Maryland Legislative Lobby for Life, Inc.
P.O. Box 5481
Towson, MD 21285-5481

Oppose

February 28, 2020

SB0701 End of Life Option Act

(Richard E. Israel and Roger "Pip" Moyer Act)

Good Afternoon,
My name is Sheila Wharam, secretary of Maryland Legislative Lobby for Life.
-We oppose the End of Life Option Act, Senate Bill 701, in and of itself because of flaws in the bill.
-But we also oppose it because of the complete change in social policy it would bring to Maryland. Our state was constituted "in compact" "solely for the good of the whole" [2]. Encouraging Marylanders to kill themselves is the opposite of the good of the whole. Legislators must also think long and perhaps consult with the Maryland Medical Board before they decide to give the police power of the state to kill to each and every doctor.

We Marylanders are blessed to have one of the lowest suicide rates in the nation, ranked 47 out of the 50 states. As the national suicide rate has continually raised ours has risen only slightly. We don't want to change that.
-We know that suicide is socially contagious[1]. None of us want to encourage suicide
.
-The bill also opposes medicine's ethic of supporting the life and care of the patient throughout every stage of the patient's lifetime.
-The ethic in this bill abandons the patient when the patient is most in need of support, when it is believed that medical arts cannot reverse or slow the fatal disease. Please see the attachment of just how open to abuse the ill can be.

Destruction of medicine's life and health ethic

As one who suffered and prayed and scoured the internet for any possible slowdown or turn back from the disease that paralyzed my beloved husband more every day, and with due respect to those who have endured and suffered with the sufferings of their beloved family members and friends, that care and that endurance for your loved ones is not enough reason to destroy the life ethic of the medical profession in Maryland: the life ethic of the doctors and the nurses and anyone else who gives hands-on care to the sick.

No to abandonment of the Ill

It is not enough reason to change Maryland into the kind of society that is impatient with those of the ill who want to live, with those who don't understand that they would be better off dead and we would be better off not having to worry and suffer on their behalf.

No to destruction of Trust

The suffering and heartache we have suffered on behalf of our suffering loved ones is not reason enough to destroy the trust that Marylanders have that their doctors are working to maximize

their health and minimize their pain. In other states giving doctors the right to help kill patients has led doctors to include suicide as a treatment option offered to the patient. How horrible to be upset and scared and sick and have your doctor offer to help to kill you.

Last November the 11,000 member Ohio Nurses Association took a position in favor of doctor assisted suicide. That should outrage and worry everyone in Ohio.

Outrage because the good responsible caring nurses in Ohio may now be looked upon with suspicion as someone who will lobby the patient to kill himself, worry because patients cannot be sure where their nurse stands on the suicide issue.

Marylanders have been groomed to accept suicide and euthanasia.

The bills that started us on the path to accepting people killing themselves were put in in 1976, baby steps, trying to replace consultation with you or your family or health care agent with checking a piece of paper, first the advanced directive, then the M O L S T, but Compassion and Choices pushed the baby steps hard in order to change the focus of medicine from maximizing a patient's health or comfort to concentrating on the patient's time or method of death. Compassion and Choices wanted to include an option for the patient to be starved and dehydrated to death in the first advanced directives but Maryland legislators defeated that. One of the reasons we were told we had to have the right to kill ourselves was because the new incurable disease called AIDS was too terrible to face. Please see the attachment for what has happened to HIV.

Belittling of the very Ill

Dr. Leo Alexander who was at the War Crimes Trials in Nuremberg saw that a subtle change in medical ethics had preceded the acceptance of killing patients by the German medical profession for the non-curable sick during the 1930s. In an editorial the NEJM in 1949[3] he warned against an ethic of the life devoid of value. The current version of this is the Texas hospital law where once a Texas hospital decides a patient's quality of life no longer warrants the hospital's giving the patient even small amounts of life-sustaining care, a ventilator, or a feeding tube, the patient's family has 10 days to find another hospital willing to take him in or the patient's life is ended by turning off equipment which sustained him, killing the patient.

What happens if this bill passes?
What are "Safeguards" now, are "barriers" next year

The supposed safeguards in the bill are a sales pitch to get the bill accepted so that, as has happened in other states, in a year or two a new bill will be proposed to remove the cruel "barriers" to mercy that are in this bill.

For example:

"Self-administered" is claimed to be a safeguard this year, but it will be claimed as a barrier soon: Think of persons like my husband who couldn't move a muscle. If people capable of self-administering have the right to kill themselves why should others who can't self-administer be denied that right? Such a terrible barrier. So "self administered moves on to becomes "other-

administered", i.e. homicide. And if it is other administered why does it have to be by mouth? Why not just give an injection and have full scale euthanasia/homicide.

Waiting period: If someone is in terrible pain why should they have to wait 2 weeks to kill themselves? Such a barrier.

Signing and dating the Request: How could someone like my husband, who could not write for more than a year before his death, comply? Such a barrier.

Paying to see two or three doctors: A safeguard this year soon to be argued against as a mean barrier to the sick or poor. Such a barrier.

The Next Step- Wouldn't it be more merciful for the doctor to just give you an injection of the numerous things that so many of the "Angels of Death" who have killed patients in hospitals have used to kill patients?

Problems with the Bill

It creates a new Medical Specialty of assisted suicide physician- the way this is set up in the bill is the definition of "**attending physician**" who doesn't even know the patient and has to ask for a driver's licenses or voter registration cards (pg 11) to know where the patient lives. Kaiser Permanente in Oregon in 2002 advertised for physicians who would work as physicians who would sign off on assisted suicide requests. A California doctor who left medicine to become a photographer has returned to medicine now that the state of California has given him the power to kill patients.

Enmeshes Hospice in Patient's Suicides- page 13 line 13. This will put suspicion on the motivations of hospices as well as be a place where suicide contagion spreads.

Has no provision to protect the consciences of pharmacists.

Makes MDs who disagree with this be an accessory by having to send records to a doctor who will kill the first doctor's patients. The patient should be given the records and then go to whomever they want.

The Suicide Protocol is now a mess since the barbiturates once used have become unavailable or exorbitantly expensive:

The Suicide protocol is glibly referred to as taking a pill. In fact when Oregon became to first place to legalize doctor assisted suicide it took 100 opened barbiturates mixed in applesauce to kill oneself. Now that the barbiturate has effectively been removed from the market there is **no** successful self administered way to be sure of a quick or peaceful death. The mixtures the euthanasiaists have put together have had some people screaming with pain as it burned their mouths and throats and others have left patients with many hours or days to die. This will be another reason that a new bill will follow- one to legalize full scale euthanasia.

We would all be naïve to pretend that the reasons given to kill patients will not expand.

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Holland now allows euthanasia for infants and children from age 12 up and is discussing adding "mature" younger children to those eligible for euthanasia.

Oregon has recorded people with diabetes being approved for physician assisted suicide.

The great lawgiver Moses gave advice in such circumstances as we find ourselves,

"I have set before you life and death, the blessing and the curse, therefore choose life."

Thank you,
Sheila Wharam, Secretary
MLLL, Inc.

[1]Maryland Constitution, page 1.

[2]The Dangerously Contagious Effect of Assisted-Suicide Laws, Aaron Kheriaty, MD, November 20, 2015.

[3]"The ease with which destruction of life is advocated for those considered either socially useless or socially disturbing instead of educational or ameliorative measures may be the first danger sign of loss of creative liberty in thinking, which is the hallmark of democratic society.

All destructiveness ultimately leads to self-destruction; the fate of the SS and of Nazi Germany is an eloquent example.

The destructive principle, once unleashed, is bound to engulf the whole personality and to occupy all its relationships. Destructive urges and destructive concepts arising therefrom cannot remain limited or focused upon one subject or several subjects alone but must inevitably spread and be directed against one's entire surrounding world, including one's own group and ultimately the self. The ameliorative point of view maintained in relation to all others is the only real means of self-preservation.

A most important need in this country is for development of active and alert hospital centers for the treatment of chronic illnesses. They must have active staffs similar to those of the hospitals for acute illnesses, and these hospitals must be fundamentally different from the custodial repositories for derelicts, of which there are too many in existence today. Only thus can one give the right answer to divine scrutiny: Yes, we are our brothers' keepers." *433 Marlborough Street*

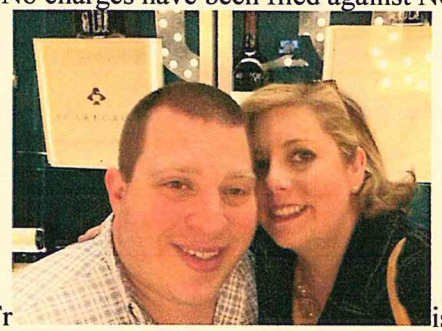
Dr. Leo Alexander was Instructor in psychiatry, Tufts College Medical School; director, Neumann Unit, Division of Psychiatric Research, Boston State Hospital; chief consultant to the Secretary of War, on duty with the Office of the Chief of Counsel for War Crimes, Nuremberg, United States Zone Germany, 1946-1947. "***Medical Science Under Dictatorship***", The New England Journal of Medicine, vol 241, no 2, July 14, 1949

Frisco Hospice Owner Urged Nurses to Overdose Patients So They Would Die Quicker, FBI Says

by APFLI | Mar 29, 2016 | Euthanasia / Assisted Suicide - Archive, Treatment Concerns - Definitions / Living Wills / Palliative Care / Terminal or Excessive Sedation / Organ Donation / DCD or NHBD / Hospice / POLST / DNR | 0 comments

The owner of a Frisco medical company regularly directed nurses to overdose hospice patients with drugs such as morphine to speed up their deaths and maximize profits and sent text messages like, "You need to make this patient go bye-bye," an FBI agent wrote in an affidavit for a search warrant obtained by NBC 5.

The executive, Brad Harris, founded the company, Novus Health Care Services Inc., in July 2012, according to state records. Novus' office is on Dallas Parkway in Frisco. No charges have been filed against Novus or Harris. Harris, 34, did



not return messages left with a receptionist and at his Frisco home.

Harris, an accountant, told a nurse to overdose three patients and directed another employee to increase a patient's medication to four times the maximum allowed, the FBI said.

In the first case, the employee refused to follow the alleged instructions, the agent wrote in the affidavit. The document does not say whether the other three patients were actually harmed.

Harris also told other health care executives over a lunch meeting that he wanted to "find patients who would die within 24 hours," and made comments like, "if this f— would just die," an FBI agent wrote in the warrant.

An FBI spokeswoman declined to comment on the investigation.

Novus' website says the company offers hospice and home health care services.

"We have a saying at Novus, be fast and treat people the way we would want to be treated," the website says. "This encourages us to go the extra mile to make patients feel comfortable and secure about their special needs and requests."

'Aggregator cap'

Health care providers do not necessarily make more money for longer hospice stays.

That's because hospices are subject to an "aggregator cap," which limits Medicare and Medicaid payments based on the yearly average hospice stay, the FBI said.
If patients live longer than that, the provider can be forced to pay back part of their payments to the government.

"Hence, hospice providers have an incentive to enroll patients whose hospice stays will be short relative to the cap,"The FBI said its investigation into Novus started in October 2014 and initially focused on allegations that for the previous two years, the company recruited patients "who did not qualify for services" and charged the government for services that were not medically necessary.

subsequent sixty-day recertification, needed to include an explanation of why the clinical findings of the face-to-face encounter supported a life expectancy of six months or less.

III. Continuous Care

13. Hospice services could be billed to Medicare as routine or continuous care. Continuous care covered nursing care for as much as a twenty-four hours per day during periods of crisis. A period of crisis was a period in which the individual required continuous care which was predominantly nursing care to achieve palliation or management of acute medical symptoms. The decision to place a Medicare beneficiary on continuous care needed to be made in accordance with an individualized, physician-established plan of care, and a hospice company had to ensure that these direct patient care services were clearly documented and were reasonable and necessary.

14. Medicare payments for claims for continuous care were substantially greater than the payments for claims for routine hospice services. For example, in 2013 Medicare paid hospice providers a daily rate of $153.45 for routine care. Daily rates for continuous care ranged from $303.60 to $895.56, depending on the amount of continuous care provided, from a minimum of eight hours to a maximum of twenty-four hours per day.

IV. The Defendants

15. Defendant **Bradley Harris** founded and served as the Chief Executive Officer (CEO) of Novus. **Bradley Harris** was a certified public accountant without any medical licenses.

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Opinions

The dangerously contagious effect of assisted-suicide laws

By Aaron Kheriaty , M.D.
November 20, 2015
Aaron Kheriaty is an associate professor of psychiatry and director of the medical ethics program at the University of California at Irvine School of Medicine. This piece is adapted from a longer commentary that appeared in the Southern Medical Journal in October.

The debate over doctor-assisted suicide is often framed as an issue of personal autonomy and privacy. Proponents argue that assisted suicide should be legalized because it affects only those individuals who — assuming they are of sound mind — are making a rational and deliberate choice to end their lives. But presenting the issue in this way ignores the wider social consequences.

What if it turns out that the individuals who make this choice in fact are influencing the actions of those who follow? Ironically, on the same day that Gov. Jerry Brown (D) signed the bill to legalize physician-assisted suicide in California last month, an important study was published by British scholars David Jones and David Paton demonstrating that legalizing assisted suicide in other states has led to a rise in overall suicide rates — assisted and unassisted — in those states. The study's key findings show that, after controlling for demographic and socioeconomic factors and other state-specific issues, physician-assisted suicide is associated with a 6.3 percent increase in total suicide rates. These effects are greater for individuals older than 65 (for whom the associated increase was 14.5 percent). The results should not surprise anyone familiar with the literature on the social contagion effects of suicidal behavior. You don't discourage suicide by assisting suicide.

Consider what social scientists call the Werther effect — the fact that publicized cases of suicide can produce clusters of copycat cases, often disproportionately affecting young people, who frequently use the same method as the original case. The name comes from Goethe's 18th-century novel "The Sorrows of Young Werther," in which the protagonist, thwarted in his romantic pursuits, takes his own life with a pistol. After the publication of this immensely popular book, authorities in Germany noted a rash of suicides among young men using the same means. This finding has been replicated many times since in rigorous

epidemiological studies, including research demonstrating this effect following cases of doctor-assisted suicide.

Because this phenomenon is well validated, the U.S. Centers for Disease Control and Prevention, the World Health Organization and the U.S. surgeon general have published strict journalistic guidelines for reporting on suicides to minimize this effect. It is demoralizing to note that these guidelines were widely ignored in the reporting of recent instances of assisted suicide, with the subject's decision to end his or her life frequently presented in the media as inspiring and even heroic.

A related phenomenon influences suicide trends in the opposite direction, however; the so-called Papageno effect suggests that coverage of people with suicidal ideation who do not attempt suicide but instead find strategies that help them to cope with adversity is associated with decreased suicide rates. The name comes from a lovesick character in Mozart's opera "The Magic Flute," whose planned suicide is averted by three child spirits who remind him of alternatives to death.

The case of Valentina Maureira, a 14-year-old Chilean girl who made a YouTube video begging her government for assisted suicide, illustrates the Werther and Papageno effects. Maureira admitted that the idea to end her life began after she heard about the case of Brittany Maynard, a 29-year-old woman with terminal brain cancer who campaigned prominently for the right to assisted suicide before ending her life last year. But Maureira changed her mind after meeting another young person also suffering from the same disease, cystic fibrosis, who conveyed a message of hope and encouraged her to persevere in the face of adversity. With our laws, we can encourage vulnerable individuals in one of these two directions: the path of Werther or the path of Papageno.

Aside from publicized cases, there is evidence that suicidal behavior tends to spread person to person through social networks, up to three "degrees of separation" away. So my decision to take my own life would affect not just my friends' risk of doing the same, but even my friends' friends' friends. No person is an island.

Finally, it is widely acknowledged that the law is a teacher: Laws shape the ethos of a culture by affecting cultural attitudes toward certain behaviors and influencing moral norms. Laws permitting physician-assisted suicide send a message that, under especially difficult circumstances, some lives are not worth living — and that suicide is a reasonable or appropriate way out. This is a message that will be heard not just by those with a terminal illness but also by anyone tempted to think he or she cannot go on any longer.

Debates about physician-assisted suicide raise broad questions about our societal attitudes toward suicide. Recent research findings on suicide rates press the

question: What sort of society do we want to become? Suicide is already a public health crisis. Do we want to legalize a practice that will worsen this crisis?

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Suicide numbers and rates in Maryland

Year	MD suicide number	MD rate per 100,000	US rate	rank in cause of death for all ages	# of suicides age 10-14	rank in cause of death age 10-14	# of suicides age 15-24,	rank for death for 15-24
		13						
1995	507	10.0	12.0	13	3	4th	67	3rd
1996	501	9.9	11.7	11	6	---	63	3rd
1997	516	10.1	11.4	11	2	---	70	3rd
1998	494	9.6	11.3	11	6	4th	58	3rd
1999	437	8.4	10.7	14	2	---	63	3rd
2000	474	9.0	10.6	13	8	3rd	70	3rd
2001	452	8.3	10.1	14	4	---	64	3rd
2002	474	8.7	10.9	13	7	2nd	73	3rd
2003	482	8.7	10.5	13	5	4th	72	5th
2004	492	8.7	10.9	13	6	3rd	57	3rd
2005	464	8.3	10.6	14	4	3rd	63	3rd
2006	486	8.4	10.9	12	5	3rd	70	3rd
2007	508	8.9	11.3	12	2	8th	66	3rd
2008	493	8.5	11.6	12	3	7th	56	3rd
2009	546	9.3	11.8	12	6	4th	67	3rd
2010	505	8.4	12.1	11	2	10th	64	3rd
2011	550	9.1	12.3	11	5	5th	63	3rd
2012	557	9.0	12.6	11	4	7th	65	3rd
2013	561	9.0	12.6	11	6	4th	77	3rd
2014	593	9.6	13.0	11	6	5th	72	3rd
2015	550	8.7	13.3	12	8	4th	56	3rd
2016	581	9.3	13.5	11	6	4th	66	3rd
2017	630	9.9	14.0	11	8	5th	77	3rd
2018	652	10.2	14.2	11	3	---	90	3rd

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Certain causes of death: numbers and rates per 100,000 in Maryland

Year	MD suicide numbers	suicide rate per 100,000	US suicide rate	MD crude death rate	MD homicide numbers	MD homicide rate per 100,000	MD HIV death numbers	MD HIV death rate per 100,000
1995	507	10.0	12.0	826.6	639	14.0	1,293	25.4
1996	501	9.9	11.7	826.2	604	11.8	1,061	20.9
1997	516	10.1	11.4	818.2	551	10.7	591	11.6
1998	494	9.6	11.3	817.4	575	11.2	501	9.8
1999	437	8.4	10.7	829.7	524	10.1	587	11.4
2000	474	9.0	10.6	823.2	500	9.4	549	9.9
2001	452	8.3	10.1	810.8	502	9.3	568	10.5
2002	474	8.7	10.9	804.6	540	9.9	602	11.0
2003	482	8.7	10.5	805.3	555	10.1	637	11.6
2004	492	8.7	10.9	776.5	537	9.8	551	9.5
2005	464	8.3	10.6	781.7	574	10.2	526	9.4
2006	486	8.4	10.9	774.5	567	10.1	480	8.5
2007	508	8.9	11.3	776.0	576	10.4	431	7.3
2008	493	8.5	11.6	778.3	528	9.5	431	7.2
2009	546	9.3	11.8	767.8	446	7.9	355	5.9
2010	505	8.4	12.1	749.2	437	7.6	315	5.0
2011	550	9.1	12.3	748.9	435	7.5	262	4.1
2012	557	9.0	12.6	749.6	414	7.0	255	3.9
2013	561	9.0	12.6	766.5	421	7.2	226	3.5
2014	593	9.6	13.0	764.5	382	6.6	192	2.9
2015	550	8.7	13.3	764.5	598	10.3	189	2.8
2016	581	9.3	13.5	812.5	579	9.6	191	2.8
2017	630	9.9	14.0	826.3	588	10.2	200	2.8
2018	652	10.2	14.2	838.5	544	9.0	180	2.5