

Centennial Institute

POLICY BRIEF

Suicide By Doctor

What Colorado Would Risk
on the Slippery Slope
of Physician-Assisted Suicide¹

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Editor: Following the lead of five other states and several foreign countries, proponents in Colorado this year are seeking both legislation and a ballot initiative to allow a physician to assist with a patient's suicide.

If such a measure became law, it would invert the doctor's time-honored role from the sacred duty of sustaining life to the ghoulish power of terminating it.

Centennial Institute asked two respected attorneys formerly with our sister organization Alliance Defending Freedom and now with the Colorado Freedom Institute, for a legal and ethical analysis of what is at stake as both the Colorado General Assembly and citizens of Colorado confront this issue. Here is their report.

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OVERVIEW: EUGENICS FOR THE INFIRM

From the earliest times, doctors have taken an oath to do no harm to patients and have been trusted and reliable caregivers and healers for the elderly, the infirm, and the physically and mentally disabled. Today, prompted by the suicide of Brittany Maynard, a 29-year-old woman with brain cancer, pressure continues to mount from “progressives” to allow those doctors who don’t take their oaths to heart to abandon their historic roles as healers and instead to help their patients commit suicide. Doctor-prescribed suicide proponents call it “death with dignity.”

In 2014, the suicide of Robin Williams, who had also been diagnosed with a terminal illness and was suffering from deep depression, caused millions to mourn. Yet, as with Ms. Maynard’s death, radical doctor-prescribed-suicide advocates are back in the public arena, twisting these and other unfortunate deaths into support for their ignoble cause.

Blackstone called it “self-murder”

Though its proponents promote doctor-prescribed suicide as “death with dignity,” doctor-prescribed suicide is anything but dignified. It is motivated by crass economic considerations -- motivations like “we’ll pay for your poison, but not your healing medicines” or “we’re here to end your life, not heal you.” The truth is that doctor-prescribed suicide amounts to eugenics for the infirm, but with the government’s stamp of approval. Tragically, patients must now worry that doctors in many jurisdictions are no longer necessarily committed to “first do no harm” but to “first consider assisted suicide.”

Physician-assisted suicide is dangerous for a myriad of reasons and should be aggressively resisted.

DISTINCTION FROM EUTHANASIA OR REFUSAL OF TREATMENT

As with any examination of an issue, it is important to understand the various terms used when discussing “physician-assisted suicide”—what it is and what it is not.

Physician-assisted suicide requires the affirmative assistance of a trained and licensed physician to facilitate the death by suicide of her patient. The doctor supplies death-inducing drugs to her patient; then her patient, at least theoretically, performs the act that ultimately causes death (*i.e.*, consumes the fatal drugs).³ The doctor does not even need to be present at the time the patient takes the drugs, if, in fact, the patient **does** take the drugs, rather than having them administered, perhaps unknown to the patient, by another. In Oregon, for example, the most commonly prescribed drugs for physician-assisted suicide are secobarbital and pentobarbital, bitter drugs in lethal doses that are mixed with juice in an attempt to make them more palatable.⁴

After the patient drinks this concoction, death may or may not come quickly.⁵ According to official reports available in Oregon and Washington, the overwhelming majority of the time, a physician is *not* even present at the time of the suicide or ingestion of the fatal prescription.⁶

Euthanasia, in contrast, refers to a circumstance where the doctor, rather than the patient, performs the act that causes the death of the patient. Theoretically, this is done after the patient expresses the wish to end his or her life, although there is substantial and growing evidence that, in many instances, physicians have euthanized patients without an expressed request by the patient.⁷

Importantly, neither physician-assisted suicide nor euthanasia involves the situation where a patient, as a patient has a right do, *refuses medical treatment* or where the administration of the lethal drug be withdrawn or cancelled.⁸

Indeed, it is well-settled that competent adults have the ability to either receive or refuse medical care and treatment. In those instances, as opposed to physician-assisted suicide or euthanasia, death is from natural causes and is not a result of an act by either the patient or doctor.

HISTORY OF PHYSICIAN-ASSISTED SUICIDE AND THE RIGHT TO DIE

Throughout history, suicide—and assisting another person in committing suicide—has been condemned. For over 700 years going back to the pre-Norman era, Anglo-American legal tradition has disapproved of, or even punished as a crime, suicide and assisting another in committing suicide.⁹

In the 13th century, Henry de Bracton noted in a legal treatise that a man committed a felony by killing another person or himself. Indeed, the property of a person who killed himself was subject to forfeiture.

Sir William Blackstone, centuries later, referred to suicide as “self-murder” and ranked it among the highest of crimes. The American colonies followed this English common-law approach although they ultimately reduced or eliminated the harsh common-law penalties.

Notably, the historic prohibitions against suicide included the prohibition of assisting another in committing suicide, with no exceptions for those who were near death.¹⁰

Efforts to legalize physician-assisted suicide have consequently been met with tremendous and justified resistance. This has necessitated slick messaging campaigns by those in the “right to die” movement as they have sought to engage contributors and increase popular support. (See further discussion in Appendix.)

Organization names have even been changed over the years in an effort to repackage their message and blur its implications. For example, the much maligned Hemlock Society changed its name to the softer-sounding “Compassion and Choices” organization. But, the underlying purposes have remained essentially the same. Despite their efforts, physician assisted suicide remains unlawful and morally unacceptable throughout most of the world.

IN THE WORLD

Of the world’s 195 countries, only a miniscule fraction permits physician-assisted suicide.

Switzerland has tolerated assisted suicide for many years, and even today physician-assisted suicide is not clearly regulated by Swiss law.¹¹

In *Nazi Germany*, Dr. Karl Brandt, Hitler’s personal physician, was in charge of the Nazis’ T-4 Euthanasia Program, which was instrumental in euthanizing thousands of people. Brandt later testified at his Nuremburg trial, “The underlying motive was the desire to help individuals who could not help themselves and were thus prolonging their lives of torment.”¹²

Hitler’s doctor: His motive was to “help”

The Netherlands was first exposed to assisted suicide in 1973 when a physician, Dr. Geertruida Postma, gave a lethal injection to her 78-year-old mother who was deaf and partially paralyzed. While Dr. Postma was later convicted of murder, the court, finding her act to be “compassionate,” suspended her sentence effectively exonerating her.¹³ Tolerated thereafter, physician-assisted suicide formally became legal in the Netherlands in 2002.

In 1996 assisted suicide was legalized for a brief time in the Northern Territory of *Australia*, though that was quickly repealed.¹⁴

In 1997, *Colombia's* Supreme Court found a constitutional right to euthanasia for those terminally ill patients who requested it.¹⁵

Luxembourg legalized euthanasia and physician-assisted suicide in 2009.¹⁶

Belgium legalized euthanasia in 2002, and in 2014 the law was extended to permit euthanasia for children.¹⁷

In 2015, *Canada's* Supreme Court legalized doctor-prescribed suicide. Ironically, it did so pursuant to the “right to life” and other protections set forth in Canada’s constitution.¹⁸ The court suspended implementation of its ruling for one year. Notably, the court’s opinion did not limit doctor-prescribed suicide to those with a terminal illness. In January 2016, Quebec confirmed the first case of legal doctor-prescribed suicide and others are being reported, and a joint parliamentary committee has been appointed to review the issue.¹⁹

IN THE UNITED STATES

In the United States, only five states permit physician-assisted suicide.²⁰ However, proponents of doctor-prescribed suicide have made numerous efforts to bring this death by doctor mechanism to other states through both ballot initiatives and legislative measures. Ballot initiatives were defeated in Washington (1991), California (1992), Michigan (1998), Maine (2000), and Massachusetts (2012).²¹ In addition, there have been over 175 legislative proposals in more than thirty-five different states since 1994.²²

The citizens of *Oregon* passed a physician assisted suicide referendum in 1994, promoted as “Death with Dignity.” The Oregon referendum narrowly passed, receiving only 51 percent of the vote while 49 percent of citizens voted against the referendum. After a long legal battle, physician-assisted suicide was implemented in Oregon in 1998.

Ten years later, in 2008, physician-assisted suicide was approved by a ballot measure in *Washington State*, and went into effect in 2009.

In 2009, the *Montana* Supreme Court ruled that a consent defense was available for physicians who assisted their patients with suicide as there was nothing in Montana case law or statutes that indicated that “physician aid in dying is against public policy.” This judicial opinion is considered by many to have *de facto* legalized doctor-prescribed suicide in Montana.

In 2013, *Vermont's* legislature legalized doctor-prescribed suicide. Although certain provisions of the law were scheduled to sunset in 2016, the legislature made all provisions permanent in 2015.²³

In *New Mexico*, the legality of doctor-prescribed suicide was litigated in 2015, *but rejected* by the New Mexico Court of Appeals when it overturned the ruling of a state district court judge that terminally ill patients had a right to assisted suicide under the state constitution. Recently, the New Mexico Supreme Court unanimously ruled that there is no

“absolute and fundamental right” to doctor-prescribed suicide in New Mexico’s constitution and the state’s law against aiding or assisting another to end his or her life is, in fact, constitutional.

In 2015, the *California* legislature passed a bill legalizing doctor-prescribed suicide during a special session. California Governor Jerry Brown signed the bill into law on October 5, 2015. The California law, which took effect on June 9, 2016, allows California doctors to prescribe lethal medications to terminal patients with less than six months left to live. One stated purpose of the bill was to “stabilize the General Fund’s costs for Medi-Cal.”

There is no doubt that permitting doctors to prescribe a deadly overdose of drugs to patients will save money for California. But at what cost to vulnerable patients?

IN COLORADO

In *Colorado*—where Compassion and Choices, formerly the Hemlock Society, is based – a so-called Death with Dignity law was once again introduced in the state legislature. Despite previous decisive defeats, proponents of assisted suicide aggressively continue their legalization efforts.

In 1995, Colorado Democratic Representative Peggy Lamm introduced House Bill 95-1308, *Enactment of Referred Measure on Colorado Dignity in Death Act*, seeking to bring assisted suicide to Colorado for the first time. The bill was defeated. The very next year, a similar bill, House Bill 96-1185, *Colorado Dignity in Death Act*, was again introduced by Representative Lamm and also defeated. Last year, Colorado Democratic Representatives Ginal and Court introduced House Bill 15-1135, again seeking to legalize doctor-prescribed suicide in Colorado. The Ginal-Court bill was defeated in committee by a bipartisan vote.

In 2016, Representatives Ginal and Court again introduced a doctor-prescribed suicide bill in the Colorado House of Representatives. Though a nearly identical bill introduced in the Colorado Senate was defeated by a Senate committee, a House committee passed the bill. Eventually, the 2016 bill was defeated.

Up for consideration in November of 2016, ballot initiative 145 seeks to make physician-assisted suicide legal in Colorado.

U.S. SUPREME COURT CASES REGARDING THE RIGHT TO DIE

While physician-assisted suicide has most often been dealt with at the state level, the United States Supreme Court has also weighed in on the issue. The Court has decided four cases involving the right to die, three of which involved physician-assisted suicide.

The Supreme Court first addressed the right to die, at least indirectly, in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). Nancy Cruzan had been severely injured in an automobile accident. When doctors opined that Cruzan, though not considered “terminally ill,” would never recover from what they termed a “persistent vegetative state” nor regain cognitive functioning, her parents sought a court order to direct the removal of her food and hydration.²⁴

***Cruzan case
opened the door***

Cruzan’s so-called “persistent vegetative state” left her incompetent and unable to make an “informed and voluntary” decision regarding whether to continue or refuse medical treatment. Missouri had established safeguards requiring that an incompetent patient’s wishes regarding withdrawal of treatment be established by clear and convincing evidence. In the initial proceedings, her parents were unable to provide “clear and convincing evidence” of her expressed desire to withdraw life support before she had become incompetent.

The Court held that a competent person has a right under the Fourteenth Amendment’s Due Process Clause to refuse unwanted medical treatment. *Id.* at 278 (citing *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905)). The Court confirmed that the protection and preservation of human life is a legitimate state interest.²⁵

“[I]ndeed, all civilized nations demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide,” stated the majority opinion. “We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.”²⁶

The Court acknowledged that in some circumstances, family members will not act to protect a patient,²⁷ and that an erroneous decision to withdraw life-sustaining treatment could not be corrected.²⁸

Although the Cruzans technically lost at the U.S. Supreme Court with the Court ruling that the U.S. Constitution did not prevent the State of Missouri from requiring clear and convincing evidence of an incompetent patient’s wishes to withdraw life-sustaining treatment, the Cruzans ultimately prevailed.

Shortly after the Supreme Court ruling, the Cruzans went back to state court with new “clear and convincing evidence,” and were granted a court order to remove Nancy’s food and hydration. Nancy Cruzan died twelve days later.

A few years later, the U.S. Supreme Court specifically addressed the issue of physician-assisted suicide in two cases brought by pro-euthanasia advocates. The Court held that statutes criminalizing physician-assisted suicide violated neither the Due Process Clause nor the Equal Protection Clause of the Fourteenth Amendment. *Washington v. Glucksberg*, 521 U.S.

***Glucksberg and Vacco cases
deferred issue to states***

702 (1997), involved a constitutional challenge to a Washington statute criminalizing physician-assisted suicide,²⁹ alleging that the statute violated the Fourteenth Amendment.

The Court held that the Fourteenth Amendment Due Process Clause does not provide a “fundamental liberty interest” in physician-assisted suicide.³⁰ The Court found that the Washington statute was “reasonably related” to a compelling state interest, including protecting life, preventing suicide, preserving the integrity of the medical profession, protecting vulnerable groups, and avoiding the slippery slope from voluntary to involuntary euthanasia.³¹

In another case, decided the same day, *Vacco v. Quill*, 521 U.S. 793 (1997), the Supreme Court held that a New York statute criminalizing assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment.³² The plaintiffs, three New York physicians and their terminally ill patients, had argued that physician-assisted suicide was essentially the same as allowing a mentally competent, terminally ill patient to refuse treatment and attempted to use the *Cruzan* decision in support of their position.

The Court flatly rejected this argument and stated that while “[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide.”³³ The New York law was upheld as constitutional and reasonably related to essentially the same compelling state interests discussed in *Washington v. Glucksberg*.³⁴

While neither *Glucksberg* nor *Vacco* recognized a constitutional right to physician-assisted suicide, neither case equated to a ban on the practice. Consequently, yet another case arose, *Gonzales v. Oregon*, 546 U.S. 243 (2006), wherein the Supreme Court again addressed physician-assisted suicide, this time in the context of the Oregon Death with Dignity Act.

In 2001, the U.S. Attorney General under President George W. Bush, Alberto Gonzales, had issued an Interpretive Rule providing that “assisting suicide is not a ‘legitimate medical purpose’ ...and that prescribing, dispensing, or administering federally controlled substances to assist suicide violates the Controlled Substances Act.”³⁵

The Court found in *Gonzales* that the Interpretive Rule did not actually “interpret” the relevant federal statute, but expanded upon it, and that the CSA did not authorize the Attorney General to prohibit doctors from prescribing federally regulated drugs to terminally ill patients to assist their suicides.³⁶

***Bush Administration's
anti-suicide rule
struck down***

The practical effect of this holding was that the Attorney General could not use the Controlled Substances Act to prohibit doctors from prescribing federally-regulated drugs under Oregon’s Death with Dignity Act, and ultimately it advanced the legalization of physician-assisted suicide.

It is important to recognize that there are no Supreme Court cases that stand for the proposition that life does not deserve to be preserved and protected, even if someone does not think that life to be valuable. It is neither a constitutional nor a civil right to commit suicide. It is certainly neither a constitutional nor a civil right for someone who desires to commit suicide to enlist the assistance of another to do so. The government should neither encourage suicide nor become an accomplice to suicide by authorizing doctors to prescribe lethal drugs to kill another.

EIGHT REASONS TO REJECT PHYSICIAN-ASSISTED SUICIDE

There are a plethora of reasons why voters and legislators across the country, and in Colorado, should embrace the historic tradition of Western civilization to preserve and protect human life and reject physician-assisted suicide.

While there can be heart-wrenching cases that cause any compassionate person to question his or her position on this issue, those cases are rare given the current state of medical care and technology. As the stakes are huge, important public policy should not be based on a handful of exceptional cases, but rather on sound, rational reasoning that supports life.

One: All human life, including the lives of those who are elderly, infirm, or disabled, should be preserved and protected.

All human life is precious and deserves to be protected. The United States Supreme Court has repeatedly held that the preservation and protection of life is a legitimate and valuable state interest.³⁷ While all lives are valuable and to be protected, it is paramount that society protect its more vulnerable members—the elderly, the infirm, and the disabled. In addition to providing safeguards for their physical well-being, there must also be safeguards regarding decision-making by and for these vulnerable populations. This is particularly true in the context of physician-assisted suicide.

In states where physician-assisted suicide has been legalized, statistical reports are consistent with elder abuse.³⁸ Elder adults with a larger net worth are prime targets for abuse, often at the hands of family members.³⁹ The majority of physician-assisted suicides are elder, well-educated people, who are covered by insurance.⁴⁰ These people are more likely to have heirs, thus providing an incentive to promote suicide and preserve the wealth for the victims' heirs.

Dangerously, some of the physician-assisted suicide laws permit heirs and beneficiaries to be at least one of the witnesses to the “request” for physician-assisted suicide. While there is a façade of neutrality created by the requirement that one witness not be so interested, that façade is shattered when it is recognized that there are virtually no other requirements for the second witness. Consequently, the two “witnesses” could be the victim’s heir and the heir’s best friend – hardly an objective, disinterested pair.

Two: The integrity of the medical profession should be preserved and protected.

The Supreme Court has held that states have a legitimate interest in preserving the integrity and ethics of the medical profession.⁴¹ The Court acknowledged that physician-assisted suicide could undermine the trust that is critical to the physician-patient relationship by “blurring the time-honored line between healing and harming.”⁴²

Throughout history, physicians have been the healers, not the harmers. Doctors provide care and treatment for their patients, as opposed to killing them. The Hippocratic Oath, the oldest and most popularly administered medical oath, essentially compels doctors to “do no harm.” The traditional oath includes the provision: “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”⁴³

As Justice Scalia noted in his dissent in *Gonzalez v. Oregon*, “virtually every medical authority from Hippocrates to the current American Medical Association (AMA) confirms that assisting suicide has seldom or never been viewed as a form of ‘prevention, cure, or alleviation of disease,’ and (even more so) that assisting suicide is not a ‘legitimate’ branch of that ‘science and art,’” and that physician-assisted suicide is wholly incompatible with the physician’s role as healer.”⁴⁴ It would seem that proponents of physician-assisted suicide really want to include physicians in the suicide process in order to give legitimacy to a historically repugnant act.

***Don’t blur the line between
healing and harming***

The largest physician-based organization in Colorado, the Colorado Medical Society, opposes physician involvement in patient suicide. According to the CMS Policy Manual, adopted in September 2013: “The professional and societal risks of involving physicians in medical interventions intended to cause patients’ deaths are too great to condone euthanasia or physician-assisted suicide. Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care.”⁴⁵

Similarly, the American Medical Association, in an ethics opinion opposing physician-assisted suicide, stated:

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.

Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients

near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.⁴⁶

In the face of this, however, and ominously, some of the physician-assisted suicide legislative proposals require government officials to falsify information on death certificates by declaring that “actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide.”⁴⁷ That is simply false; physician-assisted suicide, regardless of what it is called, is suicide by definition.

AMA: Patients shouldn't be abandoned

It is imperative that the rights of conscience for physicians and other healthcare providers be protected. While there are many secular reasons to oppose physician-assisted suicide, there are many faith-based reasons to do so, as well. The religious liberties of medical professionals must be protected in this context.

Three: Depression and mental health reasons, not pain relief, are significant motivators in requests for physician-assisted suicide.

One of the primary arguments proponents of physician-assisted suicide posit is that it is necessary to alleviate the pain and suffering of those who have been diagnosed with terminal illnesses. However, intolerable pain and suffering is not a requirement in any of the physician-assisted suicide laws in the United States.

Moreover, no studies support the assertion that pain is the primary motivation behind physician-assisted suicide requests.⁴⁸ Much of the research demonstrates that depression, hopelessness, and fear of loss of autonomy and control are the primary motivations behind physician-assisted suicide requests.⁴⁹ The statistics gathered in Oregon and Washington to date confirms this. In Oregon, from 1998 to 2009, only 22 percent of patients who died as a result of physician-assisted suicide reported being in pain or afraid of being in pain.⁵⁰

According to the 2013, 2014, and 2015 Annual Report for Oregon, “inadequate pain control or concern about it” was next to the bottom of the list of patients’ end of life concerns.⁵¹

The top three concerns were losing autonomy, being less able to engage in activities making life enjoyable, and loss of “dignity.” The statistics reported in the 2013 and 2014 Annual Reports for Washington are the same. It is important to note that these are just concerns or fears, and may not even be reality.

In the Netherlands and Belgium, people who are not terminally ill, but rather those who suffer from depression or who are in the early stages of dementia are now being euthanized or assisted to suicide.⁵² In 2012, the Life-Ending Clinic went into operation in order to “assist” those whose personal physicians refused to assist in their suicides or euthanize them.

Even a psychiatrist seen as a pioneer of the Dutch euthanasia movement has commented that the law has “gone off the rails.”⁵³ There are countless tragic stories of healthy people suffering from depression being assisted with suicide—including a 35-year-old woman.

**Dutch euthanasia advocate:
Trend “off the rails”**

Significant advancements in palliative and medical care and treatment have made it such that it is only in extremely rare instances that physicians are unable to alleviate a patient’s pain.

Four: Misdiagnoses or inaccurate prognoses can lead to faulty decisions to request physician-assisted suicide.

If physician-assisted suicide is legalized, those who have been diagnosed with terminal illnesses will make decisions based on the information they have been provided by their doctors. They will make the decision of whether to take their own lives based on a *guess* as to when they may die from their illnesses. Yet there are plenty of instances where diagnoses have been incorrect or the guess as to how much time a person has left has been just plain wrong. (Maryann Clayton’s story, given in Appendix, is one dramatic example.)

The states that permit physician-assisted suicide require a diagnosis that death will result in six months or less. There is no legal guidance as to how to determine how long a person will live, and short of suicide or murder, there is simply no way to ascertain that with any degree of certainty. Indeed, many people who are terminally diagnosed and given six months to live survive beyond time period. Thus, patients are making decisions in the context of physician-assisted suicide based on faulty information and guesswork.

Dr. Nicholas Christakis is a Harvard professor of sociology and medicine whose own mother was given only a 10% chance to live more than three weeks when Christakis was only six years old and *yet lived another 19 years*. He has researched when patients die in comparison with the prognosis they receive from their physicians. His finding: at least 17% of patients – about one person in six – outlive their prognosis.⁵⁴

According to a paper published in the Journal of the American Medical Association, 70% of the 900 patients eligible for hospice care lived longer than six months.⁵⁵ That’s more than two persons in three.

It seems that one area where people can agree is that the six-month prognosis often required for physician-assisted suicide is arbitrary, and it is difficult to ascertain what will really happen with a person six months into the future.⁵⁶

Given the uncertainties and potential for misdiagnoses and inaccurate prognoses, it is important to consider that, just as the Supreme Court noted with decisions to withdraw life-sustaining treatment, an erroneous decision to commit suicide is not susceptible to correction.

Five: In the states where assisted suicide has been legalized, there is little oversight of the process and medications prescribed.

Amazingly, none of the states where doctor-prescribed suicide is legal require the presence of the prescribing physicians at either the time of ingestion or the time of death. The physician issues the prescription and it is filled by the patient or his or her agent at a local pharmacy. Thereafter, only the patient or those near the patient have any ability to determine what happens to the lethal drugs that have been dispensed to the patient. The statistics from Oregon and Washington reveal that a disturbing number of lethal doses of these medications are unaccounted for.

In Oregon, according to the 2015 Death With Dignity Act Report, prescriptions were written for 218 people during 2015. Of those people, 125 ingested the lethal drugs and died, whereas 50 people did not ingest the lethal drugs, but died “of other causes.” Ingestion status is unknown for 43 patients.

Consequently, the whereabouts of approximately 43% of highly lethal drug dosages are undocumented, unaccounted for, and likely unknown. And that is just for 2015. Were the prescriptions filled? Under what conditions are or were the lethal doses stored? Were unused dosages returned? If not, how were they disposed of? These are all questions that nobody can answer because the statutes provide no transparency, no accountability, and there is a complete lack of oversight in all states where assisted suicide has been legalized.

In Washington, according to the 2014 Death With Dignity Act Report, the most recently available report, medication was *dispensed* to 176 patients in 2014. 170 of those patients are known to have died. Of those, only 126 died after ingesting the lethal drugs, whereas 17 did not take the lethal drugs; the ingestion status for the remaining 27 people is unknown. Thus of 176 fatal doses of lethal drugs, the whereabouts of 50 highly lethal drug dosages are undocumented and likely unknown. Again, that is just for the year 2014.

None of these laws have any procedures for overseeing or accounting for these lethal drug prescriptions once issued. The laws merely direct that unused medications be disposed of according to medication take-back programs. The FDA information on disposal of unused medications is hardly sufficient to address drugs so powerful that they can kill within a minute of being ingested.⁵⁷ Essentially, once the lethal prescriptions leave the pharmacy, there is no telling where they will end up.

Perhaps even more troubling is the fact that these laws do not require the consent of the patient at the time the lethal drugs are administered, nor do they require the presence of the prescribing physician—or anyone else, for that matter.⁵⁸ Consequently, a terminally ill patient could obtain and fill a prescription to have as a “back up” plan just in case the drugs were later wanted, but then have the drugs administered to them by another person at a time when the patient was unable or unwilling to consent.

In Oregon, the prescribing physician was present when medication was ingested and death occurred in only 8 cases (out of 122 prescriptions issued) in 2013. The rest of the cases, over 90%, were unsupervised. In 2014, the prescribing physician was present when medication was ingested in 14 cases and in 15 cases in 2015. While the figures for the last two years represent an increase, they demonstrate that in the overwhelming number of cases, the prescribing physician is nowhere around when the lethal dose he or she prescribed is ingested.

Recently, Portland, Oregon Dr. William Toffler wrote that doctor-prescribed suicide in Oregon “has been detrimental to patients, degraded the quality of medical care, and compromised the integrity of the medical profession.” Worse, he added, “[t]here is a shroud of secrecy over the whole process that was built into the law. The data is all self-reported, often second or third hand, from doctors that believe in this paradigm and support it.” According to Toffler, Oregon is not tracking the circumstances that surround each patient’s assisted suicide, including how they took the drugs, whether someone witnessed the suicide, and whether those present had something to gain from the suicide.⁵⁹

In Washington, the prescribing physician was present for ingestion of the drugs in only *two* instances in 2013, and no statistics are available for 2014.

Essentially, a handful of doctors are issuing these fatal prescriptions and then failing to provide any oversight of the actual process. Such is a process ripe for abuse.

Six: Cost savings are not a legitimate reason to permit suicide by doctor.

Derek Humphreys, founder of the Hemlock Society now known as Compassion and Choices, acknowledged that money was an “unspoken” argument in favor of physician-assisted suicide, noting that hastening the death of the infirm would “free resources for others.”⁶⁰ He estimated the amount could run into the “hundreds of billions of dollars.”⁶¹

While Compassion and Choices and other euthanasia advocates now conveniently, and wisely, leave this resource argument out of their physician-assisted suicide talking points, it is indeed a major motivating factor for some.⁶² That money is an underlying motive behind the push for physician-assisted suicide is readily apparent in Oregon, as Barbara Wagner and Randy Stroup know all too well.

Ms. Wagner and Mr. Stroup, each diagnosed with terminal cancer, received chemotherapy prescriptions that could extend their lives by slowing the cancer’s progression and also make them more comfortable. Each applied for payment for their prescribed treatments through the Oregon Health Plan, the state’s Medicaid program. However, rather than receiving coverage for these life-sustaining treatments, each received a letter from the State of Oregon informing them that the state would *not* pay for the prescribed drugs, but *would* pay for physician-assisted suicide drugs.⁶³ One physician noted the financial incentive the state had to pay for death rather than life: the drug prescribed to Ms. Wagner,

***Oregon to cancer patients:
Please die***

would cost the state \$4,000 each month whereas the assisted-suicide drugs would cost less than \$100, once.⁶⁴

Nor were Ms. Wagner and Mr. Stroup the only two patients to receive such bleak news. A similar morbid letter was sent to terminally ill patients across the entire State of Oregon, stating that Oregon will not provide life-prolonging treatment unless there is a greater than 5% chance the treatment will assist the patient in living at least five more years; however, the State will pay for physician-assisted suicide, defining it as means of “comfort.”⁶⁵

Seven: The suggestion that suicide is the “dignified” way to die is offensive to the thousands of Americans who die naturally *and* with dignity each year, as well as to those who care for them.

Advocates of euthanasia and assisted suicide have taken care to package the patient’s suicide as “death with dignity.” Indeed, this is the formal title of Colorado’s proposed legislative act. The suggestion is that committing suicide is the dignified way to die.

This is utterly false. Thousands of people with terminal illnesses die naturally in this country each year.

It is disgraceful and offensive to attribute “indignity” to those who fought valiantly until their natural deaths, as well as to those medical professionals and caretakers who dedicated their careers and lives to caring for the terminally ill.

It might be fairer to ask whether those who *choose* suicide as a result of their terminal illness have tragically fallen victim to their own fatalism.

Eight: The slope is indeed slippery.

Dr. Ezekiel J. Emanuel, an oncologist, former White House adviser, and brother of Chicago Mayor Rahm Emanuel, has asserted that assisted suicide is a slippery slope:

Once legalized, physician-assisted suicide and euthanasia would become routine. Over time doctors would become comfortable giving injections to end life and...comfort would make us want to extend the option to others who, in society’s view, are suffering and leading purposeless lives.⁶⁶

This is most certainly true in other places where assisted suicide and euthanasia have been legalized. In Switzerland, there is the “suicide tourism” phenomenon. In Belgium, two healthy but deaf brothers, concerned with becoming blind and the potential resultant loss of independence, were euthanized.

Switzerland is seeing suicide tourism

An elderly Belgian couple, worried about loneliness in the event that the other would die first and that the cost of a good retirement home would be unaffordable, announced, with

the blessing of their children, their plan to commit suicide. Indeed, their son *assisted* them with physician-shopping, helping them locate a doctor willing to perform the euthanasia.⁶⁷

What began in those countries as an alleged effort to help those suffering with unbearable pain and agony at the end of their lives has evolved into the legalization of the “murder” of those who are depressed, children with deformities or illnesses, and victims in all sorts of other tragic scenarios. There is absolutely nothing to prevent those same evils here.

In fact, as just described, Oregon residents with terminal illnesses who have not requested physician-assisted suicide are being told the State will pay for them to kill themselves but won't pay for life-prolonging treatment. That would cost the State too much money.

Moreover, once consideration of the victim's own resources enters the picture, the slope becomes all the more slippery as even the personal resources a terminally ill person spends on his or her own treatment are then unavailable for the younger, the healthy and the heirs.

CONCLUSIONS

Suicide is a final, irreversible act.

*The doctor's essential obligation of sustaining life must be kept inviolate,
not tainted with the license to play God by terminating life
before that person's appointed time.*

*People of good will in Colorado and elsewhere must solidly stand
against the evil of physician-assisted suicide.*

APPENDIX

Strategems of the Suicide Movement: Further from Page 4

Perhaps the most well-known of the “right to die” organizations is the Hemlock Society. Derek Humphrey founded the Hemlock Society in 1980 as a euthanasia advocacy group. The group published a “suicide manual,” and first, unsuccessfully proposed legalizing physician-assisted suicide in California in 1986.

Five years later the organization published “*Final Exit*,” a “how, where and when to kill yourself or someone else” guide designed to provide instruction on orchestrating the “perfect death.”

After determining that the Hemlock Society needed a name and image change due to its “baggage,” the organization’s name was changed to “End-of-Life-Choices.” In 2004, it was merged with another organization and is now called “Compassion and Choices.”

Under this bland, the group today aggressively pursues its pro-euthanasia, pro-eugenics agenda across the country. Indeed, it is behind the scenes in many of the attempts to push assisted suicide bills through state legislatures, showing up on scene with publicists, lobbyists, and large amounts of money to persuade lawmakers or voters.

It is important that the public understand, however, that it is really hearing from the same old Hemlock Society, just packaged with a new alias. See Rita Marker, *Assisted Suicide & Death with Dignity: Past, Present & Future – Part I*, InternationalTaskForce.Org, Jan. 2005, <http://www.patientsrightscouncil.org/site/rpt2005-part1/>

Prognoses Disproved: Further from Page 12

Maryann Clayton, at age 62, was diagnosed with Stage IV lung cancer and a metastasized tumor and given two to four months to live. Alive and well four years and many family vacations later, Ms. Clayton spoke out about her experience when Washington sought to legalize doctor-prescribed suicide. See Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, available at <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>.

In this same article other similar stories are recounted. One is by Dr. J. Randall Curtis, who describes a patient he treated who was suffering from septic shock and multiple organ failure; he kept her on life support “against his better judgment because her family insisted,” despite his belief that she had only days or weeks to live. That woman improved, left the hospital, and subsequently returned to visit him.

There are many, many more of these stories. Vermont Alliance for Ethical Healthcare has documented the stories of several witnesses who testified against doctor-prescribed

suicide in Vermont.⁶⁸ For example, Erica Riel of Barre, Vermont, had been diagnosed with a terminal illness three times by Vermont doctors, only to have a Massachusetts doctor, seen at the encouragement of family members, advise her that “not only would she live, but would live to be 80 years old!” Jeannine Young testified about her father’s erroneous prognosis; he in fact lived another twenty years—long enough to walk six daughters down the aisle, attend the weddings of two of his sons, and for the birth of sixteen grandchildren and the wedding of a granddaughter. Clara Schoppe testified that 24 years earlier she had received a terminal diagnosis of Stage 4 non-Hodgkins Lymphoma and had been given less than a year to live.

These and countless other stories make Brittany Maynard’s decision to commit suicide all the more tragic, and the conclusion that Colorado must *reject* doctor-prescribed suicide inescapable.

ENDNOTES

¹ This paper, originally published in February 2015, has been supplemented by the authors Michael J. Norton and Natalie L. Decker in order to provide the most current information on physician-assisted suicide in Colorado and elsewhere.

² Michael J. Norton is the President and General Counsel of the Colorado Freedom Institute, a Colorado-based nonprofit legal organization dedicated to restoring religious freedom to Coloradans and to people across America. He previously served as the United States Attorney for Colorado and holds a masters of divinity degree from Denver Seminary. Natalie L. Decker is an attorney who has been licensed to practice in Colorado since 1997. She has extensive experience in criminal justice, elder law and probate. Ms. Decker is a contributing attorney to the Colorado Freedom Institute. Both Norton and Decker are also in the private practice of law.

³ See Ezekiel Emanuel, *Whose Right to Die?*, The Atlantic Online, March 1997, available at <http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/>.

⁴ Jennifer Fass, *et al.*, *Physician-Assisted Suicide: Ongoing Challenges for Pharmacists*, *Am J. Health Syst. Pharm.* (2011) 68(9):846-849, available at http://www.medscape.com/viewarticle/742070_3.

⁵ See Oregon Public Health Division, *Death With Dignity Act Report, 2015*, at 7. In 2015, the range of minutes between ingestion and death was 5 minutes to 34 hours.

⁶ *Id.* at 6. Of the 132 known physician-assisted suicide deaths in 2015 in Oregon, the prescribing physician was present in only 14 of those deaths (10.8%). Notably, there were 218 prescriptions written for the lethal prescription in 2015 in Oregon. The numbers of prescriptions issued annual has steadily increased, with an exception of eight fewer prescriptions issued in 2004 than in 2003. See also Washington State Dept. of Health, *2014 Death With Dignity Act Report*, at 9. Of the 176 lethal prescriptions issued in Washington in 2014, 126 are known to have died after ingesting the drugs.

⁷ See, e.g., Emanuel, *supra* note 3.

⁸ *Id.*

⁹ Chief Justice Rehnquist, in *Washington v. Glucksberg*, 521 U.S.702, 710-716 (1997), provides an excellent overview of the history of opposition to suicide and assisted suicide.

¹⁰ *Id.*

¹¹ Saskia Gauthier *et al.*, *Suicide Tourism: A Pilot Study on the Swiss Phenomenon*. *J. Med. Ethics* 2014.

¹² K. Green, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the “Slippery Slope.”* 13 *Ind. Int’l*

& Comp. L. Rev. 639, 649 (2003). See also *T4 Program*, Encyclopedia Britannica, available at <http://www.britannica.com/event/T4-Program>. In a directive issued by Hitler, Dr. Karl Brandt and Chancellery chief Philipp Bouhler were “charged with responsibility for expanding the authority of physicians...so that patients considered incurable, according to the best available human judgment of their state of health, can be granted a mercy killing.” *Id.* Additionally, a thorough, albeit chilling, discussion of medical killings and euthanasia in Nazi Germany is available in Robert Jay Lifton’s book, *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, 1986.

¹³ Emanuel, *supra* note 3.

¹⁴ See, e.g., Christian Medical & Dental Associations, *Standards 4 Life: Physician-Assisted Suicide*, available at <http://cmda.org/library/doclib/physician-assisted-suicide-02-04-14.pdf>.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Carter v. Canada (Attorney General)*, 2015 SCC 5. The Canadian Supreme Court stated: “Insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, ss. 241(b) and 14 of the *Criminal Code* deprive these adults of their right to life, liberty and security of the person under s. 7 of the *Charter*. The right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which deal with concerns about autonomy and quality of life, are also engaged. An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The prohibition denies people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty. And by leaving them to endure intolerable suffering, it impinges on their security of the person.”

¹⁹ Graeme Hamilton, *First Quebec Euthanasia Case Confirmed, Two Others Reported*, January 15, 2016, available at <http://news.nationalpost.com/news/canada/first-quebec-euthanasia-case-confirmed-two-others-reported>; The Canadian Press, *Doctor-Assisted Suicide Canada: 11 MPs Named to Joint Committee on Divisive Issue*, January 12, 2016, available at http://www.huffingtonpost.ca/2016/01/12/joint-committee-on-doctor-assisted-suicide-dying-sets-first-meeting-for-monday_n_8964130.html.

²⁰ Indeed, in the United States, thirty-eight states have laws that prohibit assisted suicide, and three prohibit it by common law. A state-by-state summary of physician-assisted suicide laws is available at <http://euthanasia.procon.org/view.resource.php?resourceID=000132>.

²¹ See Patients Rights Council, *Attempts to Legalize Euthanasia and Assisted Suicide in the United States*, available at <http://www.patientsrightscouncil.org/site/failed-attempts-usa/>

²² *Id.*

²³ See Vermont S. 108, available at <http://legislature.vermont.gov/assets/Documents/2016/Docs/BILLS/S-0108/S-0108%20As%20Passed%20by%20Both%20House%20and%20Senate%20Official.pdf>.

²⁴ A former deputy assigned to guard Nancy Cruzan’s room in order to prevent anyone from providing assistance to her once her parents were finally granted court permission to remove her food and hydration has expressed doubt as to the PVS diagnosis. Dennis Graves, *Emotions Still Linger from Nancy Cruzan’s Right-to-Die Case*, Free Republic, Oct. 22, 2003, available at <http://www.freerepublic.com/focus/fnews/1371221/posts>.

²⁵ *Cruzan*, 497 U.S. at 278 (citing *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905)).

²⁶ *Id.*

²⁷ *Id.* at 281.

²⁸ *Id.* at 283.

²⁹ RCW § 9A.36.060(1).

³⁰ 521 U.S. at 728. The case was originally filed in the U.S. District Court for the Western District of Washington and was decided as *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994).

³¹ *Id.* at 728-33.

³² 521 U.S. at 808-09.

³³ *Id.* at 800 (emphasis in original)

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- ³⁴ *Id.* at 808-09.
- ³⁵ *Gonzales*, 546 U.S. at 253-54 (quoting Dispensing of Controlled Substances to Assist Suicide, 66 Fed. Reg. 56,607, 56,608 (Nov. 9, 2001)).
- ³⁶ *Id.* at 274-75.
- ³⁷ *Glucksberg*, 521 U.S. at 710; *Cruzan*, at 280; see also *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833 (1992).
- ³⁸ Margaret Dore, *Death With Dignity: A Recipe for Elder Abuse & Homicide (Albeit Not By Name)*, 11 Marq. Elder Advisor 387, 396 (2010).
- ³⁹ *Id.*; see also *Broken Trust: Elders, Family and Finances*, MetLife Mature Mkt. Inst., (2009); *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders*, MetLife Mature Mkt. Inst. (June 2011).
- ⁴⁰ See Dore, *supra* note 39 at 397; Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, The New York Times, Oct. 27, 2012, available at http://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/?_r=0; Oregon 2015 Death With Dignity Act Report, *supra* note 5, Washington 2014 Death With Dignity Act Report, *supra* note 6.
- ⁴¹ *Glucksberg*, 521 U.S. at 731.
- ⁴² *Id.*
- ⁴³ Peter Tyson, *The Hippocratic Oath Today*, March 27, 2001, available at <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.
- ⁴⁴ *Gonzalez*, 546 U.S. at 285-286 (Scalia, J., dissenting).
- ⁴⁵ Colorado Medical Society, *Policy Manual*, September 2013, at 16.
- ⁴⁶ American Medical Association, *Opinion 2.211 – Physician-Assisted Suicide*, AMA Code of Medical Ethics, June 1994.
- ⁴⁷ See proposed §§ 25-48-109, 120, C.R.S., in Colorado HB 16-1054. See also O.R.S. 127.880 §3.14.
- ⁴⁸ Emanuel, *supra* note 3.
- ⁴⁹ See Emanuel, *supra* note 41; Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 Mich. L. Rev. 1613 (2008); Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 J. Am. Med. Ass'n 19 (2000).
- ⁵⁰ Emanuel, *supra* note 41.
- ⁵¹ Oregon 2015 Death With Dignity Act Report, *supra* note 5.
- ⁵² Tragically, there are many examples in Europe of people suffering from depression being euthanized or receiving assistance with committing suicide. For example, in Belgium, a woman suffering from depression was killed without advance notice being provided to her family. The woman's doctor of more than 20 years had refused her request, but after a donation to the Life End Information Forum, a doctor who co-founded that organization carried out her request to die. See Alliance Defending Freedom, *Case of Doctor Who Killed Depressed Woman Goes Back to Belgian Criminal Court*, available at <http://www.adfmedia.org/News/PRDetail/?CID=86265>. In yet another example, a 38-year-old Belgian woman was euthanized after breaking up with a man. The doctor who administered the lethal drugs failed to bring bandages to hold the needle in place, had no place to hang the infusion bag which fell on the woman's face as she died, and then described her death as a "lethal injection administered to a favourite pet to end its suffering." Michael Cook, *A Peek Behind Belgium's Euthanasia Curtain*, February 8, 2016, available at <http://www.mercatornet.com/careful/view/a-peek-behind-belgiums-euthanasia-curtain/17572>.
- ⁵³ Nadette de Visser, *The Dutch Debate Doctor-Assisted Suicide for Depression*, Feb. 4, 2014, available at <http://blog.no euthanasia.org.au/2014/02/the-dutch-debate-doctor-assisted.html>
- ⁵⁴ Nina Shapiro, *Terminal Uncertainty*, *Seattle Weekly*, January 13, 2009, available at <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>. Interestingly, in an interview, Brittany Maynard's husband said that *he* picked up the drugs for Brittany while she was traveling and that he did so in May, six months prior to Brittany's death. Her original diagnosis was in January 2014, and apparently modified to six months in April 2014. There is no way to know for certain how long Brittany would have lived had she not committed suicide, but certainly she would have exceeded the six month prognosis. See

<http://www.today.com/video/today/56780613>.

⁵⁵ *Id.* Federal Medicaid will pay for hospice for patients with a prognosis of six months or less to live.

⁵⁶ *Id.*

⁵⁷ FDA, *Disposal of Unused Medicines: What You Should Know*, available at

<http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm>.

⁵⁸ See Dore, *supra* note 39.

⁵⁹ See Dennis Thompson, *Is Oregon's Assisted Suicide Law Rife With Problems?* August 21, 2015, available at <http://www.bizjournals.com/portland/blog/health-care-inc/2015/08/ohsu-doc-doctor-assisted-suicide-law-rife-with.html>.

⁶⁰ See Neil Gorsuch, *The Legalization of Assisted Suicide and the Law of Unintended Consequences: A Review of the Dutch and Oregon Experiments and Leading Utilitarian Arguments for Legal Change*, 2004 Wis. L. Rev. 1347, 1389 (2004).

⁶¹ *Id.*

⁶² See Dore, *supra* note 39. See also Simon Caldwell, *Elderly Couple to Die Together by Assisted Suicide Even Though They Are Not Ill*, Daily Mail, Sept. 25, 2014, available at

<http://www.dailymail.co.uk/news/article-2770249/Healthy-OAP-couple-die-assisted-suicide-Husband-wifesupport-three-children.html>. For a discussion of the expansion of euthanasia in Europe and, including organ harvesting from victims and numerous tragic examples of suicide, see Wesley J. Smith, *Medicinal Murder: Charting the Steady Expansion of Euthanasia in Europe*, May 2013.

⁶³ Vermont Alliance for Ethical Healthcare, *Oregon's Physician-Assisted Suicide: Abused and Exploited*, available at www.vaeh.org.

⁶⁴ Susan Harding, *Letter Noting Assisted Suicide Raises Questions*, Oct. 30, 2013.

⁶⁵ Dan Springer, *Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care*, July 28, 2008, available at <http://www.foxnews.com/story/2008/07/28/oregon-offers-terminal-patients-doctor-assisted-suicide-instead-medical-care.html>.

⁶⁶ Emanuel, *supra* note 3.

⁶⁷ Caldwell, *supra* note 63.

⁶⁸ Vermont Alliance for Ethical Healthcare, *Doctors Often Misdiagnose the Terminally Ill*, available at <http://www.vaeh.org/resources/DoctorsOftenMisdiagnose.htm>. The examples cited here are just a few of the examples available from Vermont Alliance for Ethical Healthcare.

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Suicide By Doctor: What Colorado Would Risk on the Slippery Slope of Physician-Assisted Suicide

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