

**Testimony against SB167 Implement Aid in Dying  
Wednesday February 9, 2011**

My name is Moe Wosepka, and I serve as Executive Director of the Montana Catholic Conference which is the public policy arm of the two Catholic Diocese in Great Falls-Billings and Helena.

This is a difficult issue that is very complex. Currently there are those of us who say that assisted suicide is illegal in the state and there are those who say it is legal. When death is the goal of assisted suicide I don't think it's in our best interest to allow this issue to continue in such a state of uncertainty. Today you have the option of clearing up that uncertainty by prohibiting assisted suicide or legalizing it. However it appears there is an elephant in the room that we aren't talking about and that's the two tier health care system that in part has helped to make assisted suicide an alternative health care choice.

I have had the opportunity to work for the poor for the past 15 years or so. We developed ministries for the homeless, the low income, disabled, those in nursing homes, mental hospitals and prisons. Most of those in this group are invisible, and don't want to be seen. Their needs are not often addressed even when the issue is as serious as this one.

We have a two tiered health care system in the US. There are those who can afford good medical insurance have great care, and those that don't. It's like a buffet where one group can choose what care they want. The poor can only select from a few options on this end of the serving table. For those who don't have adequate health care they have the choice of taking the cheapest option which unfortunately is death, or sacrifice all they have to get the expensive treatment to keep them alive.

For most of us in this room we don't have that problem. We all have pretty good health care, but for today we have to try to see this issue through the eyes of the poor and those who do not have those options. Our health care system is broken. Our Catholic hospitals provide an incredible amount of free care for the poor, but we can't provide enough to create a level playing field. What's going on in this session is reflective of problems with our health care system. There are over 130 bill requests that somehow address health care.

This isn't just the very poor. I worked with many are families that are trying to transition from welfare to work, but when they get just beyond the point where they qualify for Medicaid, but not yet able to purchase health insurance. They are out there all by themselves. Too many of us, including me, are one serious health crisis away from bankruptcy. Until we address our broken health care system we shouldn't provide death as the cheapest solution.

I've also worked with many people who were severely depressed. While they were in that state they often did not make good decisions for their life, and for their families. I have worked with several who due to financial or family matters were suicidal. When they made it through the depression they were glad that they hadn't committed suicide. When people are depressed they are looking at any way out and suicide becomes a valid escape. We know that in Montana because we often have the highest suicide rate per capita than any other state in the nation.

I can't imagine a person getting a terminal diagnosis and not being at least a little bit depressed. Yet according to the Oregon Department of Health, even though depression occurs in a significant percentage of cases, in 2009 only 3 of 63 patients in Oregon who requested lethal medications were referred for psychiatric evaluation. Likewise, in Washington, 95 prescriptions were written, resulting in 59 deaths. None of the 59 patients was referred for psychiatric evaluation. Those controls are in Montana law also, but they don't seem to be working in Oregon and Washington. Why is that? Is it because of lack of controls, or oversight?

This is also a group on the whole that does not have a very strong voice when public policy decisions are made. They lack in self esteem and as such are very vulnerable to coercion. Even suggestions that physician assisted suicide would be an option for them might sway them to make a choice that they would not have pursued if their depression had been treated first. These are the ones that I am most concerned about with this issue.

I'm also concerned about the lack of oversight. Are there no controls? No oversight? Is this an issue that we will trust Drs to make the decisions for those who are looking for a solution to their pain? To make sure that the person meets all the conditions? The conditions and requirements are written in the law, but where is the provision for oversight? Where is the fiscal note? How do you insure the safeguards are being met without some kind of oversight? How do you provide for oversight if you don't have anyone doing that? You cannot do that for free.

Maybe we can trust the Doctors to abide by all the rules, but all we need to do is look at the problem with how Doctors are dealing with medical marijuana to have some concerns about how this might work. It certainly would give me pause. The compassionate people in the state wanted their neighbors to have an option for ending or controlling their pain, when they voted for medical marijuana. This session is full of bills trying to fix the problem. How much time and money will we spend fixing that problem? I think it should give us pause as to opening this option up to trust Doctors to do the right thing with this issue. 99% of the Drs in this state are great, but 28,000 medical marijuana cards issued in Montana should create some concern that there are those who may not have the patient's best interest at heart.

Are we concerned that abuse could occur? Would we be concerned about the number of people who died each year through this program? Would we be concerned that all the conditions provided for in law were met? Would we be concerned that the Doctors followed all the guidelines, or whether or not the person was depressed or coerced? If we would then we should understand that you cannot put together safeguards, controls, and requirements for reporting without spending any money.

Washington and Oregon don't spend any money or very little on follow up, and oversight. Is it just not necessary in these cases? Is every doctor doing the right thing for the right reasons?

If you are going to legalize a program as serious as this one, you had better consider serious oversight, and you cannot provide oversight without any money. And is this the time to be starting a new program in health and human services, when we are cutting all the existing programs?

In summary: The state of Montana has a compelling interest in protecting the life of any at risk individual or group who may be adversely affected by instituting physician assisted suicide and if even one person is harmed, or killed we have made a terrible mistake. Neither the courts, nor the states of Washington or Oregon have provided all the answers we would need to institute public policy for an issue that raises as serious and final consequences as this issue. Until every question is answered, and all risk of harm has been eliminated we must resist making a decision that will compromise the safety of some to provide a perceived benefit to others.

We stand in strong opposition to the passage of sb167