SB 0701

Dr. Frank Arlinghaus

Opposed

I ask the committee to oppose Senate Bill SB0701, The End of Life Option Act. I believe there are many reasons to oppose the bill. Even for those who support the principle of assisted suicide or medically enabled death, the many flaws within the bill are reason to oppose this particular bill.

1. 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 15 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).

2. Assisted Suicide or Aid In Dying?

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.

3. Recent medical declarations by medical societies oppose physician-assisted suicide.

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 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. In June 2019, the American Medical Association voted with 71% support to reaffirm their opposition to physician-assisted suicide, that it is “incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.” They joined the American College of Physicians and the World Medical Association, who had reaffirmed their opposition in 2017 and 2015 respectively.

## 4. Assisted Suicide is incompatible with the vision of doctor as healer.

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.

## 5. The bill is based on a false compassion

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 about 25% of the time in the 2018 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.

## 6. Statistics that deceive

Proponents of the bill will cite 40 years of legality to dismiss problems. We have not had 40 years of legality, we have had 40 state-years. Only in Oregon do we have 20 years of legality, and we will note some of the gaps and some of the trends, drawing directly from the 2017 Oregon report (https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year21.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 five years. 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). Note that 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.

7. Safeguards leave holes, particularly with respect to the lethal medications.

I will refer repeatedly to the 2018 Oregon report listed above. 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. One need only look to the opioid death epidemic and a recent case in Ohio to some potential abuses in other contexts.

8. Safeguards still leave patients vulnerable.

At the 2019 House hearing on the End of Life Options bill, 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). It also fails to adequately protect patients who may be depressed--note that only 3 of over 200 patients in Oregon were referred for counseling, that doctors are only required to refer if they believe the depression rises to the level of impairing the patient's judgement, 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.

9. 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 other 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. 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. 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 (as in the case of Diane Rehm’s husband). 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 2019, three bills were submitted in Oregon to relax the rules of their Death with Dignity Act. One example was House Bill 2232, which sought to change the medical restrictions from a 6 month terminal diagnosis to any disease that would eventually lead to death. In Hawaii, similar relaxation of rules is being sought. This leads to:

10. There will be an economic incentive to push assisted suicide that leaves the poor more vulnerable.

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. 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. These same conditions apply to the disabled.

11. Those with some form of medical limitation will be at 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 ARC of Maryland and others provide, and only wish to reinforce that they constitute a group at much higher risk than many others. Disability Rights groups overwhelmingly oppose assisted suicide laws because they fail to provide adequate protections.

12. “Doctor Shopping” will exist.

In the 2018 Oregon report, 103 doctors wrote 249 prescriptions, but at least one doctor wrote 35 of those. 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.

13. Abuses reflect these issues while reporting requirements interfere with their detection.

Their are specific examples from Oregon for each of the following:

Doctor shopping gets around safeguards.
Depression and psychiatric disability aren’t treated
Patients are not well protected from economic pressures and coercion
Nurses who have violated the law by assisting in suicides have not been prosecuted

14. Conscience protections should be extended further.

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.

15. The bill sends an ambiguous message on suicide to our youth and to the rest of society.

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. 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.

16. 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 it 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.