TESTIMONY OF JESSICA GORSKI
Maryland WISE Women, Healthcare Huddle Facilitator
IN SUPPORT OF SB 701,
End-of-Life Option Act
BEFORE SENATE JUDICIARY COMMITTEE

Chairman Will Smith and Members of the Senate Judiciary Proceedings Committee, thank you for this opportunity to testify in support of SB 701, to authorize medical aid in dying in Maryland. My name is Jessica Gorski, and I am a member of Maryland WISE Women, an organization composed of over 800 women in Anne Arundel County. We advocate for representation consistent with our mission and commit ourselves to modeling the values of inclusion, tolerance and fairness. I am the facilitator of the WISE Healthcare Huddle, a group dedicated to ensuring Marylanders' have access to the quality, affordable care they desire. I strongly encourage the committee to vote for this compassionate option that allows terminally ill, mentally capable, adults with six months or less to live the option to receive a prescription for self-ingested medication for a peaceful death.

I respectfully request opponents to stop referring to this legislation as Assisted Suicide. Patients who are considering medical aid in dying find the suggestion deeply offensive, stigmatizing, shameful and inaccurate. The American Association on Suicidology (AAS), a national suicide policy and prevention organization affirmed this distinction by stating "that the practice of physician aid in dying is distinct from the behavior that has been traditionally and ordinarily described as 'suicide,' the tragic event our organization works so hard to prevent." The AAS mission "is to promote the understanding and prevention of suicide and support those who have been affected by it". AAS lists their vision statement as "an inclusive community that envisions a world where people know how to prevent suicide and find hope and healing." In November 2017 the AAS released a statement addressing the subject of medical aid in dying with this conclusion.

"*In general, suicide and physician aid in dying are conceptually, medically, and legally different phenomena, with an undetermined amount of overlap between these two categories. The American Association of Suicidology is dedicated to preventing suicide, but this has no bearing on*

the reflective, anticipated death a physician may legally help a dying patient facilitate, whether called physician-assisted suicide, Death with Dignity, physician assisted dying, or medical aid in dying. In fact, we believe that the term "physician-assisted suicide" in itself constitutes a critical reason why these distinct death categories are so often conflated, and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS. '

The End of Life Option does not contribute to the phenomena suicide contagion. The median age of patients seeking this option is 74 years old, of which 90% are already undergoing hospice treatments, the overwhelming majority has health insurance and most patients seeking this option have cancer. They are competent prepared patients who want control over the manner of their death. The death certificate lists the terminal illness as the causation of death. To further understand the distinction there is a webinar class given by the American Association of Suicidology on their website addressing long-standing tensions between suicide prevention and medical aid in dying, this webinar explores the background for and content of the American Association of Suicidology's recent Statement, "Suicide is not the same as Physician Aid in Dying." At the end of the webinar AAS states participants will be able to identify factors contributing to increased awareness of aid in dying in jurisdictions across the developed world as well as differentiate suicide and physician aid in dying, and much more.

Most suicides occur in the context of serious psychiatric illness. Yet patients who express suicidal ideation in the context of a condition such as major depression rarely want to die. They want their emotional pain to go away. I know this first hand as I have a close family member that survived suicide several years ago. I sat in their hospital room with them along with the nurse and the police outside their room, telling them how much they were loved and how precious their life was to everyone who knew them. They were deeply depressed and believed that no one would notice or care if they were gone and trying to cope seemed too much that day. They said it was my crying that made them click on, the realization they were loved by not only me but so many

others. They received the medical interventions and emotional and mental support they needed and today they are a thriving, happy individual. However that day, that day that almost ended their life story, will never leave my memory. I question those that would use the term suicide when describing this legislation and equate it to a preventable form of death that is a major health issue. Suicide is the second leading cause of death in teens and young adults and they need to know that there are resources available to help them such as the National Suicide Prevention Lifeline at 1-800- 273-8255.

The majority of opposition to medical aid in dying comes from religious groups citing their beliefs that only God can decide when to end one's life. I respect their beliefs and support their intentions, however the people who want to utilize this option are dying horrific, complicated, painful, and sometimes drawn out deaths due to terminal illnesses. The end of their life has been decided. I am Catholic. I have completed every sacrament I can to this point in my life. My faith in God is unwavering. I believe that through empathy, compassion and mercy we can lead lives that emulate what God wants for all of us. No physician, pharmacist, nurse, or any type of care facility may be forced to participate in providing this additional option. Whether by religious belief, moral objection or personal view, every person potentially involved in this process may refuse to participate.

Quality hospice care and palliative care have improved the end-of-life experience of thousands of patients, and advances in end-of-life care continue. But not all suffering can be managed in this way. Suffering is defined by the patient, not the doctor. The End of Life Option Act is only one option for care for those suffering from a terminal diagnosis of less than 6 months left to live. It can provide courage and hope allowing them to live fully to the end of their days while not fearing their death but rather passing peacefully when death is imminent. This decision is the same as refusing to continue medical care or interventions, refusing to eat or drink, refusing to continue life sustaining medications or agreeing to begin palliative care as one traverses their journey towards their death. None of these choices are the cause of the patient's death. These choices are all being discussed because their death is upon them.

The End of Life Option is not a suicide. The end has already been decided. And for my three family members who died from terminal illnesses over the past two years I believe they deserved the death they wished for and I deeply regret that it was unavailable for them to choose. The mental and emotional well being of those who oppose this legislation should never supersede the rights of the person who is actually dying and their ability to make decisions about their personal healthcare.

In supporting the Maryland End of Life Option Act, I hope that Maryland is the next state to join seven states and the District of Columbia in authorizing medical aid in dying. Thank you for listening to me today as a representative of WISE Women Maryland, and as someone who personally believes this is needed legislation. I urge a favorable report of SB 701.