NCPD
NATIONAL CATHOLIC PARTNERSHIP ON DISABILITY
• • • *faith • giftedness • partnership*

July 2, 2015

Assembly Member Mark Stone
Chair of the Judiciary Committee
California Assembly Room 104
C/O State Capital, 1020 N Street
Sacramento, CA 95814

Assembly Member Rob Bonta
Chair of the Health Committee
California Assembly Room 6005
C/O State Capital, 1020 N Street
Sacramento, CA 95814

Re: S.B. 128, "End of Life Option Act."

Dear Committee Chairs Stone and Bonta:

My name is Stephen L. Mikochik.[1] I am Professor Emeritus of Constitutional Law at Temple University in Philadelphia and past Chair of the National Catholic Partnership on Disability (NCPD). NCPD was established thirty years ago to implement the *Pastoral Statement on People with Disabilities* of the U.S. Catholic bishops. On behalf of NCPD and the thousands of disabled Catholics it serves, I would urge you to reject S.B. 128 that, in legalizing assisted suicide, is an open invitation to patient abuse.

A brief survey of legal history will place my concerns in context. For over seven hundred years, Anglo-American law has condemned suicide.[2] Self-murder was a felony at common law; but since the deceased was beyond penalty, his property was forfeited as a deterrent to others.[3] Recognizing the harm this caused innocent families, English and American law gradually decriminalized suicide.[4] This development, however, did not mark the moral acceptance of suicide since aiding its commission remained a common law offense.[5] At the close of the Civil War, most states criminalized assisting a suicide.[6] By 1997, when

---

[1] B.A., M.A. in Rel. Stud., M.A. in Phil., J.D., LL.M.
[2] *See Washington v. Glucksberg*, 521 U.S. 702, 711 (1997).
[3] *See id.* at 711-13.
[4] *See id.* at 713.
[5] *See id.* at 713-14.
[6] *See id.* at 715.

The McCormick Pavilion, 415 Michigan Avenue, N.E., Suite 95, Washington, DC 20017-4501
202-529-2933; 202-529-2934 (tty); 202-529-4678 (fax); www.ncpd.org
NCPD is a 501(c)(3) tax exempt nonprofit corporation

the Supreme Court rejected the claim that physician-assisted suicide was a constitutional right,[7] the vast majority of states had made it criminal.[8]

Nevertheless, assisted suicide has recently become controversial and, spearheaded by Compassion and Choices, the successor to the Hemlock Society,[9] has gained a foothold in American law. By ballot initiative in 1994, Oregon became the first state to allow physician assisted suicide.[10] Its so-called "Death with Dignity Act" set the pattern for the successful 2008 ballot initiative in Washington State.[11] The Vermont legislature adopted its own version last year,[12] while the Montana Supreme Court held in 2009 that physician-assisted suicide was not against that state's public policy.[13] All other attempts to legalize assisted suicide, either by ballot initiative or legislative enactment, have failed. Last year, for example, the New Hampshire House of Representatives defeated H.B. 1325 by a vote of 219 to 66;[14] and this year alone, legislative initiatives in Colorado, Connecticut, Maine, Maryland, Nevada, New York, Utah, and Wyoming have failed.

Before turning to the specifics of S.B. 128, I will address three threshold questions. First, how can laws that require consent constitute government decisions about what lives are worth living? Americans hold as self-evident that all men are "endowed by their Creator with certain unalienable rights; that among these [is the right to] life …; [and] that, to secure these rights, governments are instituted among men [.]"[15] As life is an unalienable right, we can neither destroy our lives nor ask others to assist in their destruction.[16] When government secures such rights for some but not others, when it relaxes laws against aiding the suicide of terminal patients but not the able-bodied, it is saying this class deserves less protection of their lives, its members deserve less safeguards of their unalienable rights, in other words, they deserve less respect because in some way they are less human. In discounting such rights entrusted to its care, government thus compromises the very grounds on which it is instituted.

---

[7] *See id.* at 735.
[8] *See id.* at 718.
[9] *See* Ian Dowbiggin, *A Concise History of Euthanasia* 146 (2007).
[10] *See* O.R.S. § 127.800 *et seq.*
[11] *See* Wash. Rev. Code Ann. § 70.245.010 *et seq.* (West 2009).
[12] *See* 18 V.S.A. § 5281 *et seq.*
[13] *See Baxter v. Montana*, 354 Mont. 234. Additionally, an Albuquerque district judge last year barred prosecution of physicians for assisting the suicide of terminal patients. *See* James Monteleone, *Death Aid Case Appeal Possible*, ALBUQUERQUE JOURNAL, January 24, 2014, available at http://www.abqjournal.com/342190/news/attorney-general-might-appeal-ruling-on-assisted-suicide.html. The New Mexico Attorney General, however, has appealed that ruling. *See* Alex Schadenberg, Attorney General Appeals Court Ruling to Legalize Assisted Suicide, Life News, March 12, 2014, available at http://www.lifenews.com/2014/03/12/new-mexico-attorney-general-appeals-court-ruling-to-legalize-assisted-suicide.html. The case is pending before the New Mexico Court of Appeals. *See* Chris McKee, *'Right to Die' in Hands of NM Court of Appeals,* **ALBUQUERQUE (KRQE), Jan. 26, 2015, available at** http://krqe.com/2015/01/26/court-of-appeals-to-hear-right-to-die-case/.
[14] *See Death with Dignity Act' finds little support in NH House*, UNION LEADER, Mar. 6, 2014, available at http://www.unionleader.com/article/20140306/NEWS0621/140309414.
[15] THE DECLARATION OF INDEPENDENCE, para. 2 (U.S. 1776).
[16] JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT, Ch. IV, §23, available at http://www.constitution.org/jl/2ndtr04.htm ("For a man, not having the power of his own life, cannot, by compact, or his own consent, enslave himself to any one, nor put himself under the absolute, arbitrary power of another, to take away his life, when he pleases. No body [sic] can give more power than he has himself; and he that cannot take away his own life, cannot give another power over it.").

Second, how can ingesting a lethal drug constitute suicide when the patient is already dying from a terminal condition?[17] If the terminal prognosis is wrong, the lethal drug is the sole cause of death. If correct, it is an intervening cause. In either event, it is the cause in fact and, as either the sole or intervening cause, the legal cause of death.[18] Thus, the patient dies, not from the underlying condition, but from ingesting the lethal drug that, if self-administered, constitutes suicide.

Third, why should the disabled community in particular concern itself with laws legalizing assisted suicide that, on their face, are limited to terminal patients? As physical impairments that substantially limit life activities,[19] terminal conditions are disabilities. Thus, to provide, as does S.B. 128, that a patient is not qualified for assistance in suicide "solely" because of a disability[20] is simply incoherent. Moreover, predictions of death within six months required for aid in dying[21] are notoriously fallible.[22] Thus, even if terminal and disabling conditions are different, the separating line is porous. [23]

Further, the primary reasons terminal patients give for requesting aid in dying—loss of autonomy, loss of dignity, inability to participate in activities that make life enjoyable[24] — are the same reasons disabled people seek suicide.[25] If people with only six months to live can end such distress, why not those who face it for a lifetime?[26]

---

[17] *See* S.B. 128, § 443.1(b) (implying that the underlying condition, not the lethal drug, is the cause of death).
[18]Even if ingesting the lethal drug is regarded as merely hastening the patient's death from the underlying terminal condition, it remains a cause in fact and a legal cause of death. See *Oxendine v. State*, 580 A.2d 870 (Del. 1987) (an act that accelerates death from a prior lethal act is an actual cause of death). *See also* Joshua Dressler, *Understanding Criminal Law* (4th ed.) 198-99 (2006).
[19] *See, e.g.*, 42 U.S.C. §§12102(1) (A) (Americans with Disabilities Act).
[20] S.B. 128, § 443.2(b).
[21] *See id.*at § 443.1(q).
[22] As a prognostic standard, "reasonable medical judgment," *id.*, merely requires the attending physician to predict that the underlying condition will, "*more likely than not*, RESULT IN DEATH WITHIN 6 MONTHS." S.B. 676, § 5-6A-03© (Md. 2015) (emphasis added) (paraphrasing "reasonable medical judgement" in lay terms).
[23]Of course, for those who die from a lethal prescription, their terminal prognosis is a self-fulfilling prophecy.
[24] As in prior years, the three most frequently mentioned end-of-life concerns reported by Oregon in 2014 were: "loss of autonomy" in 91.4% of cases, "decreasing ability to participate in activities that made life enjoyable" in 86.7% of cases, and "loss of dignity" in 71.4% of cases. *See* **REP. OF ORE. PUBLIC HEALTH DIV., OREGON'S DEATH WITH DIGNITY ACT--2014**, available at https://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/documents/year17.pdf. Surprisingly, fear of protracted pain was not among the major reasons given for requesting lethal drugs, with "[i]nadequate pain control or concern about it" given as an end of life worry in only 31.4% of cases that year, and in only 23.7% of cases for the prior sixteen years. *See id.,* **OREGON'S DEATH WITH DIGNITY ACT—2014.** Washington State reported similar findings for 2013, the last year for which statistics were available. *See* WASH. DEPT. PUBLIC HEALTH, 2013 DEATH WITH DIGNITY ACT REPORT, *available at* http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf. Though "pain control or concern about it" was an "end of life concern" for 53% of Washington patients dispensed lethal drugs in 2013, in contrast, percentages ranged from 33%-36% in prior years. *See id.*
[25] *Cf.* Diane Coleman, Editorial, *State's Rights Versus Civil Rights*, SEATTLE POST-INTELLIGENCER, September 29, 2005, available at http://www.seattlepi.com/local/opinion/article/States-rights-versus-civil-rights-1183888.php.
[26] *See, e.g., Assisted Suicide in the United States: Hearing before the Subcomm. On the Constitution of the Comm. on the Judiciary, House of Representatives*, 104th Cong., 2d Sess. 127-38 (Apr. 29, 1996) (prepared testimony of Herbert Hendin, M.D.). During his testimony, Dr. Hendin stated:

Turning to the specifics of S.B. 128, it is first worth noting that nothing in its terms requires the presence of or potential for insufferable pain as a qualifying condition.[27] Further, its language tracks the provisions of, and thus shares the major flaws in, the assisted suicide laws enacted by Oregon and Washington State. Though it imposes a waiting period before the prescription is written, patients can have a lethal drug in hand fifteen days after the terminal diagnosis is made,[28] clearly insufficient time to acclimate to a terminal prognosis.

Though either the attending or consulting physician can refer patients for psychological or psychiatric evaluation if they suspect clinical depression or other mental disorders that can impair judgement, [29] many physicians lack training to recognize such depression;[30] and nothing in S.B. 128 or its exemplars requires that they have it. Not surprisingly, referrals were almost never made in the seventeen-year history of the

---

> Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help *i.e.* euthanasia to those who could not affect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination.

[27] *Cf.* S.B. 128, § 443.2(a-b) (listing qualifying conditions); *id.* at § 443.1(q) (defining "terminal condition" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.").

[28] *See* S.B. 128, § 443.2(a) (a patient seeking a lethal prescription "shall submit two oral requests, a minimum of 15 days apart, and a written request [.]"). *Cf.* O.R.S. §§ 127.840& 127.850; Wash. Rev. Code Ann. §§ **70.245.090 & 70.245.110(1)** (West 2009). Both Oregon and Washington, however, additionally require a forty-eight hour waiting period between signing the written request and writing the lethal prescription. *See* O.R.S. § 127.850; Wash. Rev. Code Ann. § 70.245.110(2) (West 2009).

[29] *See* S.B. 128, § 443.5(a) (1) (ii) ("If there are indications of a mental disorder, the [attending] physician shall refer the individual for a mental health specialist assessment."); *id.*at § 443.6(d) (same for consulting physician). *Cf.* O.R.S. § 127.825("If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling."); Wash. Rev. Code Ann. § 70.245.060(West 2009) (same).

[30] *Cf. Washington v. Glucksberg*, 521 U.S. at 730-31 ("[A] New York [blue-ribbon] [t]ask [f]orce, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs." (citations omitted)).

Oregon Act and, thus far, Washington is following suit.[31] Given that the Supreme Court has reported that many people, terminal or not, seeking suicide suffer from clinical depression and often lose the urge when the condition is treated,[32] the absence of reported referrals in these states is most troubling for the future of S.B. 128.

Further, the Senate Bill allows persons with a financial interest in the patient's death to be one of the two witnesses to the written request, attesting to the patient's competence and the lack of coercion.[33] Though patients can revoke their request "in any manner [,]"[34] *including, for those with difficulty speaking, "communicating through a person familiar with the patient's manner of communicating [,]"*[35] nothing prevents the interested witness to the patient's written request from filling that role.[36] That same person can be the only witness present when the lethal drug is taken since S.B. 128 fails to require an objective observer to the act. This is an open invitation to patient abuse[37] since no one will know if the patient

---

[31] For example, of the 105 Oregon residents who died from a lethal prescription in 2014, only 3 had been referred for a psychiatric or psychological evaluation. *See* **OREGON'S DEATH WITH DIGNITY ACT—2014,** *supra* note 24. Oregon's yearly reports from 1998 through 2013 reveal similar statistics; showing: 2 out of 71 in 2013; 2 out of 77 in 2012; 1 out of 71 in 2011; 1 out of 65 in 2010; 0 out of 59 in 2009; 2 out of 60 in 2008; 0 out of 49 in 2007; 2 out of 46 in 2006; 2 out of 38 in 2005; 2 out of 37 in 2004; 2 out of 42 in 2003; 5 out of 38 in 2002; 3 out of 21 in 2001; 5 out of 27 in 2000; 10 out of 27 in 1999; 4 out of 21 in 1998 were referred for evaluation. See Ore. Death with Dignity Act Annual Reps., available at https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx. Similarly, in Washington, of the 173 residents for whom lethal drugs were dispensed in 2013, only 2 had been referred for such evaluation. *See* Washington's **2013 DEATH WITH DIGNITY ACT REPORT,** *supra* note 24. Washington's yearly reports from 2009 through 2012 reveal similar statistics; showing: 3 out of 121 in 2012; 5 out of 103 in 2011; 3 out of 87 in 2010; 3 out of 63 in 2009 were referred for evaluations. *See* Wash. Death with Dignity Act Annual Reps., available at http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData.

[32] *See Glucksberg*, 521 U.S. at 730-31 ("Research indicates … that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." (citations omitted)).

[33] "Only one of the two witnesses … may … be entitled to a portion of the … [patient's] estate upon death [,]" S.B. 128, § 443.3©(1); cf. O.R.S. § 127.810(2)(b); Wash. Rev. Code Ann. § 70.245.030(2)(b)(West 2009), or "Own, operate, or be employed at a health care facility where the … [patient] is receiving medical treatment or resides." S.B. 128, § 443.3©(2). Cf. O.R.S. § 127.810(2)(c); Wash. Rev. Code Ann. § 70.245.030(2)(c)(West 2009). The latter witness could well have a financial interest in "freeing up the bed" for a paying resident. Finally, the phrase, "[t]he request shall be witnessed by at least two other adult persons [,]" in Section 443.3(b) (3) refers back to the witnesses to the written request already required by the prior paragraph, *see id. at* § 443(b)(2)("The request shall be signed and dated, in the presence of two witnesses in accordance with paragraph [443.3(b)](3)," rather than adding a layer of informal witnesses, not necessarily subject to the restriction against having a financial interest in the patient's death.

[34] *Id.* at § 443.5(a)(6.

[35] *Id.* at § 443.1(d).

[36] Though S.B. 128 provides several safeguards for non-English speakers, *see e.g.*, *id.* at §443.9(b)(3)(translators who prepare written requests for lethal drugs in English shall not be "entitled to a portion of the … [patients'] estate upon death"), none apply to patients who are non-verbal or have difficulty speaking.

[37] *See* generally, Margaret K. Dore, *Physician-Assisted Suicide: A Recipe for Elder Abuse and the Illusion of Personal Choice*, 36-WTR Vt. B.J. 53 (2011).

resisted.[38] S.B. 128 compounds the problem by repeatedly referring to patients "ingesting"[39] (that is, swallowing), rather than "self-administering,"[40] the lethal drug, blurring the line between assisted suicide and euthanasia.[41]

Moreover, if California follows existing practice, the drug regiments of choice are,[42] to say the least, not hazard-free.[43] For example, in 2005, an Oregon patient regained consciousness sixty-five hours after ingesting a lethal prescription and finally died fourteen days later.[44] Again, in 2011, one Oregon patient regained consciousness approximately fourteen hours following ingestion and died about thirty-eight hours later; another briefly regained consciousness and died approximately 30 hours later.[45] Further, in 2012, another Oregon resident regained consciousness two days following ingestion, but remained minimally responsive, and died four days later.[46] This is hardly ending life in "a humane and dignified manner."[47]

---

[38] *Secobarbital and pentobarbital (Nembutal) are the drugs most prescribed in Oregon and Washington for aid in suicide. See* **OREGON'S DEATH WITH DIGNITY ACT—2014,** supra note 24; Washington's **2013 DEATH WITH DIGNITY ACT REPORT,** *supra* note 24. Both drugs are water-soluble and can be mixed with alcohol, for example, in a reluctant patient's drink. *See* Seconal Sodium (Secobarbital Sodium Capsules) Drug Information, available at http://www.rxlist.com/seconal-sodium-drug.htm ; Nembutal (Pentobarbital) Drug Information, available at http://www.rxlist.com/nembutal-drug.htm.

[39] *See* S.B. 128, §§ 443.1(i)(4)("'Informed decision' means … [a decision] that is made after being fully informed of … [t]he possibility that the individual … may obtain the drug but may decide not to ingest it"); *id.* at §§ 443.4 ("An individual may at any time … decide not to ingest an aid-in dying drug"); *id.* at §§ 443.5(a)(2)(B-C) & (5)(A-B, E)("Before prescribing an aid-in-dying drug, the attending physician shall … [c]onfirm that the individual is making an informed decision by discussing … [t]he potential risks associated with … [and t]he probable result of ingesting the requested aid-in-dying drug … [and c]ounsel the qualified individual about … [h]aving another person present when he or she ingests the aid-in-dying drug[;] … [n]ot ingesting the aid-in-dying drug in a public place[;] … [and m]aintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.").

[40] *See id.* at § 443.1(p)("'Self-administer' means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug[.]").

[41] Though S.B. 128 denies authorizing active euthanasia, *see id.* at § 443.16, who would know if it occurred since, without objective observers, the only witness to the act is dead.

[42] *See supra*, note 38.

[43] The total duration between ingestion and death set out in the Oregon annual reports ranges from 1 minute to 104 hours and, in the Washington reports, 2 minutes to 41 hours.

[44] *See* **OREGON'S DEATH WITH DIGNITY ACT--2005**, available at https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf.

[45] *See* **OREGON'S DEATH WITH DIGNITY ACT--2011**, Available at https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf.

[46] *See* **OREGON'S DEATH WITH DIGNITY ACT--2012**, Available at https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. Oregon also reported in 2010, without elaboration, that "[two patients] did not die after in[g]estion [;a]nother 2 regurgitated and regained consciousness." **OREGON'S DEATH WITH DIGNITY ACT--2010**, Available athttps://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf.

[47] S.B. 128, § 443.9.

Finally, once the prescription is written and the lethal drug dispensed, the attending physician's duty to the patient ends. He is not obliged to re-evaluate the patient's competence before the drug is taken, even though weeks or months have passed.[48] He is not obliged to be present when the drug is taken, and, in Oregon and Washington, seldom is.[49] Despite claims that it will vindicate patients' rights, what S.B. 128 really does is immunize doctors who prescribe lethal drugs, in "good faith" compliance with its check-list, from civil and criminal liability and professional sanctions.[50] At bottom, S.B. 128 is simply a safe-haven for doctors who would disavow that ancient oath "[t]o please no one will I prescribe a deadly drug, nor give advice which may cause his death."[51]

At a time not so long in the past, our laws were misused to mask reality, for example, the pre-bellum slave codes equated human beings with items of property, "reduced[ing] … [slaves] to animals, or real estate, or even kitchen utensils [.]"[52] Reflecting on this shocking phenomenon, Judge Noonan of the Ninth Circuit has observed: "law can operate as a kind of magic. All that is necessary is to permit legal legerdemain to create a mask obliterating the human person being dealt with. Looking at the mask … is not to see the human reality on which the mask is imposed."[53]

Like the slave codes, S.B. 128 operates as a kind of magic. By offering safeguards that serve instead to place patients at risk of abuse, it employs legal slight-of-hand. By calling "aid in dying"[54] practices that simply help patients make themselves dead, it recites empty incantations.[55] By not affirming patients' lives but rather abandoning them to their despair, it creates only an illusion of compassion. True compassion, however, "leads to sharing another's pain; it does not kill the person whose pain we cannot bear."[56] The plain fact is that S.B. 128 will legalize assisted suicide, and no legal magic can mask that reality. I would urge you to reject this dangerous and deceptive bill.

---

[48] For example, eleven Oregon patients, with prescriptions written in 2012 and 2013, died after ingesting the lethal drug in 2014. *See* **OREGON'S DEATH WITH DIGNITY ACT—2014,** supra note 24. Similarly, Washington reported a lapse of twenty-five weeks or more between the first oral request and death for sixteen patients in 2013. See Washington's **2013 DEATH WITH DIGNITY ACT REPORT,** *supra* note 24.

[49] Based on **Oregon's annual reports for 2001-2014,** prescribing physicians were present when 133 of 789 patients (17%) ingested lethal drugs; similarly, in Washington for 2009-2013, such physicians were present when 14 of 359 patients (4%) ingested lethal drugs.

[50] S.B. 128, § § 443.12(a) & (b). Of particular concern is Section 443.12© that omits even the minimal safeguard of "good faith compliance." *See id.* ("[A] health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability *for participating in this part, including, but not limited to, [determining a patient's diagnosis, prognosis, capacity, and providing the patient with information or a referral]." (emphasis added)).*

[51] The Oath of Hippocrates, available at http://www.aapsonline.org/ethics/oaths.htm#hippo.

[52] John T. Noonan, *The Root and Branch of Roe v. Wade*, 63 NEB. L. REV. 668, 669 (1984).

[53] *Id.*

[54] *See* S.B. 128, § 443.9(a)(entitling the written request form: "REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER"); *id.* at § 443.1(b)(labeling the lethal drug as "Aid-in-Dying").

[55] S.B. 128 simply decrees that conforming actions "shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse[.]" *Id.* at § 443.16. *See id.* at § 443.12(d)(2)(No conforming action "shall constitute or provide the basis for any claim of neglect or elder abuse [.]").

[56] St. John Paul II, *Evangelium Vitae* [Encyclical Letter on the Gospel of Life] ¶ 66 (1995).

Respectfully submitted,

Stephen L. Mikochik

Stephen L. Mikochik

Cc: Gov. Edmund G. Brown