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Testimony regarding HB-0403

“End of Life Option Act”

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My name is Dr. Daniel Sulmasy. I am a general internist and a philosopher, the André Hellegers Professor of Biomedical Ethics and Director of Georgetown University's Kennedy Institute of Ethics. I have served on New York State Task Force on Life and the Law under Governor Pataki and on the Presidential Commission for the Study of Bioethical Issues under President Obama. I am currently a member of the Council on Ethical and Judicial Affairs of the American Medical Association. I am here today to express my strong opposition to HB-0403, the "End of Life Option Act." This law represents bad medicine, bad ethics, and bad public policy and should not be permitted to obtain the force of law.

First, a word on language. This bill legalizes a form of suicide with the assistance of a physician. Proponents call it "aid in dying," but that is merely a euphemism concocted to gain support. I aid lots of dying patients. It is my job to accompany them, care for them, treat their symptoms, and ease their dying. This bill does something different. In plain speech, it would enable patients to kill themselves by overdosing on medication prescribed by a physician. In more honest language, that means it legalizes physician assisted suicide. This dishonesty is compounded when physicians are forced to lie on death certificates, as other states have done, making them state the cause of death as the underlying illness, not an intentional overdose.

Physician assisted suicide (PAS) is bad medicine. It subverts the meaning of healing to which medicine is dedicated. No patient is healed by being made dead. PAS runs roughshod over the Hippocratic Oath which states, with good reason, "I will not give a deadly drug to any patient, even if asked, nor will I make such a suggestion." It has been recognized since ancient times that profound trust is required to enable vulnerable patients to bare their bodies and their secrets to doctors. The bare minimum of the Oath assures patients that their doctors will not disclose their secrets will not have sex with them, and will not kill them. Everyone is a potential patient, and no one should ever fear that the doctor secretly wants to do her in.

PAS is also bad medicine since it should not be necessary. We can do more than has ever been possible in the history of humankind to heal the physical suffering of patients—drugs, electrical stimulation, complementary therapies. Studies from Oregon and Europe bear this out. The chief reason patients opt for PAS and euthanasia is not pain (which can be treated) but loss of control. They say they feel like burdens. Should we say yes, you are a burden? They say they are tired of life or lonely. Is the answer enlisting doctors to help them kill themselves? DO NOT be deceived into believing the false dilemma that patients have a choice of either being strapped to machines, poked with needles, and racked with pain, or they can seek assisted suicide. Hospice and palliative care can treat physical symptoms, even, if necessary, to the point of rendering a patient unconscious through invoking the rule of double effect and the careful practice of palliative sedation. Even shortness of breath can be treated (with lower doses of morphine than it takes to treat pain). This whole movement is about something else—a very small but vocal, forceful, and powerful group of people who want to have the freedom to kill themselves rather than depend upon other people to help them. They often enroll in hospice, but refuse its routine services, demanding that they be given the drugs with which to end their lives. Most patients, however, when they learn what palliative are and hospice are about, want these services and take advantage of them.

And if the health care system is not delivering such good, state of the art hospice and palliative care to the citizens of Maryland, then fix your health care system, don't legalize medical aid in suicide.

PAS is bad ethics. Not only does it undermine the trust that ought to undergird the patient-physician relationship, it gives state sanction (and medical sanction) to the notion that being dependent upon others is so awful a state that it makes life no longer worth living. That is why the disabled are so fearful of these laws. They do not expect to have their wheelchairs lined up so that they can be forcibly injected (at least not yet). What sends shivers down their spines is that the state has said that lives like theirs are so bad that they are not worth living. They know that once it is permissible for an individual to declare his *own* life is not worth living, it is a very short step to third party determinations that the lives of *others* are not worth living—the physically disabled, the cognitively and intellectually challenged, and so many other vulnerable groups that we physicians treat. The state has an interest in cultivating a medical profession that sees the sick and disabled as worthy of service.

You see, PAS flips the default switch. At present, patients are presumed to want to live until treatments become more burdensome than beneficial, and then we stop. Once PAS is on the table, however, the question becomes, "Why haven't you done it yet? Why are you still burdening yourself and us by continuing? Here's your prescription, just in case you want to use it." That poisons medical ethics.

Personal autonomy is not absolute, and there is a difference between the negative right to be free of unwanted therapy and the positive right to receive whatever treatment one wishes, including suicidal medication. As Wittgenstein once observed, if suicide is allowed, anything is allowed. If we are to have ethics and the rule of law it must be based on the idea that all lives are worthy of respect and that no one, not the state, not the doctor, not the patient, should have the power to end lives deemed unworthy of living.

PAS is also bad public policy. PAS cannot be controlled by regulations and additional amendments. Maryland should not let this genie out of the bottle. Abuse happens, and will happen. But the regulatory structures in this bill, modeled on Oregon, make it nearly impossible to detect abuse. The data collected are really bare bones. Everything depends on self reporting by physicians, who are really smart. They know how to say what will keep them out of trouble, and they don't want a lot of bureaucratic hassle. Only state officials have access to the data, and we can't know what we don't observe. We do know, however, that while, on average, about 40% of terminally ill patients can be expected to be depressed, in Oregon less than 5% of PAS patients (in some years no one) is referred for psychiatric assessment. Anorexia nervosa has been deemed a terminal, qualifying condition. Diabetes has been called terminal if you decide not to take your insulin. Demented patients have used the law, even though patients are supposed to have decisional capacity. Family members have assisted patients who are too weak to self-administer, even though that constitutes euthanasia which is not permitted by the law. There are disturbing anecdotes.

Moreover, suicide of any form has a social contagion effect. We have an epidemic of suicide in this country, and data suggest that legalized PAS leads to more suicide in the general population. That's misguided policy.

The cost-constrained environment of contemporary medical care is a really unsuitable atmosphere into which to release PAS. There are a number of anecdotes describing patients who have been offered PAS by insurers who simultaneously denied overage for life-extending therapies. My colleagues and I have shown that there is a strong correlation between a cost-saving attitude and a pro-PAS attitude among physicians. And the Canadians have been bold enough to publish a recent cost-effectiveness analysis on how much their law will save for the health care budget.

Most importantly, assisted suicide is just the beginning. You see, once PAS is legalized, logic and law lead inexorably to euthanasia. Every proposed safeguard will be re-interpreted as a barrier. Waiting times will be shortened. Nurses will be permitted to prescribe. Residency requirements will be dropped. It will be declared discriminatory to prevent patients who are paralyzed from equal access, and that requires active euthanasia for a person can't take the pills. And what about the demented? Can't one claim that grandma would have wanted to be made dead quickly if she knew she had become demented? That will require euthanasia by third party consent. In Canada and Belgium, 5% of all deaths are by euthanasia. The indications for euthanasia in Belgium and the Netherlands include psychiatric illness since psychiatric suffering is as great as physical suffering. Canada is poised to follow them. In Belgium and the Netherlands, euthanasia is prescribed for children and for infants born with genetic disorders. Pass this bill and you'll end up in Brussels, not Portland.

Why has this not happened in yet in the US? Proponents have been very disciplined in not expanding their campaigns beyond asking for PAS until they have enough states on board. Maryland could be their tipping point. With a large mid-Atlantic state legalizing PAS, proponents will be able to claim enough momentum to carry a few more states and then the calls will start. Actually, a few such bills have already been passed in Oregon, Vermont, New Mexico, Hawaii, and California. Waiting periods are being shortened. Nurses empowered to prescribe. Residency requirements dropped. You know the real zealots don't quit. How many PAS bills have already been introduced in Maryland? They will not stop with PAS. I have attached a recent article by law professor and advocate Thaddeus Pope, who has been frank in admitting that the law you are thinking about passing is only the beginning of where advocates want to go.

So be courageous leaders for Maryland, and be careful. Bear in mind that a recent well-intentioned venture in bad medicine, bad ethics, and bad public policy led us to the present opioid epidemic. Policymakers just a few years ago were urging physicians to prescribe more pain medication and not cruelly leave patients in pain. That policy shift took on a life of its own and led to our current opioid crisis.

I care deeply about compassionate care for the dying and have worked hard over my whole career to make that care better. Physicians and legislators can work together to do improve the care of the dying through expanding access to hospice and palliative care, expanding social work and chaplaincy services, and educating physicians to do a better job in care at the end of life. That's what the vast majority of patients want and deserve. Assisted suicide plays no role in that care.

Don't pass this bill, which will do far more harm than good.

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World Medical Association. Declaration on Euthanasia and Physician-Assisted Suicide. 2019. https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.

Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient.

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5.7 Physician-Assisted Suicide Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at *the end of life. Physicians: (a) Should not abandon a patient once it is determined that cure is impossible. (b) Must respect patient autonomy. (c) Must provide good communication and emotional support. (d) Must provide appropriate comfort care and adequate pain control.*

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Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws

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OPEN PEER COMMENTARIES

Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws

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Pullman argues that when it comes to medical aid in dying (MAID), "Canada … has much to learn from California" (Pullman 2023). Canada and California have similar populations: each about 40 million citizens. But, each year, while fewer than 1,000 Californians take MAID medications, more than 10,000 Canadians use MAID. This ten-fold difference is astonishing and merits attention. But how should we interpret it?

Pullman describes the Canadian numbers as "disturbingly high." I take the opposite approach and contend the California numbers are disturbingly low. Pullman rightly notes that MAID in California is subject to "strict eligibility criteria" and that we take a "more cautious approach in the United States" (Pullman 2023). But even Pullman concedes ingenuousness in how best to strike the balance between safety and access. He does not know whether the Californian "criteria are too restrictive" or the "Canadian criteria are too liberal" (Pullman 2023).

But we already have the evidence. Significant data and testimony gathered by researchers and state legislatures show that U.S. criteria for MAID are too restrictive and impede access to individuals who want to relieve suffering at the end of life (Kusmaul et al. 2023). Similar evidence is emerging in other restrictive MAID jurisdictions like Australia and New Zealand. In this Open Peer Commentary, I describe the top ten new and needed expansions of U.S. MAID laws. These are not the only indicated reforms. We need better data to identify other barriers and disparities (Riley 2023).

PERMIT NON-PHYSICIAN PROFESSIONALS

For decades, only physicians could provide MAID in the United States. But it became increasingly obvious that this limited access (Pope 2020). Especially in rural areas, physicians weren't always available. So, when New Mexico enacted its MAID statute in 2021, it also authorized advanced practice registered nurses and physician assistants to provide MAID. In 2023, Hawaii and Washington followed suit. Today, both current and prospective MAID states are considering legislation that would authorize not only physicians but also APRNs and PAs. Furthermore, the states are also expanding the types of clinicians authorized to conduct the mental health exams always required in Hawaii and required in other states when the attending or consulting clinician is uncertain of the patient's capacity.

SHORTEN OR WAIVE WAITING PERIODS

Another way states are already expanding access to MAID is by reducing or waiving waiting periods. For decades, one of the standard safeguards in U.S. MAID statutes required that the patient make two separate oral requests, the second after a waiting period of at least 15 days. The rationale was to permit patients to calmly reflect and deliberate about their decision. But over two decades of experience with MAID shows that many patients cannot wait that long. Since many patients don't seriously consider MAID until the late stages of their illness, they either die or lose decision-making capacity before the end of the 15-day period. In

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short, the waiting period frequently constitutes an undue burden.

In response, several states have either shortened or waived the waiting period. Both California and New Mexico reduced their waiting periods from 15 days to 48 h. Hawaii, Vermont, and Washington also reduced their waiting periods (Meisel, Cerminara, and Pope 2023). Today, bills in both current and prospective MAID states propose similar reductions. In addition to, or instead of, shortening the waiting period, some states exempt patients from having to satisfy the waiting period, however long it is, when the patient isn't expected to survive that period. New Mexico and Oregon, have already enacted such waiver laws. Bills in both current and prospective MAID states propose the same.

DROP RESIDENCY REQUIREMENTS

Traditionally, states limited MAID to their own residents (Pope 2020). Many patients have been able to satisfy these residency requirements by, for example, briefly renting an apartment in the MAID jurisdiction. But while surmountable, residency requirements still pose an obstacle. Consequently, physicians and patients brought federal lawsuits challenging residency requirements in Oregon and Vermont as violating the privileges and immunities clause of the U.S. Constitution. After settling the lawsuits, those states removed the residency requirement. That opened the door to patients traveling to Oregon and Vermont for MAID from other states. Now, bills in other states similarly propose authorizing MAID without a residency requirement. States appear to recognize that they can't constitutionally limit healthcare services to their own residents. A new lawsuit is proceeding in New Jersey.

ENFORCE TRANSPARENCY LAWS

All U.S. MAID laws include broad conscience clauses for both institutions and individual clinicians. Invoking these rights, many religiously affiliated institutions have opted out of participating in MAID. But to help patients make informed decisions about where to seek treatment, California and Washington require facilities to publicly post their MAID policies. That way, patients seeking MAID can make informed choices, for example to avoid enrolling in a nonparticipating hospice. Unfortunately, compliance is poor and states have not enforced the transparency requirements. Colorado now seems poised to do a better job.

PERMIT ASSISTED SELF-ADMINISTRATION

Some individuals otherwise currently eligible for MAID are unable to self-administer their medications because of neurological conditions like ALS. A recent debate in this Journal discussed whether the Americans with Disabilities Act permits, or even requires, clinicians or others to assist these patients in self-administering MAID medications when their physical disability prevents them from completing administration by themselves (Shavelson et al. 2023). Even Pullman admits that California should permit this much (Pullman 2023).

DROP THE SIX-MONTH REQUIREMENT

All U.S. MAID jurisdictions require that the patient have a prognosis of six months or less to live. This strict temporal requirement is unusual compared to other countries, such as Canada, which require only that the patient have a "grievous and irremediable medical condition." Indeed, many seriously and irreversibly ill individuals not within six months of dying may still suffer greatly every day from their disease. A growing number of advocates (including within Pullman's target jurisdiction, California) want U.S. laws to be more like broader laws in Australia, Belgium, Canada, Luxembourg, Netherlands, Spain, and Switzerland (www.abetterexit.org).

PERMIT INTRAVENOUS ADMINISTRATION

Under U.S. MAID laws, medications can be self-administered orally, rectally, or through a feeding tube. All three methods require ingestion (through the stomach and intestines). But evidence from other countries shows that intravenous infusion is more reliable and faster than ingestion (Pope 2020). Unfortunately, IV administration is unavailable in the United States because MAID laws specifically prohibit ending a patient's life "by lethal injection." To allow safer and more effective IV administration, state legislatures should repeal that prohibition. This would not cross the line from MAID to euthanasia. While clinicians would set up the IV, the patient would take the final step of opening the valve to let the medication into their body.

REQUIRE PATIENT DECISION AIDS

All MAID laws have multiple safeguards that help assure the patient's voluntary and informed consent. But because the stakes are so high, we should use the best means available. Patient decision aids are evidence-based educational tools that dramatically improve patient understanding of their options compared to clinician discussion alone (Pope 2022). Other end-of-life decisions are already supported by decision aids. We must develop a PDA for MAID. And we must get it certified by the Washington State Health Care Authority (Pope 2017).

PERMIT ADVANCE REQUESTS

Many older Americans fear living with late-stage dementia. But MAID isn't an option for these individuals. By the time they're terminally ill, they no longer have capacity. And when they still have capacity (for example, in early stages of Alzheimer's), they're not yet terminally ill. In response, some advocates are pushing to permit individuals to arrange MAID through an advance directive. This is already permitted in some European countries and is being actively considered in Canada. In the meantime, there has been a significant interest in VSED advance directives which direct caregivers to stop providing food and fluid by mouth (Pope 2021; Quill et al. 2021).

REPEAL ASFRA

While MAID is primarily a state matter, many terminally ill patients are on Medicare. That impedes access because the Assisted Suicide Funding Restriction Act of 1997 prohibits federal money from being spent on MAID. Consequently, patients must find another way to pay roughly $750 for the medications. Furthermore, ASFRA deters many hospices and other providers from offering MAID because they worry about inadvertently billing Medicare for it. For these reasons, while most advocacy has been at the state level, some advocates seek to repeal ASFRA.

CONCLUSION

The Dubai World Cup is often referred to as the "world's richest horse race." In 2017, one of the favorites was Highland Reel, an Irish thoroughbred racehorse. He took an early lead and kept it for most of the race. But Highland Reel lost his lead 400 meters from the finish line. Worse, he was then passed by the entire field and relegated to a dead last finish. Analogously, the United States took an early worldwide lead with MAID when Oregon enacted its Death with Dignity Act in 1994. But like Highland Reel, the United States has lost its lead. And it is quickly falling to the back of the pack in terms of MAID safety and access.

DISCLOSURE STATEMENT

Professor Pope is a regular consultant to the American Clinicians Academy on Medical Aid in Dying (ACAMAID) and has served as an expert witness in federal litigation challenging the California End of Life Option Act.

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Position: UNF

Americans
United
for Life

Written Testimony of Danielle Pimentel
Policy Counsel, Americans United for Life
In Opposition to House Bill 403
Submitted to the House Judiciary Committee and the Health and Government Operations Committee
February 16, 2024

Dear Chair Clippinger, Chair Pena-Melnyk, Vice-Chair Bartlett, Vice-Chair Cullison, and Members of the Committees:

My name is Danielle Pimentel, and I serve as Policy Counsel at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states.[3] Courts have cited AUL briefs, including the Supreme Court decision in *Washington v. Glucksberg*,[4] which ruled the federal Due Process Clause does not recognize suicide assistance as a fundamental right, and the Massachusetts Supreme Judicial Court's recent decision in *Kligler v. Attorney General*, which ruled there is no fundamental right to assisted suicide under the state constitution.[5] Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

Thank you for the opportunity to testify against House Bill 403 ("H.B. 403"). It is my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and

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[1] *Pro-Life Model Legislation and Guides*, Ams. United for Life, https://aul.org/law-and-policy/ (last visited Feb. 7, 2024). AUL is the original drafter of many of the hundreds of pro-life bills enacted in the States in recent years. *See* Olga Khazan, *Planning the End of Abortion*, Atlantic (July 16, 2020), www.theatlantic.com/politics/archive/2015/07/what-pro-life-activists-really-want/398297/ ("State legislatures have enacted a slew of abortion restrictions in recent years. Americans United for Life wrote most of them."); *see also* Anne Ryman & Matt Wynn, *For Anti-Abortion Activists, Success of 'Heartbeat' Bills was 10 Years in the Making*, Ctr. Pub. Integrity (Jun. 20, 2019), https://publicintegrity.org/politics/state-politics/copy-paste-legislate/for-anti-abortion-activists-success-of-heartbeat-bills-was-10-years-in-the-making/ ("The *USA TODAY/Arizona Republic* analysis found Americans United for Life was behind the bulk of the more than 400 copycat [anti-]abortion bills introduced in 41 states.").

[2] *Defending Life: State Legislation Tracker*, Ams. United for Life, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 6, 2024).

[3] *See, e.g., Revoking Your Rights: The Ongoing Crisis in Abortion Care Access Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life); *What's Next: The Threat to Individual Freedoms in a Post-Roe World Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life).

[4] 521 U.S. 702, 774 n.13 (1997) (citing Brief for Members of the New York and Washington State Legislatures as *Amicus Curiae*).

[5] 491 Mass. 38, 40 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical and Dental Associations).

coercion, the bill's "safeguards" fail to adequately protect vulnerable end-of-life patients, and the bill erodes the integrity and ethics of the medical profession.

I. *Suicide by Physician Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion*

Individuals living in poverty, the elderly, and those living with disabilities are already exposed to greater risks of abuse, neglect, and coercion. Maryland should be protecting these vulnerable citizens rather than subjecting them to additional abuse under H.B. 403. If enacted, not only would the bill perpetuate false narratives about assisted suicide and its impact on vulnerable persons, but it would also promote both ableism and ageism.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management reasons. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control" or just *concern* about inadequate pain control as a reason for choosing suicide by physician.[6] Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington).
- Losing autonomy (86.3% in Oregon, 83.0% in Washington).
- Loss of dignity (61.9% in Oregon, 69.0% in Washington).
- Burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington).
- Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[7]

Physicians should ensure that their patients receive the best palliative care and help them cope with feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, in states that have legalized assisted suicide, vulnerable patients are being encouraged to take their own lives, which opens the door to real abuse, especially for the elderly and those with disabilities.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states which have decriminalized suicide by physician. These include a lack of reporting and accountability, coercion, and failure to ensure the competency of the requesting patient.[8] In Oregon and Washington, individuals have died by assisted suicide even though they were not terminally ill and did not have the capacity to

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[6] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9, 14 (Mar. 8, 2023); WASH. DISEASE CONTROL & HEALTH STATS., 2022 DEATH WITH DIGNITY ACT REPORT 7 (June 2, 2023).

[7] *Id*.

[8] José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see also* WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).

consent.[9] Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.[10] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[11] These examples from Oregon and Washington evidence the wide-spread abuse vulnerable end-of-life patients face when considering to engage in assisted suicide.

Notably, in November 2023, the American Medical Association (AMA) affirmed its opposition to assisted suicide and euthanasia.[12] The current policy will remain in place, which states,

> [e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.[13]

The AMA also refused to change the term "assisted suicide" to the misleading and inaccurate euphemism, "medical aid in dying."[14]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, advocacy groups continue to promote its legalization. This has led to a "suicide contagion," or the Werther Effect.[15] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[16] One study demonstrates that legalizing suicide by physician in certain states has

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[9] *See* Disability Rights Education & Defense Fund, *Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DREDF, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_edn1 (last visited Feb. 7, 2024).

[10] *See Id*.

[11] Richard Doerflinger, *Lethal Non-Compliance with Washington's "Death with Dignity Act"*, CHARLOTTE LOZIER INST. (Dec. 20, 2022), https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/.

[12] Wesley J. Smith, *AMA Retains Policy Against Assisted Suicide*, NAT'L REV. (Nov. 13, 2023), https://www.nationalreview.com/corner/ama-retains-policy-against-assisted-suicide/.

[13] American Medical Association, *CEJA Report B – A-91 Decisions Near the End of Life*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/5.8%20Euthanasia%20--%20background%20reports.pdf (last visited Feb. 6, 2024).

[14] Smith, *supra* note 12.

[15] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOV'T (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.*, Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/.

[16] *See id*.; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RSCH. 137 (2004).

led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[17] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[18] Unfortunately, these effects are even greater for individuals older than 65, which has seen a 14.5% increase in overall suicide rates for that demographic.[19] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[20]

Legalizing suicide by physician is neither "compassionate" nor an appropriate solution for those who may suffer from depression or loss of hope at the end of their lives. H.B. 403 targets these vulnerable individuals and communicates the message that their lives are not worth living simply because of their physical or mental disability, illness, or age.[21] However, these individuals are worthy of life and are entitled to equal protection under the law, which is why the Committees should reject this bill.

II. *H.B. 403's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although the bill includes so-called "safeguards," in effect, these provisions cannot adequately protect vulnerable end-of-life patients. For example, under § 5–6A–06, a physician is only required to refer a patient to a mental health professional, if the physician believes the "individual may be suffering from a condition that is causing impaired judgement or otherwise does not have the capacity to make medical decisions." Yet, counseling referrals for patients considering assisted suicide are astonishingly rare.[22] In Oregon in 2022, for example, assisted suicide physicians prescribed lethal drugs to 431

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[17] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (2015), https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CENTRE (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf.

[18] Jones & Paton, *supra* note 17, at 601.

[19] *Id*. at 603.

[20] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, Jan-Feb 2015, available at https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").

[21] Physician assisted suicide is rife with discrimination. *See*, *e.g.*, *United Spinal Association v. State of California*, No. 2:23-cv-3107 (C.D. Cal. filed Apr. 25, 2023) (case challenging California's physician assisted suicide law as unlawful for discriminating against persons with disabilities); *see also* Carolyn McDonnell, *A Time to Choose: Suicide Assistance or Suicide Prevnetion?*, AMS. UNITED FOR LIFE (May 2023), https://aul.org/wp-content/uploads/2023/04/2023-05-A-Time-to-Choose-Suicide-Assistance-or-Suicide-Prevention-Web.pdf (stating that physician assisted suicide "creates a 'two-tiered system for measuring the worth of human life'" where "[t]he young and vital who become suicidal would receive suicide prevention. . . . At the same time, the suicides of the debilitated, sick, and disabled, and people with extended mental anguish . . . would be shrugged off as merely a matter of choice").

[22] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 6, at 14.

patients yet only referred three of these patients for counseling—*approximately 0.7% of patients*.[23]

Additionally, although the bill requires the attending physician to have "primary responsibility for the medical care" of the patient, the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[24] The short duration of these relationships raises serious concerns as to whether a physician can accurately determine the capacity of the patient. Accordingly, if the bill is passed, the likelihood of a Maryland physician referring an end-of life patient for an evaluation is extremely low, especially when the physician may have only known the patient for less than five weeks.

The lack of counseling referrals for vulnerable end-of-life patients is gravely concerning. Scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[25] "[A]round 25–50% of patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed."[26] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[27] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[28]

Moreover, on the off chance that a Maryland physician refers a patient to a mental health professional for an assessment, the bill has no requirement that the patient and mental health professional meet more than once. In § 5–6A–01 (M), the bill defines "mental health professional assessment" as "one or more consultations between an individual and a licensed mental health professional . . ." This means that a psychologist or psychiatrist just needs to meet with the patient once before that patient can be deemed competent to end their own life. This raises serious informed consent issues because healthcare professionals have limited abilities to diagnose mental health issues when evaluating referred patients considering assisted suicide. As one study has shown, "[o]nly 6% of psychiatrists were very confident that *in a single evaluation* they could assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[29] Nevertheless, under the bill, an individual suffering from depression can be deemed competent to take their own life after one meeting with a mental health professional. For these reasons, it is difficult to argue that any of these alleged "safeguards" will allow medical providers, or mental health

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[23] *Id*. at 9.

[24] *Id.* at 14.

[25] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).

[26] *Id*. at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").

[27] *Id*.

[28] *Id*.

[29] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996) (emphasis added).

professionals to accurately assess an individual's mental health and whether they have the requisite "capacity."

Lastly, the bill assumes that physicians can correctly diagnose a patient with a "terminal condition." Under § 5–6A–04, the bill requires the attending physician to determine if the patient is a "qualified individual," *i.e.*, the individual has a terminal illness that will result in the patient's death within six months. This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating the life expectancy of a terminally ill patient. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[30] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[31]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[32] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[33] which resulted in the individual's death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their prognosis.[34] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[35] In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness or would have outlived a six months life expectancy.

In sum, these purported "safeguards" fail to protect vulnerable end-of-life patients. The bill leaves patients susceptible to coercion and abuse by family members and caregivers, and does not—and cannot—ensure patients have given their informed consent to die through medicalized suicide. H.B. 403 does not give end-of-life patients "control over their deaths," as some proponents of the bill may argue. Instead, the bill gives physicians the unfettered ability to prematurely end their patients' lives in direct violation of their Hippocratic Oath "to do no harm."

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession*

Prohibitions on physician-assisted suicide protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor

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[30] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).
[31] *Id*. at 22.
[32] Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VERYWELL HEALTH (Aug. 2, 2018), https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481.
[33] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, THE LOCAL (Apr. 24, 2014), https://www.thelocal.ch/20140424/swiss-doctor-acquitted-for-aiding-seniors-suicide (reporting the doctor was not held accountable for his negligence).
[34] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[35] *See id.*

make a suggestion to this effect."[36] Despite these ethical obligations, physicians are using experimental lethal drugs when assisting in suicide. There is no standardized drug nor required dosage for assisted suicide. "[T]here is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[37] The Food and Drug Act regulates pharmaceuticals at the federal level and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[38] Assisted suicide medication could never meet the safety or efficacy requirements for treating mental or physical ailments, because it is treating an individual's health condition with a lethal drug overdose.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[39] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[40] As the U.S. Food and Drug Administration ("FDA") notes on its website, "[c]ompounded drugs are not FDA-approved. *This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients*."[41] Consequently, physicians have experimented their lethal drug compounds on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients."[42]

Under § 5–6A–04 (C), the bill only requires the attending physician to inform the patient of the risks with taking the lethal drugs and the "probable result of self-administering the medication to be prescribed for aid in dying." However, the bill does not require that the physician inform the patient that such medication is *experimental* and not approved by the FDA. Furthermore, the bill is silent as to what drugs doctors must use and there are absolutely no safeguards preventing doctors from using experimental lethal drug compounds directly on patients. This is one of the many informed consent issues in the bill because the patient may not understand that she is agreeing to an experimental overdose that is not FDA approved, has not undergone clinical drug trials, and has virtually no oversight from the government or medical institutions.

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[36] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

[37] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POLL. & CIV. RTS. L. REV. 323, 339 (2006).

[38] *Id*. at 340.

[39] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).

[40] *See* Robert Wood et al., *Attending Physicians Packet*, END OF LIFE WASH. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors' experiments with different lethal drug compounds).

[41] *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies (emphasis added).

[42] Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, THE ATL. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.

Even the U.S. Supreme Court has acknowledged that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[43] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, he pointed out: "[v]irtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[44] The bill directly contradicts Maryland's legitimate interest in protecting the integrity and ethics of the medical profession. Instead, the bill allows physicians to freely violate their ethical obligations and cause lethal harm to their patients through experimental drugs.

Consequently, H.B. 403 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. The bill opens the door for physicians to be forced to violate medical ethics, such as the Hippocratic Oath, and increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits.

IV. *Conclusion*

Physician-assisted suicide is not healthcare. Instead, it acts as a limited exception to homicide liability under state law and allows physicians to use experimental drugs directly upon patients without FDA approval nor clinical trials. Accordingly, the majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Since Oregon first legalized the practice in 1996 more than "200 assisted-suicide bill have failed in more than half the states."[45] Likewise, the Committees should reject H.B. 403 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession.

Sincerely,

Danielle Pimentel
Policy Counsel
AMERICANS UNITED FOR LIFE

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[43] Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

[44] Gonzales v. Oregon, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

[45] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 53 (2018).

2024 HB403 PAS Opposition personal.pdf

Uploaded by: Deborah Brocato

Position: UNF

Opposition Statement HB403
End-of-Life Option Act

Deborah Brocato
3206 Glouchester Dr, Fallston MD 21047
410.440.6348

My name is Deborah Brocato and I urge you to oppose this suicide bill known as the End-of-Life Option Act or House Bill 403.

I know something about suicide. My father suffered from depression and alcoholism as a result of physical and emotional abuse at the hands of his father. My father was violent and struggled to hold down a job. Several stints in alcohol rehabilitation failed. After years of struggling and failing to overcome his afflictions, he decided his family would be better off without him. He hung himself.

My father's suicide left our family broken and in shock. We wanted him to get well, not die. Years later, my siblings and I admitted to each other that we had each thought about suicide. We just wanted to stop the pain. Suicide almost became a family legacy. One person kills himself and others start thinking that might work for them. Thankfully, none of us ever took action on those thoughts.

Suicide is the result of despair. Suicide is not a cure for depression. Suicide is not a cure for alcoholism. Suicide is not a cure for pain. Suicide is not a cure for anything. Suicide is not healthcare.

If you want more suicide, then pass this bill. According to the National Institute of Health (NIH), "Legalizing PAS has been associated with and increased rate of total suicides relative to other states and no decrease in nonassisted suicides." (https://pubmed.ncbi.nlm.nih.gov/26437189/)

Suicide already happens every day without a law prescribing how to do it. According to the CDC (Centers for Disease Control), in 2021, there were over 48,000 suicides which breaks down to **132 suicides per day**. (See Suicide Fact Sheet)

Do not normalize suicide by passing this bill. Do not turn suicide into some kind of healthcare choice. Killing yourself is a result of despair, not a decision of a healthy mind.

There are millions of people in healthcare dedicated to helping those who are suffering whether it is emotional, psychological or physical pain**.**

Do not turn healthcare professionals into executioners.

In contrast, I cared for both my mother and, more recently, my brother during their battles with cancer. Both received chemotherapy treatments until they realized the cancer was winning. The treatments didn't save them but they did gain extra time with their families. If this legislation was in effect, the insurance companies would be incentivized to offer the cheaper prescription of suicide drugs over the life-extending chemotherapy. They might not have been given a choice. People with fatal diseases do have choices but suicide should never be put into the healthcare codes as a legitimate medical treatment.

Suicide is not compassionate. Putting physician in front of it does not make it healthcare. The American Medical Association (AMA) has reaffirmed it's position that suicide is against their medical ethics. Their statement says, "Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could be extended to incompetent patients and other vulnerable populations."

Opposition Statement HB403
End-of-Life Option Act

Deborah Brocato
3206 Glouchester Dr, Fallston MD 21047
410.440.6348

Many proponents of Assisted Suicide express fear of pain or fear of suffering. Fear is not a good reason for suicide. There is no good reason to encourage suicide. That’s cruelty. When our fellow human beings are suffering, they need appropriate treatment. They need true compassionate care.

If you want less compassion, then pass this bill. If you want more suffering, then pass this bill.

The American Clinicians Academy on Medical Aid in Dying has put out a manual on Assisted Suicide, *Medical Aid in Dying, A Guide for Patients and Their Supporters* (https://www.acamaid.org). While it is supposed to be a positive guide for assisted suicide, it reveals the unpleasant reality of this prescribed death. Between the barbiturates, the anti-emetics and the analgesics, the prescription can be as much as 100 pills. The length of time it takes to die varies from one person to another. **Death can take hours or even days**. No one can say for sure if death is pleasant because the person is dead. Once the person is dead, they cannot report on their death or whether or not they voluntarily took the medication.

What a suffering person needs is to know they are worth the effort for them to receive true, compassionate care including effective pain management, psychological and emotional care and physical care.

Do not normalize suicide. Do not turn healthcare into deathcare. Do not make Maryland a haven for death.

I urge you to promote compassion and appropriate treatment for those who suffer. Reject this inhumane bill. **Please give an unfavorable report on HB403.**

Suicide Fact Sheet.pdf

Uploaded by: Deborah Brocato

Position: UNF

U.S.A. SUICIDE: 2021 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths
Nation	48,183	132.0	14.5	1.4
Males	38,358	105.1	23.3	2.1
Females	9,825	26.9	5.9	0.6
Whites	41,426	113.5	16.5	1.4
Blacks/African American	3,807	10.4	8.4	0.8
American Indian/Alaska Native	733	2.0	16.8	2.5
Older Adults (65+ yrs.)	9,652	26.4	17.3	0.4
Young (15-24 yrs.)	6,528	17.9	15.2	17.0
Middle Aged (45-64 yrs.)	14,668	40.2	17.6	2.1

Group (Number of Suicides)	Rate
White Male (33,139)	26.4
White Female (8,287)	6.6
Black/African American Male (3,058)	14.1
Black/African American Female (749)	3.2
Asian (1,409)	6.9
Native Hawaiian/Other Pacific Islander (92)	10.7
More than One Race (716)	7.3
Hispanic/Latino (4,907)	7.8
Non-Hispanic/Latino (43,157)	16.0

Fatal Outcomes (Suicides): ***a 3.6% rate increase was seen from 2020 to 2021 (a 3.4% decrease was observed from 2019 to 2020)***

- Average of 1 person every 10.9 minutes killed themselves—1 male every 13.7 minutes, 1 female every 53.5 minutes
- Average of 1 older adult every 54.5 minutes killed themselves; Average of 1 middle aged adult every 35.8 minutes
- Average of 1 young person every 1 hour and 20.5 minutes killed themselves. (If the 607 suicides below age 15 are included, 1 young person every 1 hour and 13.7 minutes)
- 11th ranking cause of death in U.S.— 3rd for **young** -->>
- 3.9 male deaths by suicide for each female death by suicide
- Suicide ranks 11th as a cause of death; Homicide ranks 16th

Leading Causes of Death 15-24 yrs

Cause	Number	Rate
All Causes	38,307	88.9
1-Accidents	15,792	36.7
2-Homicide	6,635	15.4
3-Suicide	6,528	15.2
10-14 yrs	598	2.8
15-19 yrs	2,343	10.9
20-24 yrs	4,185	19.4

Nonfatal Outcomes (Attempt Survivors§) (figures are estimates):

- 1,204,575 annual attempts in U.S. (using 25:1 ratio) or one attempt every 26.2 seconds
- 2021 SAMHSA study: 1.7 million adults (age 18 and up) and 892,000 adolescents (12-17 years old)
- Translates to 1 every 18.6 seconds for adults and 1 every 35.4 seconds for adolescents
- 25 attempts for every death by suicide for nation (one estimate); 100-200:1 for young; 4:1 for older adults
- 3 female attempts for each male attempt

Postvention (Exposure and Survivors of Suicide Loss)

Exposed ("Affected") – those who "know" someone personally who has died by suicide † (figures are estimates)

°Recent (Cerel et al,, 2019) research-based estimate suggests that for each suicide death →135 people are *exposed* (for 2021, 6.5 million annually) – among the exposed there are subgroups with a variety of effect levels (see Cerel et al., 2014) – as many as 40-50% of the population have been exposed to suicide in their lifetime based on a 2016 representative sample's results (Feigelman et al., 2017)

Suicide Loss Survivors (those bereaved of suicide - definition below): *† (figures are estimates) [Subgroup of "Exposed" above]*

°Survivors of Suicide Loss = experience high levels of distress for a considerable length of time after exposure (Jordan & McIntosh, 2011)

°Among those exposed to a death by suicide, *more than* 6 experience a major life disruption (loss survivors; a low, non-research based estimate see Cerel et al. 2020)

- *If each suicide has devastating effects and intimately affects > 6 other people, there are* ***over 289,000 loss survivors a year***
- Based on the 948,090 suicides from 1997 through 2021, therefore, the number of *survivors of suicide loss* in the U.S. is *more than* 5.69 million (1 of every 58 Americans in 2021); number grew by more than 289,098 in 2021
- If there is a suicide every 10.9 minutes, then there are *more than* 6 new loss survivors every 10.9 minutes as well

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides (1st)	26,328	7.9	54.6%	All but Firearms	21,855	6.6	45.4%
Suffocation/Hanging (2nd)	12,431	3.8	25.8%	Fall (4th)	1,184	0.4	2.5%
Poisoning (3rd)	5,568	1.7	11.6%	Cut/pierce (5th)	965	0.3	2.0%

U.S.A. Suicide Rates 2011-2021

(Rates per 100,000 population)

Group/ Age	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Group/ Age
5-14	0.7	0.8	1.0	1.0	1.0	1.1	1.3	1.5	1.3	1.5	1.5	5-14
15-24	11.0	11.1	11.1	11.6	12.5	13.2	14.5	14.5	13.9	14.2	15.2	15-24
25-34	14.6	14.7	14.8	15.1	15.7	16.5	17.5	17.6	17.5	18.4	19.5	25-34
35-44	16.2	16.7	16.2	16.6	17.1	17.4	17.9	18.2	18.1	17.4	18.1	35-44
45-54	19.8	20.0	19.7	20.2	20.3	19.7	20.2	20.0	19.6	18.0	18.2	45-54
55-64	17.1	18.0	18.1	18.8	18.9	18.7	19.0	20.2	19.4	16.9	17.0	55-64
65-74	14.1	14.0	15.0	15.6	15.2	15.4	15.6	16.3	15.5	14.5	15.3	65-74
75-84	16.5	16.8	17.1	17.5	17.9	18.2	18.0	18.7	18.6	18.4	19.6	75-84
85+	16.9	17.8	18.6	19.3	19.4	19.0	20.1	19.1	20.1	20.9	22.4	85+
65+	15.3	15.4	16.1	16.7	16.6	16.7	16.8	17.4	17.0	16.4	17.3	65+
Total	12.7	12.9	13.0	13.4	13.7	13.9	14.5	14.8	14.5	14.0	14.5	Total
Men	20.2	20.6	20.6	21.1	21.5	21.8	22.9	23.4	23.0	22.5	23.3	Men
Women	5.4	5.5	5.7	6.0	6.2	6.2	6.3	6.4	6.2	5.6	5.9	Women
White	14.5	14.7	14.9	15.5	15.8	15.9	16.5	16.8	16.4	15.7	16.5	White
Nonwh	5.8	6.1	6.0	6.0	6.3	6.8	7.2	7.5	7.6	7.8	8.4	NonWh
Black	5.3	5.5	5.4	5.5	5.6	6.1	6.7	7.0	7.1	7.5	8.4	Black
45-64	18.6	19.1	19.0	19.5	19.6	19.2	19.6	20.1	19.5	17.4	17.6	45-64

15 Leading Causes of Death in the U.S.A., 2021

(total of 3,464,231 deaths; 1,043.8 rate)

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	209.6	695,547
2 Malignant neoplasms (cancer)	182.4	605,213
3 COVID-19	125.6	416,893
4 Accidents (unintentional injuries)	67.8	224,935
5 Cerebrovascular diseases (stroke)	49.1	162,890
6 Chronic lower respiratory diseases	42.9	142,342
7 Alzheimer disease	36.0	119,399
8 Diabetes mellitus (diabetes)	31.1	103,294
9 Chronic liver disease and cirrhosis	17.0	56,585
10 Nephritis, nephrosis (kidney disease)	16.4	54,358
11 Suicide [Intentional Self-Harm]	**14.5**	**48,183**
12 Essential hypertension and renal disease	12.9	42,816
13 Influenza & pneumonia	12.6	41,917
14 Septicemia	12.4	41,281
15 Parkinson's disease	11.6	38,536
- All other causes (Residual; > 15)	201.9	670,042
16 Homicide (Assault)	7.8	26.031

• Older adults made up 16.8% of 2021 population, but 20.0% of suicides • Young made up 13.0% of 2021 population and 13.5% of suicides •

• Middle Aged made up 25.2% of the 2021 population, but were 30.4% of suicides •

1,414,041* Years of Potential Life Lost Before Age 75 (43,671 of 48,183 suicides are below age 75)

* alternate YPLL figure: 1,409,143 using individual years in calculations rather than 10-year age groups as above.

Many figures appearing here are derived or calculated from data in the following *official data sources:* downloaded 11 January 2023 from CDC's WONDER website: https://wonder.cdc.gov. • Other references cited on this page are listed on the State Data Page. •

suicide rate = (number of suicides by group / population of group) X 100,000

Suicide Data Page: 2021

12 January 2023

Prepared and © by Christopher W. Drapeau, Ph.D. & John L. McIntosh, Ph.D.

§ Alternate terms = **Survivors of Suicide Attempts** or those with **Lived Experience** (of suicide attempt)

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2021*

Rank	State [Division / Region]	Deaths	Rate
1	Wyoming [M / West]	190	32.8
2	Montana [M / West]	350	31.7
3	Alaska [P / West]	220	30.0
4	New Mexico [M / West]	533	25.2
5	Colorado [M / West]	1,384	23.8
6	South Dakota [WNC / Midwest]	203	22.7
7	Nevada [M / West]	691	22.0
7	Oklahoma [WSC / South]	877	22.0
7	Vermont [NE / Northeast]	142	22.0
10	West Virginia [SA / South]	375	21.0
11	Oregon [P / West]	889	20.9
12	Arkansas [WSC / South]	618	20.4
12	Idaho [M / West]	387	20.4
14	Arizona [M / West]	1,475	20.3
15	Maine [NE / Northeast]	277	20.2
16	North Dakota [WNC / Midwest]	156	20.1
17	Utah [M / West]	643	19.3
18	Kansas [WNC / Midwest]	560	19.1
18	Missouri [WNC / Midwest]	1,177	19.1
20	Kentucky [ESC / South]	816	18.1
21	Tennessee [ESC / South]	1,222	17.5
22	Iowa [WNC / Midwest]	549	17.2
23	Indiana [ENC / Midwest]	1,129	16.6
24	Alabama [ESC / South]	827	16.4
25	Mississippi [ESC / South]	480	16.3
26	New Hampshire [NE / Northeast]	223	16.1
27	Washington [P / West]	1,229	15.9
28	Georgia [SA / South]	1,676	15.5
28	South Carolina [SA / South]	802	15.5
30	Florida [SA / South]	3,351	15.4
31	Wisconsin [ENC / Midwest]	905	15.3
32	Ohio [ENC / Midwest]	1,766	15.0
33	Louisiana [WSC / South]	689	14.9
34	Michigan [ENC / Midwest]	1,485	14.8
35	Nebraska [WNC / Midwest]	288	14.7
36	Pennsylvania [MA / Northeast]	1,885	14.5
	Nation	**48,183**	**14.5**
37	Minnesota [WNC / Midwest]	808	14.2
37	Texas [WSC / South]	4,193	14.2
39	Hawaii [P / West]	202	14.0
40	Delaware [SA / South]	137	13.7
40	North Carolina [SA / South]	1,448	13.7
40	Virginia [SA / South]	1,188	13.7
43	Illinois [ENC / Midwest]	1,454	11.5
44	Connecticut [NE / Northeast]	401	11.1
45	Rhode Island [NE / Northeast]	117	10.7
46	California [P / West]	4,148	10.6
47	Maryland [SA / South]	620	10.1
48	Massachusetts [NE / Northeast]	604	8.6
49	New York [MA / Northeast]	1,660	8.4
50	New Jersey [MA / Northeast]	688	7.4
51	District of Columbia [SA / South]	46	6.9

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Suggested citation: Drapeau, C. W., & McIntosh, J. L. (2023). *U.S.A. suicide: 2021 Official final data.* Minneapolis, MN: Suicide Awareness Voices of Education (SAVE), dated January 12, 2023, downloaded from https://save.org/about-suicide/suicide-statistics.

Division [Abbreviation]	Rate	Number
Mountain [M]	22.4	5,653
West North Central [WNC]	17.3	3,741
East South Central [ESC]	17.2	3,345
West South Central [WSC]	15.5	6,377
South Atlantic [SA]	14.5	9,643
Nation	**14.5**	**48,183**
East North Central [ENC]	14.3	6,739
Pacific [P]	12.5	6,688
New England [NE]	11.7	1,764
Middle Atlantic [MA]	10.1	4,233

Region [Subdivision Abbreviations]	Rate	Number
West (M, P)	15.7	12,341
South (ESC, WSC, SA)	15.2	19,365
Midwest (WNC, ENC)	15.2	10,480
Nation	**14.5**	**48,183**
Northeast (NE, MA)	10.5	5,997

Source: Obtained 11 January 2023 from CDC/NCHS's *WONDER*
(to appear in *Deaths: Final Data for 2021*, forthcoming)
http://www.cdc.gov/nchs/products/nvsr.htm

[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2021
12 January 2023

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SAVE
SUICIDE AWARENESS
VOICES OF EDUCATION

These sheets posted online at:
https://save.org/about-suicide/suicide-statistics &

Other suicide data, and an archive of state data, appear at the website:
https://jmcintos.pages.iu.edu/SuicideDataCompiled.htm

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2024 MGA pdf.pdf

Uploaded by: Dr. James Kelly
Position: UNF

AAPS
Association
of American
Physicians
and Surgeons

Testimony is respectfully submitted on behalf of the nationwide Association of American Physicians and Surgeons - to the Maryland General Assembly in opposition to SB 443/HB 403 in March 2024 by Dr. James Kelly- a Maryland physician and adult, child, adolescent and forensic psychiatrist for 37 years.

I am a Maryland psychiatrist treating incarnated Marylanders. Maryland outlawed the death penalty for violent murders. This bill reestablishes the death penalty from law abiding citizens; it approves the use of the same deadly drugs for self- murder / assisted suicide that are used for the death penalty.

Incarcerated citizens are a vulnerable population. They have less choices and less control over their health care. Profits will always be greater to substitute death in place of medical treatment especially for a vulnerable population.

Research has shown that most people seeking legal assisted suicide do so for **emotional**, **social and financial reasons** such as depression, feeling unwanted and a burden and **NOT** due to physical illness terminal illnesses, or unbearable pain.

People suffering from unbearable pain or terminal illnesses want to live and do not want to kill themselves generally, until they become depressed, feel unloved and a burden to their family. Research has shown that suicides tend to be a “contagious” and that children of parents who suicide have a 300% increase of suicide. This bill is asking you legislators to personally decide if you vote that **SELF-MURDER/ SUICDE** is a good thing -that the government should legalize, legitimize and promote or is suicide a tragedy!!!

What is the point of all of the funding of suicide prevention programs if now the Maryland legislature is going to say that the M.G.A. is against suicide -- except when someone is actually suicidal and wants to kill themselves????

Please do not be deceived this bill is **NOT** about providing compassionate care options or providing autonomy to suffering people. Every year there are over 800,000 suicides in America -that means every 40 seconds someone kills themselves.

The choice, methods, time and place of suicide have always been tragically available and under the control of each individual - this is proven by a suicide every 40 seconds. This bill is about replacing helpful treatments with legitimizing and promoting self-murder /suicides.

Promoters of suicide claim that all people suffering from depression or any mental illness will be referred to a “mental health care provider” for a “mental health assessment”. But the truth is far different from their claims.

Research has shown that such claims are never true. Recent research has shown that the majority of people requesting assisted suicide have symptoms of depression illness by that only 1%- 3% of patients in Oregon actually have a mental health assessment- and such assessments are rarely comprehensive psychiatric evaluations done by expert psychiatrists.

Proponents of the bill claim that many well-documented continual neglectful circumstances and abuses of physician assisted suicide observed in other countries and other states will never of course occur in Maryland --as it has occurred everywhere else in the world and in other states that have legalized physician assisted suicide.

Proponents of this bill -in an effort to gain your approval -claim that this bill provides plenty of adequate safeguards- but they know very well that those hypothetical safeguards will be reinterpreted, challenged in court, changed and eliminated and will be at best only temporary.

This bill gives providers/facilities legal protection and justification, and the means and power to prescribe deadly experimental unproven poisons to the most vulnerable people in our communities. This bill demands that physicians become liars. It demands that physicians lie by documenting that the patient died from some potential future natural cause instead of reporting the truth- that they were killed from prescription poisons. This bill gives doctors the power and authorization to arrange the deaths of vulnerable desperate people. It legitimizes abandoning the physicians' Hippocratic oath and promise- to never abuse or harm their patients, and to become liars. Once this **permanent damage** is made to the doctor-patient relationship how can we ever **trust our physicians again**?

Please do not be fooled by the professional suicide promoters who are claiming that this bill will actually help a few people. They may have solicited some supporters who may actually believe that this will help some people -- but the real net result will be **promoting, legitimizing and increasing death and suicide** and establishing new Maryland-based **for-profit government- approved suicide industries**. It will also legitimize **denying care** to people and **encouraging suicides** in an effort to **save money and increase profits.**

The Association of American Physicians and Surgeons respectfully requests that you **DO NOT** give doctors or the healthcare industry approval to **prescribe deadly poisons**.

Please vote **NO** on **SB 443/HB 403**

2024.HB0403.Arlinghaus.pdf

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Position: UNF

HB0443

Dr. Frank Arlinghaus

Opposed

I ask the committee to oppose House Bill 443, The End of Life Option Act. I join both the National Council on Disability and the American Medical Association in opposition to this bill (as well as numerous other disability rights and medical groups). I believe there are many good reasons for such opposition. Additionally, I find a number of reasons for those who support the ideas in the bill to oppose this particular bill on the basis of its flaws, particularly the insufficient protections for many vulnerable groups. I outline a few of these reasons below.

The National Council on Disability opposed Physician Assisted Suicide in a comprehensive 2019 report.

Please note that if you were to refer to one resource for information, I would ask that you look at the National Council on Disability report from October 2019 (at https://beta.ncd.gov or by searching on "The Danger of Assisted Suicide Laws") "The Danger of Assisted Suicide Laws: Part of the Bioethics and Disability Series", which documents a number of issues which contradict the narrative from Compassion and Choices. Importantly, this 70 page paper analyzes the law and examines whether the previous predictions by the NCD about these laws was correct (for example, their prediction on the ineffectiveness of claimed safeguards). For a shorter read, I recommend the 4 page executive summary on pages 11-14 of the report. However, I mention a few quotes from that summary:

"Many national disability organizations have taken positions opposing these laws due to concerns regarding their impact on people with disabilities" (p.11)

"Insurers have denied expensive, life-sustaining treatment but offered to subsidize lethal drugs" (p.11)

"People with the disability of depression are subject to harm where assisted suicide is legal" (p.11)

"Assisted Suicide laws apply the lowest culpability standard possible to doctors…which creates the potential for abuse" (p.12)

“Evidence of suicide contagion in states where assisted suicide is legal has been found in several studies” (p.13)

“States should not legalize any form of assisted suicide” (p.14)

The NCD is not the only organization to oppose PAS. However, in their bioethics report on PAS, they document evidence for these and other claims made in that executive summary. Other groups opposed range from the Disability Rights Education and Defense Fund or the Patients Rights Council to Not Dead Yet. All of these groups are concerned that patients with disabilities are put at even greater risk by these laws. Proponents of the law cite the number of safeguards and assert the strength of those safeguards; however, the NCD report addresses the problems with those safeguards by providing specific examples, many from the state of Oregon.

1. **Vulnerable populations are at risk from this bill**

-There will be an economic incentive that leaves the poor more vulnerable. The “right to die” will become a “duty to die”.

Medical care options vary by socioeconomic status, and insurance companies and the healthcare industry are driven by profit. Over time, options offered to people may be limited, particularly for expensive end-of-life care. **There are no protections from insurance companies who will offer to pay for ending one’s life, but not for the treatment to prolong that life**. Two such examples are the 2008 case of Barbara Wagner in Oregon (whose lack of treatment by the Oregon Health Plan can be compared to the Randy Stroup case, and which is described on page 20 of the NCD report referenced above with further details in the article “Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients–Paying to Die but not to Live”) and the 2016 case of Stephanie Packer in California (referenced on page 16 of the NCD report and both the Center for Bioethics and Culture Network and Patient Rights Action Fund). Such arguments are already being made in Canada, utilitarian arguments that recognize the expense of end-of-life health care (note that savings is provided by hospice options which promote positive experiences for patients and families). One envisions a not-to-distant future where some will experience a pressure not to hang on to life; long before that, it is not difficult to predict that insurance will have at least a bias toward end-of-life solutions over those which prolong life, and that the limiting of options will fall more heavily on the poor. In fact, these arguments are being made already in Canada, which legalized assisted suicide less than a decade ago, and is moving toward euthanasia, and each year gets progressively worse for those in vulnerable groups.

-Those with some form of medical limitation (physical or mental challenges, for example) will be at greater risk.

I make this claim based on our history of mistreatment and misunderstanding of those who are born less than perfect and those who have some progressive medical condition that puts them in a higher risk category. I defer to the examples that the disability rights community provide, and only wish to reinforce that they constitute a group at much higher risk than many others. Similarly, many of us are familiar with the increased vulnerability of our parents and other elderly persons as they become more susceptible to such risk. You have heard many of these stories over the past eight years, and you see that society lacks respect for those vulnerable groups–the physically or mentally challenged, the elderly, the poor, the depressed.

2. **Mental Health protections are inadequate**.

The bill fails to adequately protect patients who may be depressed--note that only 5 of over 200 patients in Oregon (cf. Oregon 2017 report) were referred for counseling, and these numbers declined in 2020-2022 despite the number of deaths and prescriptions rising dramatically (cf Oregon 2022 report); that doctors are only required to refer if they believe the depression rises to the level of impairing the patient's judgment; and that doctors may have no training in detecting or fully understanding depression. Significantly, almost three times the number of patients cite being a burden than cite pain as a reason for terminating their life. A proper mental health evaluation should be done for each patient before a prescription can be issued. The case of Michael Freeland presented on pages 23-24 of the 2019 NCD report involves a man with a 43 year history of depression whose history was ignored by a C&C-associated doctor, and who was rescued by Physicians for Compassionate Care, who treated his depression instead. In fact, a British Medical Journal study of 58 patients in Oregon receiving lethal prescriptions showed that 26% presented for depressive disorder and 22% for anxiety disorder. We're seeing suicide rates increasing dramatically as well as significant amount of depression, but we rarely see the doctors involved referring for depression (perhaps this is because the median length of time of the doctor-patient relationship in the Orgon cases is only 5 weeks).

3. **The bill sends an ambiguous message on suicide to our youth and to the rest of society at a time when suicide is increasing across the United States.**

As **the parent of a teenager who considered suicide,** I have had to deal with responding to her concerns that society allows people to kill themselves, so why shouldn't she be permitted to do so. I have another child who dealt for multiple years with depression, and who was at similar risk. Both of them have heard the message we're sending, and it makes it more challenging for me (and for them).

Whether we call aid in dying "suicide" or not, we are allowing a segment of society to self-terminate life with the cooperation of medical professionals. The United States is seeing a continued increase in suicide, mental health issues are increasing, and our teenagers are considering suicide at an alarming rate. Suicide increases have been even higher in states that have legalized assisted suicide. The message this bill sends is that suicide under certain circumstances is acceptable, and it's not surprising for people to extend those parameters under which suicide is acceptable. If such laws become more prevalent across the United States, one of the next debates we will be having will cover the various circumstances under which we'll permit this, as we've seen other jurisdictions expand suicide laws to wider populations. If we just look at Oregon, between 1999 and 2010, the suicide rate among the age group 35-64 rose 49% compared to a 28% increase nationally, and the overall suicide rate in Oregon went from near average levels to 41% above the national average. Between 2011 and 2019, the number of suicides (excluding those which were physician assisted by lethal prescription) rose from 685 to 906 (an increase of 32%). During that same time period, the number covered by Oregon's version of this bill rose by more than 100 additional deaths, and in 2020 would result in over 250 additional deaths.

Additionally, we are in a state of emergency concerning the mental health of minors, and a mental health crisis across all ages. Just **one adult category that is at even greater risk is that of our veteran population**. At the same time, the study of reasons in Oregon that people seek this treatment includes the top two warning signs for suicide listed by the US National Institute of Mental Health. Talking about wanting to die, feeling guilt or shame, or believing that one is a burden to others, and planning or researching ways to die are warning signs for other patients, and things which we seek to treat with counseling, not counseling those people to die.

4. **Safeguards still leave patients vulnerable.**

In previous hearings, caregivers, family, and medical professionals presented specific scenarios of vulnerable patients that should raise serious concern. Each of these cases is an existential threat under the law proposed in this bill. Beyond that, the law leaves patients vulnerable due to potential financial interest of heirs (as an heir of my father, I need only have a friend serve as the other witness, so we could conspire to influence my father toward PAS; he has a number of underlying conditions that without treatment, would qualify under current

Oregon law). Other scenarios mentioned above include the vulnerability of the economically disadvantaged, especially the poor, the immigrant, the disabled, experiencing a form of health care rationing where insurance companies or providers steer them toward PAS and away from life-extending treatment (two examples cited above are the Wagner and Packer cases).

Within the Senate, during a previous year's committee hearing, the legal and medical standards were questioned by one of the senators, and the main sponsor did not have an answer for the weaker standards. One specific case of this is the unwarrantedly weak standard for physicians that replaces the standard negligence model (used for virtually all other physician duties) to the weaker "good faith" model. This is indicative of how flawed the bill is when examined carefully, and the extensive analysis presented in that hearing provides guidance as to the areas of greatest concern, including multiple areas where the professional standards protect doctors more than the proposed patients, whether standards of care or level of scrutiny by those who watch over and protect those patients. The good faith model is the **weakest standard** we would use, and is **lower than what we use for almost all other physician duties.** It is designed to protect the doctor and not the patient.

Furthermore, **the investigatory powers of the state are limited**, so protections from abuse are perfunctory at best. To quote the Oregon Department of Health and Human Services, " We are not given the resources to investigate and, not only do we not have the resources, but **we don't have the legal authority** to insert ourselves".

5. **Bill fails to provide "Death with Dignity" and moves physicians from healer to agent of death.**

With no doctor or other medical personnel present to attend to any difficulties while taking a megadose of pills, likely in a slurry of some sort, the likely scenario for consuming the lethal medication is anything but dignified. This bill has further complications from moving doctors from their traditional role as healers, and instead having them prescribe death.

Much time will be spent discussing the Hippocratic oath and how it might fit into the modern context. Instead I look to the Marbella statement made in 1992 at the 44th World Medical Assembly well after the international right to die movement had pushed for assisted suicide and aid in dying. It said **"Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession."** In the years since, most medical groups continued their opposition to such legislation, while the right to die lobbying efforts have tried to get them to stay neutral. Doctors remain uncomfortable at prescribing lethal medications, and are even more uncomfortable at being present (thus we have a law in which **the "attending physician" rarely attends the patient during the lethal act)**. These acts are in fundamental conflict with the view of doctor as healer.

6. **The term " Medical Aid In Dying" gets confused with hospice care.**

Supporters of the bill object to the term "Assisted Suicide" because the language weakens their support. To be accurate, we have a patient who seeks to end their life, who administers the means of ending that life by their own hand, and who is enabled in self-termination by a physician prescribing a lethal dose of medication. If the same patient were to commit this same act by collecting the same dose on their own, administering it the same way the law prescribes, but without a physician's involvement, we would call it suicide. However, "Assisted Suicide" conjures up images of Dr. Jack Kevorkian who set back the Aid in Dying movement at least a decade. In the meantime, the term "medical aid in dying" makes one think of hospice care, which has an entirely different approach, providing palliative care and comfort, and which the state should instead make an increased investment in. Additionally, polls which use the term "Medical Aid in Dying" gain broad support due to this confusion.

7. Holes in **safeguards for lethal medications leave dangerous medication unaccounted for.**.

I will refer repeatedly to the 2017 Oregon report listed elsewhere in the report. Once a prescription is obtained and filled, there is no effective tracking of the medication. A significant portion of the lethal medication is prescribed and never used. Proponents claim that the prescription is rarely filled in that case, but there's no evidence of that. Given the types of medication used, the state should have an obligation to track it more carefully. In the case where the prescription is filled and is not used, there is a real potential for abuse of several types, including use on an unwilling victim as well as abuse of the drug in other ways. Once the prescription is filled, a patient who changes their mind is at risk for coercion or unwittingly consuming the medication. Record-keeping rules inhibit investigations of such scenarios, making it difficult to expose and investigate problems. One need only look to the opioid death epidemic and a recent case in Ohio to some potential abuses in other contexts. Proponents of the bill fail to consider the risk of those drugs being used on a patient who has changed their mind, or used on someone else.

In the most recent version of the Oregon report available (2022), 431 people were reported to have received lethal prescriptions, and of them, 246 had died by ingesting the medications (278 patients had died, but 32 had received the lethal drugs in 2021 or earlier). The past four years have seen an increasing number of prescriptions unused.

8. **Canadian and European examples show that further risks to patients are likely to rise in the future**

There is a steady progression over time where such laws "evolve". Sometimes we refer to the potential for a "slippery slope" while others may refer to it as the method for "boiling a frog". Proponents point to court cases that fundamentally changed what is permitted, and yet dismiss the possibility of it happening again. The Candians have had PAS legal for less than a decade, and yet many of the concerns expressed are becoming a reality there. Some of the examples we're concerned about may not be happening in this country yet, but are some of the next logical steps in such a progression, and in fact, supporters of this bill in other states have proposed amendments relaxing protections, extending the scope of the bill, or even using the courts to argue for doing the same. Thirty years ago, I argued against denying patients nutrition and hydration when the law changed to allow them to decline medical treatment. Refusing medical treatment didn't guarantee death as long as patients were given food and water. In order to guarantee they would die, rules had to "evolve" to treat nutrition and hydration as a medical treatment that could be refused. This would allow one to guarantee death. Now denying nutrition and hydration is cited as an inhumane way to die, justifying more humane methods. Perhaps the proper response is not to permit the inhumane way rather than to find other ways one may choose to die. We have seen a similar progression in European countries regarding assisted suicide and even euthanasia. The medical establishment and the courts may decide that medical treatments aren't worth the cost, that patients should die against their wishes (in Belgium, where a patient was physically restrained by their own family) or the wishes of their parents (in England even to the point of not allowing a child to be treated out of country at someone else's expense). In such cases, we are not all treated as equally valuable with an equal right to life-extending treatment, and unfortunately, the first to be devalued are the disabled and the elderly. Furthermore, those in poorer communities have less opportunity for life-affirming treatments, less access to mental health care, and are at greater risk. The cases cited above from the NCD report include evidence that denial of treatment of medical conditions in favor of PAS was based on estimated 5 year survival rate (which is a far different standard than the 6 month standard).

9. **Conscience protections should be extended further–to nurses, pharmacists, other health care workers, and facilities.**

Given the definitions within the bill, it's not clear that a healthcare facility could prohibit assisted suicide deaths on its site. Additionally, if a facility permits assisted suicide deaths on its site, additional protections are needed to prevent that facility from requiring participation (or other forms of facilitation) by pharmacists, nurses, and other health care workers. Additional protections should be put into the bill to protect them more fully.

10. **Statistics that deceive: what's missing leads to serious questions on use of medication among other points.**

Proponents of the bill will cite over 80 years of legality to dismiss problems. We have not had 80 years of legality, we have had over 80 state-years (one state-year is one year of legality in one state). Only in Oregon do we have as many as 20 years of legality, and we will note some of the gaps and some of the trends, drawing directly from the 2017 Oregon report (the 2021 and 2022 reports show a big increase in death, consistent with https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year20.pdf). Note that the number of deaths has increased in all but two of the years, and that there is a steady trend upward with greater increases over the last nine years of the data. Elsewhere the report lacks a number of items of interest. The data not collected often would answer opponents' objections which are at this hearing dismissed by proponents, including the tracking of medication and ingestion of said medication (prescription versus fulfillment of said prescription versus death of the patient by ingestion). Many of the times between ingestion and death are mostly unknown, but even given that, the time to unconsciousness and death can be much longer than expected. Further buried in the report is the detail that in 2017, morphine sulfate became one of the two prominent medications used, of further concern because of the better known abuse potential of morphine, and now a variety of drug mixtures is used.

11. **The bill is based on a false compassion: doctors who specialize in care for the elderly are less likely to support the bill, and pain is not one of the core underlying reasons PAS is pursued..**

People on both sides have genuine concerns, but the premise of compassion (in ending suffering) is contraindicated in two ways. First is that pain is cited less than 25% of the time in the most recent Oregon report. Also previous medical surveys have shown that the doctors more involved with patients favor bills like this at a much lower rate, and the lowest rate of approval comes from specialists in palliative care and care of the elderly. Those who attend the elderly and those in hospice see the greatest suffering in their patients. Seeing patients near the end of their lives, they should approve of this in the name of compassion. A survey by the Glasgow University Institute of Law and Ethics in Medicine showed pharmacists supported physician-assisted suicide at rates twice as high as medical general practitioners. A survey of over 3700 physicians by the National Council for Palliative Care showed that over 90% of doctors who specialized in palliative care or in the care of the elderly did not support making changes in the law to allow physician-assisted suicide.

12. **"Doctor Shopping" will and does exist.**

In the 2017 Oregon report, 92 doctors wrote 218 prescriptions, but at least one doctor wrote 29 of those. In 2021, a single doctor wrote 47 prescriptions, while in 2022, a single doctor wrote 51 prescriptions. In a 2015 article in the Oregonian ("Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die," *Oregonian*, February 4, 2015. Available at: http://www.oregonlive.com/health/index.ssf/2015/02/physician-assisted_suicide_a_f.html), a case of doctor shopping was described, one which raises additional questions on the testimony of the proponents of this legislation. A woman died of assisted suicide under Oregon's "Death with Dignity Act," even though she was suffering from early dementia (a condition which appears to disqualify her from being able to make the decision). Her own physician declined to provide a lethal prescription for her. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly pushing for it and her daughter seemed to be coaching her to do so (another disqualifying condition). She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, she was assessed by a managed care ethicist who determined that she qualified for assisted suicide, and the lethal dose was prescribed. Beyond this, one could imagine a doctor who would be receptive to helping patients he felt were in need--we had one where I grew up in Michigan whose name became infamous--and this case from 2015 shows the potential for redefining who qualifies for help.

14. **The state has an obligation to err on the side of protecting life**

From a purely secular governmental view, this state has an obligation first to protect its citizens. Ask yourself what level of "collateral damage" you are willing to accept given that such damage involves ending someone's life. Those susceptible to abuse are among the most vulnerable and in greatest need of protection.

These are only some of the reasons for opposing this flawed bill. You may also stand with the religious opponents of the bill, ministers and leaders of many faiths who find the bill objectionable on moral grounds. You may stand with the many doctors, nurses, and other health professionals who find the bill objectionable on professional and ethical grounds. You may find yourself favoring personal autonomy in principle, but see that in practice this bill is too flawed to provide sufficient protection to people at risk. In any of these cases, I ask that you stand against this bill.

15. **This is a continued public relations campaign of the international right-to-die movement, the positions of the Hemlock Society dressed up in the guise of compassion and of choices.**

The ideas in the bill are very similar to those debated in the 1980's and 1990's when Derek Humphry's Hemlock Society was pushing for medically assisted and medically enabled death, and were strongly opposed by the medical establishment. In the past 20 years, there has been a calculated public relations campaign to dress up the same ideas to be more palatable to the public and to legislators. At this hearing, you will hear objections to language that might weaken public opinion, and statistics presented using language designed to elicit your support. Anything that I claim you are welcome to question, and I will be happy to provide appropriate references (contact me at farlinghaus@yahoo.com). I also ask that you test this by offering amendments to the bill to provide reasonable protections mentioned.

I respectfully ask that you oppose this bill. Even if you are a supporter of this conceptually, the bill is fundamentally flawed and must be amended to provide additional protections for so many of the things mentioned here.

HB403 End of Life Option Act.pdf

Uploaded by: John Miller

Position: UNF

Please oppose HB403 End of Life Option Act.

Assisted Suicide legislation puts Maryland's most vulnerable populations at risk-including individuals with disabilities, minorities, those experiencing poverty, individuals being treated for or have a history of mental illness, our veterans, and those suffering from prescription or other drug addictions.

Lawmakers nationwide reject Assisted Suicide. The Maryland General Assembly has rejected some form of this bill at least six times. Your peers made their legislative intent very clear that Assisted Suicide is a criminal act and should remain so.

Maryland's leading disability rights groups recognize the many dangers the bill poses to those with intellectual and developmental disabilities.

The America Medical Association has always opposed this. No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.

Taxpayers foot the bill to pay for the lethal drugs and doctor visits.

For these reasons, please oppose HB403. Thank you.

UNFAVORABLE.HB403.SB443.LauraBogley.MDRTL.pdf

Uploaded by: Laura Bogley

Position: UNF

Opposition Statement HB403/SB443

Assisted Suicide/ ‘End of Life Option Act’
Laura Bogley, JD
Executive Director, Maryland Right to Life

Assisted Suicide is Wrong for Maryland

On behalf of the Board of Directors of Maryland Right to Life, and medically vulnerable patrons across our state, we strongly oppose the so-called “End of Life Option Act” and the legalization of “assisted suicide” or voluntary euthanasia. By licensing doctors and other medical providers to prescribe lethal drugs to bring about a person’s death, the state would be reducing the standard of medical care for all people with potentially disparate impact on the poor and underinsured.

Despite 270 failed attempts by proponents to enact this law nationwide, 40 states including Maryland, have repeatedly rejected licensing doctors to kill by assisted suicide. The Maryland Department of Health does not have the ability to provide effective oversight of Assisted Suicide practices and any proposed safeguards are only as good as the state’s enforcement. This bill is the wrong policy for Maryland, particularly as we are experiencing an epidemic of suicide, especially among youth and veterans.

PAS Creates Healthcare Disparities

This bill would put Maryland’s most vulnerable populations at risk, including individuals with disabilities, those experiencing poverty, individuals in need of treatment for mental illness, our veterans, and those suffering from drug addiction.

Legalizing assisted suicide will create great inequities in healthcare for Maryland residents. A *right to die* chosen by the wealthy few, will become a *duty to die* for many on public insurance. In Oregon, where this has been legal since 1994, nearly 70% of people who died from Assisted Suicide were Medicare or Medicaid patients, while only 30% had private insurance. This suggests a lack of access to alternatives to lethal prescription for those on government insurance.

Leading Medical Associations and Disability Rights Organizations Oppose Assisted Suicide

More than a dozen national medical organizations oppose Assisted Suicide. In fact, the **American Medical Association** voted in the Fall of 2023 to maintain its longstanding position against Physician Assisted Suicide stating

> *"Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations."* [1]

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[1] https://code-medical-ethics.ama-assn.org/ethics-opinions/euthanasia

23 national disability rights organizations oppose Assisted Suicide including the National Council on Disability, Disability Rights Education and Defense Fund and the World Institute on Disability. 14 national religious organizations stand in opposition including Agudath Israel, the Southern Baptist Convention and the Unites States Conference of Catholic Bishops.

Safeguards for Patients Ineffective

Proponents of this bill are concerned with immunity of doctors and other providers who kill their patients, but across the country they have rejected safeguards for patients as "barriers to care".

In 2019 the proponents of the bill withdrew their support after state senators attached amendments that would have provided critical safeguards for patients. During the 2019 House of Delegates hearing on this bill, when asked about adding patient safeguards, Kim Callinan, CEO of **Compassion and Choices** refused stating:

> *"There are other states who currently have this legislation who are looking to remove some of the regulatory roadblocks."*

In states where this policy has been enacted, the proponents have attempted to amend the law to remove existing protections for patients including the following:

- Non-physicians and pharmacists to participate in assisted suicide.
- No lethal diagnosis required. PAS prescribed for mental health reasons including depression.
- Minors may request suicide without parental consent.
- Waiting period requirements eliminated.
- Residency requirement eliminated .

Oregon Law is Cautionary Tale, Not Model

This bill is based on the Oregon law, which in no model law, but a cautionary tale of the slippery slope to euthanasia. We have the benefit of looking at two decades of history in Oregon to evaluate the credibility of the safeguards in this legislation. The dangers presented to vulnerable populations far outweigh any perceived benefit being sold by the bill's out-of-state, well-funded proponents.

Oregon data reveals that the vast majority (70%) of those being prescribed suicide were on government insurance and there was a steep decline in mental health evaluations. Oregon also reported a 6.3% increase in suicide rates among the general population following legalization.

Oregon is an example of failed oversight and as a result serious abuses have come to light. In fact Dr. Katrina Hedberg, of the **Oregon Department of Human Services** and a proponent of the law stated

> *"We are not given the resources to investigate [assisted suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to assert ourselves."*[2]

Unfortunately, substantially similar language in Oregon law has only wrought problems rather than protections for patients' rights. The following illustrate immense problems with this legislation based on the data available to us, including:

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[2] DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.

- the violation of physician's Hippocratic Oath to heal not kill
- the reality of coercion and undue influence
- the denial of lifesaving alternatives
- the gravely flawed definition of terminal illness
- the mandate to falsify death certificates
- the failure to guarantee competence and mental health
- the lack of a required witness at the time of death
- the lack of a doctor-patient relationship and reality of doctor shopping
- the indefinite requirement of self-administration, especially for those with disabilities
- the lack of oversight and accurate data collection
- the inability of the state to be able to reasonably enforce violations of this policy and
- the stories of Michael Freeland, Helen X, Dr. Charles Bentz, Kate Cheney, Kathryn Judson, Mrs. Neill, Randy Stroup, Barbara Wagner, Barbara Houck, Patrick Matheny, and others experiencing firsthand the failures of safeguards in states with legal doctor-prescribed suicide.

FALLACY 1: "The Patient Must Be Competent/Have the Capacity to Make Medical Decisions"

The capacity to make medical decisions and the requirement of a patient being a 'qualified individual' to request aid-in-dying, pose numerous problems. Though there is a requirement to posses "the capacity to make medical decisions", substantial research and practical requirements of the legislation can offer no guarantee of competence or mental health.

Depression is a Normal Response to Terminal Diagnosis

Research studying numerous cases of suicide has concluded a well-established psychological fact that nearly every terminally ill patient who desires death is suffering from a treatable mental disorder.[3] It is not uncommon for these patients to express depressive or suicidal thoughts, which may be a normal part of emotionally processing a severe diagnosis. Nonetheless, depression and suicidal ideation can be successfully treated and reversed. The worst response to a patient with suicidal thoughts is to affirm his or her worst fears of insignificance and of being a burden by helping that person end his or her life.

No Requirement of Assessment by Mental Health Professional

Additionally despite language allowing the attending physician or consulting physician to refer a patient for a mental health professional assessment, there is absolutely no requirement that such action ever occurs in this bill. In practice, under the proposed language, if a mental health professional is given the opportunity to determine that a patient does suffer from a mental disorder or depression, if they also determine the person has decision-making ability, the individual can receive the lethal prescription.

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[3] Barraclough, Bunch, Nelson, & Salisbury, *A Hundred Cases of Suicide: Clinical Aspect*, 125 BRIT. J. PSYCHIATRY 355, 356 (1976) and E. Robins, THE FINAL MONTHS 12 (1981).

Data from Oregon's experience show only 4.9% of patients were referred for an evaluation in over 19 years of the practice.[4] In real numbers, that means 1,213 patients ended their lives through lethal prescriptions without being reviewed by a licensed mental health professional to ensure competency and clear decision making ability. This massive danger has resulted in documented cases reported in *The Oregonian* newspaper of patients suffering from depression and dementia receiving doctor-prescribed suicide.[5] One proponent of this legislation testified in the workgroup that patients with diagnosed depression are not disqualified from using this law in Oregon. Language in this legislation is not sufficient to protect patients.

Depression is Treatable

In Oregon, a patient by the name of **Michael Freeland** was diagnosed with lung cancer and received a lethal prescription under Oregon's law. Over a year after receiving his first prescription (clearly calling into doubt the validity of the 6-month lifespan diagnosis) he was admitted to a psychiatric treatment facility with depression and suicidal intent. After being treated and seeing great improvement, his caregivers ensured his 32 guns and all ammunition were removed from his home before Mr. Freeland could return home. However, his guardians knowingly allowed Mr. Freeland to keep the lethal prescription. Mr. Freeland's treating psychiatrist even submitted a letter to the court after his discharge indicating Mr. Freeland was not competent and was in need of a guardian. Fortunately after accidentally dialing a suicide prevention group when attempting to call an assisted suicide advocacy group, he was able to continue quality treatment for his depression and receive help in reconciling with his estranged daughter. He died naturally and in comfort almost two years after receiving a lethal prescription. Mr. Freeland released his medical records for public review.[6]

Unattended Ingestion and Death

Because of the bill's lack of safeguards, there is serious concern as to whether a patient will still be competent at the time she or he actually ingests the lethal prescription. Patients prescribed a lethal prescription under this bill may not ingest it either for a period of time, or ever. 35.18% of patients prescribed a lethal prescription never take it (692 never ingested of 1,967 total prescriptions, 692 figure calculated from presentation of 1,275 patients who were reported having died from 1,967 lethal prescriptions written).[7] If a patient does not take the prescription, a lethal substance remains unmonitored and unregulated, potentially accessible to unintended recipients.

Additionally, the time reported between first request for death and actual ingestion is as little as 14 days to as high as 1,009 days (approaching 3 years).[8] Three years with a severe diagnosis can be one of dramatic changes. Aside from seriously challenging the definition of "terminal", it is unknown what changes to the patient's condition or life occurred in that time. Did the person's mental state

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[4] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[5] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

[6] Patients Rights Council | N. Gregory Hamilton, MD and Catherine A. Hamilton, MA, "Competing Paradigms of Response to Assisted Suicide Requests in Oregon," American Journal of Psychiatry, June 2005, pp. 1060 - 1065.

[7] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[8] Ibid.

deteriorate? Did the person's condition improve to no longer be considered terminal? Did caregivers tire of caring for a sick relative? Simply put, we don't, and will likely never know.

Death Doctor Shopping

There is also no requirement in this legislation that the doctor has any notable relationship with the patient. Oregon's data show that 'doctor shopping' exists. A network of doctor-prescribed suicide proponents ensure that patients will receive lethal prescriptions[9], even when their family doctor knows their desire for death is transient and could be alleviated. Oregon's data show that patients were prescribed fatal prescriptions after a duration of a "patient-physician relationship" of 0 weeks.[10] Clearly, the reality of a person searching for a willing physician after a family physician denying a request for suicide exists because of this bill's permissive allowance of it.

With regard to doctor shopping, **Compassion and Choices** openly admitted that they have worked with between 75% and 95% of all patients ending their lives in Oregon[11], advertised their willingness to connect patients with willing doctors on their Washington chapter's website[12], and promoted their referral program on their Vermont chapter's website[13].

In Oregon, the story of **'Helen X'** clearly shows this. She had a history of breast cancer and was enrolled in hospice. She was using a wheelchair for two weeks and used oxygen when shortness of breath struck her. She reported no pain and was still doing aerobic exercises regularly. Her physician declined her request for a lethal prescription. A second physician she saw did the same due to feeling she was showing signs of depression. Her husband called Compassion and Choices and found a willing physician- Dr. Peter Reagan, a known advocate for doctor-prescribed suicide. Despite reporting surprise at her eagerness to die, Dr. Reagan nonetheless wrote the lethal prescription.[14]

Likewise, **Dr. Charles Bentz** diagnosed a malignant melanoma in an elderly man who had been under his care for 10 years. After the patient underwent radiation therapy, the radiation oncologist informed Dr. Bentz that the patient was depressed due to his diminished physical stamina. At about the same time, the patient completed his chemotherapy and requested a lethal prescription from his medical oncologist. The medical oncologist sought Dr. Bentz to be the required second physician, noting that secobarbital "works very well" and that the oncologist had used it many times. Dr. Bentz refused to agree citing the patient now had documented depression and needed appropriate therapy. The oncologist rather than reevaluating the effort to obtain a lethal prescription, found a willing second

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[9] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

[10] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[11] "FAQs." Compassion & Choices Oregon, n.d. Web. 12 Feb. 2016. <https://www.compassionandchoices.org/what-you-can-do/in-your-state/oregon/frequently-asked-questions/>

[12] "Death with Dignity Act - End of Life Washington." End of Life Washington. End of Life Washington, n.d. Web. 12 Feb. 2016, Feb 2019. <http://endoflifewa.org/dwd/>

[13] "Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life." Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life (2014): Compassion & Choices Vermont. Web. <https://www.compassionandchoices.org/userfiles/Talking-to-Your-Doctor-About-Act-39.pdf>

[14] Patients Rights Council | Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective, *Michigan Law Review*, Vol. 106:1613 (June 2008), p. 1616.

physician and did not refer the patient back to Dr. Bentz. Two weeks later, the patient ingested the lethal prescription and died.[15]

FALLACY 2: "The Patient Must Be Terminally Ill"

Terminal illness is often difficult to predict. While physicians do their best to care for patients, there is a plethora of evidence that non-terminal patients have received lethal prescriptions. We are now seeing evidence from other states that lethal drugs may be prescribed for non-lethal and even mental health diagnoses, including depression or anorexia.

The aforementioned data indicating as long as 1009 days between first request for death and actual death indicates an obvious problem with the practicality of restricting this policy to only terminal patients.

Diabetes Can be Basis for Lethal Prescription

Simply put, the definition of terminal in this legislation is overly broad. The definition does not preclude someone from ceasing treatment of an otherwise non-terminal condition in order to qualify. For instance, an insulin reliant diabetic could qualify under this bill. Whereas essentially no one would consider the condition terminal, a person with the condition could qualify if he or she ceases to administer the required insulin. In Oregon, patients with HIV/AIDS, multiple sclerosis, diabetes, viral hepatitis, and a number of other potentially non-terminal conditions ended their lives via this policy.[16]

FALLACY 3: "The Request Must Be Voluntary"

While the bill states that the patient must request suicide voluntarily, the risk of coercion and undue influence is possible in several ways.

Bill Authorizes Heir to Witness Request

While the bill states that coercion and undue influence are prohibited, it simultaneously allows an heir to serve as a witness for a request for doctor-prescribed suicide. In fact, there is no language in this bill to prevent an heir from serving as a witness- under 'Declaration of Witnesses' in the "Maryland Request for Medication for Aid in Dying" form and explicitly authorized in the bill, language specifically allows an heir to be a witness who knows of his or her benefit from the patient's death, and allows another person to benefit from the patient's death providing that benefit is merely established after the written request. One of the two of these beneficiaries is allowed to be a relative by blood, marriage, or adoption.

Oregon data show that people regularly request doctor prescribed suicide due to the feeling that they are a burden on friends, family, and/or caregivers (43.7% of patients dying under this policy cited this

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15 Patients Rights Council

16 Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

reason since legalization of the policy).[17] It is unknown how many of these patients would have made a different decision with true compassion or with the absence of coercive pressure.

Kate Cheney was a woman diagnosed with terminal cancer and asked for a lethal prescription. Her doctor refused to write a prescription because of questions surrounding her competence due to dementia and referred her to a psychiatrist. The psychiatrist noted Kate Cheney's short term memory loss and that her daughter seemed much more interested in doctor-prescribed suicide than Cheney did, going so far as noting that, "[Kate] does not seem to be explicitly pushing for this," and that the patient lacked the, "very high capacity required to weigh options about assisted suicide." While Kate Cheney seemed to accept the verdict, her daughter did not. A third effort done by Kate's HMO determined she was capable of making the decision and authorized the writing of the prescription. Later, she went into a nursing home so her family could have a respite from caring for her. After returning home she proclaimed a desire to take the pills.[18] Kate Cheney, a patient with dementia, not only had a caregiver advocating for her death, but one willing to doctor shop until finding a willing doctor. Sadly, it was her own insurance coverage which helped authorize ending her life.

Doctors May Pressure Patients

The same pressure has been documented from health care providers as well. **Kathryn Judson's** husband was gravely ill when brought to the doctor. To her shock, she overheard his doctor giving a sales pitch for doctor-prescribed suicide. "Think of what it will spare your wife, we need to think of her," she noted the doctor said. They quickly changed physicians and Mrs. Judson's husband lived another five years. Mrs. Judson was appalled by this treatment and feared leaving him alone with medical professionals again, remarking, "It's not a good thing, wondering who you can trust in a hospital or clinic."[19]

The same horror stories have already occurred in Vermont. **Mrs. Neill** was admitted to the Berlin Health and Rehab Center in Vermont for four months. Her daughter, Beth Neill, reports that her caregivers repeatedly reminded her of her 'right' to use Act 39 (Vermont's doctor-prescribed suicide law), going so far as to say, "it is the law" and the patient could "off" herself at any time. The repeated, ceaseless discussions initiated by caregivers after Mrs. Neill expressed she was not interested, caused unwanted pressure on the patient. Interestingly, Mrs. Neill was in generally good health and had no terminal illness. The privilege of a strong, involved family and personal physician opposed to doctor-prescribed suicide helped her to resist the unwarranted pressure.[20]

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17 Ibid. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

18 Patients Rights Council | Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian,* October 17, 1999. | Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective, *Michigan Law Review*, Vol. 106: 1613 (June 2008), p. 1624

19 Patients Rights Council | Letter to editor, "Assisted Suicide? 'I was afraid to leave my husband alone again with doctors and nurses'" *Hawaii Free Press*, February 15, 2011.

20 Patients Rights Council | "From the Netherlands to Vermont: Patients Under Pressure to Die - True Dignity." *True Dignity*. True Dignity Vermont, 13 July 2015. Web. 15 Feb. 2016. <http://www.truedignity.org/from-the-netherlands-to-vermont-patients-under-pressure-to-die/>.

Pain Basis for Only ¼ of Lethal Prescriptions

Oregon's data show only about 1 in 4 patients (25.8%) cite inadequate pain control or a concern about it. Despite the image of a patient suffering being the appeal to emotion behind support for this legislation, the evidence does not support it. Only 1 in 4 patients dying from fatal prescriptions cite this, and a notable proportion of these people may merely have been concerned about what may happen in the future, rather than experiencing any improperly controlled pain presently. In fact, this reason is not even in the top five reasons a patient asks for the lethal drugs.

Economic Pressure

Realistically, coercion could arise out of a mere lack of affordable 'feasible alternatives'. Although the bill requires that the patient be informed of "feasible alternatives and health care treatment options, including palliative care and hospice", there is no such requirement that any of these alternatives be covered in insurance plans. This particularly hurts those in poverty and anyone without insurance or without enough insurance.

A striking example of coercion highlights precisely why we are opposed to the policy of doctor prescribed suicide generally. In Oregon, **Randy Stroup** and **Barbara Wagner** were each denied treatment they wanted and needed to survive by the Oregon Health Plan (Medicaid) and were informed in the same letter that they could instead "choose" doctor-prescribed suicide, which would be covered.[21] In a program designed to give true dignity to people in poverty through access to healthcare, the very opposite happens- wanted lifesaving treatment is denied because ending the lives of sick people is easier and cheaper than treating them.

The mere legalization of doctor-prescribed suicide threatens the access to wanted healthcare of everyone in society. There are surely many more people affected who didn't have the courage to come forward. Just as this occurred with a public plan, the same can occur in state healthcare exchanges, and with any private insurance plan operating in the state. After all, private health insurance plans have the same, if not more, motivation for profit; eliminating the extent of coverage for treatment because there is a cheaper "option" can unquestionably occur right here in Maryland.

FALLACY 4: "The Patient Must Self-Administer"

While the bill requires a person to self-administer the fatal drugs, many legal observers argue that this provision is one court challenge away from being overruled. For instance, the Oregon Attorney General's office has stated that if there is a person with a particular disability which prevents the ability to swallow, the requirement in statute to self-administer is unconstitutionally discriminatory.[22] Realistically, this means **lethal injection euthanasia** is merely a court challenge away from being legal in Maryland, if this bill would pass.

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[21] Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, Aug. 6, 2008, and Susan Harding and KATU web staff, "Letter noting assisted suicide raises questions," July, 30, 2008.

[22] Letter from Oregon Deputy Attorney General David Schuman to State Senator Neil Bryant, March 15, 1999, "Oregon controversy: How assisted can suicide be?" *American Medical News*, April 12, 1999.

During the 2019 House of Delegates hearing on this bill, Dr. Michael Strauss, the leading Physician promoting the bill, unintentionally revealed the truth that the bill does permit others to administer the poison testifying:

> *"The capsules- by either the patient or a family member – are pulled apart, the powder goes into about four to six ounces of a liquid and the patient ends up consuming the four to six ounces of liquid." "A physician could be there or a family member could put the powder in a liquid."*

There are already numerous stories of inappropriate "assistance" provided to patients' suicide attempts. **Barbara Houck** was diagnosed with Amytropic Lateral Sclerosis (ALS or colloquially Lou Gehrig's Disease). She immediately called Dr. Peter Rasmussen (an assisted suicide supporter) for a prescription which was written a few months later when Dr. Rasmussen thought she was closer to a terminal condition. He was present with her on the day of her death where he emptied the 90 capsules in her lethal prescription into a bowl of chocolate pudding and her two sons spoon fed it to her. She died about twelve hours after being fed because of illegal assistance.

Patrick Matheny was only 43 years old when contemplating doctor-prescribed suicide. He, too, had ALS. He set numerous arbitrary deadlines only to see them reached and extended. On March 10, 1999, Matheny tried to swallow the barbiturates mixed into a chocolate nutrition drink, sweetened with a sugar substitute. He reportedly had difficulty swallowing and the only person present — his brother-in-law Joe Hayes — had to "help" him die. Hayes did not disclose how he "helped" his father-in-law die, but he did state, "It doesn't go smoothly for everyone…For Pat it was a huge problem. It would have not worked without help."[23]

FALLACY 5: "The State Will Punish Violations"

There are numerous concerns about the ability of the state to adequately monitor and prevent violations of this bill, if it would become law. The Maryland Department of Health already is overstretched and the medical boards have little responsibility to report violations and take disciplinary action.

Low Liability Standard

The bill only holds a physician to a "good faith compliance" standard, rather than the higher "malpractice standard" applied to other health providers and to the same physicians in different medical circumstances. When dealing with a policy literally intending to cause death, physicians should be expected to uphold the highest professional standard.

Insufficient Reporting Requirement

While there is a requirement for the Department of Health and Mental Hygiene to promulgate regulations to collect data, the bill is silent on what data must be collected. Data should be collected at least on the points currently collected by Oregon and featured in their annual report. Additionally, there must be means in place to enforce a reporting requirement, one significant reality missing in Oregon.

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23 Patients Rights Council | Erin Hoover Barnett, "Dilemma of assisted suicide: When?", *Oregonian*, January 17, 1999 | Erin Hover Barnett, "Man with ALS makes up his mind to die," *Oregonian*, March 11, 2000.

Falsification and Fraud

Likewise, this bill would mandate, by statute, falsifications of death certificates. The bill mandates that death certificate for an individual using this option would be falsified to state that the individual died of "natural causes". This prevents any ability to investigate a death or to monitor the frequency and circumstances involved in deaths under this policy. Therefore, when combined with a lack of specific points required in reporting, there could be absolutely no way to know the number of real suicides through this policy in Maryland.

In Conclusion

Because of the plethora of concerns with this legislation, Maryland Right to Life asks the committees to put patients before profits and support the concerns of people with disabilities, the underinsured and the medically vulnerable by issuing an unfavorable report on this deadly bill.

There are simply too many grave concerns- each in and of itself significant enough to halt pursuing this policy- to correct with a simple amendment. The very policy is so innately flawed that it cannot be implemented as good public policy in Maryland.

For the sake of vulnerable populations across our state, we respectfully request that you maintain your opposition to legal Assisted Suicide and issue an **unfavorable report** on the deadly "End of Life Options Act".

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PAS - Unfavorable vote HB403.pdf

Uploaded by: Laura Jones

Position: UNF

Unfavorable – OPPOSE – HB 403

Laura Jones
Annapolis, MD
410-246-5561

My Name is Laura Jones and I oppose the End-of-Life Option Act because even the name is disingenuous. It does not promise an option at the end of your life, it promises to remove all future options by ending your life.

This bill's only function is to offer suicide by drug overdose to terminally ill people, but the bill states it is not suicide. That should be your first red flag. Why lie about what is happening?

Would you ever suggest to a friend or family member they should take an overdose of drugs and die? That sounds so harsh! Yet it is easy to say, "You are having such a hard time, why don't you use the end of -Life option Act?" This appears to be a statement of concern and compassion, but it is no different than the first.

Notably, the legalization of PAS does not grant someone the personal autonomy to decide how they will die. Anyone can find a way to overdose. Instead, it gives people the legal right to ask the medical community to help them commit suicide. It will corrupt the medical establishment by coopting the services of doctors, psychiatrists, pharmacists, hospice nurses, and medical examiners.

The bill calls upon medical professionals to change the way they serve the public in the following ways:

- **Medical doctors** are asked to provide a prescription for a lethal dose of drugs to patients who want to die, even if there are alternate treatments available to help them live.
- **Psychiatrists** may be consulted to evaluate people with the expectation they can deem them to be of sound mind when they want to kill themselves by drug overdose.
- **Pharmacists** would be the ones to combine the lethal dose of drugs for patients. Such drug combinations are not standardized. They have not been tested or approved by the FDA for use to end human life.
- **Nurses** who work within hospice and palliative care would need to add the lethal drugs to a liquid to enable the individual to drink the lethal dose. They first need to administer an anti-nausea medication. Complications such as seizures, vomiting, and gasping for air may occur.
- **Medical examiners** must falsify the death certificate and report the cause of death as an illness, not a drug overdose.

- **Emergency personnel, law enforcement and suicide prevention agencies** will not be able to follow well established protocols to prevent people from intentional death by drug overdose.

This law is not needed! Suicide is already too easy. People who want to have full autonomy to end their life must do it on their own without the help of anyone, especially the medical professionals we rely on to help us stay alive. No law should expect medical professionals to offer suicide as a "medical treatment" for illness.

If you pass this bill and give us a legal right to request drugs from our doctor, you also give our health insurance agency the right to provide the drugs. This gives the doctor the obligation to offer the option to take the drugs as a treatment for our illness. This forces us to consider if we should end our life or continue to be a burden on others who care for us.

When we are weak, upset, and facing a terminal diagnosis, it is unwise to offer us suicide as a treatment for our illness. When doctors and family suggest we use the End-of-Life Option it will make us feel like we are dispensable. How will we find the strength to continue to live if others offer us this option. Our choices will be based on the actions of others. Nearly 48% (On average over 25 years) choose to end their life because they felt like a burden. (See page 14 of the Oregon Death with Dignity annual report) We are all going to be a burden when we become sick.

Every year proponents say there is no correlation between legalizing this option and a rise in suicide. That cannot be true. The whole goal of the law is to allow another way for people to get drugs so they can overdose and commit suicide.

They say it is a preventative measure to reduce suicide by allowing the patient to have these important discussions and get help, but that is not happening. The Oregon report analyzes 25 years and found only 1% received a psychiatric evaluation last year. You cannot reduce suicide by offering suicide as a treatment for illness.

It also discriminates against people who are terminally ill. The only group of people who are not counseled against commiting suicide are those with a terminal illness with less than 6 months to live.

Whereas people who express a plan to commit suicide are sent for counseling (MD Health-Gen Code 10-613 permits involuntary hospitalization of someone determined to be a danger to himself or others), this law excludes those with a terminal illness from this protection.

Instead, the law sets parameters which cause the doctor to see their request as one of personal autonomy, and directs them to help facilitate their death. According to the bill, one of the safeguards to is the requirement for the patient to ask for the deadly drugs several times, but rarely is it seen as a cry for help. (In Oregon, only 1% of the people who died using the DWDA were sent for a psychiatric evaluation. 25-year analysis)

When the doctor is expected to respect the autonomy of the dying patient, is it disrespectful to ask them to get a psychiatric evaluation? The doctors who provide this service believe everyone should have this choice, and making them feel like a crazy person for asking for the drugs is not something they are willing to do.

Suicide is no longer our own personal decision. Now anyone can suggest we do it and few people will be inclined to talk us out of it. That would be disrespectful.

The Maryland bill targets people with a terminal illness and hurries them towards death. People of sound mind should be held in great esteem and valued as the influencers of society and wise counselors within the family unit. Being of sound mind should not be a qualifier for assisted suicide. Terminal illness may be the factor that brings someone closer to death, but their lives have value up to the last day. When they can no longer provide for others, they become the person for whom others find their purpose and mission by providing for them.

When someone has 6 months left to live, they should view each day as an opportunity to live and love to the fullest. Do not pass the End-of-Life Option act. The option is final and a complete loss of the opportunity to experience another tomorrow.

Do not align with Suicide and death as answer to our illness.
Oppose HB403

Sincerely,
Laura Jones
The Dignity Mandate

EPC Maryland Statement .pdf

Uploaded by: Meghan Schrader

Position: UNF

We, the disability rights advocates, doctors and lawyers on the board of the Euthanasia Prevention Coalition USA strongly oppose HB0403 and urge legislators to invest time and resources into improving palliative and home care instead. Passing this bill enables a movement that is harmful to people with disabilities, to members of other marginalized communities and to the medical profession. Please consider the following facts:

- -The American Association of Suicidology made a 2017 statement saying that "MAiD" was not suicide. But in 2023 the AAS had to retract that statement https://suicidology.org/2023/03/08/aas-update-on-previous-statement/ because it was used in the 2019 Truchon decision that expanded assisted suicide to disabled Canadians. https://twitter.com/TrudoLemmens/status/1666067817035190272 , which was opposed by the Canadian Association for Suicide Prevention. https://suicideprevention.ca/media/statement-on-recent-maid-developments/ The consequences of the AAS's statement are an example of how green lighting assisted suicide for the terminally ill easily results in violence against people with disabilities.
- -In 2021 the United Nation's Special Rapporteur on the Rights of People with Disabilities released a statement that even assisted suicide laws that are limited to the terminally ill violate its Convention on The Rights of People with Disabilities https://www.ohchr.org/en/press-releases/2021/01/disability-not-reason-sanction-medically-assisted-dying-un-experts
- -Compassion and Choices has acknowledged that an eating disorder specialist published a case study about suggesting "MAiD," to people with eating disorders and helping them carry it out, (https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2022.11.9.4 , https://www.compassionandchoices.org/news/colorado-response), but then its representatives say that these laws have never been abused. So, has the law been abused or not?
- -Harvard and Stanford Medical Schools disgustingly invited the director of Canada's euthanasia program to come talk to them about how much she loves her job killing disabled people; her book is readily available at booksellers across the country. https://m.youtube.com/watch?v=LtysjDKxmLg&t=8s&pp=ygUmSGFydmFyZCBNZWRpY2FsIFNjaG9vbCBzdGVwaGFuaWUgZ3JlZW4%3D, Spotify Podcasts) Regardless of what any individual may want, passing these bills rewards and empowers a global network of people whose actions are undermining suicide prevention for people with disabilities.
- -Well-known right to die leader Thaddeus Mason Pope has tweeted that he thinks it's good for disabled people to die by suicide. https://twitter.com/ThaddeusPope/status/1669450726831976449 The director of Compassion and Choices appeared on Dr. Phil with Thaddeus Mason Pope in January of 2023.
- -Disabled people already experience a higher rate of suicide than the general population and peer-reviewed research indicates that people are more likely to think suicide is acceptable if the victim has a disability. https://pubmed.ncbi.nlm.nih.gov/26402344/ Passing these laws clearly further normalizes the sentiment that disabled people's suicides might be a good thing, and that is a monstrous way for society to bully people in the disabled community.

Vigilantly safeguarding equality and justice for people with disabilities as a group and ensuring that people with disabilities retain equal access to life-affirming medical treatment in the long term is more important than the proponents' individual autonomy. Do not erect the scaffolding for the right to die movement's broader agenda by passing this bill.

Colleen E. Barry, Chairperson

Josephine L.A. Glaser, MD.,FAAFP

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