

Testimony of

# Mr. Wesley Smith

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Testimony of Wesley J. Smith, JD, Before the U.S. Senate Judiciary Subcommittee on the Constitution, Civil Rights, & Property Rights,  
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Good afternoon. My name is Wesley J. Smith. I am a lawyer, author, and consumer advocate. I am a senior fellow at the Discovery Institute, an attorney and consultant for the International Task Force on Euthanasia and Assisted Suicide, and a special consultant to the Center for Bioethics and Culture.

For more than ten years I have been deeply engaged internationally in public policy debates about the most important bioethical issues facing our nation and global community. These include researching and writing about the ongoing erosion of Hippocratic medical values in bioethics involving areas such as assisted suicide, end of life medical treatment, and other areas of concern. I am the author or coauthor of 11 books, including *Forced Exit: Euthanasia, Assisted Suicide, and the New Duty to Die*, which was first published in 1997 and has just been published in its third edition. I also wrote *Culture of Death: The Assault on Medical Ethics in America*. *Culture of Death* was named "Best Health Book of the Year" at the 2001 Independent Publishers Book Awards. Both books deal substantially with the issue of euthanasia/assisted suicide. My abridged CV is attached to my testimony.

My work in the fields about which I advocate is entirely secular, which I believe is appropriate to the creation of public policy in a nation governed by the rule of law.

I appear today to argue that there is a proper public policy role for the federal government against assisted suicide, such as prohibiting federally controlled substances from being used to intentionally end life, and in the application of other government policies consistent with the standards of federalism. This would be in keeping with existing federal government policy that already prohibits federal money from being used to fund assisted suicide under the Medicaid program.

There are two deep ideological beliefs asserted by advocates for legalizing assisted suicide. The first is radical individualism that perceives the right of personal autonomy as being virtually absolute. Accordingly, promoters of assisted suicide generally believe that "the individual's right to self-determination--to control the time, place, and manner of death" is a paramount liberty interest. The second ideological principle underlying assisted suicide advocacy is that killing (ending life) is an acceptable answer to the problem of human suffering.

Assisted suicide is usually couched in terms that would limit assisted suicide to those who are terminally ill. But given the philosophical/ideological principles that underlie the euthanasia movement--that autonomy is paramount and killing is a valid answer to human suffering--restricting assisted suicide to the dying becomes utterly illogical. After all, many people experience far greater suffering and for a far longer period than people who are terminally ill. Thus, once the premises of assisted suicide advocacy become accepted by a broad swath of the medical professions and the public, there is little chance eligibility for "permitted" suicide will remain limited to the terminally ill.

We need only look to the experience of the Netherlands to see the destructive force that the implacable logic of euthanasia ideology unleashes. The Dutch have permitted euthanasia and assisted suicide since 1973. Euthanasia became an integral part of Dutch medicine after a court ruling that refused to meaningfully punish a physician, Geetruida Postma, who had euthanized her mother. The court accepted the premise--supported by both the prosecution and the defense--that most Dutch doctors favored euthanasia in some cases. Accordingly, even though convicted of murder, Dr. Postma received only a one-week suspended sentence and a year's probation.

To justify its action, the Court established the first "boundaries" for euthanasia practice in the Netherlands. Among these were the requirements that the patient be considered incurable, implying that the patient must suffer from a severe physical illness; that the patient's suffering be subjectively unbearable; that the request for termination of life be in writing; and that there should be adequate consultation with other physicians before euthanasia could be carried out. Inclusion of these conditions in the court's decision became the basis for subsequent public and government acceptance of euthanasia in the Netherlands.

With the Postma decision, the Dutch stepped boldly onto a steep slippery slope. Other court decisions soon followed,

with each widening and further liberalizing the conditions under which euthanasia would not be punished. Thus, even though euthanasia remained technically illegal until 2002, it soon became entrenched in Dutch medical practice.

In 1993, the Dutch Parliament formalized the permissive "decriminalized" system of euthanasia permissiveness that had been first crafted by the courts. Under this approach, so long as doctors followed the guidelines when euthanizing patients, they would not be prosecuted. These guidelines included:

? The request must be made entirely of the patient's own free will and not under pressure from others.

? The patient must have a lasting longing for death.

? The request must be made repeatedly over a period of time.

? The patient must be experiencing unbearable suffering.

? There must be no reasonable alternatives to relieve suffering than euthanasia.

? Doctors must consult with at least one colleague who has faced the question of euthanasia before.

? Only a doctor can euthanize a patient.

? The euthanasia must be reported to the coroner, with a case history and a statement that the guidelines have been followed.

In actual practice these guidelines were porous and provided scant protection for the weak, vulnerable, and despairing, nor, as we shall see, have they inhibited doctors from euthanizing patients who fell outside the guidelines' parameters.

At this point it is important to recall that when euthanasia was first accepted in the Netherlands, it was supposed to be a rare event, to be resorted to only in the most unusual cases of "intolerable suffering." The guidelines were designed specifically to keep euthanasia occurrences few and far between by establishing demanding conditions that had to be met, at the risk of criminal prosecution. Over time, however, doctors began to interpret the conditions loosely and even ignore them altogether. In the few circumstances where the law took notice, the courts accommodated expanded euthanasia through continual loosening of the meaning of the guidelines.

This is the typical pattern of the assisted suicide movement. Life-ending actions by doctors are always presented to the public as being advocated as a "rare" occurrence, to be applied only when nothing else can be done to alleviate suffering. Proponents soothingly assure a doubtful public, as the New York euthanasia advocate Dr. Timothy Quill once put it, that assisted suicide will be restricted to "the patient of last resort, [to be] taken only when hospice care stops providing comfort and dignity," when "all alternatives have been exhausted." But once accepted widely and put into actual practice--as the Dutch experience clearly demonstrates--it quickly ceases to be rare, nor is killing resorted to only when all else fails. Instead, in the words of the physician, Dr. K. F. Gunning, perhaps the most notable Dutch opponent of euthanasia, "Once you accept killing as a solution for a single problem, you will find tomorrow hundreds of problems for which killing can be seen as a solution."

Euthanasia was finally formally legalized in the Netherlands in 2001, effective 2002. In the thirty-plus years since euthanasia was redefined in the Netherlands as a legitimate tool of medical practice instead of a serious crime, cultural biases have changed. No longer constrained by conscience or culture, thanks to a redefinition of euthanasia as medical treatment instead of killing, Dutch doctors now terminate categories of people whose assisted deaths would have once provoked outrage, and do so in numbers that were not anticipated when the practice was first promoted in 1973. Rather than being rare, statistics show that euthanasia is now almost a matter of medical routine.

### The Rummelink Report

In 1990, responding to the ongoing heated debate about Dutch euthanasia and the many anecdotes being told internationally about the involuntary killing of patients by doctors, the Dutch government decided to determine how euthanasia was actually being carried out and appointed an investigative committee for that purpose. Called the Committee to Investigate the Medical Practice Concerning Euthanasia, it was commonly known as the Rummelink Commission, after the committee's chairman, Professor J. Rummelink, then the attorney general of the Dutch Supreme Court.

The commission's two-volume report, known as the Rummelink Report, was issued in 1991. The Rummelink Report included complete statistical data upon which it based its conclusions. Independent analysis of this rich source of information had a profoundly negative impact on the world's view of Dutch euthanasia. According to the Rummelink Report, about 130,000 people die each year in the Netherlands. Of these, approximately 43,300, or about one third, die suddenly--from catastrophic heart attacks, stroke, accidents, etc.--thus precluding medical decision making about end-of-life care. That leaves approximately 90,000 people whose deaths involve end-of-life medical decision making each year.

With that in mind, here are the figures about euthanasia-related deaths in 1990, derived from the Rummelink Report's published statistical data:

? 2,300 patients were euthanized (killed) by their doctors upon request, and 400 people died through physician-

assisted suicide, for a total of 2,700 doctor-induced deaths. That is approximately 3 percent of all deaths involving end-of-life medical care. The equivalent percentage in the United States would be approximately 41,500 deaths. ? 1,040 died from involuntary euthanasia, lethal injections given without request or consent--three deaths every single day. These deaths constitute slightly more than 1 percent of all cases involving end-of-life medical care. (The same percentage in the United States would be approximately 16,000 involuntary killings per year.) Of these involuntary euthanasia cases, 14 percent, or 145, were fully competent to make their own medical decisions but were killed without their request or consent anyway. (The same percentage in the United States would be more than 2,000 who would be killed.) Moreover, 72 percent of the people killed without their consent had never given any indication they would want their lives terminated.

? 8,100 patients died from an intentional overdose of morphine or other pain-control medications, designed primarily to terminate life. In other words, death was not a side effect of treatment to relieve pain, which can sometimes occur, but was the intended result of the overdose. Of these, 61 percent (4,941 patients) were intentionally overdosed without request or consent. The equivalent percentage in the United States would be approximately 78,000.

These figures are startling. Of the approximately 90,000 Dutch people whose deaths involved end-of-life medical decision-making in 1990, 11,140 were intentionally killed (euthanized) or assisted in suicide--or 11.1 percent of all Dutch deaths involving medical decision-making! This is approximately 8.5 percent of Dutch deaths from all causes. Of these killings, more than half were involuntary (1,040 involuntary lethal injections and 4,941 involuntary intentional overdoses). Applying those percentages to the U.S. death rate would mean more than 170,000 deaths each year caused by euthanasia or assisted suicide, and about 85,000 of these involuntary, more than the current number of U.S. suicides and homicides combined.

It should also be kept in mind that the Rummelink statistics probably underestimate the actual number of deaths caused by euthanasia and assisted suicide. A study conducted by the Free University at Amsterdam revealed that two thirds of Dutch general practitioners have certified a patient's death as resulting from natural causes when in fact it was euthanasia or assisted suicide. Another Dutch study arrived at a similar conclusion, finding that only 28 percent of doctors were honest about their euthanasia killings when filling out death certificates. A more recent Dutch study, written up in the *New England Journal of Medicine* in November 1996, found that only 41 percent of all euthanasia deaths were reported to the authorities. This same study revealed that 23 percent of physicians interviewed had killed patients without having received an explicit request. Along a similar vein, a 2003 study published in *The Lancet* found that "the rate of euthanasia had significantly increased" between 1995 and 2001, while "the rate of ending life without a patient's explicit request remained virtually unchanged."

#### A Practice Beyond Effective Control

In 1999, a statistical analysis of Dutch euthanasia practices published in *Journal of Medical Ethics* concluded that the Dutch promise of "effective regulation ring hollow" and that killing by doctors in the Netherlands "remains beyond effective control." And for good reason: As University of Haifa's Raphael Cohen-Almagor a self-described ideological believer in euthanasia admitted in his 2004 book, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing*, Dutch euthanasia policy:

...does not work because all of the guidelines, without exception, are broken time and time again. It is not always the patient who makes the request for euthanasia or physician-assisted suicide. Often the doctor proposes euthanasia to the patient. Sometimes, the family initiates a request. The requirement that the request be voluntary is thus compromised. On occasion, the patient's request is not well considered...[T]here have been cases in which no request was made and patients were put to death. Furthermore, the patient's request is not always durable and persistent as required.

Beginning with the Rummelink Report and continuing thereafter with virtually every other study of Dutch euthanasia practices--whether by proponents or opponents of medicalized killing--report after report has demonstrated clearly that guidelines do not protect and do not restrict. And why should they? The Dutch government has clearly indicated it has no interest in forcing doctors to toe the line by its infrequent prosecution of doctors who violate euthanasia regulations, and in the rare case of a conviction, never imposing meaningful punishment. For example, the *British Medical Journal* reported on a general practitioner who killed his elderly comatose patient with a lethal injection, was convicted of murder but received a one week suspended sentence, hardly a meaningful penalty despite having violated virtually every protective guideline.

But the issue goes much deeper than law enforcement authorities refusing to enforce the rules. What euthanasia really did to the Dutch was to profoundly alter the nation's conception of right and wrong. With the widespread acceptance of a euthanasia consciousness in the Netherlands, the guideline limitations became mere window dressing that made little actual difference at the bedside to doctors or, indeed, to much of the general public. Finding the proverbial exception to the rule became a standard practice, which in turn, soon changed the exception into the

rule. The official guidelines then expanded to meet the actual practice.

The psychiatrist Dr. Herbert Hendin, medical director of the American Foundation for Suicide Prevention, is one of the world's foremost experts on Dutch euthanasia. Over the last several years, Hendin has held extensive discussions with Dutch doctors who euthanize patients and has reviewed the records of actual cases. Dr. Hendin believes that many doctors in the Netherlands feel justified in performing involuntary euthanasia, because a system that accepts killing as a legitimate medical practice "encourages some to feel entitled to make [euthanasia] decisions without consulting the patient." As an example, Hendin recounts his interview with a pro-euthanasia doctor who justified killing a nun who had requested not to be killed on the basis of religious belief, because he felt she was in too much pain.

To prove the existence of cases that violate the official guidelines, it is not necessary to rely on anecdotal evidence. Such cases have even been documented in euthanasia-friendly documentaries originally produced in the Netherlands and later shown in the United States. One such documentary, broadcast over public television on the program *The Health Quarterly* in 1993, revealed how broadly the Dutch guidelines are interpreted.

One case documented in the film concerns a man named Henk Dykema, who at the time of filming was asymptomatic HIV-positive. Dykema feared the afflictions that he expected to befall him and had been asking his doctor to kill him for more than a year. The film shows the doctor telling Dykema that he might live for years at his current stage of infection, but the patient wants none of it. The doctor, a general practitioner, then discussed Dykema's case with a colleague, also a general practitioner. Significantly, no psychiatrist was consulted or involved. Finally, the doctor agreed to provide a poisonous drug cocktail to Dykema, even though he was not suffering any significant physical symptoms.

Dykema's assisted suicide was clearly not a last resort, as required by the Dutch guidelines. He and his doctor did not explore all other possible options, such as psychiatric treatment, which could well have alleviated his anxiety and depression. Nor was he told of the actions the doctor could have taken to relieve his suffering when he did become ill. The doctor didn't even wait until his patient had actual symptoms of AIDS.

Dr. Hendin, analyzing Dykema's case from a psychiatrist's perspective, commented, "The patient was clearly depressed. The doctor kept establishing that the man was persistent in his request, but did not address the terror that underlay it." Now consider this: had the doctor called in suicide prevention experts to help Dykema instead of assisting his suicide, Dykema might well have survived long enough to benefit from the drugs that now extend the lives of HIV patient for many years.

The documentary also shows Maria, a twenty-five-year-old woman with anorexia nervosa, asking for euthanasia. She is in remission but fears a recurrence of her malady, stating: "I've thought about dying day and night, and I know that if relief does not come, I will return to the old pattern, the pattern of self-punishment, hurting myself I know it. I feel it, and therefore I hope the release will come soon and I die." Maria's doctor agrees to assist her suicide, justifying his abandoning his patient to her worst fears, "It is not possible to have a good quality of life for her." This case was even too much for the authorities, who brought charges against the doctor. However, the euthanasia consciousness had so permeated the justice system that a judge ruled that Maria's assisted suicide was justified because her suffering had made her life unbearable.

Similar tragedies can be found in many published investigations of Dutch euthanasia. For example, *The Oregonian* reported on a woman with skin cancer who was euthanized. She was not in pain, nor was she in a terminal stage of her illness. Rather, she was upset by the scars on her face and demanded euthanasia from her doctor, or else--the threat being that she would "jump from the balcony." Her doctor, to his later expressed regret, accommodated her wish to die.

Studies indicate that families, rather than patients, sometimes decide when the time has come for euthanasia.

According to Dr. Hendin, doctors called in such cases "usually advocate euthanasia," because they "support the relatives' desire to be free from the burden of caring for the patient." One such case occurred when a wife told her husband to choose euthanasia or a nursing home. Not wanting to be cared for by strangers, he chose death. The doctor killed him, despite knowing of the coercion.

*Dancing With Mr. D*, a revealing book written a few years ago by a Dutch doctor, Bert Keizer, demonstrated how farcical the protective guidelines have become in the Netherlands. Keizer works in a nursing home, where he cares for--and sometimes kills--disabled, elderly, and dying people. He looks upon euthanasia as a necessary and proper, albeit distasteful, part of his job. As depicted in the book, so do his colleagues, patients, and their families.

Keizer is brutally honest in revealing his own attitudes about his patients. He depicts the lives of frail and dying people as pointless, useless, ugly, grotesque. Those with whom Keizer interacts all seem to share these views, including his colleagues, family members of patients, and the patients themselves. This allows Keizer to kill patients without consequence other than having a few bad dreams.

And kill his patients Keizer does, again and again. One man he euthanizes probably has lung cancer but the diagnosis is never certain. A relative tells Keizer that the man wants to be given a lethal injection, a request later

confirmed by the patient. Keizer quickly agrees to kill the man. Demonstrating the utter uselessness of "protective guidelines," Keizer never tells his patient about treatment options or how the pain and other symptoms of cancer can be palliated effectively. He never checks to see if the man has been pressured into wanting a hastened death or is depressed. Keizer doesn't even bother to confirm the diagnosis with certainty. When a colleague asks why rush, and points out that the man isn't suffering terribly, Keizer's radical view of autonomy and his acceptance of killing as an answer to serious human illness, leads him to snap irritably:

Is it for us to answer this question? All I know is that he wants to die more or less upright and that he doesn't want to crawl to his grave the way a dog crawls howling to the side walk after he's been hit by a car.

Another of Keizer's patients is disabled by Parkinson's disease. The patient requests to be killed, but before the euthanasia can be carried out, he receives a letter from his brother, who uses a religious argument to urge him to change his mind. The letter causes the man to hesitate, upsetting Keizer, who writes:

I don't know what to do with such a wavering death wish. It's getting on my nerves. Does he want to die or doesn't he? I do hope we won't have to go over the whole business again, right from the very start.

Keizer involves the nursing home chaplain to assure the man that euthanasia will not upset God. The man again thinks he wants to die. Keizer is quick with the lethal injection, happy the man has "good veins," and the man expires before his uncertainty can disturb his doctor's mood again.

Dutch doctors now also assist the suicides of depressed people who are not physically ill--and the practice was approved explicitly by the Dutch Supreme Court in the death of Hilly Bosscher. Bosscher wanted to kill herself because she had lost her two sons--one to suicide in 1986 and the other to brain cancer in 1991. Bosscher had briefly received psychiatric treatment years earlier for the depression and suicidal thoughts she experienced after her son's suicide. On the day her second son died, she failed in an attempt to kill herself. She still wanted to die but hesitated at unassisted self-destruction for fear that she would be hospitalized if she tried and failed again. However, she moved the graves of her two sons to the same cemetery and purchased a burial plot for herself so that she could be buried between them.

Bosscher began to attend meetings of the Dutch Euthanasia Society, where she met Dr. Boudewijn Chabot. She told Chabot that she didn't want therapy, "because it would loosen the bonds with her deceased sons." Chabot took her as a patient anyway and met with her on four occasions between August 2 and September 7, 1991. Chabot did not attempt to treat her. Rather, he interviewed her to determine her prognosis. After these interviews and his consultations, believing her to be suffering from "incurable grief"--and despite the complete absence of any physical illness--he helped Bosscher kill herself on September 28, 1991.

Chabot was prosecuted, although it was never contemplated that he would be jailed or otherwise meaningfully punished. Indeed, the government's own witness supported the assisted suicide. The Dutch Supreme Court, with the minor caveat that Chabot erred by not having a colleague independently examine the patient, validated Chabot's actions. The basis of the ruling was that the law cannot distinguish between suffering caused by physical illness and suffering caused by mental anguish--which, of course, is where euthanasia leads with the sheer force of logic.

#### Dutch Euthanasia Leads to Permitted Infanticide

In the Netherlands, infants are killed because they have birth defects, and doctors justify the practice. A 1997 study published in the British medical journal, *The Lancet*, revealed how deeply pediatric euthanasia had metastasized into Dutch neonatal medical practice. According to the report, doctors killed approximately 8 percent of all infants who died in the Netherlands in 1995. Assuming this to be typical, this amounts to approximately 80-90 infanticides per year. Of these, one-third would have lived more than a month. At least 10-15 of these killings involve infants who did not depend on life-sustaining treatment to stay alive. The study found that 45 percent of neonatologists and 31 percent of pediatricians, who responded to study's questionnaires, had killed infants. A follow up study of end-of-life decisions made for infants published in the April 9, 2005, found that nothing had changed. In 2001, "in 8%" of cases, drugs were administered to infants "with the explicit intention to hasten death."

In 2004, Groningen University Medical Center made international headlines when it admitted to permitting pediatric euthanasia and published the "Groningen Protocol," infanticide guidelines the hospital utilized when killing 15-20 disabled newborns each year." The Protocol creates three categories of killable infants: infants "with no chance of survival," infants with a "poor prognosis and are dependent on intensive care," and "infants with a hopeless prognosis," including those "not depending on intensive medical treatment but for whom a very poor quality of life...is predicted." Par for the course, authorities refused to prosecute even though pediatric infanticide is clearly murder under Dutch law.

Apologists for the infanticide applauded Dutch doctors for going public with the Protocol. "As things are," Eduard Verhagan, head of Groningen's children's clinic told the Associated Press, "people are doing this secretly and that is wrong. In the Netherlands we want to expose everything to let everything be subject to vetting."

Contrary to Dr. Verhagan's assertion, it has long been known Dutch doctors kill disabled and dying babies--as The Lancet study of 1995 infanticides (published in 1997) cited above demonstrates. Indeed, a 1990 report of the Royal Dutch Medical Association (KNMG), Life-Terminating Actions with Incompetent Patients, set forth "requirements for careful medical practice" when ending the lives of handicapped newborns. The standard for permitting pediatric euthanasia was based on what Dutch doctors call an "unlivable life." Rita Marker discussed Dutch infanticide in her seminal expose` of the international euthanasia movement, *Deadly Compassion*. I also wrote about Dutch infanticide practices in my 1997 edition of *Forced Exit*.

Infants are not the only children who are eligible for euthanasia. Pediatric oncologists have provided a *hulp bij zelfdoding* (self-help for ending life) program for adolescents since the 1980s, in which poisonous doses are prescribed for minors with terminal illness. Moreover, children who want physician-assisted death may be able to receive it without consent of their parents. Dutch euthanasia advocates have also agitated to reduce the age of consent to euthanasia to 12-year-olds.

### Drawing Conclusions

Unlike the Dutch, Americans do not come to the decision whether to accept legalized assisted suicide blindly. We have the Dutch experience to guide us. On the basis of their experience with euthanasia, what can we learn? First, the slippery slope is very real. As Dr. Gunning put it, the Dutch have proved that once killing is accepted as a solution for one problem, tomorrow it will be seen as the solution for hundreds of problems. Once we accept the killing of terminally ill patients, as did the Dutch, we will invariably, over time, accept the killing of chronically ill patients, depressed patients, and ultimately perhaps, even children.

Second, adopting killing as an acceptable answer to human suffering eventually changes popular outlooks. The law not only reflects our values, but in our diverse age, it tells us right from wrong. Accordingly, once killing is redefined as medical treatment, it becomes transformed from "bad" into "good." Thus, the guidelines intended to "protect against abuse" eventually are viewed not as protections but instead as hurdles separating sick and dying patients from the beneficence of death. In such an intellectual and cultural milieu, it becomes easy to justify ignoring or violating "guidelines."

Third, the Netherlands is a much more tolerant society than we are, generally more accepting of differences among people, such as those of race, gender, and sexual orientation. An editorial in the *New England Journal of Medicine* cited a plethora of studies that uncovered significant race-based inequality in the delivery of health care in the United States, and opined that the disparities in the delivery of health care apparently caused by racism need to be focused upon with the "rigor and attention given to other health concerns of similar magnitude." These and other factors make it likely that legalizing and especially "routinizing" euthanasia in the United States would be especially dangerous for marginalized populations.

Finally, the euthanasia virus is catching. A 2000 report found that 10 percent of Belgian deaths appear to result from euthanasia. With Belgian doctors clearly eager to follow the lead of their Dutch neighbor, Belgium formally legalized euthanasia in 2002. Notably, the first Belgian case, the killing of a man with multiple sclerosis, violated the guidelines; and just as occurs routinely in the Netherlands, the doctor involved faced no consequences. Now Belgium is set to legalize euthanasia for children. Indeed, Belgian doctors in Flanders have been found to commit infanticide in about the same numbers as their Dutch counterparts. Moreover, according to a study published in *The Lancet*, nearly 70% "of the physicians questioned...had either used lethal drugs for this purpose [to end infants' lives] or could conceive of situations in which they would use them."

Given the profound import of the debate over assisted suicide, the federal government has a crucial role to play. By pursuing its own national public policy that unequivocally opposes transforming suicide and euthanasia, it can influence the national debate without infringing on important principles of federalism. Such policies could include enacting a statute declaring suicide not to be a legitimate medical use of federally controlled substances. It can broaden the prohibition of using federal funds for use in assisted suicide, under Medicaid, Medicare, in Veterans hospitals, and the like. Engaging the issue at the federal level would be consistent with the government's obligation to promote the general welfare and I urge the Senate to explore this important issue fully toward achieving these ends.