska v. Native Village of Venetia*, 856 F.2d 1384, 1389 (9th Cir. 1988) (equating fair chance of success with raising serious questions on the merits). Even if the balance of hardships tips decidedly in favor of the moving party, it must be shown as an irreducible minimum that there is a fair chance of success on the merits or questions serious enough to require litigation. *Stanley v. University of Southern California*, 13 F.3d 1313 at 1319; *Sports Form, Inc. v. United Press Intern., Inc.*, 686 F.2d 750 (9th Cir. 1982) (citation omitted). No chance of success at all will not suffice. *Id.*

**Equal Protection**

Plaintiffs allege that Measure 16 violates the rights of the terminally ill to equal protection under the law. Under Oregon law, a person may be convicted of manslaughter in the second degree for intentionally causing or aiding another to commit suicide. ORS 163.125. In addition, a person acting with
a reasonable belief, is justified in using physical force on another to thwart a suicide attempt. ORS 161.205. Oregon law also provides for commitment proceedings for a person who, because of a mental disorder is "dangerous to self." ORS 426.070 et. seq. Measure 16 arguably creates exceptions to coverage of the statutes for terminally ill patients. It prohibits criminal liability for anyone who participates in good faith within its terms, and provides that a patient's request for assistance cannot be the sole basis for the appointment of a guardian or conservator. Amended Complaint #17, Exhibit A, Section 4.01(1), (3).

The Equal Protection Clause of the Fourteenth Amendment states that no state shall "deny to any person within its jurisdiction the equal protection of the laws." This means that all persons similarly situated should be treated alike. *Plyler v. Doe*, 457 U.S. 202, 216 (1982). "The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest." *Schweiker v. Wilson*, 450 U.S. 221, 230 (1981). The Equal Protection Clause allows states wide latitude when social legislation is at issue. However, the rational basis test does not apply where a state law impinges on personal rights protected by the Constitution or involves a suspect class. In such a case, the state law must be suitably tailored to serve a compelling state interest. *City of*
Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432, 440 (1985) (race, gender, alienage, national origin are suspect classes, while age and mental retardation are not).

Among the questions concerning whether plaintiffs' rights to equal protection under Oregon law will be violated are the following:

1. Must the state show only that Measure 16 is rationally related to a legitimate state interest?

2. The state has identified its interests in Measure 16 as preventing continued pain and suffering of competent terminally ill patients and support of Oregon voters' rights to participate in the democratic process. However, "pain and suffering" is not contained in the terms of Measure 16.

3. Is there a rational basis for the classification of "terminally ill" patient if, as plaintiffs claim:

   a. Physicians often misdiagnose terminal illness (See Affidavit of Dr. Fenigsen #33), or

   b. A physician's prognosis of six months to live is often fallible, i.e., plaintiff Stotler claims she was given 6 months to live in 1992 (Affidavit #25) and see Affidavit of Dr. Fenigsen #33, or,

   c. It may be contrary to reasoned medical judgment to include a patient who can live a normal life span with medication, i.e., a diabetic taking insulin, but not without it.

4. Is it a legitimate state interest to provide that only
competent individuals can receive a lethal dosage, but remain silent about whether only competent individuals can take that lethal dosage?

5. Are persons who have a terminal disease disabled for purposes of the Americans With Disabilities Act and if so, does this mean they are a suspect class?

6. Must Measure 16 serve a compelling state interest, and does it?

7. Does Measure 16 "deny" terminally ill patients the protections of Oregon's criminal and civil commitment statutes or does it give them the benefit of opting out of coverage under those laws?

Due Process

The Due Process Clause of the Fourteenth Amendment provides that "[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law." Plaintiffs allege that Measure 16 unconstitutionally deprives persons who have the disability of a terminal disease of protections for their right to live. They also claim that Measure 16 violates plaintiffs' liberty interests because it does not sufficiently guarantee that the choice to end life will be both informed and voluntary.

The concept of "liberty" has been well-articulated in the plurality opinion in Planned Parenthood v. Casey, 112 S.Ct. 2791, 2807 (1992):
Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Measure 16 is the first attempt by a state to sanction physician assisted death. Many states have statutes which criminalize an individual's conduct in aiding another to commit or attempt to commit suicide. Terminally ill patients and their physicians have challenged such statutes as violations of fundamental liberty interests to choose physician assisted death. See, e.g., Compassion in Dying v. State of Washington, 850 F.Supp. 1454 (W.D. Wash. 1994) (on appeal); Quill, et al. v. Koppell, Civil No. 94-5321 (TPG) slip op. (SDNY Dec. 15, 1994) (opinion by Chief Judge Griesa); Hobbins v. Attorney General, No. 99752, slip op. (Mich. Dec. 13, 1994). These courts have reached contrary results.

The Supreme Court's decision in Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) is helpful. In Cruzan, the issue was whether the Due Process Clause allowed a
state to require a currently incompetent patient in an irreversible vegetative state to remain on life support absent clear and convincing evidence that avoiding the treatment represented that patient's choice while competent. The Supreme Court held that a competent person has a liberty interest in refusing unwanted medical treatment, but stopped short of deciding that such a person had a constitutionally protected right when death was the likely result. The Court also found it permissible for the state: (1) to require additional safeguards for incompetent patients to assure that ending life was within their express wishes while competent, and (2) to decline to make judgments about the quality of life an incompetent person may enjoy and simply assert an unqualified interest in the preservation of life. Justice O'Connor, in a concurring opinion noted:

Today we decide only that one state's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, New State Ice Co., v. Liebhann, 285 U.S. 262, 311, 52 S.Ct. 371, 386-87, 76 L.Ed. 747 (1932) (Brandeis, J., dissenting), in the first instance.

There are serious questions on the merits of the due process claims, because Measure 16 is the first of its kind and the Supreme Court has expressly limited its holdings on related issues. Among the serious questions raised and which require further briefing and argument are:

1. Does Measure 16 deprive a person of constitutional
rights? Before a state can allow an individual to waive a federal constitutional right, must it also ensure that the waiver is voluntary and informed?  

Among the questions raised by plaintiffs are the following: Are there sufficient "due process" safeguards to ensure that a judgment-impaired, or unduly influenced patient is not allowed to request assisted death?

Section 3.03 of Measure 16, provides that a requesting patient is referred to a licensed psychologist or psychiatrist only if the attending or consulting physician believes the patient may not be able to make a voluntary choice. Should these physicians also be deciding whether "a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment"?

According to Dr. Carol Gill, research indicates that up to 95% of persons who wish to commit suicide are suffering from depression or other emotional disorders that could be eased or eliminated through support, therapy, or medication. Affidavit of Dr. Carol Gill, Ph.D. #29. According to Dr. Patricia Wesley, a recent suicide study in Cook County, Illinois, indicates that 88-94% had a psychiatric disorder at the time they committed suicide, 25% had seen a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. The contacts were for vague physical complaints. "The general practice physician did not, and probably could not have picked up either the psychiatric condition or the suicidal intention." Affidavit of Patricia Wesley, M.D. (#28), citing David C. Clark, "Rational Suicide and People with Terminal Conditions or Disabilities," 8 Issues In Law & Med. 147, 152 (1992). This is not to minimize the contrary affidavits of defendants' experts, who have far different opinions of the connection of depression with suicide, but plaintiffs' experts are cited here because it is the plaintiffs' burden to raise the questions.

Section 3.05 of Measure 16 provides that an attending physician shall ask a patient to notify next of kin of the request for a lethal dosage of medication but the request cannot be denied if the patient declines or is unable to notify. Should family or guardian notification be required, when possible, because it may be significant: (a) in diagnosing the severity of a patient's depression, (b) in providing emotional support that may be lacking and lead the patient to decide to live, (c) in assisting a trained professional to determine whether the patient is being unduly influenced?

Are safeguards required so that a terminally ill, judgment-impaired or unduly influenced patient is not allowed to take a lethal dosage, even if they received the lethal dosage when they
2. A state does not have a constitutional duty to protect members of the general public, with a few exceptions. *Deshaney v. Winnebago County DSS*, 489 U.S. 189 (1989). Does this rule of law apply when the state enacts a law and allows a state operated facility, Oregon Health Sciences University, to implement the law on its premises?

3. Is plaintiffs' due process claim, in essence, a facial constitutional challenge to Measure 16 and if so, what is the appropriate test to determine the constitutionality of Measure 16?

4. If Measure 16 implicates a terminally ill person's liberty interest, does that interest outweigh that of the state?

**Americans with Disability Act**

Plaintiffs allege that "Ballot Measure 16 unlawfully deprives persons who have the disability of a terminal disease of protection afforded other persons under Oregon law in violation of the Americans with Disabilities Act (ADA) and to the extent the statute applies to federally funded programs, Section 504 of the Rehabilitation Act of 1973." First Amended Complaint (#17), p. 31.

Defendants argue that the ADA does not require any disabled individual to utilize assisted suicide.

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were competent?

Are there sufficient safeguards so that terminally ill patients are making an informed choice? Is it necessary for an independent third party, i.e., a probate or other court, to oversee decision for and implementation of an assisted death request?
Defendants' arguments in this regard assume that the "option" of assisted suicide is a "benefit" under the law.

The parties' arguments about the application of the ADA to Measure 16 involve whether the "option" of assisted suicide is a "benefit" or a "deprivation" under the law. It may be necessary to decide whether the parties' positions are based on philosophical, moral, or religious beliefs or whether they are subject to statutory analysis.

Plaintiffs' ADA claim raises interesting questions. It is unnecessary to decide whether these questions are "serious" because a preliminary injunction may issue based on my earlier findings.

Vagueness

Plaintiffs allege that the definition of "terminal illness" in Measure 16 is unconstitutionally vague, and, therefore, violates the due process and/or equal protection clause of the Fourteenth Amendment.

Defendants argue that "regardless of the 'vagueness' of the definition, Measure 16 does not mandate or prohibit any particular conduct." Defendants' Memorandum (#69), p. 20.

In Grayned v. City of Rockford, 408 U.S. 104 (1972), the United States Supreme Court held:

It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary
intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them.


Ballot Measure 16 defines "terminal illness" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." Section 1.01(12).

Plaintiffs argue that some diseases, such as diabetes, are terminal absent regular medication and that the "statutory definition of this key term is unclear as to whether it sweeps in this class of persons or not." Brief in Support (#22), p. 107. Therefore, the argument goes, doctors and health care facilities are exposed to liability because they cannot know whether to advise people with such illnesses of the alternative of assisted suicide under the requirements of the federal Patient Self-Determination Act, 42 U.S.C. § 1395cc(a)(1).

Defendants argue that the vagueness doctrine applies only when a law is so vague that persons subject to the law cannot determine what conduct is prohibited. *Grayned v. City of Rockford*, supra. "Because Measure 16 is strictly voluntary, it cannot be invalidated on the grounds of vagueness." Defendants' Memorandum, p. 29.
However, the "flip side" of what is prohibited by a statute is what is permitted. Since Measure 16 creates an exception to other Oregon criminal laws (see e.g., section 4.01, "Immunities"), it may be illogical to hold that the vagueness doctrine is not applicable simply because the conduct permitted under the measure is "voluntary."

In Grayned, the Supreme Court noted: "Condemned to the use of words, we can never expect mathematical certainty from our language." Grayned v. City of Rockford, supra at 110. "[I]t will always be true that the fertile legal imagination can conjure up hypothetical cases in which the meaning of [disputed] terms will be in nice question." Id., n. 15 (quoting American Communications Ass'n v. Douds, 339 U.S. 382, 412 (1950)).

However, the rights and liabilities of a physician requested to intentionally provide a lethal prescription to an individual with a medically controlled terminal condition which may not involve great pain and suffering raises serious questions.

First Amendment

Plaintiffs allege that certain provisions of Measure 16 require complicity of physicians and health care providers that is contrary to plaintiffs' religious and moral convictions and violates the Free Exercise Clause and freedom of association protections of the First Amendment and the Religious Freedom Restoration Act.
Plaintiffs contend that the following aspects of Measure 16 infringe on their freedom of association and freedom to exercise their religious beliefs:

1. Measure 16 requires health care providers to transfer records at a patient's request if a facility is unwilling to comply with the patient's wishes;

2. Oregon's "informed consent" law requires physicians to discuss available treatment options with patients. "As a result, Plaintiffs will be required to advise patients of their right to assisted suicide." First Amended Complaint (#17), p. 34.

3. The federal Patient Self-Determination Act, 42 U.S.C. § 1395cc(a)(1) et seq., requires health care facilities to inform patients of their rights under state law. "As a result, medical care facilities will be required in Oregon to advise patients of their right to assisted suicide and to appoint a witness to witness written requests for assisted suicide." Id.

4. Measure 16 prohibits facilities from denying staff privileges to or otherwise disciplining physicians who choose to honor a patient's request for medication.

Defendants contend that plaintiffs' discussion of religious freedom is "largely irrelevant" because "(n)o one denies that freedom of association and the free exercise of religion are protected by the 1st Amendment." Defendants' Memorandum in Opposition (#69), p. 29. Defendants argue that the
"Infringements" alleged by plaintiffs "do not really exist."

Id., p. 30.

If a health care provider or physician is required to perform acts to facilitate or accommodate a request for assisted suicide and based on sincerely held religious convictions, reasonably believes that their participation constitutes "complicity" in the suicide, there is a serious question regarding an infringement on religious beliefs against such conduct.

Defendants also argue that the issue whether a physician may be disciplined or denied staff privileges for complying with a patient's request for medication under Measure 16 "is more properly litigated when and if that issue arises in a live dispute between a physician and a health care facility."

Defendants' Memorandum, p. 31. However, as noted in the section regarding "irreparable harm," the loss of First Amendment freedoms even for "minimal periods of time" may constitute an irreparable injury.

Irreparable Harm

Under the "sliding scale" analysis described earlier, the required degree of irreparable harm increases as the probability of success decreases. Oakland Tribune, Inc. v. Chronicle Publishing Co., 762 F.2d 1374, 1376 (9th Cir. 1985). The logical corollary is that the greater the degree of irreparable injury, the less probability of success on the merits is.
Dr. Lee alleges that many of his patients suffer from depression, "although physicians are not well-trained in depression so the problem is generally undertreated." First Amended Complaint (#17), p. 5. Dr. Lee further alleges that depression and the debilitating effects of the disability of a terminal disease make his patients highly susceptible to the suggestion that their lives are not worth living.

Defendants' argument that "(t)hese plaintiffs will suffer absolutely no harm whatsoever if the Measure takes effect," Defendants' Memorandum (#69), p. 33, does not address plaintiffs' concern that terminally ill persons will in the future request assisted suicide due to undue influence from judgment impairing depression or other undue persuasion.

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3 "An essential prerequisite to the grant of a preliminary injunction is a showing of irreparable injury to the moving party in its absence." Dollar Rent a Car v. Travelers Indem., 774 F.2d 1371, 1375 (9th Cir. 1985) (emphasis added). Therefore, any consideration of the harm to defendants from being denied the availability of assisted suicide is more appropriately considered in terms of the balancing of hardships. The moving party must demonstrate a "significant threat of irreparable injury." Oakland Tribune, supra at 1376. However, it is not necessary to "weigh" the respective injuries to determine whether there is a potential irreparable injury.

4 In addition, expert testimony submitted by plaintiffs suggests that Measure 16 is a "public signal to many who harbor suicidal plans" and "an important political value statement." Supplemental Affidavit of David C. Clark, Ph.D. (#43). Dr. Clark expects that many persons will pursue assisted suicide on the first days "when a sizeable back-log of 'pioneers,' publicity seekers, frightened medical patients, political activists, and psychologically compromised persons will rush" to be the first to die. Id. 'Defendants' experts believe just the opposite.
Death is overwhelmingly final and not subject to reversal, mitigation, or correction. Although death may be viewed as a release from suffering, it is nevertheless the end of life and, therefore, the legal equivalent to an injury to life. Death constitutes an irreparable injury and I find that the possibility of unnecessary death by assisted suicide has been sufficiently raised to satisfy the irreparable harm requirement for a preliminary injunction.

I have found above that serious questions are raised by plaintiffs' First Amendment claims. Therefore, it is also appropriate to consider the possibility of irreparable harm in connection with those claims.

In Birod v. Burne, 427 U.S. 347 (1976), non-civil service employees of the Cook County, Illinois sheriff's department brought a class action for declaratory, injunctive, and other relief, alleging that they were fired or threatened with dismissal for the sole reason that they were not affiliated with or sponsored by the political party of the current sheriff. The District Court found that the plaintiffs had failed to demonstrate irreparable injury, denied the motion for preliminary injunction and ultimately dismissed the complaint for failure to state a claim. The Court of Appeals reversed and remanded with instructions to grant appropriate preliminary relief. In affirming the judgment, the Supreme Court commented:

At the time a preliminary injunction was sought in the District Court, one of the respondents was only
threatened with discharge. In addition, many of the members of the class respondents were seeking to have certified prior to the dismissal of their complaint were threatened with discharge. . . . It is clear therefore that First Amendment interests were either threatened or in fact being impaired at the time relief was sought. The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury. See New York Times Co. v. United States, 403 U.S. 713, 91 S.Ct. 2140, 29 L.Ed.2d 822 (1971). (emphasis added).

Elrod v. Burns, supra at 373.

I find that plaintiffs have demonstrated that irreparable harm to First Amendment rights could occur in the absence of a preliminary injunction.

Public interest and balance of hardships:

Plaintiffs' argument that "the public has a strong public interest in having constitutional guarantees enforced for all," Plaintiffs' Reply (#75), p. 23, presupposes that Measure 16 in fact deprives some people of constitutional rights guaranteed to all citizens. My finding herein is only that serious questions are raised by plaintiffs' claims. Plaintiffs cannot bootstrap a presumed success on the merits into the balancing analysis.

Another hardship claimed by plaintiffs is the risk that suicide attempts by lethal drug overdose may fail to cause death and result instead in serious physical impairments and protracted suffering.\(^5\)

\(^5\) Jerome R. Wenow, a pharmacist and biomedical ethicist, indicates that the dosages of pentobarbital sodium or secobarbital sodium necessary to cause death in humans has not been determined. According to Dr. Pieter Admiraal, Wenow Affidavit (#76), p. 3, 75% of physician assisted suicide patients die within three hours, the
The possible hardships created by the complications associated with failed suicide attempts and the public interest in protecting against misdiagnosed "terminal" (within six months) illness should be considered when evaluating the public interest.

As noted in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990):

An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.

*Cruzan v. Director*, supra at 283.

It is also true, as defendants point out, that the public has a strong interest in the enforcement of laws duly enacted by a majority of the voting electorate. However, any law must survive constitutional scrutiny.

My findings concerning this motion are not intended to minimize the interests of individuals who may wish to avail themselves of the alternative provided by Measure 16 or to

remainder "can last 32 days or longer." *Id.*

Barbiturate poisoning has been characterized by other experts as "the most uncertain method of taking one's life." See Warnow Affidavit (#76), p. 4. If a patient fails to die after taking an "overdose," serious physical complications may arise and a "slow miserable death" may result. *Id.*, pp. 4-5.
ignore that the prospect of constant pain constitutes an enormous hardship.

A preliminary injunction in this case results in the maintenance of the status quo for a limited period of time to thoroughly consider the constitutionality of Measure 16. Although the status quo will be regarded as a hardship by some terminally ill patients who want the "option" of physician assisted suicide to be immediately available, the public interest in protecting vulnerable citizens from the irreparable harm of death is greater. Surely, the first assisted suicide law in this country deserves a considered, thoughtful constitutional analysis.\(^6\)

I find that the balance of hardships favors plaintiffs and that the issuance of the preliminary injunction sought by plaintiffs is in the public interest.

DATED this 27\(^{th}\) day of December, 1994

[Signature]

\(^6\) It is the court's firm intention to require the parties to promptly prepare this matter for resolution on the merits.

27 - OPINION
February 16, 1995

To: Robert A. Lockwood, Chairman
Members of the Judiciary & Family Law Committee

From: Judith Delisle, Director
Respect Life Office

Re: TESTIMONY OF C. EVERETT KOOP, M.D.
IN OPPOSITION TO HB-339

Attached please find the testimony of Dr. Everett Koop in OPPOSITION TO HB-339 that I am submitting on his behalf.

When Dr. Koop became aware of HB-339, he forwarded his testimony to my office and requested his opposition to this legislation be presented and duly recorded at this hearing.
February 14, 1995

To Whom it May Concern:

Re: House Bill #339

I have practiced medicine for more than 50 years and was Surgeon General of the United States from 1981-1989. I think I have a good understanding of the various problems stemming from legislation such as House Bill #339.

Western Medicine has been well-served by the Hippocratic Tradition for 2400 years, and although it was new and different in 400 B.C., societal consensus has confirmed it over two millennia. The Hippocratic Oath, per say, stands absolutely against physicians assisting in suicide or even suggesting it.

Unfortunately, when one repudiates the Hippocratic consensus, the full burden for ethical choices in medicine falls on the patient. It is my opinion that the typical patient is rather poorly equipped, because of his state of health, to make fundamental moral choices -- especially as the end of life approaches. Therefore, I believe that adequately informed consent is very difficult in terminal illness.

I stand with renowned cultural anthropologists, such as Margaret Meade, in the belief that the profession of medicine cannot be both the healer and the killer of society. If we ever let ourselves be placed in that position, we will all be in jeopardy.

During my lifetime, the emphasis on the need for euthanasia has shifted from the inability of the medical profession to relieve intractable pain to a variety of other reasons for leaving this life. It has been my experience that, in the process, many elderly folks, especially those who are ill and frail, feel a sense of diminished value and seek an early death for the wrong reasons.

If nothing else, we should profit by the experiments in the Netherlands over the past eight years. What began there as a well-controlled, court-sanctioned but, nevertheless, illegal plan to affect few people has become a wide-spread abuse of the original intent. In the Netherlands today, hospital patients are terminated by lethal injection in spite of the fact that they never requested it and without the knowledge of their families. In fact, the procedure has been carried to non-cognitive elderly people, as well as newborns -- neither of whom could give informed-consent.
I urge you to halt legislation of this type because of its effect on untold numbers of patients, but also on the profession of medicine and the very ethical underpinnings of society.

Sincerely yours,

C. Everett Koop, M.D.
Sheila E. Carter & Thomas Bugely  
P.O. Box 401  
Franklin, NH 03235  

re: FOGG, MELBA  
A# 169997-4  

Dear Ms. Carter and Mr. Bugely,  

Enclosed is a copy of the post-mortem examination on Mrs. Fogg. The most important finding was the widely metastatic cancer which included spread to the heart and the brain. Also, at the time of death she had pneumonia and her kidneys had failed. These were a consequence of her course at the end of her life. The only other disease found was mild hardening of the arteries in the heart.  

I think the post-mortem, particularly with the evidence of metastases to the brain, confirm the appropriateness of Mrs. Fogg's and your decision not to continue therapy and that she would have continued to suffer significantly had we all pushed on.  

Sincerely,  

Kenneth W. Burchard, M.D.
|| DARTMOUTH-HITCHCOCK MEDICAL CENTER | Autopsy No.: A93-052 |
|-----------------------------|------------------|
| Department of Pathology     | Hosp. No.: 806032-2 |
| Lebanon, NH 03756           | Patient: FOGG, Melba E. |
| Autopsy Report (3)          | D.O.B.: 09-19-22 (70) |
| Title: METASTATIC MUCINOUS ADENO-CARCINOMA OF COLON | Sex: Female Race: White |
| Clinician: Kenneth Burchard, MD | Date and Time: |
| Andrew D. Perrone, MD       | Admission: 01-27-93 1428 |
| Service: General Surgery    | Death: 03-13-93 1515 |
| Pathologist: Ann E. Perry, MD | Autopsy: 03-14-93 |
| Michele P. Normandin, MD    | Photographs: No |
| Ref. Phys.:                 |                  |
| Final Diagnoses:            |                  |

I. History of adenocarcinoma of the colon
(with histologic mucinous features), 1989
A. Widely metastatic mucinous adenocarcinoma involving: subcutaneous adipose, thoracic lymph nodes, periaortic lymph nodes, pericardial adipose tissue, myocardium, retroperitoneum, right adrenal gland, omentum and cerebellum

B. Status post colectomy
1. Numerous small bowel adhesions
2. Baker tube in small bowel, draining yellow-green fluid

II. Lungs with bilateral acute bronchopneumonia and pulmonary edema

III. Arteriosclerosis
A. Coronary artery involvement with 30% stenosis of right coronary artery, 20% stenosis of anterior descending artery and 20% stenosis of circumflex artery
B. Aorta, mild involvement

IV. Acute tubular necrosis, severe

MAY 17 1993
This 70-year-old white female had a history of widely metastatic mucinous adenocarcinoma of the colon which was diagnosed in 8/89 as Duke's C-II with 11 out of 11 lymph nodes positive for metastases, and a CEA of 14.9. At that time, a right hemicolectomy was performed. In 12/90 she had a recurrence at which time a colectomy was performed, which was complicated by postoperative adult respiratory distress syndrome. The recurrence was classified as a Duke's B, T3M0N0. In 6/92 a new right breast mass was biopsied, which showed metastatic mucinous adenocarcinoma involving subcutaneous tissue. In 12/92 a CT scan was performed which revealed multiple subcutaneous metastases, enlarged thoracic lymph nodes, retroperitoneal masses, as well as enlarged retroperitoneal lymph nodes. On 12/24/92, a left subclavian mediport was placed. From 1/11 to 1/17 she was given chemotherapy consisting of 5 fluorouracil with leucovorin rescue. A repeat CT scan showed worsening metastatic disease as compared to the CT scans in November and December, indicating no evidence of response to the chemotherapy. She presented for admission on 1/27 with abdominal pain, nausea, and vomiting, and dehydration. She was diagnosed with a small bowel obstruction on 1/28 and was taken to surgery for an exploratory laparotomy and lysis of adhesions. A Baker tube was placed at that time. Postoperatively she failed to thrive, and support was withdrawn on 2/14/93. The patient was given comfort measures only as per her own request. Her condition gradually worsened and she died on 3/13/93. Other past medical history includes a history of transient ischemic attacks, COPD and depression. Past surgical history includes splenectomy, abdominal hysterectomy in 1948, bilateral salpingo-oophorectomy in 1990, cholecystectomy in 1959, and right palmar fascia release.

At autopsy, the body was that of a thin, graying woman weighing approximately 110 pounds with two well-healed abdominal scars, one in the midline approximately 25 cm. in length, and one in the right upper quadrant approximately 13 cm. in length. A Baker tube was present in the right upper quadrant which was draining yellow-green fluid. There was no evidence of cyanosis, jaundice or edema. A nasogastric tube was present. No serosanguineous pleural effusions were identified. The lungs weighed 770 and 700 gm., right and left respectively. Both had smooth and shiny pleural surfaces and on cut surface there was a diffuse patchy bronchopneumonia. Sections show a large amount of proteinaceous fluid within the alveoli consistent with pulmonary edema. Sections also show areas with numerous polymorphonuclear leukocytes, hemorrhage and macrophages within alveoli, consistent with acute bacterial bronchopneumonia. In several areas, bacterial colonies can be seen within the alveoli, composed of cocci in chains and clumps. There is marked congestion of the septal blood vessels. No hyaline membranes are identified. A few foci of intravascular fibrin clots are identified in smaller vessels. Within the panniculus adipose, numerous irregular white mucoid nodules were identified ranging from 3 cm. to less than 0.5 cm. in greatest dimension. Increased numbers of these nodules were present within the breast tissue. Sections of these nodules show lakes of mucin within which there are neoplastic cells with irregular hyperchromatic nuclei and eosinophilic cytoplasm. Many of these cells are signet-ring forms. This is consistent with her prior history of mucinous adenocarcinoma of the colon. The heart, weighing 470 gm., showed no evidence of hypertrophy, but was floppy and grossly had a diffuse subendocardial pallor. There were several irregular gray-white mucoid nodules within the pericardial fat, predominantly around the vessels, ranging from 3 cm. in greatest dimension.
SUMMARY: (continued)

to 0.3 cm. in greatest dimension. All of the valves were normal. The coronary arteries showed mild to moderate atherosclerotic disease with 30% stenosis of the right coronary artery, and 20% stenosis of the anterior descending and circumflex. Sections show patchy interstitial fibrosis of the myocardium consistent with chronic ischemia. There is also patchy hyperesinophilia within the subendocardial region, consistent with terminal subendocardial ischemic/hypoxic change. In the apex, neoplastic cells within lakes of mucin with the same histology as in the subcutaneous nodules are identified both within the myocardium and within the pericardial adipose tissue. Groups of these neoplastic cells are also present within vessels. The liver, weighing 1,200 gm., grossly had a nutmeg appearance and no grossly identifiable metastatic nodules. The sections show chronic passive congestion with centrilobular necrosis. The kidneys, each weighing 140 gm., grossly were normal. Sections show severe acute tubular necrosis with few viable tubules being present. The glomeruli are relatively preserved, with no pathologic change. There is no evidence of a glomerulonephritis or a pyelonephritis. Both ureters passed unobstructed into the bladder which was normal. The left adrenal was normal, however, grossly the right adrenal consisted of a gray-white mucoid 6 x 5.0 x 5.0 cm. mass, with a necrotic center. Sections show a thin rim of adrenal cortex surrounding tumor of the same histology of lakes of mucin with neoplastic cells within them. Tumor was also identified in the peritracheal/peri-aortic regions. Her uterus, tubes and ovaries were absent. There were numerous small and large bowel adhesions, and the colon was absent. The pancreas was grossly normal with no evidence of metastasis. Sections show a normal lobular architecture and no metastatic disease. Postmortem cultures from the lung grew out Staphylococcus aureus, and postmortem blood cultures grew out staphylococcus, streptococcus, and gram-negative bacilli.

Within the cerebellum, three mucoid, glistening masses were identified, ranging from 5 cm. to 3 cm. in greatest dimension. Microscopic examination shows these are metastases composed of mucinous adenocarcinoma. See neuropathology report.

In conclusion, this 70-year-old white female had widely metastatic mucinous adenocarcinoma of the colon. At autopsy she had metastases involving her retroperitoneum, numerous peri-aortic and thoracic lymph nodes, right adrenal gland, myocardium and pericardial adipose tissue, both cerebellar hemispheres, and subcutaneous tissues. In addition, she had bilateral bronchopneumonia, pulmonary edema, severe acute tubular necrosis, and acute and chronic ischemic change within her myocardium.

Michele P. Normandin, MD
Resident

Ann E. Perry, MD
Pathologist
Patient: FOGG, Melba E.  
Pathologist: William F. Hickey, MD  
Prosector: Michele P. Normandin, MD

Autopsy No.: A93-052  
Hospital No.: 806032-2  
Date of Death: 03-13-93  
Date of Autopsy: 03-14-93

**Gross:**

The weight of the brain in the fixed state is 1200 gm. The dura is available and is normal on gross examination, with the dural sinuses being patent and free of clot. The cerebral blood vessels show no atherosclerosis. There are no aneurysms present. The cranial nerves cannot be assessed, secondary to artifactual damage in removal of the brain. The cerebral hemispheres are symmetrical with a normal gyral pattern and normal meninges. There is no evidence of tumor, mass effect, inflammation, or recent or old infarct. The cerebellum was grossly asymmetrical with a 5 cm mucoid, glistening, irregular mass being present in the right superior cerebellar hemisphere. The tumor has sharp edges where it is adjacent to the brain tissue. There is another mucoid mass on the left, 4 cm in greatest dimension. The brain stem is of normal size and shape for the brain. On cut surface, the cortical ribbon is of normal thickness without focal defect. The centrum semiovale is of normal mass. The putamen, globus pallidus, and caudate are all unremarkable. The thalamus and internal capsules are normal. On cut surface, the cerebellum is distorted by the two previously described masses. A third intraparenchymal mass, 3 cm in greatest dimension, is found within the right cerebellar hemisphere. It has the same mucoid glistening appearance as the previously described masses. On serial horizontal section, the brain stem is unremarkable. Within the mesencephalon, the substantia nigra is normally pigmented. The aqueduct is patent and of normal size. The mass of the pons is normal. The medulla and inferior olivary nuclei are grossly normal.

**Sections Submitted:**

1. Frontal lobe  
2. Hippocampus  
3. Parietal lobe  
4. Ball of tumor from right superior cerebellar hemisphere  
5. Medulla  
6. Intraparenchymal mass within right cerebellar hemisphere  
7. Ball of tumor from left cerebellar hemisphere

**Microscopic:**

Microscopic sections of the frontal lobe, parietal lobe and hippocampus show no pathologic features. No neurofibrillary tangles or plaques are seen within the hippocampus. The cortical areas are all microscopically normal. There is some degenerative change of the choroid plexus, however, this is normal with age. Sections of the ball of tumor within the right superior cerebellar hemisphere show the same histologic features as in the
Microscopic: (continued)

previously described tumor with pleomorphic cells, some signet shaped, floating in lakes of mucin. The cerebellar tissue surrounding the tumor shows changes consistent with compression, with an occasional drop-out of Purkinje cells. No other pathology is identified within the cerebellum.

Pathologic Diagnoses:

I. Metastatic mucinous adenocarcinoma within the cerebellum

Michele P. Normandin, MD
Resident

William F. Hickey, MD
Neuropathologist
Voting Sheets
HOUSE COMMITTEE ON JUDICIARY AND FAMILY LAW

EXECUTIVE SESSION on HB 339

BILL TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: 3/7/95
LOB ROOM: 208

Amendments:

Sponsor: OLS Document #: Adopted/Failed
Sponsor: OLS Document #: Adopted/Failed
Sponsor: OLS Document #: Adopted/Failed

Motion: OTP, OTP/A, ITL, Re-Refer, Interim Study (please circle one)
Moved by Rep. HESS
Seconded by Rep. KENNEDY

Vote: (Please attach record of roll call vote)

Motion: OTP, OTP/A, ITL, Re-Refer, Interim Study (please circle one)
Moved by Rep. HART
Seconded by Rep. BROWN

Vote: (Please attach record of roll call vote)

CONSENT CALENDAR VOTE:
(Vote to place on Consent Calendar must be unanimous)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Sandra Balomenos Kean, Clerk
<table>
<thead>
<tr>
<th>Name</th>
<th>Votes</th>
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<tbody>
<tr>
<td>Lockwood, Robert A.</td>
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<td>Hess, David W., V Chairman</td>
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<td>Battles, Marjorie H.</td>
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<tr>
<td>Hart, Nick</td>
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<td>Kennedy, Richard E.</td>
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<td>Mittelman, David T.</td>
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<td>Keans, Sandra Balomenos, Clerk</td>
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<td>Brown, Julie M.</td>
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<td>Jacobson, Alf E.</td>
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<td>Barry, Janet Gail</td>
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<td>McCarthy, John J., Jr.</td>
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<td>Hallyburton, Margaret D.</td>
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<td>Letendre, Evelyn S.</td>
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<td>McMahon, Donald F.</td>
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<td>Streeter, Janice B.</td>
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<td>Wall, Janet G.</td>
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<td>DePecol, Benjamin J.</td>
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<td>Allison, David C.</td>
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<td>Johnson, Lionel W.</td>
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<td>Mayhew, Josephine</td>
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<tr>
<td>Pratt, Irene A.</td>
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**Total Vote**: 6-1-15-3

- Appeared in Favor
- Appeared in Opposition
Committee Report
COMMITTEE REPORT

COMMITTEE:  JUDICIARY AND FAMILY LAW

BILL NUMBER:  HB 339

TITLE:  relative to death with dignity for certain persons suffering from a
terminal condition.

DATE:  3/7/95  CONSENT CALENDAR  YES ___  NO ___x___

___  OUGHT TO PASS

___  OUGHT TO PASS WITH AMENDMENT

___  INEXPEDIENT TO LEGISLATE

___  RE-REFER

___  REFER TO COMMITTEE FOR INTERIM STUDY

(AVAILABLE ONLY IN SECOND YEAR OF BIENNium)

STATEMENT OF INTENT

(Include Committee Vote)

This bill brings out the necessity of some process or method to take better
care of our terminally ill. The committee voted 12 to 6 not to kill this
bill. By a 15-3 vote the committee felt further study might bring out some
other vehicles to help persons suffering from a terminal condition.

Vote 15-3.

Rep. Nick Hart
FOR THE COMMITTEE

Original:  House Clerk
cc:  Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT
JUDICIARY AND FAMILY LAW

HB 339, relative to death with dignity for certain persons suffering from a terminal condition. RE-REFER

Rep. Nick Hart for Judiciary and Family Law: This bill brings out the necessity of some process or method to take better care of our terminally ill. The committee voted 12 to 6 not to kill this bill. By a 15-3 vote the committee felt further study might bring out some other vehicles to help persons suffering from a terminal condition. Vote 15-3.
COMMITTEE REPORT

COMMITTEE: JUDICIARY AND FAMILY LAW
BILL NUMBER: HB 339
TITLE: relative to death with dignity for certain persons suffering from a terminal condition.
DATE: CONSENT CALENDAR YES ___ NO √
___ OUGHT TO PASS
___ OUGHT TO PASS WITH AMENDMENT
___ INEXPEDIENT TO LEGISLATE
√ RE-REFER
___ REFER TO COMMITTEE FOR INTERIM STUDY

(AVAILABLE ONLY IN SECOND YEAR OF BIENNIAL)

STATEMENT OF INTENT
(Include Committee Vote)

This bill brings out the necessity of some procedure or method to take better care of our terminally ill. The committee voted 12 to 6 NOT to kill this bill. By a 15-3 vote the committee felt further study might bring out some other vehicles to help persons suffering from a terminal 15-3 condition.

Rep. [Signature]
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT
COMMITTEE: JUDICIARY AND FAMILY LAW

BILL NUMBER: HB 339

TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: October 25, 1995    CONSENT CALENDAR YES ___ NO ___

___ OUGHT TO PASS

___* OUGHT TO PASS WITH AMENDMENT

___ INEXPEDIENT TO LEGISLATE

___ RE-REFER

___ REFER TO COMMITTEE FOR INTERIM STUDY

(AVAILABLE ONLY IN SECOND YEAR OF BIENNIALM)

STATEMENT OF INTENT

(Include Committee Vote)

HB 339 extends the right to die with dignity under sharply defined restrictions. The bill imposes no mandate on anyone. This bill is a basic freedom of choice legislation.

Vote 12-7.

Rep. Alf E. Jacobson
FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT
MAJORITY
COMMITTEE REPORT

COMMITTEE: JUDICIARY & FAMILY LAW
BILL NUMBER: HB 339
DATE: 10/25/95 CONSENT CALENDAR: YES NO X

OUGHT TO PASS

OUGHT TO PASS WITH AMENDMENT √

LEGISLATE
INEXPEDITION TO LEGISLATURE

RE-REFER TO COMMITTEE (1st year session)

REFER FOR INTERIM STUDY (2nd year session)

VOTE: 12-7

STATEMENT OF INTENT


The FN calls for state expenditures of $_________ in FY '91 and $_________ in FY '92. The Committee amendment increases/decreases House expenditures.

______________________________________________
Signature

Original: House Clerk
cc: Committee bill file

USE ANOTHER FORM FOR MINORITY REPORT
HR 339 extends the right to die with dignity under sharply defined restrictions. The bill does not impose no mandate on anyone. The bill is a basic freedom of choice legislation.
Bill # HB339

Public Hearings

Executive Session 10/25/95

COMMITTEE REPORT: OTPbAm 3960L + 3919L

<table>
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<th>YEAS</th>
<th>NAYS</th>
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Lockwood, Robert A., Chairman
Hess, David W., V Chairman
Battles, Marjorie H.
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Kennedy, Richard E.
Mittelman, David T.
Keane, Sandra Balomenos, Clerk
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McMahon, Donald F.
Streeter, Janice B.
Wall, Janet G.
Healy, Daniel J.
DePecol, Benjamin J.
Allison, David C.
Johnson, Lionel W.
Mayhew, Josephine
Pratt, Irene A.

Richardson, Barbara Hull
TOTAL VOTE

Appeared in Favor | Appeared in Opposition
MINORITY COMMITTEE REPORT NO. 1

COMMITTEE: JUDICIARY AND FAMILY LAW

BILL NUMBER: HB 339

TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: October 25, 1995 CONSENT CALENDAR YES ___ NO ___

___ OUGHT TO PASS

___ OUGHT TO PASS WITH AMENDMENT

___ INEXPEDIENT TO LEGISLATE

___ RE-REFER

___ REFER TO COMMITTEE FOR INTERIM STUDY

(AVAILABLE ONLY IN SECOND YEAR OF BIENNIALM)

STATEMENT OF INTENT

(Include Committee Vote)

I am opposed to both passage and/or interim study of HB 339 on moral and ethical grounds. The AMA has developed policies prohibiting physician-assisted suicide. It is my belief that physician-assisted suicide is likely, in the long run, to cause more problems than it hopes to solve.

Vote 7-12.

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT
COMMITTEE: JUDICIARY & FAMILY LAW

BILL NUMBER: HB-339

DATE: 10/25/95  CONSENT CALENDAR: YES  NO  

OUGHT TO PASS

OUGHT TO PASS WITH AMENDMENT

LEGISLATE

INEXPEDIENT TO LEGISLATE  

RE-REFER TO COMMITTEE (1st year session)

REFER FOR INTERIM STUDY (2nd year session)

VOTE:

STATEMENT OF INTENT

I am opposed to passage and/or interim study of HB 339 on moral & ethical grounds. The AMA has developed policies prohibiting physician-assisted suicide. 

Let it be my belief that physician-assisted suicide is likely in the long run to cause more problems than it hopes to solve.

The FN calls for state expenditures of $ in FY '91 and $ in FY '92. The Committee amendment increases/decreases House expenditures.

Original: House Clerk
cc: Committee bill file

Signature

USE ANOTHER FORM FOR MINORITY REPORT
MINORITY COMMITTEE REPORT NO. 2

COMMITTEE: LEGISLATIVE ADMINISTRATION

BILL NUMBER: HB 339

TITLE: relative to death with dignity for certain persons suffering from a terminal condition.

DATE: October 25, 1995 CONSENT CALENDAR YES ___ NO ___

___ OUGHT TO PASS

___ OUGHT TO PASS WITH AMENDMENT

___ INEXPEDIENT TO LEGISLATE

___ RE-REFER

___ REFER TO COMMITTEE FOR INTERIM STUDY

(AVAILABLE ONLY IN SECOND YEAR OF BIENNIIUM)

STATEMENT OF INTENT

(Include Committee Vote)

Even those legislators who support this bill acknowledge that it is poorly crafted. There are a great many unanswered questions which the majority has chosen not to address for the sake of "sending a message." If we are to pass an act of this magnitude, it deserves to be coherent, workable, and internally consistent.

Vote 7-12.

Rep. Margaret D. Hallyburton
Rep. Lionel W. Johnson
FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT
MINORITY #2
COMMITTEE REPORT

COMMITTEE: Judiciary & Family Law

BILL NUMBER: HB389

DATE: 10-25-95 CONSENT CALENDAR: YES NO X

OUGHT TO PASS

OUGHT TO PASS WITH AMENDMENT

LEGISLATE

INEXPEDIENT TO LEGISLATE

RE-REFER TO COMMITTEE (1st year session)

REFER FOR INTERIM STUDY (2nd year session) X

VOTE:

STATEMENT OF INTENT

Refer for Interim Study, Reps. M. Hallyburton and H. Johnson. Even those legislators who support this bill acknowledge that it is poorly crafted. There are a great many unanswered questions which the majority has chosen not to address for the sake of "sending a message." If we are to pass an act of this magnitude, it deserves to be coherent, workable, and internally consistent.

The FN calls for state expenditures of $________ in FY '91 and $________ in FY '92. The Committee amendment increases/decreases House expenditures.

Original: House Clerk
cc: Committee bill file

USE ANOTHER FORM FOR MINORITY REPORT