<u>Opposing House Bill HB0403</u>

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Health and Government Operations Committee

Room 241
House Office Building
Annapolis, Maryland 21401

Dear Health and Government Operations Committee Member,

My name is Sahayini Kumar, and I am a practicing internal medicine physician in Baltimore, MD. I have been in practice for almost 15 years. I currently provide primary care to patients and teach internal medical residents. In my years of practice, I have cared for elderly patients during their final years of lives and terminally ill patients.

I wish to give reasons for opposing the proposed bill of physician-assisted suicide (PAS) and respond to the reasons of those who propose PAS.

Reasons for opposing PAS:

1. Disruption of the physician-patient trust: As physicians, we are called to care for patients and relieve their suffering. We take an oath not to harm or intentionally kill anyone. Physicians enabled to end the lives of the very patients they are called to care for will create mistrust in patients. This is especially true in those who are vulnerable- i.e., older patients with chronic illness, lower socioeconomic class, minorities, and patients with disabilities. Historically, we have seen examples of economically disadvantaged and minority racial groups not being given equal healthcare and being subjected to unethical practices. Currently, we see a lot of mistrust of health

professionals from minority groups. This mistrust will only worsen if PAS is legalized, and health professionals will not be able to discuss end-of-life issues and the best course of action to help the patients.

2. Social pressure on caregivers and patients: Our society has an increasing number of elderly population. High-quality medical care for the elderly and terminally ill can be costly not only financially but also in terms of the burden of care for the caregivers. PAS can be a way to eliminate these burdens that the insurance companies will find lucrative and that the caregivers of vulnerable people may abuse. Similarly, the elderly and the terminally ill may see themselves as burdens on their caregivers and will feel pressured to choose PAS as a way of relieving the caregiver burden. They may think that it is their "duty" to request it. There is a slippery slope of PAS being a right to die becoming a duty to die.

3. Decrease in research and funding towards relieving pain and improving palliative care: PAS is a cost-effective way of dealing with elderly and terminally ill patients. This will be an attractive option for insurance companies who would like to cut down on their costs instead of paying for better medications and procedures that can help with pain and suffering with fewer side effects but may be more costly.

While I sympathize with the proponents of PAS, I would like to counter the following reasons for supporting PAS.

1. It is argued that PAS is a way to die without pain, loss of dignity, and dependence. The fear of pain, the fear of indignity, and the fear of dependence are the three most common fears that result in requests for PAS. The answer to this is good palliative care and not PAS. Modern palliative care, which has a multidisciplinary team of care including physicians, nurses, physical/occupational therapists, mental health counselors, and chaplains, treats the whole person to alleviate the pain of dying. More than physical pain, emotional pain, pain from broken relationships, and the need for spiritual health are more prevalent in terminal illness and can be exacerbated by loneliness, isolation, and bitterness. Compassionate care mingled with respect by a team in palliative care is the answer to dying with dignity. Increasingly, palliative care is moving into the homes of patients, where patients die surrounded by family with hope and joy as well as tears and pain. Good palliative care also helps embrace dependence on others by allowing the caregivers and the patient to see each other locked in as a community and bound together by duties of care, responsibility, and compassion.

2. It is put forward that PAS protects patient autonomy. While patient autonomy must be respected, there should be a boundary where self-destruction should be considered a harm to be avoided rather than a right to be assisted. The patient's autonomy should not conflict with the safe and ethical practice of medicine. There are also logical

inconsistencies that will arise with patient autonomy without protecting patient safety; they are as follows: If personal autonomy is a justification for ending the lives of people, why should they wait till the end of their lives? If a patient chooses to die, why should they be forced till they have only six months predicted to live? If severe suffering is a justification for killing, then PAS should not be restricted to those who only chose to die. It should be offered even if patients don't express the wish to die. This is the basis of the slippery slope of legalizing PAS. It can lead to the gradual extension of patient-initiated PAS to patients who are not terminally ill and patient-un-initiated PAS to those whose life seems futile and pain-filled. This is something that has been witnessed in the state of Oregon and the Netherlands (I G Finlay BMJ 2011), two places where PAS has been legalized for many years.

As a physician, I desire to eliminate suffering, not the sufferer. I ask for your support in opposing this dangerous bill.

Thank you.

Sincerely

Sahayini Kumar, MD

Reference:

I G Finlay, R George. Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups- another perspective on Oregon's data. *J Med Ethics 2011;37: 171-174*.