

EXHIBIT 22  
DATE 2/20/2013  
HB 505

House Judiciary Committee  
February 20, 2013

Last April, my close friend Judy killed herself, alone, in her car in a parking lot and with a gun, because she could no longer bear the chronic pain of a number of incurable and progressive diseases. The day before she ended her suffering she told me that her life was unrelenting agony. She could not eat, sleep, sit, lie down or walk without pain. The prognosis was for her afflictions to worsen.

I believe she should have had access to medication she could have self-administered so she could have died painlessly and peacefully at home with her family. Please vote against HB 505 so future patients might not have to endure such a violent and lonely end to their unbearable suffering.

Respectfully submitted,



Jane Jelinski  
433 N. Tracy  
Bozeman, MT 59715  
406-587-8367  
jjjelinski@msn.com

## PHYSICIAN ASSISTED SUICIDE AND PUBLIC SAFETY

### PROTECTING THE MOST VULNERABLE

Testimony of Cort Freeman

Proponent of HB-505, Clarifying Aiding or Soliciting Suicide

House Judiciary Committee - February 20, 2013

This testimony discusses the need to clarify aiding or soliciting suicide in light of Physician Assisted Suicide (PAS), offering applicable terms, so that clear understanding and reason can be found to discourage PAS in Montana to protect the weakest and most vulnerable among us.

Physician Assisted Suicide does not promote the Common Good nor support the Montana State Constitution regarding Individual Dignity and the Right of Privacy (Article II, Section 4 and 10, Declaration of Rights).

Dignity is inviolable for every Montanan, without exception. The state cannot infringe on the Right of Privacy without showing a "compelling state interest." My testimony argues Physician Assisted Suicide (PAS) cannot be implemented without error and thus can violate Individual Dignity. There is a compelling state interest to legislate against assisted suicide, protecting the most vulnerable.

For the fiscal year ending June 31, 2012, the Operation Protect Montana Report of Adult Protective Services reveals it investigated 6,017 reported public safety cases: elder abuse, 972; exploitation, 1237; and neglect, 3808. If any of these individuals were diagnosed with six months or less to live, even if the prognosis were wrong, they would be prime targets of PAS, intentionally or unintentionally coerced into giving up and ingesting a poison pill with nobody around.

This testimony also looks at PAS from the vantage of Ben Mattlin a lifelong disabled writer and journalist. He recounts how invisible coercion, subtle and unintended, adversely affects the vulnerable and can lead the elderly, disabled and infirm, against their will, to commit suicide by a physician-prescribed lethal drug.

Ben Mattlin writes "Advocates of Death With Dignity laws who say that patients themselves should decide whether to live or die are fantasizing. Who chooses suicide in a vacuum? We are inexorably affected by our immediate environment. The deck is stacked."

## **Background:**

The greatest concern of those against Physician Assisted Suicide in Montana is the issue of public safety, especially elder abuse and coercion of the disabled, infirm and weakest among us to take a lethal dose of medication against their will even with the best intentions of safeguards to prevent this. We are asking our physicians to kill not heal. We are pushing them beyond their expertise, and too many things can go wrong.

Can involuntary death happen? Yes. Following is a portion of an article by Ben Mattlin that appeared in the New York Times, October 31, 2012 under the title: Suicide by Choice? Not So Fast. (The full text is attached as an appendix.)

Mattlin was born with a congenital neuromuscular weakness called spinal muscular atrophy. He has never walked or stood or had much use of his hands. Roughly half the babies who exhibit symptoms as he did don't live past age 2. Not only did Mattlin survive, but the progression of his disease slowed dramatically when he was about 6 years old, astounding doctors. Today, at nearly 50, he is a husband, father, journalist and author.

No longer able to hold a pencil, he writes by voice-controlled computer. He describes himself as a good, pro-choice liberal, who ought to support Physician Assisted Suicide (PAS). But as a lifelong disabled person, he cannot.

He acknowledges arguments in favor of PAS, such as: no one will be coerced into taking a poison pill, supporters insist. The "right to die" will apply only to those with six months to live or less. Doctors will take into account the possibility of depression. There is no slippery slope.

Mattlin, however, remains skeptical of PAS because abuse – whether spousal, child or elder – is notoriously underreported, and evidence is difficult to come by.

The National Center on Elder Abuse has identified at least seven different types of elder/disabled adult abuse. These are:

- **Physical abuse** is the use of physical force that may result in bodily injury, physical pain, or impairment.
- **Sexual abuse** is non-consensual sexual contact, of any kind, with an elderly person or disabled adult.
- **Emotional abuse** is the infliction of anguish, pain or distress through verbal or non-verbal acts.

- **Financial/material exploitation** is the illegal or improper use of an elder/disabled adults funds, property, or assets.
- **Neglect** is the refusal or failure to fulfill any part of a person's obligations or duties to an elderly person or disabled adult.
- **Physical Neglect** can be defined as the desertion of an elderly person/disabled adult, by an individual who has physical custody of the elder/disabled adult, or by a person who has assumed responsibility for providing care to the elder/disabled adult.
- **Self-Neglect** can be defined as the decisions or behaviors of an elderly person or disabled adult, which threaten that person's health or safety.

Montana Adult Protective Services for the fiscal year ending June 31, 2012, investigated 6,017 reported public safety cases: elder abuse, 972; exploitation, 1237; and neglect, 3808.

Mattlin writes his problem, ultimately, is this:

"I've lived so close to death for so long that I know how thin and porous the border between coercion and free choice is, how easy it is for someone to inadvertently influence you to feel devalued and hopeless — to pressure you ever so slightly but decidedly into being 'reasonable,' to unburdening others, to 'letting go.'

"Perhaps, as advocates contend, you can't understand why anyone would push for assisted-suicide legislation until you've seen a loved one suffer. But you also can't truly conceive of the many subtle forces — invariably well meaning, kindhearted, even gentle, yet as persuasive as a tsunami — that emerge when your physical autonomy is hopelessly compromised."

He also writes how easy it is to be perceived as someone whose quality of life is untenable, even or perhaps especially by doctors.

Mattlin: "Indeed, I hear it from them [sic. doctors] all the time — 'How have you survived so long? Wow, you must put up with a lot!' — even during routine office visits, when all I've asked for is an antibiotic for a sinus infection. Strangers don't treat me this way, but doctors feel entitled to render judgments and voice their opinions. To them, I suppose, I must represent a failure of their profession, which is shortsighted. I am more than my diagnosis and my prognosis.

"This is but one of many invisible forces of coercion. Others include that certain look of exhaustion in a loved one's eyes, or the way nurses and friends sigh in your presence while you're zoned out in a hospital bed. All these can cast a dangerous cloud of depression upon even the most cheery

of optimists, a situation clinicians might misread since, to them, it seems perfectly rational.

"And in a sense, it is rational, given the dearth of alternatives. If nobody wants you at the party, why should you stay? Advocates of Death With Dignity laws who say that patients themselves should decide whether to live or die are fantasizing. Who chooses suicide in a vacuum? We are inexorably affected by our immediate environment. The deck is stacked."

In conclusion, Mattlin writes: To be sure, there are noble intentions behind the "assisted death" proposals, but I can't help wondering why we're in such a hurry to ensure the right to die before we've done all we can to ensure that those of us with severe, untreatable, life-threatening conditions are given the same open-hearted welcome, the same open-minded respect and the same open-ended opportunities due everyone else.

### **Public Safety – Protecting the Most Vulnerable**

#### DEFINITIONS AND APPLICATIONS

When discussing Physician Assisted Suicide in Montana, supporters talk about autonomy, humanity and dignity. What do these terms mean?

In the latest "Death With Dignity" proposed legislation, or SB-220, the word "autonomy" is neither mentioned nor defined, but supporters' testimony mentioned "autonomy" constantly.

**Autonomy** means self-sufficiency or independence, and the capacity to make decisions and act on them. If there is autonomy for some individuals, then by definition there has to be others who lack (or don't have) autonomy.

**Humanity and Dignity:** The words humane and dignified are mentioned all through the text of SB-220. However, the Death With Dignity Bill never defines "humane and/or dignified." How should these be understood in the context of committing suicide in a humane and dignified manner?

**Humane is from Humanity,** which is defined as the human race as a whole or qualities of human being considered as a whole to be characteristic of human beings. A secondary connotation is compassion or mercy for others.

**Dignity** defined for all humanity, as part of human nature, is "Intrinsically" worthy of respect. Dignity defined as self-respect is "Extrinsic" when applied to a particular person. Extrinsic dignity is about individual self not about everyone -- all humanity.

So, is there such a thing as committing suicide in a humane and dignified manner?

1. Let's start with guiding principles for a better understanding and definition of human dignity as regards Physician Assisted Suicide, public safety, and fairness and justice for all.

The Constitution of the United States opens with these words, "We the people of the United States, in Order to form a more perfect Union, establish Justice, etc. ... The Pledge of Allegiance ends with "Liberty and Justice for All."

The Montana Constitution says, "The dignity of the human being is inviolable [sic. absolute, can't be repudiated or infringed]. No person shall be denied equal protection of the law. Neither the state .... shall discriminate against any person .... on account of social condition."

By social condition is meant an existing circumstance, situation or state affecting the life, welfare and relations of human beings in community. For example, some may think the elderly, infirm and disabled use too many community resources. This social condition doesn't negate the protection afforded to Montanans in the Dignity Clause of the Montana Constitution.

As noted, we are concerned with two forms of dignity: Intrinsic, pertaining to everyone, and Extrinsic, pertaining only to a certain class

2. If human dignity is defined as "intrinsic," pertaining to all individuals as part of their human nature, then human dignity is the only guiding principle that ensures the weakest humans are not harmed. This definition cannot support PAS in Montana as there are too many opportunities for error.

3. "Extrinsic dignity" is selective -- the "worthy" and "unworthy" if you will. Extrinsic dignity only allows an autonomous individual to freely choose physician assisted suicide, meaning others will be unwittingly coerced or cave-in for lack of a viable alternative for hospice/palliative care and killed against their will. Something similar would be a person confessing to a crime he didn't commit. This happens even for death row crimes. Some of these inmates later are found innocent by additional evidence such as DNA. The confession is erroneous and perplexing.

For PAS to be workable ironclad rules for accommodating PAS need to be in place. Attempts to design such rules fall short on many levels, such as a determination by a physician of a terminally ill patient having 6 months to

live or a determination of patient competency, when, as Mattin argues through personal experience, coercion can be invisible. There are just too many "what ifs."

Extrinsic dignity fails to protect those who have lost their autonomy or who never had autonomy -- the weak, disabled, elderly. These are the individuals who don't have personal independence and are more likely to be manipulated, coerced or abandoned. As a matter of public safety, they need protection.

Will PAS usher in a slippery slope of death? If other jurisdictions, such as the Netherlands are any indication, approving PAS only opens the door for the next push -- euthanasia and expanding death alternatives. This expansion to euthanasia now is being argued in the State of Washington.

Euthanasia is different from PAS in that a doctor can inject a patient with a lethal drug instead of the patient ingesting a poison pill, making those who are not autonomous extremely vulnerable. Public safety and protection for the most vulnerable exponentially multiplies as you slide down the slippery slope of more and more.

But accommodations will be made for the autonomous. For example, the quest for autonomy has reached such a macabre level in the Netherlands that last year the Royal Dutch Medical Association expanded the list of conditions legalizing euthanasia to include "loneliness."

4. Intrinsic Human Dignity in which even the most vulnerable and weak are protected should be the guiding principle for determining what is medically ethical when it comes to physician assisted suicide. It's a matter of justice.
5. Defense of intrinsic dignity is the ultimate ethical measure. To affirm that **all** human beings -- by their very nature -- have dignity means to deny the pretext of "extrinsic dignity," which distinguishes between the "worthy" and "unworthy" -- those who want to commit suicide, and those who don't but become victims.
6. The elimination of the concept of dignity founded on human nature would mean the elimination of its universalistic perspective. On a rational level, human dignity is the only objective reference that affirms every human being, without distinction, has dignity. This conforms to Montana's Constitution.
7. If the protection of human dignity is inviolate in the Montana Constitution and also is the primary value in determining if Physician Assisted Suicide

should be allowed in Montana, it means limits must be placed on an individual's desire for Physician Assisted Suicide in order to protect the freedom of others, particularly the weakest members of society. This speaks to a compelling state interest regarding public safety and retains the Montana Constitution's Right to Privacy Clause.

8. The principle of "intrinsic dignity" orients PAS in a direction of justice, which can be based only on the equality of all human beings, including the impaired and aged.

9. Now, does Montana have a compelling state interest to infringe on Montana's constitutional Right of Privacy when considering physician assisted suicide? If physician assisted suicide leads to the abuse of dignity for the most vulnerable – wittingly or unwittingly -- then their individual dignity is violated and is no longer inviolable. They are due state protection and safety.

10. So, the answer is yes. The Right of Privacy can be infringed in some circumstances and PAS would be one, which means PAS should not be allowed in Montana. The greater good is a public safety issue for the state and all Montanans.

## **APPENDIX**

### Suicide by Choice? Not So Fast

By BEN MATTLIN

Published: NYT - October 31, 2012

NEXT week, voters in Massachusetts will decide whether to adopt an assisted-suicide law. As a good pro-choice liberal, I ought to support the effort. But as a lifelong disabled person, I cannot.

There are solid arguments in favor. No one will be coerced into taking a poison pill, supporters insist. The "right to die" will apply only to those with six months to live or less. Doctors will take into account the possibility of depression. There is no slippery slope.

Fair enough, but I remain skeptical. There's been scant evidence of abuse so far in Oregon, Washington and Montana, the three states where physician-

assisted death is already legal, but abuse — whether spousal, child or elder — is notoriously underreported, and evidence is difficult to come by. What's more, Massachusetts registered nearly 20,000 cases of elder abuse in 2010 alone.

My problem, ultimately, is this: I've lived so close to death for so long that I know how thin and porous the border between coercion and free choice is, how easy it is for someone to inadvertently influence you to feel devalued and hopeless — to pressure you ever so slightly but decidedly into being "reasonable," to unburdening others, to "letting go."

Perhaps, as advocates contend, you can't understand why anyone would push for assisted-suicide legislation until you've seen a loved one suffer. But you also can't truly conceive of the many subtle forces — invariably well meaning, kindhearted, even gentle, yet as persuasive as a tsunami — that emerge when your physical autonomy is hopelessly compromised.

I was born with a congenital neuromuscular weakness called spinal muscular atrophy. I've never walked or stood or had much use of my hands. Roughly half the babies who exhibit symptoms as I did don't live past age 2. Not only did I survive, but the progression of my disease slowed dramatically when I was about 6 years old, astounding doctors. Today, at nearly 50, I'm a husband, father, journalist and author.

Yet I'm more fragile now than I was in infancy. No longer able to hold a pencil, I'm writing this with a voice-controlled computer. Every swallow of food, sometimes every breath, can become a battle. And a few years ago, when a surgical blunder put me into a coma from septic shock, the doctors seriously questioned whether it was worth trying to extend my life. My existence seemed pretty tenuous anyway, they figured. They didn't know about my family, my career, my aspirations.

Fortunately, they asked my wife, who knows exactly how I feel. She convinced them to proceed "full code," as she's learned to say, to keep me alive using any and all means necessary.

From this I learned how easy it is to be perceived as someone whose quality of life is untenable, even or perhaps especially by doctors. Indeed, I hear it from them all the time — "How have you survived so long? Wow, you must put up with a lot!" — even during routine office visits, when all I've asked for is an antibiotic for a sinus infection. Strangers don't treat me this way, but

doctors feel entitled to render judgments and voice their opinions. To them, I suppose, I must represent a failure of their profession, which is shortsighted. I am more than my diagnosis and my prognosis.

This is but one of many invisible forces of coercion. Others include that certain look of exhaustion in a loved one's eyes, or the way nurses and friends sigh in your presence while you're zoned out in a hospital bed. All these can cast a dangerous cloud of depression upon even the most cheery of optimists, a situation clinicians might misread since, to them, it seems perfectly rational.

And in a sense, it is rational, given the dearth of alternatives. If nobody wants you at the party, why should you stay? Advocates of Death With Dignity laws who say that patients themselves should decide whether to live or die are fantasizing. Who chooses suicide in a vacuum? We are inexorably affected by our immediate environment. The deck is stacked.

Yes, that may sound paranoid. After all, the Massachusetts proposal calls for the lethal dose to be "self-administered," which it defines as the "patient's act of ingesting." You might wonder how that would apply to those who can't feed themselves — people like me. But as I understand the legislation, there is nothing to prevent the patient from designating just about anyone to feed them the poison pill. Indeed, there is no requirement for oversight of the ingestion at all; no one has to witness how and when the lethal drug is given. Which, to my mind, leaves even more room for abuse.

To be sure, there are noble intentions behind the "assisted death" proposals, but I can't help wondering why we're in such a hurry to ensure the right to die before we've done all we can to ensure that those of us with severe, untreatable, life-threatening conditions are given the same open-hearted welcome, the same open-minded respect and the same open-ended opportunities due everyone else.