"COLORADO DEATH WITH DIGNITY ACT"
(Analysis of House Bill 15-1135)

The Colorado Bill[1] is an Oregon-style doctor-prescribed suicide bill.

The proposed law comes at a time when

- *More people in Colorado die annually from suicide than from motor vehicle accidents.[2]*
- *Suicides in Colorado vastly outnumber homicides.[3]*

ANALYSIS

- **HB 15-1135 (the Bill) would give government bureaucrats and profit-driven health insurance programs the opportunity to cut costs by denying payment for more expensive treatments while approving payment for less costly assisted-suicide deaths.**

  This has already been documented in Oregon – the state on which the Colorado proposal is based. The Oregon Health Plan (OHP) has notified some patients that medications prescribed to extend their lives or improve their comfort level would not be covered, but that the OHP would pay for a lethal drug prescription.[4]

  Referring to payment for assisted suicide, the Oregon Department of Human Services explains, "Individual insurers determine whether the procedure is covered under their policies, just as they do any other medical procedure."[5]

  If the Bill is approved, will health insurance programs and government health programs do the right thing – or the cheap thing?

- **The Bill would allow family members or health care providers and others to advise, suggest, encourage or exert subtle and not so subtle pressure on vulnerable individuals to request doctor-prescribed suicide.**

  The Bill would penalize anyone who "coerces or exerts undue influence"[6] on a person to request the lethal prescription. However, those words have a very narrow legal meaning. The proposal does not prohibit someone from suggesting, advising, pressuring or encouraging a patient to request doctor-prescribed suicide.

  Since victims of domestic abuse, including elder abuse, are extremely vulnerable to persuasion from their abusers, it takes little imagination to understand how the Bill could put abused individuals at risk of being persuaded to request doctor-prescribed suicide.

- **The Bill could lead an individual to doctor-prescribed suicide based on fear of being a burden to others.**

  Under the Bill, the doctor is required to "recommend that the individual notify his or her next of kin about the request" for assisted suicide.[7] But such family notification by the person is not required. If an individual fears becoming a burden and if loved ones are unaware of that concern, they are unable to reassure the person of their care and love.

  In the last official Oregon report, the fear of becoming a burden on others was given as a reason for requesting lethal drugs by more than 57 % of those who died using that state's assisted-suicide law.[8]

- **Nothing in the Bill requires that any of the requests for an assisted-suicide prescription be made in person.**

  Just as with Oregon's assisted-suicide law, the Bill requires that a person make two oral requests and a written request to the attending physician before receiving the prescription for doctor-prescribed suicide.[9]

  Since nothing in the proposal requires that any of those requests be made in person, the oral requests could be made by telephone and the written request could be mailed to the physician.

- **Under the Bill, someone who would benefit financially from the person's death could serve as a witness and claim that the individual is mentally fit and eligible to request assisted suicide.**

  The Bill requires that there be two witnesses to the individual's written request for doctor-prescribed suicide. Only one of those witnesses shall not be a relative or someone entitled to any portion of the person's estate upon death.[10]

  However, this provides little protection since it permits one witness to be a relative or someone who *is* entitled to the patient's estate. The second witness could be the best friend of the first witness and no one would know.

  Victims of elder abuse and domestic abuse are unlikely to share their fears with outsiders or to reveal that they are being pressured by family members to "choose" assisted suicide.

- **The Bill has no protections for the person once the assisted-suicide prescription is filled.**

  Like the Oregon law, the Bill only addresses activities taking place up until the doctor writes the lethal prescription. There are no provisions to insure that the patient is competent at the time the overdose is taken or that he or she knowingly and willingly takes the drugs.

Due to this lack of protection at the time of their deaths, the Bill would put patients at enormous risk. For example, someone who would benefit from the individual's death could trick or even force the person into taking the fatal drugs, and no one would know.

- **The Bill gives the illusion of choice. Yet, it would actually constrict patient choice.**

  Under the Bill, before writing a prescription for death, a doctor must "inform" the individual of "the feasible alternatives to taking the medication, including, but not limited to, palliative care, hospice care, and pain control."[11] However, being "informed" of all options does not mean that patients will have access to all options. It only means they must be told about them.

  If doctor-prescribed suicide becomes just another treatment option, and a cheap option at that, the standard of care and provision of health care changes. There will be less and less focus on extending life and eliminating pain, and more and more focus on the "efficient and inexpensive treatment option" of death.

  Patients may find that their insurance does not cover the "feasible alternatives" their doctors informed them about but, instead, will pay for doctor-prescribed suicide. This has already happened in Oregon.[12]

- **The Bill would permit assisted-suicide prescriptions for mentally ill or depressed patients.**

  Before receiving a prescription for death, patients do not need to have any psychological or psychiatric evaluation unless a doctor thinks that the person is "suffering from a psychiatric or psychological disorder or depression that may *impair his or her ability to make an informed decision*."[13] If a counseling referral is made, it may consist of only one consultation.[14]

  Even if the counselor determines that the patient has a mental disorder or disease, the prescription for suicide could still be written as long as the counselor determines that the patient's judgment is not impaired and, therefore, can make an informed decision.

  This provision is the same as that contained in Oregon's law where, in 2013, only two of the patients who received lethal prescriptions were referred for counseling.[15] A study about Oregon's law found that it "may not adequately protect all mentally ill patients."[16]

- **The Bill would allow doctors to prescribe death for individuals who could live for many years.**

  Under the Bill, doctors would be permitted to prescribe assisted suicide to patients who have a "terminal illness" or "terminal disease," which is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months."[17]

However, that definition does not require that the individual is expected to die within six months, *even with medical treatment,* nor does it require that the condition be *uncontrollable.* Therefore, it is possible that a person could be considered "terminal" for the purpose of qualifying for assisted suicide even if, with medical treatment, he or she could live much longer.

For example, diabetes can be both incurable and irreversible but it is controllable. An insulin-dependent diabetic who stops taking insulin will, within reasonable medical judgment, die within six months. Thus, under the Bill, diabetics could be eligible for doctor-prescribed suicide even though they could live virtually normal lives with insulin.

There is documentation that this has occurred under Oregon's assisted-suicide law. In the latest official report from Oregon, diabetes is noted as the underlying terminal condition that made the patient eligible for a lethal prescription.[18]

- **The Bill would permit a third party to request assisted suicide for a patient without any oversight to determine the accuracy of the request.**

  Under the Bill, patients are considered capable of requesting assisted suicide not only by communicating the decision on their own but also by "communication through persons familiar with the individual's manner of communicating if those persons are available."[19]

  This could include not only translating various languages but also facilitated communication[20] and could lead to a patient's wishes being misunderstood, misinterpreted, or disregarded. There is no requirement that the accuracy of such communication assistance be verified.

  Who will know if the person communicating on behalf of the patient is doing so accurately? What, if any, professional expertise will be required of those communicating on behalf of the patient?

- **The Bill would allow drugs for suicide to be delivered to the patient by a third party.**

  Nothing in the Bill requires the patient to obtain the drugs in person. A pharmacist can dispense the lethal drugs to an "expressly identified agent of the qualified individual."[21] That agent could be the abusive spouse or heir who persuaded the patient to request the prescription and who witnessed the patient's written request.

- **The Bill could permit a representative of an assisted-suicide advocacy organization to witness a vulnerable patient's written request.**

  In Oregon, members of the assisted-suicide advocacy group that spearheaded that state's law on which the Colorado proposal is patterned have acknowledged that they play a key role in the vast majority of deaths under the state's assisted-suicide law.[22]

[1] HB 15-1135 is sponsored by Representatives Court and Ginal.
[2] In 2012, there were 1,052 suicide deaths and 457 deaths from motor vehicle accidents in Colorado. Colorado Department of Public Health and Environment, Office of Suicide Prevention Annual Report, "Suicide Prevention in Colorado 2012-2013," November 1, 2013, p. 1. Available at: https://www.colorado.gov/pacific/sites/default/files/OSP-2012-2013-Legislative-Report.pdf (last accessed 12/30/14).
[3] In 2012, there were 1,052 suicide deaths and 205 homicide deaths in Colorado. Colorado Department of Public Health and Environment, Office of Suicide Prevention Annual Report, "Suicide Prevention in Colorado 2012-2013," November 1, 2013, p. 1. Available at: https://www.colorado.gov/pacific/sites/default/files/OSP-2012-2013-Legislative-Report.pdf (last accessed 12/30/14).
[4] KATU Television, "Letter noting assisted suicide raises questions," (interview about one such case and the response of the Oregon Health Plan). Available at: http://www.katu.com/news/26119539.html (last accessed 12/30/14).
[5] Oregon Dept. of Human Services, "FAQs about the Death with Dignity Act." Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/faqs.aspx (last accessed 12/30/14).
[6] Section 25-47-120 (2).
[7] Section 25-47-105 (f).
[8] Official report for 2013 deaths under Oregon's Death with Dignity Act, pg. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf (last accessed 12/30/14).
[9] Section 23-47-104 (1) (a).
[10] Section 23-47-104 (2) (b).
[11] Section 25-47-105 (c) (V).
[12] KATU Television, "Letter noting assisted suicide raises questions," (interview about one such case and the response of the Oregon Health Plan). Available at: http://www.katu.com/news/26119539.html (last accessed 12/30/14).
[13] Section 25-47-107. (Emphasis added.)
[14] Section 25-47-102 (5), definition of "counseling."
[15] Official report for 2013 deaths under Oregon's Death with Dignity Act, p. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf (last accessed 12/30/14).
[16] Linda Ganzini, Elizabeth R. Goy, Steven K. Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey," *British Medical Journal*, Oct. 25, 2008, pp. 973-978.
[17] Section 25-47-102 (13), definition of "terminal illness" or "terminal disease."
[18] Official report for 2013 deaths under Oregon's Death with Dignity Act, p. 7, fn. 6. Available at: http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf. (last accessed 12/30/14).
[19] Section 25-47-102 (3), definition of "capable."
[20] Facilitated communication in which a person, called a "facilitator," supports the hand or arm of a person who is impaired, using a device such as a keyboard to help the individual communicate.
[21] Section 25-47-105 (1) (l) (II) (B).
[22] Officers of Compassion in Dying/Compassion & Choices of Oregon were the chief proponents of Oregon's assisted-suicide law. They have proclaimed themselves stewards of the law. According to one spokesperson for the organization, in 2009, it was involved in 97% of deaths under the law. For documentation see: "The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization." Available at: http://www.patientsrightscouncil.org/site/oregon-assisted-suicide-deaths (last accessed 12/30/14).

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