IlanaBarLevav_FAV_SB701

Uploaded by: Bar-Llevar, Ilana

Position: FAV

Testimony of Ilana Bar-Levav, MD

Support for HB643 and SB701

The End-of-Life Option Act (The Richard E. Israel and Roger "Pip" Moyer Act)

February 2020

My name is Ilana Bar-Levav. I am a physician, board certified in Internal Medicine and a practicing psychotherapist with 30 years of experience. I am a former president of the Montgomery County Medical Society and a strong supporter of the MD End of Life Option Act.
Here is a personal story.

My dearest uncle was a high-spirited aeronautics engineer. In 2015, after 20 years of treatment and monitoring, my uncle's prostate cancer had spread throughout his body and could no longer be treated. By the summer of 2016, he told me he planned to exercise his rights under the new End of Life Option Act that had just passed in California, where he lived. He had already begun the process required to obtain a lethal dose of medication, for "when the time would come" he said. I had flown out to visit him every month during the prior year and during his slow decline, several issues became clear to me.

> **First, Hospice Care is good at monitoring physical pain, but often doesn't adequately address the emotional pain and fear-of-suffering that is pervasive with terminal disease**. **Powerlessness and losing one's ability to care for oneself due to progressive physical disability can cause emotional suffering that is as bad, if not worse than, physical pain**. Hospice nurses visited my uncle twice a week and always offered pain medication, which he generally refused. He didn't want to feel foggy headed in addition to his weakness and physical pain. He was distressed by the indignity of losing bodily functions. He could no longer empty his bladder on his own and needed to be attached to a urine bag. On my last visit, the growing tumor had *again* blocked his Foley catheter, stopping the flow of urine. We brought him urgently to his

urologist, who struggled for several hours to pass another catheter. Although he was finally successful, the urologist told him that without another surgical procedure, he would not be able to insert another catheter--which meant that when this one got blocked, it would result in acute urinary retention, which is both life threatening and very painful. My uncle decided to decline the procedure and that his time had come.

Which leads me to the second point: Medical Aid in Dying is not suicide—the act of a person whose thinking is distorted from depression and despair. For a terminally ill patient facing the reality of impending death, having the option to decide when and where to die, can relieve despair and <u>offer</u> hope by restoring a measure of authority over one's life. This option is not for everyone, and this bill does not compel anyone to utilize it. My uncle sought my support because we were close and he trusted me as a physician. He knew what lay ahead. He was thoughtful and insistent on making decisions with respect to the limited time left to his life. My offer to be with him as he ingested his last medication helped him as he faced death with courage and determination. He remained, to his last day, a man who loved life. We gathered as a family for a final day together. At the time he designated, I put on the music he requested, and sat with him as he drank the solution. He fell asleep quickly, and died within a few hours, in his den, surrounded by family.

Senators (Delegates), I urge you to vote in favor of SB 701 (HB 643) to allow a peaceful death for those with end stage disease and who desire it. For them, for my uncle, it is a gift to be able to exercise agency over the end of life, after being ravaged by an uncontrolled and untreatable condition. Death is inevitable, terminal suffering is not.

November 10, 2016.

Israel Tuchman in the center. This photo was taken within hours of his death. May his memory be a blessing.

Spielberger_ACLU_FAV_SB 701
Uploaded by: Bar-Llevar, Ilana
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Testimony for the Senate Judicial Proceedings Committee
February 28, 2020

SB 701 – End-of-Life Option Act
(Richard E. Israel and Roger "Pip" Moyer Act)

FAVORABLE

> *If decisions made in the shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of those constitutional guarantees, then what decisions are?*[1]

The ACLU of Maryland supports SB 701, the End-of-Life Option Act, which would allow individuals with terminal illnesses to request aid in dying. The ACLU fights for personal freedom, autonomy, and self-determination, especially regarding the most difficult and intimate decisions of our lives.

This bill affirms the right of terminally ill patients to self-administer a physician-issued prescription in order to end their lives in a dignified way without further suffering. It ensures that it is the *individual*, and not the *government* who has the right to make decisions about their own life and body. It also enshrines into law strong safeguards to ensure that a patient's decision to end their life is voluntary, informed, and free of any coercion.

U.S. Supreme Court Justice Louis Brandeis wrote in 1928 that a person's right to privacy, or "right to be let alone," is "the most comprehensive of rights and the right most valued by [civilization]."[2] Justice William Douglas echoed that sentiment in 1952, writing "the right to be let alone is indeed the beginning of all freedom."[3]

This principal right is at its peak in the context of intimate medical decisions. In these circumstances, these decisions should be left to a patient, their loved ones, and their doctor. If a patient is suffering from a terminal illness and meets the stringent eligibility requirements within this bill, it should not be the role of government to prevent them from making the choice to alleviate their suffering. We must give our loved ones the dignity and respect to be able

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[1] *Morris v. New Mexico*, D-202-CV-2012-02909 (Jan. 2014).
[2] *Olmstead v. United States*, 277 U.S. 438, 478 (1928).
[3] *Public Utilities Comm'n v. Pollack*, 343 U.S. 451, 467 (1952).

to make this extraordinarily difficult choice in a thoughtful, compassionate way.

In addition to the right to be let alone, the rights underscored in this bill include those of autonomy and self-determination. The choice that this bill contemplates for patients is one of the most fundamentally personal choices one could ever make in life. To be sure, it is not a decision to take lightly. Because we believe so strongly in self-determination, we share the concern about the voluntariness of this choice. And as drafted, SB 701 includes strict protections to ensure that a patient's request for life-ending medication is informed and free of coercion. Ultimately, we believe it is those who are suffering at the end of life – mothers, fathers, wives, husbands, sisters, brothers, grandparents, beloved friends, and maybe ourselves – who have the deeply personal right to make this profound choice.

In the most challenging moments for a person whose life has charted a new course dictated by disease, the most fundamental right left is to control one's destiny. This bill restores to terminally ill people that autonomy, and ensures them the right to self-determination, to be treated compassionately, to make their own decisions, and ultimately, the right to live and die with dignity.

For the foregoing reasons, we urge a favorable report on SB 701.

BarbaraBlaylock_FAV_SB701

Uploaded by: Blaylock, Barbara

Position: FAV

Richard E Israel and Roger "Pip Moyer End-of-Life Option Act, SB-701 Support

Testimony submitted by Barbara L Blaylock, M.D., February 28th, 2020

Senate Judiciary Proceedings and Regulations Committee

Thank you for the opportunity to testify in favor if SB-701, which would enable physicians to provide terminally ill patients with a prescription that would enable them to exercise a measure of control in the timing and setting of their impending death in a manner that is painless and certain.

I am a 69-year-old retired primary care physician who has served in the trenches with patients and families through life-threatening illness and impending death. I have had more than one terminally patient implore me for some way to ensure if their pain or existential suffering became unbearable as death neared, they would be able to make one last decision to pass painlessly and with certainty at a time and in a place of their choice. As a primary care physician, I felt a responsibility to do whatever I could to relieve patients of their suffering and facilitate their autonomy and dignity. So, I felt I failed them when I had to tell them that I could not help them in this way.

I have heard the argument from opponents of this measure that doctors who help patients in this way are in violation of the Hippocratic Oath. I disagree. The Hippocratic Oath instructs physicians to avoid doing harm or administering a poison. I do not believe that prescribing medication that a terminally ill patient might decide to use to hasten the hour of his own death is the equivalent of "administering poison." The medications used in this case are among those used to treat pain and suffering and induce sleep, in a dosage sufficient to induce a coma and then a painless death. Unlike poison, which causes illness, pain, or a death which would otherwise not occur, these medications provide relief from the suffering imposed by an illness that has already progressed to the point that death is certain. The underlying illness is the cause of death; the patient exercising the option to take what amounts to an overdose of pain-relieving and sleep-inducing medication in order to hasten the final event is merely exerting the only modicum of control left to him about its timing. And he, the patient, must administer the medication, should he decide to use it.

To those who say that allowing a patient to exercise an option to hasten his own death in the setting of a terminal condition is “immoral” or inconsistent with their religious beliefs, I say that forcing another person to undergo suffering he deems unbearable without relief, when relief could be made available, is immoral. The United States is a country in which the separation of church and state is a founding tenet. So, one person’s definition of “morality” or religious belief should not dictate another’s. This bill has numerous safeguards that ensure that a person seeking relief according to its guidelines is doing so with a sound mind and unwavering certainty, and that it is his own decision. No one else has the right, or is given authority by this proposed legislation, to force him to take this option. Likewise, no one else should have the right to deny it to him. Such an option is one that I hope will be available for myself when my own time comes.

Thank you for your time and attention.

PhillipBranner_FAV_SB701

Uploaded by: Branner, Phillip
Position: FAV

End of Life Testimony

Good afternoon, my name is Phillip Branner and I live in Pikesville. I come today to speak in support of SB 701.

As Delegate Shane Pendergrass has noted, “We are all just one bad death away from supporting this bill”. I could tell you of four such experiences that I’ve had, but given my two-minute time constraint, I’ll limit this to the most personal one. I got to witness my mother’s death from metastatic breast cancer when she was 49. The last two months of her life were increasingly painful, with the final three days being ones of sheer anguish – even though copious doses of morphine were administered by her caregivers. She was in such agony that her doctors considered severing nerves in her spine in order to relieve her pain. Fortunately for all, she died before that decision had to be made. Had the option for a self-administered end been available to her, I’m sure she would have chosen it before her suffering got to the stage it did.

If she had had any hope that she could continue to live, with pain and suffering reduced or eliminated, she most certainly would have done whatever was necessary to effect that result. However, she knew that she was, in fact, dying. Without legal options, she had no choice but to exist in a state of virtual torture until her disease overcame her.

For the last nearly 74 years, I have been fortunate enough to beat the odds of contracting a life-ending medical condition. As I age, I am increasingly aware that those odds grow shorter as my body deteriorates. There may come a day when a legal option for terminating my own life will be one that I would be grateful to have. I have no disagreement with anyone who would wish to not exercise such an option, for whatever reasons. I only ask that they not deny me or my loved ones that opportunity. Bluntly put, my life or death is none of their business.

I sincerely hope you will vote YES on this issue that is so close to me. Thank you.

RobertBrookland_FAV_SB701

Uploaded by: Brookland, Robert

Position: FAV

Testimony of Robert Brookland, MD

Support for SB701

The End-of-Life Option Act (The Richard E. Israel and Roger “Pip” Moyer Act)

February 2020

I am Dr. Robert Brookland, a board-certified Radiation Oncologist and Chairman of the Department at GBMC. I strongly support this bill.

I have two comments.

1. **<u>You should pass this bill for the minority of patients whose pain and suffering cannot adequately be addressed.</u>**

I have cared for thousands of cancer patients in my career. In most, my colleagues and I have been successful, either achieving cure or relieving symptoms. But in a small minority, our actions have been inadequate, and patients experienced profoundly debilitating pain and/or suffering, begging for a peaceful end. I could provide the specifics of many such examples, including family and friends, but I don’t have the time. I will simply say it is patronizing and wrong for opponents of this bill to believe they are justified in stopping this small minority of patients from ending their lives with peace and dignity. They need and deserve this law.

2. **<u>It is reasonable and ethical for physicians to participate in such programs, and that participation does NOT violate the Hippocratic Oath.</u>**

I cringe when opponents state this process violates the Hippocratic Oath, because in my mind they do not understand the entirety of the Oath. There clearly are parts relevant to today’s practice of medicine that focus on not harming patients, following moral principles, and protecting confidentiality. My problem with opposing witnesses is that they “cherry-pick” one small part of the Oath when there are many parts that today are irrelevant or inappropriate.

The Oath has one swear to the God Apollo, acknowledge only male physicians, and agree not to perform surgery, particularly mentioning removing stones. The Oath precludes abortions, but under U.S. and Maryland law physicians perform safe abortions upon proper informed consent and under accepted guidelines.

The entire focus of aid in dying involves an option, a conversation, interaction, evaluation, compassion, informed consent and, perhaps, a prescription within legally defined standards. Deciding to take the drug is the patient's option. To me, that is an ethical practice, and I support such laws.

DebraCirasole_FAV_SB0701

Uploaded by: Cirasole, Debra

Position: FAV

Testimony of Support for SB0701
The End-of-Life Option Act (The Richard E. Israel and Roger “Pip” Moyer Act)
By Debra Cirasole at 703 Blackhorse Trail, Severn, MD 21144
State Senator (District 33): Edward R. Reilly

My name is Debi Cirasole, I live in Severn, Maryland and I strongly support this bill.

I was given a terminal brain cancer diagnosis at the age of 31. I am now 38. When most people hear this their first reaction is usually something like, "see, doctors aren't always right!" However, there is quite a difference between "terminal" and "end stage"; brain cancer is an incurable, progressive disease resulting in death, but it isn't until that death is imminent that you are considered end-stage. And that is when I would meet the most important eligibility requirement for aid in dying. In my mind, there is no mistaking death's signs once its upon your doorstep.

The location of my cancer directly affects my very person, has already caused me great pain and trauma, and cost me my mobility. I am chronically disabled. Yet I persist and will continue to do so, until what is projected to be a terrible end, mostly for me but also for my loved ones.

Under this proposal, I (and others like me), will be granted the dignity of a peaceful passing under my own control, as much as can be afforded under the circumstances. I imagine a much softer, comforting release at home surrounded by my loved ones.

One last very important point. I understand that some who are chronically disabled like me and some individuals of faith oppose this bill. I respect their right to not choose aid in dying for themselves. But they should **not** have the right to stop me from pursuing what I know is best for me. This should be between my doctor and me. Being granted this right to die with comfort is a compassion that I and others deserve.

AshleyEgan_FAV_SB701

Uploaded by: Eagan, Ashley

Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of SB 701 End of Life Options Act

TO: Chair William C. Smith and Members of the Judicial Proceedings Committee

FROM: Ashley Egan, Coordinator, Unitarian Universalist Legislative Ministry of Maryland.
7604 Lanham Lane
Fort Washington, MD 20744
DATE: February 28, 2020

My name is Ashley Egan, I am the Coordinator of the Unitarian Universalist Legislative Ministry of Maryland. I am writing to ask you to support the End of Life Options Act.

Many have said, “everybody is just one bad death away from supporting ‘End of Life Options.’” For me, it was my beloved grandmother, Bonnie Herndon. Fortunately for her, she died in her sleep five years ago…. However, that was a peaceful end to almost two decades of her living in fear, not of the inevitable, but that we, who loved her so much would force her to hold on, when she was ready to go.

My grandmother was my best friend, biggest fan and a force of nature. She buried her husband in 1996, beat cancer and still played tennis on Tuesdays. However, in 2005, (three years after my husband and I moved to Camp Springs, MD) she watched the battle of Terry Schiavo and became terrified of suffering a similar fate. It started with jokes requesting us to put her on an ice flow. She then started to stash her Percocet, just in case. Her tidy home had multiple copies of her “Do Not Resuscitate” order, as per her research. Even though she was nowhere near dying, her intent was clear.

When she was in her 80's she suffered multiple strokes and dementia. After living to see her 90's, she was ready to die, we knew her wishes, but were powerless to point her in a legal and appropriate direction. Even though she literally wrote a book on aging with her gerontologist, it boiled down to one fact. She did not live in a state that allowed her to end her life.

As a Unitarian Universalist, I believe in the inherent worth and dignity of ALL people. We also believe that all people deserve a say. Especially in the ways that we want to live our life and, conversely, our death. How can we celebrate the worth of a person, while simultaneously disregarding their feelings on the quality of life they are living? And, more importantly, how can we impose our desire to keep them alive, if that life is one that does not honor their dignity? Every person looks at a situation through the prism and the lens of their life lessons and personal wisdom, we should honor that choice.

Ashley Egan
Unitarian Universalist Legislative Ministry of Maryland

SabineFrancke_FAV_SB0701
Uploaded by: Francke, Sabine
Position: FAV

In support of SB0701: The Maryland End-of-Life Options Act

From: Sabine FRANCKE
12910 Ruxton Rd
Silver Spring MD 20904

To: Members of the Senate Judiciary Proceedings Committee; Chair Smith

Dear Committee Members, thank you for your time and consideration of this important bill.

With this writing, I am documenting my full support of the SB0701, End of Life Options Act and ask the Committee to pass the bill.

I am a professional, single woman planning for retirement which ultimately includes conscious dying; I do not have children. Therefore, having a legal choice of dying with dignity is of the outmost importance to me in selecting the State to which I will retire. I have lived in Silver Spring MD for most of my professional life and would prefer to retire in a familiar environment. However, should Maryland not pass this bill, I am forced to move to a State that provides legal options for this most intimate choice at the end of one's life.

As death is one of our few birthrights, I am asking the Committee members to allow us to do it with dignity by providing end of life options in Maryland. Please pass The End of Life Options Act SB0701 by voting: Yes!

In hope of an affirmative consideration of this request, I thank you kindly for your time.

Sabine Francke
240.643.2363
Bines444@gmail.com

JeffGardere_FAV_SB701
Uploaded by: gardere, jeff
Position: FAV

Dr. Jeff Gardere Testimony in Support of SB701

Good day Chairman Will Smith, Sponsor Jeff Waldstreicher and all members of this committee. Thank you for your advocacy for the quality of life of Marylanders and thank you for your selfless and dedicated service. My name is Dr. Jeff Gardere, in addition to my private practice as a board certified psychologist, and now an ordained minister, I am also an associate professor at a New York medical school.There, I teach medical and pharmacy students about the sanctity and quality of their patients' lives and mental health, especially those who have been most ignored and the victims of severe health disparities — black and brown people and other under-represented minorities.

While some who oppose this legislation earnestly believe that people will be pressured to end their lives, this is not supported by the data. I can only promote facts and psychological expertise. We know from more than 20 years of experience in Oregon, where the nation's first medical aid-in-dying law was implemented, and the experience of other authorized jurisdictions, including neighboring Washington, D.C., there has not been one single instance of abuse or coercion. And the legislation proposed here in Maryland contains more than a dozen safeguards.

I have met with, talked to and counseled countless people, including terminally ill people and their families. None of these patients I've counseled wants to die, but they know that one day this will be their fate, and for those who are terminally ill, it will come sooner rather than later. Though I understand the fears of our Opponents, they must understand that scientifically and factually it is incorrect to equate terminally ill adults who want the end-of-life care option of medical aid in dying with people who unfortunately and sadly want to take their life prematurely. And according to the American Psychological Association, they are fundamentally different. The American Association of Suicidology argues, "Physcian Aid in Dying and suicide are conceptually, medically and legally different phenomena" In suicide a life that could have continued indefinatley is cut short, in Medical Aid in dying death is foreseeable and in some cases immiment. Most people who take their life prematurely have the choice to live but because of psychological illness choose not to. Terminal patients who may use medical aid in dying do not have the option to live, the illness has taken that decision away from them. The question then becomes how they die...not if they will die.

Many, due to their distinguished history, courage and spirit, are less afraid of the end arriving than they are frightened about what the end of their lives will look and feel like. As they move closer to their final days, concerned about their quality of life, they seek peace, comfort and most importantly, dignity. For those who believe in the afterlife, they want a perfect setting for a glorious transition. For those who see it as the final step of existence, they want a restful reward for a life well-lived.

Medical aid in dying provides that peace, comfort — and it does so by ensuring patient autonomy, a key component of respect and adulthood. Medical aid in dying is not the right end-of-life care option for every mentally capable, terminally ill patient with less than six months to live. However, it should be an option, a legal right available to independent, well-informed Marylanders facing this terminal phase of life.

I have my faith, beliefs and integrity that are firmly aligned with medical aid in dying. There are too many terminally ill, dying Marylanders who are unnecessarily suffering at the end of life. There are too many terminal adults who passed away advocating for passage of this law. We owe it to all of them to provide an end-of-life care option that offers peace and comfort. The time is now!!!!

JessicaGorski_FAV_SB701

Uploaded by: Gorski, Jess

Position: FAV

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.

CatherineHenderson_FAV_SB0701

Uploaded by: Henderson, Catherine

Position: FAV

Testimony for SB0701
Catherine Henderson
Salisbury, MD 21801
Position: SUPPORT

I was a volunteer for Hospice, and at age 72 I've sat with friends and relatives in their final stages and have seen first hand the toll it has on the family both emotionally and financially.

I remember vividly my mother in law begging for someone to shoot her. And my mother having blood drawn by several attempts just hours before passing even as they knew it was just a matter of hours.

I have multiple progressive health issues that could be long and lingering. I have been on a feeding tube for over six years and I hate the thought of laying in bed with my family on a death watch.

I am not looking forward to having to move to another state that has Death With Dignity when the time is right or of finding some other alternative that would probably scar my family.

Please let people have the choice to make their own decisions. We don't make animals suffer when all hope is gone.x

ChristineHodgdon_FAV_SB701

Uploaded by: Hodgdon, Christine

Position: FAV

Bill Number: SB0701
Testimony by: Christine Hodgdon
City: Baltimore, Maryland
Position: Support

Good afternoon, Chair Smith, members of the Senate Judicial Proceedings Committee. My name is Christine Hodgdon, I live in Baltimore, Maryland, and I submit this testimony in support of Senate Bill 701, the End-of-Life Option Act.

As a young woman living with terminal cancer, this issue is deeply personal for me. In 2015, I had just been promoted to Director of Conservation Programs at my organization and I was advancing my career as a conservation biologist. I was also training for a triathlon and living a very full and satisfying life.

But at the age of 34, the discovery of two lumps in my chest threatened to derail everything I had worked towards. A biopsy revealed I had breast cancer. Within weeks of my initial diagnosis, I also received the devastating news that the cancer in my breast had spread to my lung, making my cancer stage IV metastatic. With an average 2.5-year lifespan, I was suddenly forced to confront my own mortality.

There is no cure for stage IV metastatic cancer. On average, 116 people die every day in the United States from metastatic breast cancer, or MBC.

The reason I cannot testify in person today is because I am in Florida attending a memorial service for a friend who died from MBC. She was only 34 years old. I was with her in her final days and witnessed the unnecessary pain and discomfort she experienced, as well as the mental torment of losing her autonomy and independence.

Death is a constant in my community. I've lost several dear friends to MBC, and I know I will lose more. I've seen firsthand how painful a death from cancer can be, how it can rob individuals of their strength and agency, and take away the simple joys life can offer.

A friend of mine with MBC shared with me powerful reflections about how her disease has impacted her. “I can't do simple functional things like getting down on the floor to play with the loves of my life: my niece and nephews,” she told me. “I was a pediatric feeding specialist and I can't even pick up an infant anymore, much less what I used to do every day. I will never move normally again. That is mental torture."

Like my friends, I have no control over the trajectory of my disease. Because we still have no cure for MBC, I know that eventually, this disease will kill me. There will come a time when treatments that have kept my disease under control will no longer be effective, and I will be forced to make difficult decisions about how I want to die.

I understand that for religious reasons, many oppose this bill, but another dear friend with MBC, also a practicing Christian, reminded me that even Jesus had the power to choose to end his suffering. That informs her support for the compassionate end-of-life option this bill would provide.

Cancer is a ruthless disease that I am powerless against- MBC has taken away my career, forced me to be on drugs that can be severely debilitating, and stolen the lives of countless friends. I have learned to live my life knowing I cannot control any of these factors, but I, and other Marylanders with a terminal illness, deserve to have control over the timing and manner of our own death.

I want to die with dignity and autonomy—something all individuals with a terminal illness deserve. This is why I support Senate Bill 701 and urge you to vote "Yes" on this vitally important bill.

Thank you for your time and the opportunity to testify.

JosephKitchen_FAV_SB701
Uploaded by: Kitchens, Joseph
Position: FAV

JOSEPH KITCHEN

YOUNG DEMOCRATS OF MARYLAND
PRESIDENT

Chairman Smith, Vice Chair Waldstreicher, and Members of the Committee,

My name is Reverend Joseph Kitchen. I grew up as the son and stepson of Baptist ministers before becoming one myself. I am the President of the Young Democrats of Maryland. I am here today to offer our support for passage of SB701.

You have likely received the official copy of our position statement earlier this session. In short, we believe this bill provides a fair and clear vision for how terminally ill patients in Maryland can decide, on their own, to end debilitating suffering and decide their own terms on dying. Others will address in more detail the protections of this bill.

I want to, as a person of faith, an ordained minister of God, a student of the Bible who holds two theology degrees, and an active member of the First Baptist Church of Glenarden, offer a different view than what I expect you will or have heard from others in this community.

Throughout this debate both last session and this year we've heard the loud voices of some in the faith community. However, what you haven't heard is the voices from all of us. In fact, recent surveys, including one from Public Policy Polling show a majority of voters support this type of legislation. This includes 65% of Catholics, 62% of Protestants, 67% of Jews, and 52% of Muslims. So, when you hear those voices please know they don't speak for people of faith.

Even more so they don't actually speak for God. There is no Biblical doctrine anyone can stand on to oppose this bill. What you will hear from those opposed to this bill won't be Biblical, it will be traditional. Don't let them confuse the two.

Sadly, in far too many of our churches we are being given a version of a vengeful, repressive God. I don't know that God. My God is loving. My God is kind. My God is compassionate. My God is freeing. My God is Liberating. He'd never bind us to unforgiving pain without a purpose other than eventual death.

Too many faith leaders, including some from my church have developed this myth that the God we serve is limited. He isn't. They will preach version of an all-knowing God who foresaw terminal illness but won't acknowledge one who would deliver solutions to the suffering.

Over the course of this hearing you will hear a lot from men and women of the cloth about the church's view. When you do ask them where was the church in the battle to expand health care that might actually avoid some, not all, of these terminal cases? Ask them where was the church busses in the fight to expand the minimum wage lifting people out of poverty so they could provide quality health insurance to their families?

Before I wrap, I just want to be clear about where we are today.

The opposition won't have scripture on their side so they will call this bill a slippery slope.

They won't have morality on their side so they will call it not normal. What actually isn't normal is dying in bone crushing pain when we know we have other options to avoid it.

They won't have the facts on their side so they will call for prayer. My Bible tells me that faith without works is dead.

It's time they don't have the legislature on their side.

RonKrug_FAV_SB0701

Uploaded by: Krug, Ron
Position: FAV

Judiciary Proceedings Committee of the Maryland Senate

Testimony in Support of SB0701 – End-of-Life Options Act

February 28, 2020, East Miller Senate Building, Annapolis, MD.

Ron Krug
P.O. Box 701
Grantsville, MD. 21536

Greetings from Garrett County to the Chair and members of the Senate Judiciary Proceedings Committee. My name is Ron Krug, I live in Grantsville, and I'm with you today to express my unequivocal support for SB0701, the End-of-Life Options Act, which I ask you to pass. Thank you very much for providing me with the opportunity to share my story.

I'm a five-year-plus survivor of stage III pancreatic cancer. The five-year survival rate for my cancer is only 3%, so I am a very grateful member of a very small club. Fighting the cancer was tough, but fortunately it was never terminal. I was never given the terrible news that I had only weeks or months to live.

With Garrett County having a small population, people learned quickly about my survival. Because of this, complete strangers who became informed that a loved one or friend had been diagnosed with pancreatic cancer would contact me, asking to meet with me or to have me meet the person who had received the unfortunate diagnosis. I always said yes. Inevitably, I would remain in close contact with these folks throughout their ordeal, including frequent visits to hospitals. Unfortunately, only one of them survived more than a few months.

And here is my point: every one of these good people suffered terribly at the end of their lives. Most were in great pain, often excruciating pain. They were profoundly sad, as you would expect. And they were often worried about the costs that were piling up just to keep them alive, with no hope for recovery and with the knowledge that the pain and suffering would only become more acute until death finally brought relief.

Some of these patients told me specifically that they wish they would pass away, or that they couldn't wait for the end to come. One even stated that we treat dogs and cats more humanely than people, since we put them out of their misery when the pain becomes unbearable.

So, I ask you to please support SB0701, the End-of-Life Options Act. Give people who qualify the choice to end their lives with grace and dignity. Let the people and their families decide what is appropriate under their particular circumstances. Again, thank you very much for your time.

KristineLev_FAV_SB0701
Uploaded by: Lev, Kristine M.
Position: FAV

Senate Bill 701

Testimony by Kristine M. Lev

Address: 4814 Broom Drive in Olney, MD 20832

Position: Support

Good afternoon, Chair Smith, members of the Senate Judiciary Proceedings Committee,

My name is Kristine M. Lev. I live at 4814 Broom Drive in Olney, MD 20832.

My brother, Dean Murphy, had ALS from early 2013 until he passed away on October 1, 2017. At the time of his death, he was on a ventilator, had a feeding tube, could not speak and could not move one muscle in his body, not even his eyes.

He could not tell anyone when he had a pain or even an itch or if there was phlegm building up in the back of his throat, as it often did. He could not tell anyone when his ventilator settings were not ideal and he was not getting enough air. He suffered tremendously every day and I wish to God that he had had the option to die with dignity.

ALS is an insidious terminal illness. People with this and other terminal illnesses should have the right to not suffer at the end of their lives. Why should our loved ones have to suffer more than our pets at the end of their lives? Before Dean lost the ability to speak, he should have been able to decide and say if he wanted to die with dignity.

As Dean had the familial form of ALS, I could one day face this unspeakable disease as well.

I fully support SB0701, the End-of-Life Options Act, and I am asking the Committee to pass the bill.

The End-of-Life Options Act provides personal choice at the end of life and peace of mind for those who are dying of terminal illness.

Again, I support SB0701, the End-of-Life Options Act, and I am asking the Committee to vote Yes.

Thank you again for your time and for the opportunity to present testimony to you.

IreneLiebensfeld_FAV_SB701
Uploaded by: LIEBENSRELD, Irene
Position: FAV

Good afternoon Chair Smith and members of the Senate Judiciary Proceedings Committee;

My name is Irene Liebensfeld. I live with my wonderful family in Gaithersburg. I am surrounded by supportive neighbors. I've always loved life. I do not wish to die, but I don't have a choice. I am dying. I was diagnosed with triple negative breast cancer in 2016. Since then, my life has been a constant battle against the progression of this disease. Only 15 percent of breast cancer patients are triple negative which is the hardest to treat. There are many targeted treatments today prolonging Metastatic Breast cancer in hormone positive patients. None of these treatments works for the TN community. For the last four years, I've been on a steady regimen of at least 9 different chemo therapies. Some slowed the progression for a time. Others didn't work at all. Steadily chemo has taken its toll on various organs while tumors have filled my lungs.

There are several ways I might die from this disease. My lungs might fill with blood, and I will drown in it. Or, and I am told this is very painful, my lungs might collapse. I am hoping for a heart attack, though my heart remains strong. What many who have never faced such a disease do not realize. That these fears cripple our desire to go on. If I knew I had an off ramp, I would fight for every good moment with my family. An off ramp would give me mental strength and a feeling power instead of powerlessness.

Recently, I had a medical procedure where I insisted on a Do Not Resuscitate order horrifying the young intern.   I explained to him my fear of a painful or long, drawn out death versus dying under anesthesia and quickly. Again, I don't wish to die at least not today. But at that moment I felt I had only one way to seize control of my either painful or swift death. So, I chose swift. Of procedure went fine and the DNR was not needed.

If I knew I had an off ramp I wouldn’t rush to use it. It would simply give me the peace of mind to go on fighting as long as I can and the mental strength to do it.

I appreciate all of those kind souls who beg me to believe in miracles. But I ask you, how many souls have lost their fight waiting for a cancer miracle. New drugs take time which I am running out of. You must know that euthanasia would be administered under strict guidelines with doctors, social workers, clergy, friends and family impute to know when or if it would be time to take the off ramp. I beg you, give me the peace of mind to know I won’t have to needlessly suffer and that you care enough to help many avoid needless suffering and pain.

I have had close friends die from this disease. I’ve sat with them as their bodies filled with so much pain that all their medications could do is numb it. Unfortunately it numbed their minds as well until they weren’t really all there. Pain and drugs took over. And that is the gentle way to go. Please empower the dying. Give us the choice of an off ramp. Vote yes for Senate Bill 0701. Thank you for giving me this opportunity to be heard.

TerryLierman_FAV_SB701
Uploaded by: lierman, terry
Position: FAV

TERRY LIERMAN TESTIMONY IN SUPPORT OF SB701
END OF LIFE OPTION ACT
Feb.28 noon

Thank you, Chairman Will Smith, Sponsor Jeff Waldstreicher, and members of the JPR committee for holding this hearing on this vitally important bill.

As you have already heard from Compassion and Choices, passing this law is simply good public policy. Polls indicate that the majority of Marylanders are in support of it, and there have been no reports of undue influence since the law was enacted.

I'm here to tell my story and the story of my beloved Caroline. I married the love of my life last year on May 17, 2019, and I lost her six smonths later, on Nov. 23, 2019, to four terrible cancers: liver, bone, spine and colon. We were told of her diagnosis only 3 weeks before we married but that did not deter me from vowing to love and stand by her in both sickness and in health.

I spent the majority of our marriage watching my wife suffer excruciating pain as she begged me to let her die. We spent the last 4 months of her life in the hospital. Her pain level varied from at least 6 to 8 out of 10 every single day, even though she received copious amounts of painkillers.

You can imagine how upset I was that the hospital was unable to manage her pain.

The doctors knew she was going to die. Everyone knew she was going to die and told me so privately, but because this law had not been passed there was nothing more they could do to ease her suffering.

She finally went into hospice and they treated her with palliative sedation which helped some with her pain. But it still took her two long weeks to die. In the end, she chose voluntarily to stop eating and drinking, which basically amounted to her starving to death.

TERRY LIERMAN TESTIMONY IN SUPPORT OF SB701
END OF LIFE OPTION ACT
Feb.28 noon

No one should have to endure what she endured and what we endured along with her. Not when we have the means to end unnecessary suffering.

I promised her before she died that I would do what I could to make sure no one else suffered at the end of life like she did. At that time, I had not heard of this bill. When my daughter Brooke told me about it, I knew I had to testify and work to get this bill passed.

What purpose is served from a moral, ethical or religious perspective by forcing people to suffer terribly for the last few months of their lives if they would prefer to die peacefully?

The right to self- determination must be considered over religion when it comes to matters of State. The separation of Church and State require it.

I want to thank all the legislators who voted to pass this bill last year and encourage others to do the right thing now by supporting it. The right to die with dignity means everything to people who are suffering as we speak and to their families.

On behalf of Caroline and myself, I want to thank you.

long_fav_sb701

Uploaded by: LONG, NANCY

Position: FAV

My name is Nancy Long; I'm from Bowie, MD.

To quit his 30-year addiction to cigarettes, my husband put 8 cigarettes in reserve; they were his go-to in case of need. Marylanders in terrible pain and in the throes of terminal illness also need a go to. SB 701 sanctions access—if the dying choose it—to release from their pain. The End of Life Option Act has appropriate safeguards and protocols. In passing this legislation, you will be showing the terminally ill of our illustrious state that you have mercy.

Thank you for your attention to this critical situation.

CharlesMcNeill_FAV_SB701

Uploaded by: McNeill, Charles
Position: FAV

Terminally Ill Marylanders Shouldn’t Have to Suffer Needlessly at Life’s End

By Rev. Charles McNeill

As pastor it is my duty to guide my flock. As a former police officer, I took an oath to serve and protect and as a veteran it was my honor to put my life on the line for the country I love. It is in my very nature to preserve life, but not at all costs.

As a result of my life experiences I have become familiar with the faces of death and what happens when you are not prepared for it. I believe death without unnecessary suffering should be everyone’s goal.

That’s why I plan to testify in support of Maryland's End of Life Option Act (SB 701/HB 643) at a hearing before the Senate Judicial Proceedings Committee this Friday, Feb. 28. This compassionate legislation would allow mentally capable, terminally ill adult residents with six months or less to live to have the option to request a doctor’s prescription for medication they could decide to take if their suffering becomes unbearable and die peacefully in their sleep.

As a African American working to improve my community’s lack of access to quality healthcare, I was initially skeptical about medical aid in dying. But I’ve researched and studied this issue for years before deciding to support it. People of color need equal access to quality healthcare, including, but not limited to, medical aid in dying when no other healthcare option will provide relief from suffering.

Since 1997, **Washington, D.C.** and nine states have authorized medical aid in dying: **California, Colorado, Hawai‘i, Maine, Montana** (via state Supreme Court ruling)**, New Jersey, Oregon, Vermont,** and **Washington**. Collectively, these 10 jurisdictions represent more than one out of five U.S. residents (22%) and have decades of experience successfully implementing this medical practice without a single documented case abuse, coercion or misuse.

For example, according to the Journal of Medical Ethics: “Rates of assisted dying in Oregon...showed no evidence of heightened risk for the elderly, women, the uninsured...people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations.”

Under the Maryland bill, participating in medical aid in dying would be 100 percent voluntary for everyone, including terminally ill patients, doctors and pharmacists. I respect people who oppose medical aid in dying because of their faith, religious or spiritual values. But they should respect people with differing faiths, religious and spiritual values who need and/or support this peaceful dying option. As the Bible says in the Book of Luke 6:37-42: “Do not judge, and you will not be judged. Do not condemn, and you will not be condemned.”

Medical aid in dying is completely different from people who want to take their lives prematurely because they are depressed. You can treat depression, but you can’t treat incurable, terminal diseases. The terminally ill people who want to have this option to die peacefully would much rather live, but that option is off the table for them.

The proof that they don’t want to die is in Oregon, where the law has been in effect the longest time (more than two decades). There about one-third of the people who qualify for and get aid-in-dying medication don’t take it, according to the Oregon Health Authority. And the people who do take it wait an average of 47 days (nearly 7 weeks) after requesting it to take it. But of whether they take the medication, they get a great relief knowing they can take it if their suffering becomes intolerable, allowing them to live their final days as fully and worry-free as possible with their loved ones.

While less than one percent of terminally ill adults use medical aid in dying where it is authorized, reports show these laws improve care for many terminally ill people, by spurring doctor-patient conversations about all end-of-life care options, such as hospice and comfort palliative care, and better utilization of them. In fact, these laws and the Maryland bill require doctors to advise terminally ill patients who request medical aid in dying about all available end-of-life care options.

Medical aid in dying doesn't cause more deaths because the terminally ill people who want this option are already dying. It just results in less needless suffering at life's end.

Rev. Charles McNeill is president of the National Capital Baptist Convention, which includes Maryland and Washington, D.C.

Word count, including bio and title: 750 (word limit for The Hill)

DWDNC_PegSandeen_FAV_SB0701

Uploaded by: Sandeen, Peg

Position: FAV

Bill: SB0701, the End-of-Life Option Act
Name: Peg Sandeen, PhD, MSW
Organization: Death with Dignity National Center
Position: SUPPORT

My name is Peg Sandeen. I am testifying in support of Senate Bill 701, the End-of-Life Option Act. I am the executive director of the Death with Dignity National Center and a social worker with a PhD in Social Research. I have more than 20 years of experience working directly with people who are terminally ill, including individuals who have opted to hasten their death using medication prescribed under death with dignity legislation. In addition, I am an academic, an adjunct instructor of Social Work at Columbia University School of Social Work. I am not speaking on behalf of Columbia, but I note my role as an academic because I will be talking about several academic studies that demonstrate the soundness of death with dignity as a viable and well-researched public policy which is safe and effective.

I represent Death with Dignity and over 4,000 Marylanders, a number of whom are here today, who support the right of all individuals with a terminal illness to die on their own terms. Some of those supporters are dying themselves. People like Christine Hodgdon, a 39-year-old woman with metastatic breast cancer and a steadfast advocate for death with dignity. Like so many Marylanders who are moved personally by this issue, she submitted written testimony, and I hope you will take a moment to read her story.

Christine is but one of the strong majority of Marylanders who support this law. Recently, we commissioned a poll from Gonzales Research [1], a local polling firm, and the results show two-thirds of Marylanders support the End-of-Life Option Act. In fact, solid majorities of Maryland residents in all regions of the state, across the political spectrum, and from all demographic groups support this legislation.

Gonzales Research queried likely voters and 60 percent of respondents in Western Maryland supported the law. Similarly, 65 percent of respondents in the Baltimore suburbs supported the law as did 67 percent of those from the Eastern Shore. In the Washington Metro area, a full 71 percent of respondents stated their support for medical aid in dying.

In my career working with people who are terminally ill and dying, I have come to believe that one of the most difficult things for a terminally ill individual is the silence arising out of society’s unwillingness to face death directly. Public conversations, of which testimony to a legislative body is a perfect example, provide an avenue for private conversations about dying to occur among family members. At least one family in the state of Maryland tonight will have a difficult conversation about dying and last wishes and advance directives because they heard about this hearing today.

The proposed law you are considering today is, at its core, a medical standard of care designed to provide physicians and pharmacists with best practice guidelines for situations in which a terminally ill and competent patient requests the right to control the timing and manner of his/her death. Senate Bill 701 is modeled on legislation that has been enacted in nine jurisdictions, including your Washington, D.C. and New Jersey neighbors.

Beyond providing physicians with best practice guidelines, the End-of-Life Option Act puts decisions about easing suffering in the hands of terminally ill patients, allowing them to engage their family members, their physicians, clergy members and anyone else they choose, if they so choose. It sets aside outdated and archaic government bans on a medical practice that is currently legal for 70 million Americans, a practice that is validated, researched, effective, and full of safeguards to protect vulnerable populations.

The multiple safeguards in Senate Bill 701 include:

- A diagnosis of a terminal illness with a prognosis of six months or less to live, verified by a second opinion.
  A mandatory counseling referral if either the attending or consulting physician believes the patient may not have capacity to make this health care decision.
- Oral and written request. The written request must be witnessed by at least two people, one of whom must be someone who is not a relative or an heir set to receive an inheritance from the individual. The physicians involved cannot be witnesses.
- Information must be provided to the patient on all forms of palliative care, hospice care, and other end-of-life options.
- The patient may opt out at any time and for any reason.
- The patient must self-administer the medication.
- Any health care professional or healthcare institution may choose not to participate.

To emphasize: No physician, pharmacist, nurse, or any type of care facility may be forced to participate. Whether by conscience, religious belief or moral objection, every person potentially involved in this process may refuse to participate.

The policy you are considering has been subject to independent research protocols by individuals from a myriad of academic disciplines. These researchers have examined the safeguards and demonstrated there have not been any instances of abuse or coercion of patients in the more than two decades since the law took effect. These findings over and over refute the arguments by opponents of death with dignity.

Oregon has successfully implemented a death with dignity law for over 20 years. What do we know about the Oregon experience offering death with dignity with these same safeguards you are considering?

The law is rarely used. Statistics collected by the Oregon Health Authority [2] demonstrate only 1,459 individuals have ended their lives using the death with dignity law in 21 years. Every year, about one third of the individuals who go through the process to become qualified patients do not ingest the medication, but rather, go on to die from their underlying condition. Death with dignity for them is all about peace of mind. The median age of participants is 74; 90 percent are enrolled in hospice; over 87 percent of them die at home; over 99 percent of them have insurance, either private or government sponsored. Overwhelmingly, these patients have cancer. Oregon's law has worked exactly as intended: to give dying and suffering patients more options at the end of life.

Opponents of this legislation allege a lot of things this bill does and does not do. For more than two decades now, we have heard these same slippery slope arguments: statements that this law will target individuals who are poor or who are living with disabilities or the elderly; statements suggesting that those without medical care or access to healthcare resources will be forced to end their lives using medical aid in dying because it is cheaper than treating cancer. These slippery slope arguments are just not true. Independent researchers have concluded that the results are quite the opposite.

In 2007, Battin et al. [4] explored data out of Oregon to determine if there was a disproportionate impact of 10 groups of potentially vulnerable patients. The data led the researchers to conclude

> "…people who died with a physician's assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges…there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying—concerns that death in this way would be practised more frequently on persons in vulnerable groups."

To reiterate, there is no current factual support for the slippery slope argument that vulnerable individuals are at risk for being coerced into using the law.

Death with dignity also complements hospice and palliative care services. In a comprehensive study conducted with family members of 86 Oregonians who were participating in death with dignity, researchers [5] concluded:

> "…another concern regarding the legalization of PAD [physician aid in dying] is that PAD would become a substitute for quality end of life care…Insofar as family rating of the quality of a loved one's death is an indicator of end of life care, this

> study adds to the evidence that the choice to pursue PAD does not appear to be due to, or a reflection of, poorer end of life care."

Opponents of death with dignity spill 100 pills on a table, claiming that individuals using death with dignity must ingest all of them and asserting that the practice in Oregon was undignified. While visually startling, it is an outright untruth. No patient in any jurisdiction has been forced to ingest 100 pill capsules. It does not and cannot work that way.

Some claim a health insurance company denied them treatment, but offered medication to hasten death. It is true that insurance companies both deny treatment and cover the provisions under death with dignity laws, but linking them together to suggest that an insurance company would deny care and instead offer death with dignity, is a falsehood. Not one of these claims has ever come to pass or been independently verified. Not in Oregon. Not in Washington State. Not in Vermont. California, Colorado, Washington, D.C., Hawaii, New Jersey, Maine. Nowhere.

What we do know is that opposition to medical aid in dying comes largely from religious groups that say only God can decide when to end one's life. That is why this law contains clear opt-out provisions for medical professionals and states that only those who meet the strict criteria and safeguards in this law will be able to receive this prescription.

It is no coincidence that the very first state to pass death with dignity—Oregon—was recently identified in an article published in the *New England Journal of Medicine* [6] as a state with significant and positive differences in how people die, as compared with other states in the country. We do better than the rest of the country in such benchmarks as the number of people who die at home (as opposed to the hospital), the number of people using hospice, and the number of people who received intensive care services at the end of life. The passage of our law and subsequent end-of-life policy changes sent a signal nationwide, and in Oregon, that dying patients must be accorded more and better care. Death with dignity is part of that equation.

National research published in the *New England Journal of Medicine* indicates that physicians in every state, including Maryland [3], help patients die using prescription medication. By enacting this law, the Maryland Senate will send a strong message that a compassionate response to suffering is available in the state through medical aid in dying, but physicians must follow the carefully regulated safeguards you are considering today. The state of Maryland will shine a bright light on the process to ensure the protection of vulnerable individuals.

As legislators in this great state, if you want to improve the quality of life for dying individuals in your jurisdiction, there is nothing better that you can do than to enact a death with dignity statute. That's what the data tell us. It will be rarely used, but a great source of comfort. Its safeguards will protect vulnerable individuals from coercion.

Physicians in your state are already providing medications to patients to end their lives, but without state oversight. Medical aid in dying will likely improve the quality of end of life care for the whole population, not just for people who contemplate it or use it.

Like many other individuals with a terminal illness who have shared their stories with you and me, Christine Hodgdon cannot control the trajectory of her disease. But she should have control over the time and manner of her death: the right to die on her own terms, with autonomy and peace of mind.

It is time for dying patients in Maryland to have access to this end-of-life option. I urge you to vote yes on Senate Bill 701.

Peg Sandeen, PhD, MSW
Executive Director
Death with Dignity National Center

References (all items are appended in full text in the order listed)

[1] Gonzales Maryland Poll. Gonzales Research & Media Studies, January 2020.

[2] Oregon Public Health Division. Death with Dignity Act Annual Report, Year 21. Available at https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf Accessed February 27, 2020.

[3] Meier, D. E., Emmons, C. A., Wallenstein, S., Quill, T. Morrison, R. S., & Cassel, C. K. (1998). “A national survey of physician-assisted suicide and euthanasia in the United States.” *New England Journal of Medicine*, 338(17), pp. 1193-1201.

[4] Battin, M. P., van der Heide, A., Ganzini, L, van der Wal, G., & Onwuteaka-Philipsen, B. D. (2007). “Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in ‘vulnerable’ groups.” *Journal of Medical Ethics*, 33, pp. 591-597.

[5] Smith, K. A., Goy, E. R., Harvath, T. A., & Ganzine L. (2011). “Quality of death and dying in patients who request physician-assisted death.” *Journal of Palliative Medicine*, 14(4), pp. 1-6.

[6] Tolle, S. W., & Teno, J. M. (2017). “Lessons from Oregon in embracing complexity in end-of-life care.” *New England Journal of Medicine*, 376(11), pp. 1078-1082.

Contact: Peg Sandeen, Executive Director
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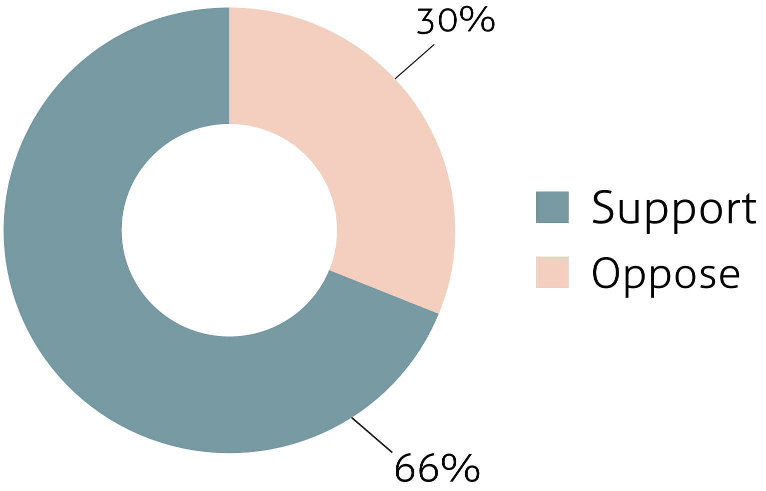
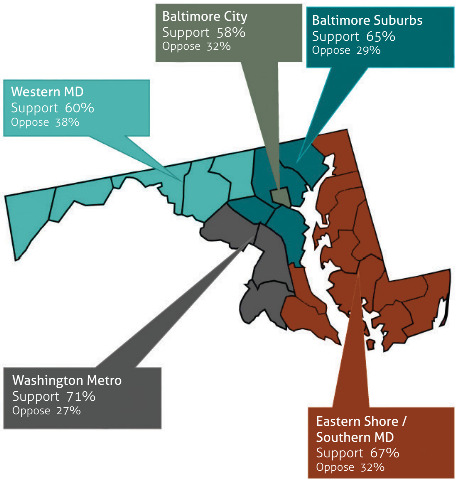
Death with Dignity
NATIONAL CENTER
www.deathwithdignity.org

Polling Shows Strong Support for Death with Dignity in Maryland

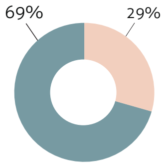
A January 2020 poll conducted by Gonzales Research & Media Services[1] shows 66 percent of Maryland voters favor "legislation that would allow a terminally ill adult patient to obtain a physician's prescription for drugs to end his or her life, voluntarily, and with informed choice."



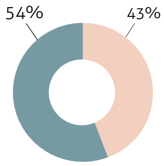


Majorities of Maryland residents in all regions of the state, across the political spectrum, and from all demographic groups support the End-of-Life Option Act.

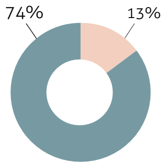
Democrat



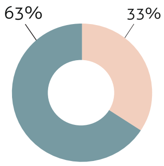
Republican



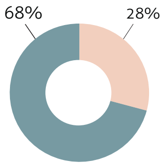
Unaffiliated



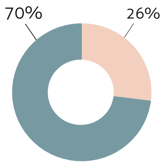
Men



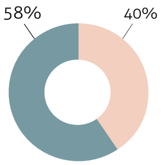
Women



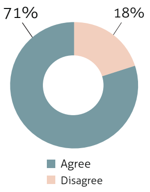
White

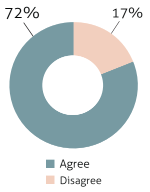


African American



"Adults in the final stages of a terminal disease have a right to stop their suffering if they choose."





"We have the right to make our own medical decisions without government interference."

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[1] This poll was conducted by Gonzales Research & Media Services from December 23rd through January 4th, 2020. A total of 838 registered voters in Maryland, who indicated that they are likely to vote in the 2020 general election, were queried by live telephone interviews, utilizing both landline (39%) and cell phone (61%) numbers. A cross-section of interviews was conducted throughout the state, reflecting general election voting patterns. The margin of error (MOE), per accepted statistical standards, is a range of plus or minus 3.5 percentage points. If the entire population was surveyed, there is a 95% probability that the true numbers would fall within this range.

January 2020

Gonzales Maryland Poll

Gonzales Poll

Table of Contents

Background and Methodology

Patrick E. Gonzales graduated magna cum laude from the University of Baltimore with a degree in political science.

His career in the field of public opinion research began in the mid-1980s as an analyst with *Mason-Dixon Opinion Research*. During this time, Mr. Gonzales helped develop, craft and implement election surveys and exit polls for television and radio in the Baltimore-Washington D.C. metro area.

Mr. Gonzales has polled and analyzed well over a thousand elections in Maryland and across the country since that time. Furthermore, he and his associates have conducted numerous market research projects, crafting message development plans and generating strategy blueprints for businesses and organizations throughout the state.

Over his 35 years conducting public opinion polls, Patrick Gonzales has been widely recognized by his peers for his ability to conduct unbiased surveys, and analyze the results in an impartial, evenhanded manner.

Mr. Gonzales frequently appears on radio and television in the Baltimore-D.C. region as a guest commentator.

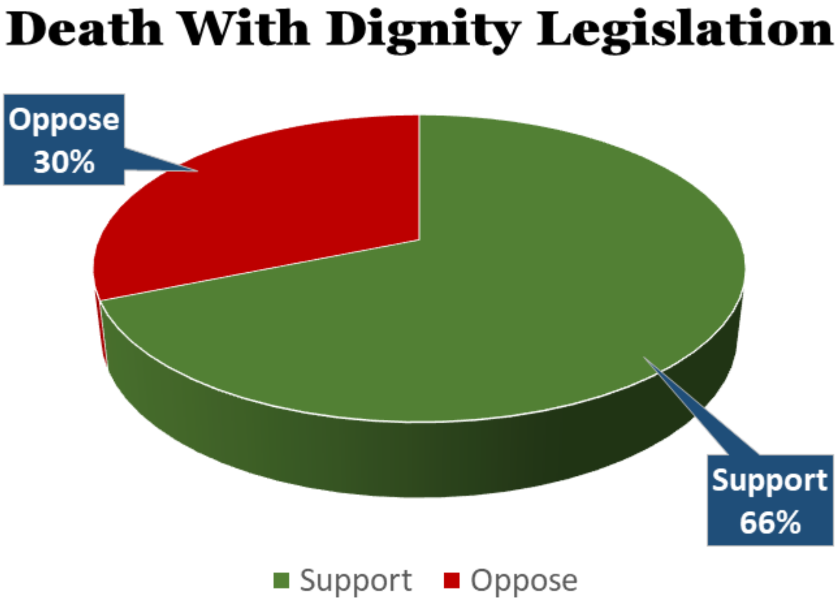
This poll was conducted by ***Gonzales Research & Media Services*** from December 23rd through January 4th, 2020. A total of 838 registered voters in Maryland, who indicated that they are likely to vote in the 2020 general election, were queried by live telephone interviews, utilizing both landline (39%) and cell phone (61%) numbers. A cross-section of interviews was conducted throughout the state, reflecting general election voting patterns.

The margin of error (MOE), per accepted statistical standards, is a range of plus or minus 3.5 percentage points. If the entire population was surveyed, there is a 95% probability that the true numbers would fall within this range.

Gonzales January 2020 Poll Results

Death With Dignity Legislation

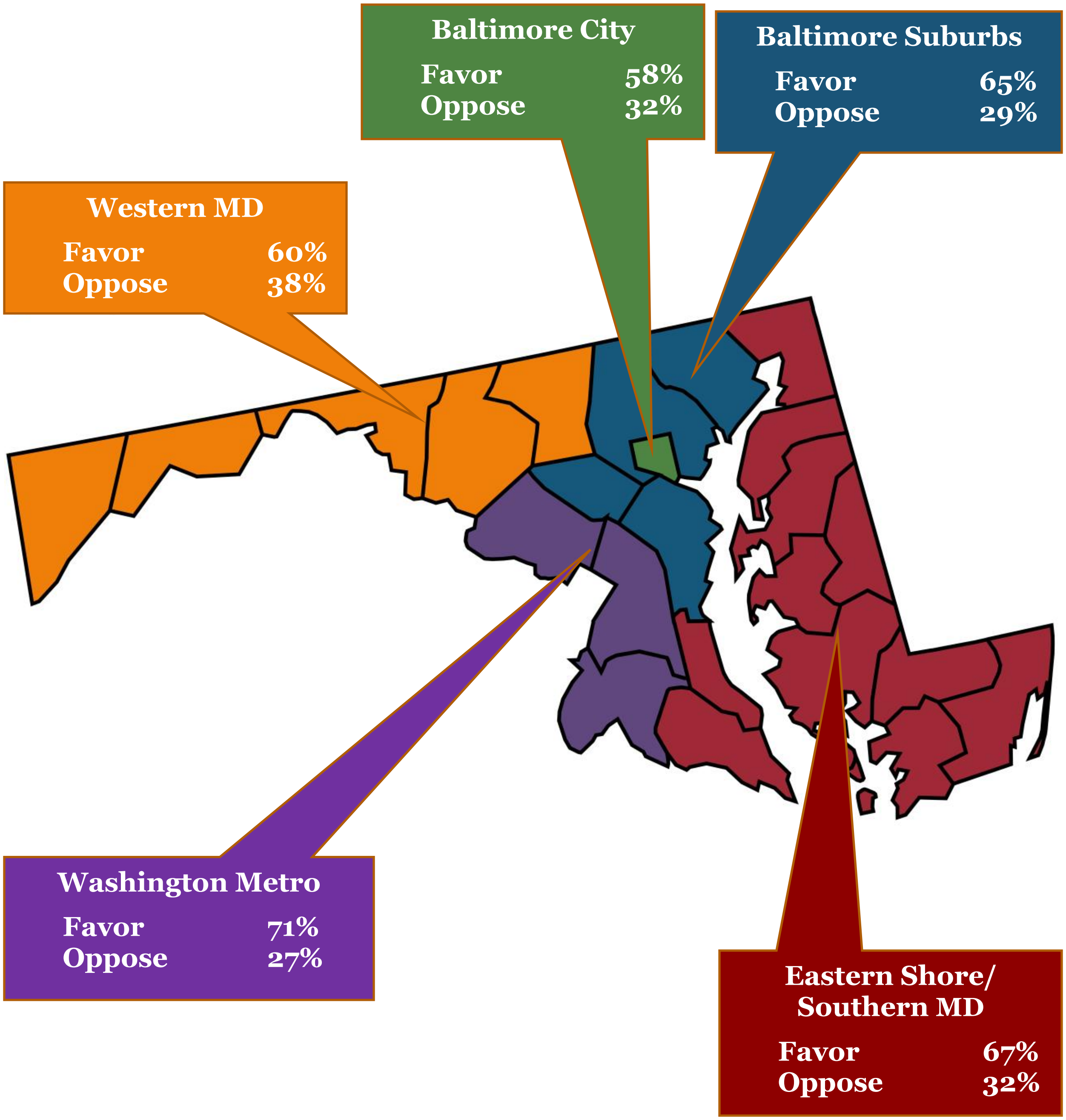
Among Maryland voters, a decisive 66% favor “legislation that would allow a terminally ill adult patient to obtain a physician’s prescription for drugs to end his or her life, voluntarily, and with informed choice” (44% “strongly favor” and 22% “somewhat favor”), while 30% oppose such legislation (18% “strongly oppose” and 12% “somewhat oppose”), with 4% providing no response.



The results by party, gender, and race:

Death With Dignity Legislation	**Favor**	**Oppose**
Democrat	69%	29%
Republican	54%	43%
Unaffiliated	74%	13%
Men	63%	33%
Women	68%	28%
White	70%	26%
African-American	58%	40%

Death With Dignity Legislation by Region



Doctors Should Never Help Patient Die or Adults Have Right to Stop Suffering

We asked Marylanders whether, "*Doctors should never take part in any activities that would help a patient die,*" or "*Adults in the final stages of a terminal disease have a right to stop their suffering if they choose*" came closer to their point of view.

Statewide, 71% say that adults in the final stages of a terminal disease have a right to stop their suffering, while 18% say that a doctor should never help a patient die, with 11% offering no opinion.

The results by gender and race:

Doctors Never or Adults' Right	**Doctors Never**	**Adults' Right**
Men	21%	69%
Women	15%	73%
White	14%	74%
African-American	28%	64%

Suicide is Morally Wrong or Right to Make Own Medical Decisions

We also asked whether, "*No matter the circumstances, suicide is morally wrong and the law should not permit it,*" or "*We have a right to make our own medical decisions without interference from the government*" came closer to their viewpoint.

Statewide, 72% say that we have the right to make our own medical decisions without government interference, while 17% say that suicide is morally wrong and the law should never permit it.

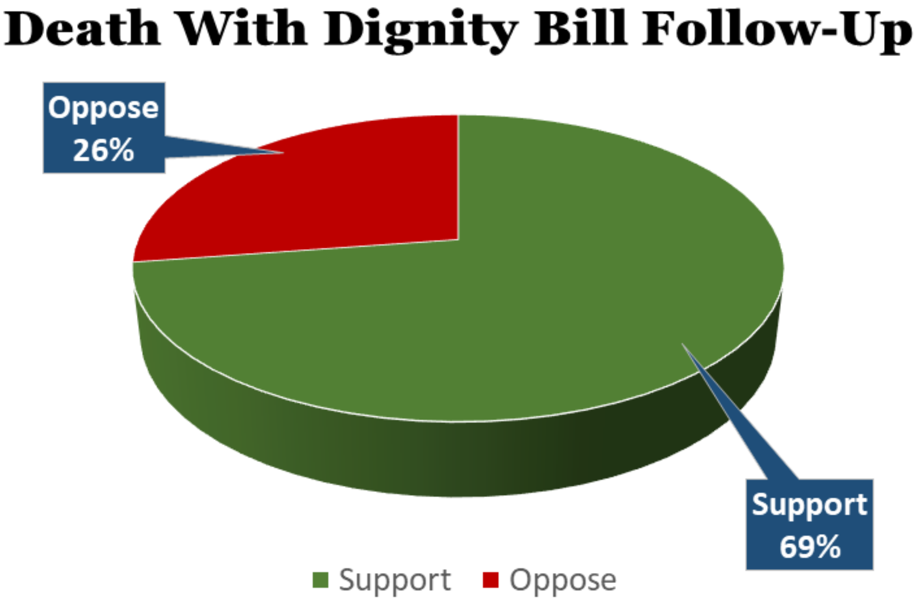
The results by gender and race:

Morally Wrong or Own Decision	**Morally Wrong**	**Own Decision**
Men	18%	70%
Women	16%	74%
White	15%	73%
African-American	21%	70%

Death With Dignity Bill Follow-Up

We ended by asking Maryland voters, "*The Maryland General Assembly is considering a death with dignity bill that would allow a terminally ill adult patient to voluntarily make an informed choice to obtain a physician's prescription for drugs to end his or her life, with the consultation of his/her doctor, family, and faith. Do you favor or oppose this legislation"*

This time, 69% favor a death with dignity bill, (45% "strongly favor" and 24% "somewhat favor"), while 26% oppose it (17% "strongly oppose" and 9% "somewhat oppose"), with 5% providing no response.



A comparison of support between the 2 questions by party, gender, and race:

Support Comparison	**Favor Question 1**	**Favor Question 2**
Democrat	69%	71%
Republican	54%	57%
Unaffiliated	74%	82%
Men	63%	68%
Women	68%	70%
White	70%	73%
African-American	58%	61%

Appendix A: Data Tables

QUESTION: Death With Dignity Legislation *The Maryland General Assembly is considering death with dignity legislation that would allow a terminally ill adult patient to obtain a physician's prescription for drugs to end his or her life, voluntarily, and with informed choice.*

Do you favor or oppose this legislation?

DEATH WITH DIGNITY LEGISLATION	Number	Percent
Favor	552	65.9 %
Oppose	253	30.2 %
No answer	33	3.9 %
Total	838	100.0 %

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
PARTY			
Democrat	326 69.4%	136 28.9%	8 1.7%
Republican	127 54.3%	100 42.7%	7 3.0%
Unaffiliated	99 73.9%	17 12.7%	18 13.4%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
GENDER			
Male	242 63.4%	127 33.2%	13 3.4%
Female	310 68.0%	126 27.6%	20 4.4%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
AGE GROUP			
Under 50	256 69.6%	95 25.8%	17 4.6%
50 or older	296 63.0%	158 33.6%	16 3.4%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
AGE			
18 to 39	137 72.9%	38 20.2%	13 6.9%
40 to 49	119 66.1%	57 31.7%	4 2.2%
50 to 59	122 63.9%	62 32.5%	7 3.7%
60 and older	174 62.4%	96 34.4%	9 3.2%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
RACE			
White	376 69.8%	138 25.6%	25 4.6%
African-American	142 58.4%	96 39.5%	5 2.1%
Other/ Refused	34 60.7%	19 33.9%	3 5.4%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
REGION			
Baltimore Metro	228 63.3%	108 30.0%	24 6.7%
Washington Metro	202 70.9%	77 27.0%	6 2.1%
Rural Maryland	122 63.2%	68 35.2%	3 1.6%

N=838	DEATH WITH DIGNITY LEGISLATION		
	Favor	Oppose	No answer
COUNTY			
Anne Arundel Co.	59 72.8%	17 21.0%	5 6.2%
Baltimore County	70 59.8%	43 36.8%	4 3.4%
Charles County	14 58.3%	10 41.7%	0 0.0%
Harford County	26 65.0%	11 27.5%	3 7.5%
Howard County	31 62.0%	14 28.0%	5 10.0%
Montgomery County	113 79.6%	24 16.9%	5 3.5%
Prince George's Co.	75 63.0%	43 36.1%	1 0.8%
Baltimore City	42 58.3%	23 31.9%	7 9.7%
Eastern Shore	63 67.0%	30 31.9%	1 1.1%
Western Maryland	59 59.6%	38 38.4%	2 2.0%

QUESTION: Death With Dignity Legislation - Intensity *The Maryland General Assembly is considering death with dignity legislation that would allow a terminally ill adult patient to obtain a physician's prescription for drugs to end his or her life, voluntarily, and with informed choice.*

Do you favor or oppose this legislation?

Is that strongly or somewhat favor/oppose?

DEATH WITH DIGNITY LEGISLATION	Number	Percent
Strongly Favor	369	44.0 %
Somewhat Favor	183	21.8 %
Somewhat Oppose	101	12.1 %
Strongly Oppose	152	18.1 %
No answer	33	3.9 %
Total	838	100.0 %

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
PARTY					
Democrat	238 50.6%	88 18.7%	62 13.2%	74 15.7%	8 1.7%
Republican	71 30.3%	56 23.9%	29 12.4%	71 30.3%	7 3.0%
Unaffiliated	60 44.8%	39 29.1%	10 7.5%	7 5.2%	18 13.4%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
GENDER					
Male	142 37.2%	100 26.2%	58 15.2%	69 18.1%	13 3.4%
Female	227 49.8%	83 18.2%	43 9.4%	83 18.2%	20 4.4%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
AGE GROUP					
Under 50	178 48.4%	78 21.2%	44 12.0%	51 13.9%	17 4.6%
50 or older	191 40.6%	105 22.3%	57 12.1%	101 21.5%	16 3.4%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
AGE					
18 to 39	101 53.7%	36 19.1%	19 10.1%	19 10.1%	13 6.9%
40 to 49	77 42.8%	42 23.3%	25 13.9%	32 17.8%	4 2.2%
50 to 59	80 41.9%	42 22.0%	25 13.1%	37 19.4%	7 3.7%
60 and older	111 39.8%	63 22.6%	32 11.5%	64 22.9%	9 3.2%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
RACE					
White	273 50.6%	103 19.1%	45 8.3%	93 17.3%	25 4.6%
African-American	75 30.9%	67 27.6%	49 20.2%	47 19.3%	5 2.1%
Other/ Refused	21 37.5%	13 23.2%	7 12.5%	12 21.4%	3 5.4%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
<u>REGION</u>					
Baltimore Metro	150 41.7%	78 21.7%	45 12.5%	63 17.5%	24 6.7%
Washington Metro	133 46.7%	69 24.2%	31 10.9%	46 16.1%	6 2.1%
Rural Maryland	86 44.6%	36 18.7%	25 13.0%	43 22.3%	3 1.6%

N=838	DEATH WITH DIGNITY LEGISLATION				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
<u>COUNTY</u>					
Anne Arundel Co.	42 51.9%	17 21.0%	7 8.6%	10 12.3%	5 6.2%
Baltimore County	42 35.9%	28 23.9%	21 17.9%	22 18.8%	4 3.4%
Charles County	6 25.0%	8 33.3%	3 12.5%	7 29.2%	0 0.0%
Harford County	18 45.0%	8 20.0%	3 7.5%	8 20.0%	3 7.5%
Howard County	23 46.0%	8 16.0%	6 12.0%	8 16.0%	5 10.0%
Montgomery County	79 55.6%	34 23.9%	10 7.0%	14 9.9%	5 3.5%
Prince George's Co.	48 40.3%	27 22.7%	18 15.1%	25 21.0%	1 0.8%
Baltimore City	25 34.7%	17 23.6%	8 11.1%	15 20.8%	7 9.7%
Eastern Shore	48 51.1%	15 16.0%	12 12.8%	18 19.1%	1 1.1%
Western Maryland	38 38.4%	21 21.2%	13 13.1%	25 25.3%	2 2.0%

QUESTION: Doctors Never or Stop Suffering *Which of the following statements comes closer to your view?* (ORDER ROTATED)

- *Doctors should never take part in any activities that would help a patient die.*

  OR

- *Adults in the final stages of a terminal disease have a right to stop their suffering if they choose.*

DOCTORS NEVER or STOP SUFFERING	Number	Percent
Doctors Never	148	17.7 %
Stop Suffering	596	71.1 %
No answer	94	11.2 %
Total	838	100.0 %

N=838	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
PARTY			
Democrat	89 18.9%	340 72.3%	41 8.7%
Republican	52 22.2%	152 65.0%	30 12.8%
Unaffiliated	7 5.2%	104 77.6%	23 17.2%

N=838	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
GENDER			
Male	81 21.2%	263 68.8%	38 9.9%
Female	67 14.7%	333 73.0%	56 12.3%

N=838	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
AGE GROUP			
Under 50	47 12.8%	271 73.6%	50 13.6%
50 or older	101 21.5%	325 69.1%	44 9.4%

N=838	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
AGE			
18 to 39	20 10.6%	145 77.1%	23 12.2%
40 to 49	27 15.0%	126 70.0%	27 15.0%
50 to 59	41 21.5%	137 71.7%	13 6.8%
60 and older	60 21.5%	188 67.4%	31 11.1%

N=838	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
RACE			
White	73 13.5%	401 74.4%	65 12.1%
African-American	68 28.0%	156 64.2%	19 7.8%
Other/ Refused	7 12.5%	39 69.6%	10 17.9%

N=838

	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
REGION			
Baltimore Metro	56 15.6%	266 73.9%	38 10.6%
Washington Metro	58 20.4%	202 70.9%	25 8.8%
Rural Maryland	34 17.6%	128 66.3%	31 16.1%

N=838

	DOCTORS NEVER or STOP SUFFERING		
	Doctors Never	Stop Suffering	No answer
COUNTY			
Anne Arundel Co.	8 9.9%	69 85.2%	4 4.9%
Baltimore County	23 19.7%	78 66.7%	16 13.7%
Charles County	10 41.7%	13 54.2%	1 4.2%
Harford County	3 7.5%	31 77.5%	6 15.0%
Howard County	8 16.0%	38 76.0%	4 8.0%
Montgomery County	16 11.3%	112 78.9%	12 8.5%
Prince George's Co.	32 26.9%	75 63.0%	12 10.1%
Baltimore City	14 19.4%	50 69.4%	8 11.1%
Eastern Shore	16 17.0%	68 72.3%	10 10.6%
Western Maryland	18 18.2%	60 60.6%	23 23.2%

QUESTION: Morally Wrong or Make Own Decisions *Which of the following statements comes closer to your view?* (ORDER ROTATED)

- *No matter the circumstances, suicide is morally wrong and the law should not permit it.*

OR

- *We have a right to make our own medical decisions without interference from the government.*

MORALLY WRONG or MAKE OWN DECISION	Number	Percent
Morally Wrong	141	16.8 %
Make Own Decision	604	72.1 %
No answer	93	11.1 %
Total	838	100.0 %

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
PARTY			
Democrat	81 17.2%	347 73.8%	42 8.9%
Republican	46 19.7%	163 69.7%	25 10.7%
Unaffiliated	14 10.4%	94 70.1%	26 19.4%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
GENDER			
Male	67 17.5%	268 70.2%	47 12.3%
Female	74 16.2%	336 73.7%	46 10.1%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
AGE GROUP			
Under 50	49 13.3%	271 73.6%	48 13.0%
50 or older	92 19.6%	333 70.9%	45 9.6%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
AGE			
18 to 39	22 11.7%	134 71.3%	32 17.0%
40 to 49	27 15.0%	137 76.1%	16 8.9%
50 to 59	39 20.4%	141 73.8%	11 5.8%
60 and older	53 19.0%	192 68.8%	34 12.2%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
RACE			
White	81 15.0%	393 72.9%	65 12.1%
African-American	51 21.0%	171 70.4%	21 8.6%
Other/ Refused	9 16.1%	40 71.4%	7 12.5%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
REGION			
Baltimore Metro	50 13.9%	263 73.1%	47 13.1%
Washington Metro	56 19.6%	215 75.4%	14 4.9%
Rural Maryland	35 18.1%	126 65.3%	32 16.6%

N=838	MORALLY WRONG or MAKE OWN DECISION		
	Morally Wrong	Make Own Decision	No answer
COUNTY			
Anne Arundel Co.	6 7.4%	66 81.5%	9 11.1%
Baltimore County	23 19.7%	81 69.2%	13 11.1%
Charles County	7 29.2%	14 58.3%	3 12.5%
Harford County	2 5.0%	29 72.5%	9 22.5%
Howard County	5 10.0%	37 74.0%	8 16.0%
Montgomery County	23 16.2%	115 81.0%	3 2.1%
Prince George's Co.	26 21.8%	86 72.3%	7 5.9%
Baltimore City	14 19.4%	50 69.4%	8 11.1%
Eastern Shore	16 17.0%	65 69.1%	13 13.8%
Western Maryland	19 19.2%	61 61.6%	19 20.4%

QUESTION: Death With Dignity Follow-Up *The Maryland General Assembly is considering a death with dignity bill that would allow a terminally ill adult patient to voluntarily make an informed choice to obtain a physician's prescription for drugs to end his or her life, with the consultation of his/her doctor, family, and faith.*

Do you favor or oppose this legislation?

DEATH WITH DIGNITY LEGISLATION FOLLOW-UP	Number	Percent
Favor	579	69.1 %
Oppose	220	26.3 %
No answer	39	4.7 %
Total	838	100.0 %

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
PARTY			
Democrat	335 71.3%	120 25.5%	15 3.2%
Republican	134 57.3%	88 37.6%	12 5.1%
Unaffiliated	110 82.1%	12 9.0%	12 9.0%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
GENDER			
Male	258 67.5%	104 27.2%	20 5.2%
Female	321 70.4%	116 25.4%	19 4.2%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
AGE GROUP			
Under 50	272 73.9%	79 21.5%	17 4.6%
50 or older	307 65.3%	141 30.0%	22 4.7%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
AGE			
18 to 39	151 80.3%	28 14.9%	9 4.8%
40 to 49	121 67.2%	51 28.3%	8 4.4%
50 to 59	132 69.1%	53 27.7%	6 3.1%
60 and older	175 62.7%	88 31.5%	16 5.7%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
RACE			
White	393 72.9%	120 22.3%	26 4.8%
African-American	147 60.5%	85 35.0%	11 4.5%
Other/ Refused	39 69.6%	15 26.8%	2 3.6%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
REGION			
Baltimore Metro	244 67.8%	96 26.7%	20 5.6%
Washington Metro	205 71.9%	65 22.8%	15 5.3%
Rural Maryland	130 67.4%	59 30.6%	4 2.1%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP		
	Favor	Oppose	No answer
COUNTY			
Anne Arundel Co.	61 75.3%	15 18.5%	5 6.2%
Baltimore County	75 64.1%	38 32.5%	4 3.4%
Charles County	13 54.2%	9 37.5%	2 8.3%
Harford County	26 65.0%	11 27.5%	3 7.5%
Howard County	34 68.0%	10 20.0%	6 12.0%
Montgomery County	114 80.3%	19 13.4%	9 6.3%
Prince George's Co.	78 65.5%	37 31.1%	4 3.4%
Baltimore City	48 66.7%	22 30.6%	2 2.8%
Eastern Shore	66 70.2%	26 27.7%	2 2.1%
Western Maryland	64 64.6%	33 33.3%	2 2.0%

QUESTION: Death With Dignity Follow-Up - Intensity *The Maryland General Assembly is considering a death with dignity bill that would allow a terminally ill adult patient to voluntarily make an informed choice to obtain a physician's prescription for drugs to end his or her life, with the consultation of his/her doctor, family, and faith.*

Do you favor or oppose this legislation?

Is that strongly or somewhat favor/oppose?

DEATH WITH DIGNITY LEGISLATION FOLLOW-UP	Number	Percent
Strongly Favor	375	44.7 %
Somewhat Favor	204	24.3 %
Somewhat Oppose	80	9.5 %
Strongly Oppose	140	16.7 %
No answer	39	4.7 %
Total	838	100.0 %

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
PARTY					
Democrat	226 48.1%	109 23.2%	51 10.9%	69 14.7%	15 3.2%
Republican	85 36.3%	49 20.9%	24 10.3%	64 27.4%	12 5.1%
Unaffiliated	64 47.8%	46 34.3%	5 3.7%	7 5.2%	12 9.0%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
GENDER					
Male	159 41.6%	99 25.9%	40 10.5%	64 16.8%	20 5.2%
Female	216 47.4%	105 23.0%	40 8.8%	76 16.7%	19 4.2%

N=838

	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
AGE GROUP					
Under 50	176 47.8%	96 26.1%	36 9.8%	43 11.7%	17 4.6%
50 or older	199 42.3%	108 23.0%	44 9.4%	97 20.6%	22 4.7%

N=838

	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
AGE					
18 to 39	98 52.1%	53 28.2%	14 7.4%	14 7.4%	9 4.8%
40 to 49	78 43.3%	43 23.9%	22 12.2%	29 16.1%	8 4.4%
50 to 59	85 44.5%	47 24.6%	18 9.4%	35 18.3%	6 3.1%
60 and older	114 40.9%	61 21.9%	26 9.3%	62 22.2%	16 5.7%

N=838

	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
RACE					
White	272 50.5%	121 22.4%	42 7.8%	78 14.5%	26 4.8%
African-American	82 33.7%	65 26.7%	32 13.2%	53 21.8%	11 4.5%
Other/ Refused	21 37.5%	18 32.1%	6 10.7%	9 16.1%	2 3.6%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
REGION					
Baltimore Metro	155 43.1%	89 24.7%	31 8.6%	65 18.1%	20 5.6%
Washington Metro	127 44.6%	66 23.2%	30 10.5%	47 16.5%	15 5.3%
Rural Maryland	93 48.2%	49 25.4%	19 9.8%	28 14.5%	4 2.1%

N=838	DEATH WITH DIGNITY LEGISLATION FOLLOW-UP				
	Strongly Favor	Somewhat Favor	Somewhat Oppose	Strongly Oppose	No answer
COUNTY					
Anne Arundel Co.	45 55.6%	16 19.8%	3 3.7%	12 14.8%	5 6.2%
Baltimore County	46 39.3%	29 24.8%	16 13.7%	22 18.8%	4 3.4%
Charles County	5 20.8%	8 33.3%	3 12.5%	6 25.0%	2 8.3%
Harford County	17 42.5%	9 22.5%	3 7.5%	8 20.0%	3 7.5%
Howard County	21 42.0%	13 26.0%	3 6.0%	7 14.0%	6 12.0%
Montgomery County	78 54.9%	36 25.4%	13 9.2%	6 4.2%	9 6.3%
Prince George's Co.	54 45.4%	24 20.2%	12 10.1%	25 21.0%	4 3.4%
Baltimore City	26 36.1%	22 30.6%	6 8.3%	16 22.2%	2 2.8%
Eastern Shore	49 52.1%	17 18.1%	9 9.6%	17 18.1%	2 2.1%
Western Maryland	34 34.3%	30 30.3%	12 12.1%	21 21.2%	2 2.0%

Appendix B: Maryland Poll Sample Demographics

PARTY	Number	Percent
Democrat	470	56.1 %
Republican	234	27.9 %
Unaffiliated	134	16.0 %
Total	838	100.0 %

AGE	Number	Percent
18 to 39	188	22.4 %
40 to 49	180	21.5 %
50 to 59	191	22.8 %
60 and older	279	33.3 %
Total	838	100.0 %

AGE GROUP	Number	Percent
Under 50	368	43.9 %
50 or older	470	56.1 %
Total	838	100.0 %

RACE	Number	Percent
White	539	64.3 %
African-American	243	29.0 %
Hispanic	56	6.7 %
Total	838	100.0 %

GENDER	Number	Percent
Male	382	45.6 %
Female	456	54.4 %
Total	838	100.0 %

REGION	Number	Percent
Baltimore Metro	360	43.0 %
Washington Metro	285	34.0 %
Rural Maryland	193	23.0 %
Total	838	100.0 %

Region Classifications

Baltimore Metro	Number	Percent
Baltimore City	72	20.0 %
Anne Arundel County	81	22.5 %
Baltimore County	117	32.5 %
Harford County	40	11.1 %
Howard County	50	13.9 %
Total	360	100.0 %

Washington Metro	Number	Percent
Montgomery County	142	49.8 %
Prince George's County	119	41.8 %
Charles County	24	8.4 %
Total	285	100.0 %

Rural Maryland	Number	Percent
Eastern Shore/Southern Maryland	94	48.7 %
Western Maryland	99	51.3 %
Total	193	100.0 %

Oregon Death with Dignity Act

2018 Data Summary

Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgments

Report written by: Public Health Division, Center for Health Statistics

Date: February 15, 2019

Revised April 25, 2019: The percents shown for end of life concerns were recalculated on April 25, 2019. See Table 1, footnote 7 for details.

For more information, see: www.healthoregon.org/dwd

Contact: DWDA.INFO@state.or.us

Executive summary

The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through the voluntary self-administration of a lethal dose of medications, expressly prescribed by a physician for that purpose. The Act requires the Oregon Health Authority to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report. In 2018, 249 people received prescriptions under the DWDA. As of January 22, 2019, 168 people had died in 2018 from ingesting the prescribed medications, including 11 who had received the prescriptions in previous years. Characteristics of DWDA patients were similar to those in previous years: most patients were aged 65 years or older (79.2%), and most had cancer (62.5%). During 2018, two physicians were referred to the Oregon Medical Board for failure to comply with DWDA requirements.

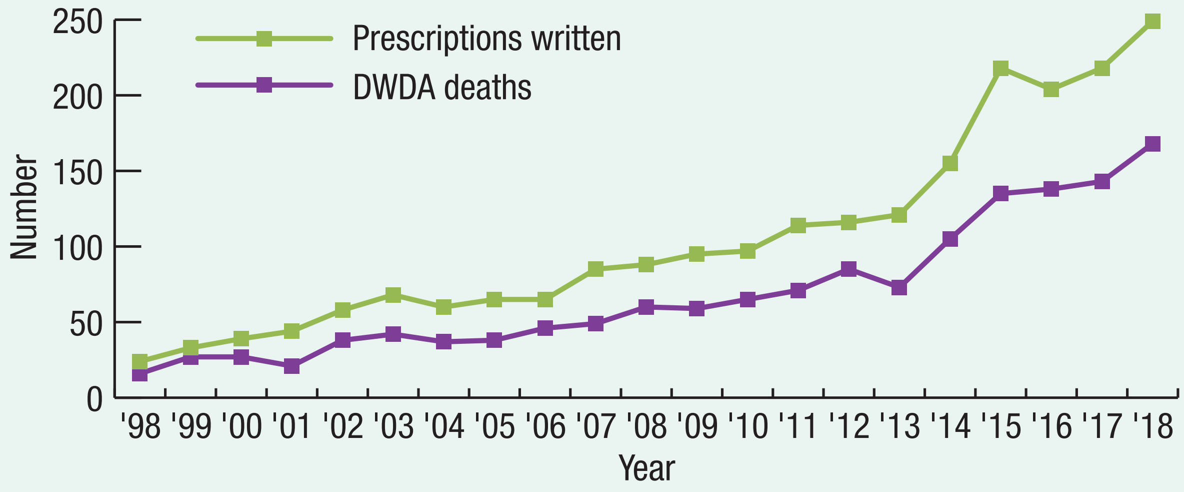
Introduction

The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregonians who meet specific qualifications to end their lives through the voluntary self-administration of a lethal dose of medications, expressly prescribed by a physician for that purpose. The Act requires the Oregon Health Authority (OHA) to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report.

The DWDA outlines specific patient requirements to participate. A patient must be: 1) 18 years of age or older, 2) a resident of Oregon, 3) capable of making and communicating health care decisions to health care practitioners, and 4) diagnosed with a terminal illness that will lead to death within six months. The attending and consulting physicians must determine whether these requirements have been met, and report that fact to OHA at the time a prescription is written. When OHA identifies any issue of noncompliance with the statutory requirements, it reports the fact to the appropriate licensing board.

Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by OHA as of January 22, 2019. More information on the reporting process, required forms, and annual reports is available at: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2018



**As of January 22, 2019*

See Table 2 for detailed information

Participation summary and trends

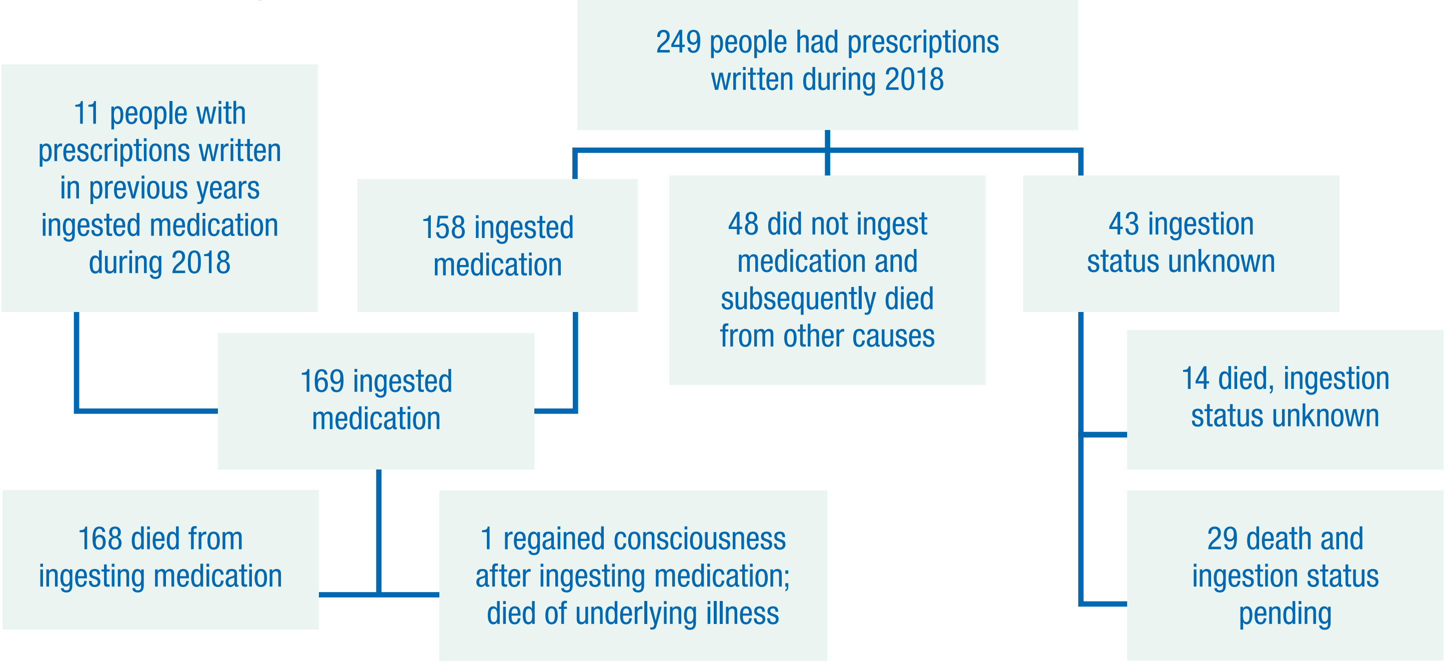
During 2018, 249 people received prescriptions for lethal doses of medications under the provisions of the Oregon DWDA, compared to 219 during 2017 (Figure 1). As of January 22, 2019, OHA had received reports of 168 people who had died during 2018 from ingesting the medications prescribed under DWDA, an increase compared to 158 during 2017.

Since the law was passed in 1997, prescriptions have been written for a total of 2,217 people under the DWDA; 1,459 people (65.8%) have died from ingesting the medications. During 2018, the estimated rate of DWDA deaths was 45.9 per 10,000 total deaths.[1]

A summary of DWDA prescriptions written and medications ingested is shown in Figure 2. Of the 249 patients for whom prescriptions were written during 2018, 158 (63.5%) ingested the medication; 157 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying from the underlying illness (therefore is not counted as a DWDA death). An additional 48 (19.3%) did not take the medications and subsequently died of other causes.

Ingestion status is unknown for 43 patients prescribed DWDA medications in 2018. Of these, 14 patients died but follow up information is not yet available. For the remaining 29 patients, both death and ingestion status are pending (Figure 2).

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2018, as of January 22, 2018



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[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2017 (36,640), the most recent year for which final death data are available.

Patient characteristics

Table 1 shows the characteristics and end-of-life care for 2018 DWDA deaths, total DWDA deaths, and deaths by five-year increments. Of the 168 DWDA deaths during 2018, most patients (79.2%) were aged 65 years or older. The median age at death was 74 years. As in previous years, decedents were commonly white (97.0%) and well educated (47.3% had a least a baccalaureate degree).

Patients' underlying illnesses were similar to those of previous years. Most patients had cancer (62.5%), followed by neurological disease (14.9%) and heart/circulatory disease (9.5%). Most patients (87.5%) died at home, and most (90.5%) were enrolled in hospice care. Excluding unknown cases, most (99.3%) had some form of health care insurance. The proportions of patients who had private insurance (32.4%) and Medicare or Medicaid insurance (66.9%) in 2018 were similar those reported during the past five years (35.8% and 63.3%, respectively).

As in previous years, the three most frequently reported end-of-life concerns were loss of autonomy (91.7%), decreasing ability to participate in activities that made life enjoyable (90.5%), and loss of dignity (66.7%).

DWDA process

A total of 103 physicians wrote 249 prescriptions during 2018 (1–35 prescriptions per physician). The number of attending physicians has increased since 1998, but has been relatively stable for the past four years (Table 2). Approximately one-half of the attending and consulting physicians practiced in the Portland metropolitan area (Table 3). Three patients were referred for psychological or psychiatric evaluation. During 2018, two physicians were referred the Oregon Medical Board for failure to comply with DWDA requirements.

The medications prescribed to DWDA patients in 2018 differed from previous years (Table 1). As in previous years, secobarbital was prescribed to slightly more than half. In 2018, however, 38.1% of patients were prescribed a combination of diazepam, digoxin, morphine sulfate, and propranolol (DDMP), compared to 13.2% in previous years. In addition, no patients were prescribed pentobarbital in 2018 (26.5% of patients in all years).

The procedure was revised in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. Prescribing physicians were present at time of death for 28 patients (16.7%); 37 additional patients (22.0%) had other health care providers present (e.g., hospice nurse). Data on time from ingestion to death are available for 62 DWDA deaths (36.9%) during 2018. Among those 62 patients, time from ingestion until death ranged from nine minutes to 14 hours.

Table 4 shows the duration from ingestion to death, by medication prescribed for known cases. The median time until death was longer for the DDMP2 compound (120 min) than for secobarbital (25 min) or pentobarbital (20 min).

Table 1. Characteristics and end-of-life care of 1,459 DWDA patients who have died from ingesting a lethal dose of medication as of January 22, 2019, by year, Oregon, 1998–2018 (Revised April, 2019)

Characteristics	2018 (N=168)		Total (N=1,459)		1998-2002 (N=129)		2003-2007 (N=212)		2008-2012 (N=340)		2013-2017 (N=610)	
Sex	**N (%)[1]**		**N (%)[1]**		**N (%)[1]**		**N (%)[1]**		**N (%)[1]**		**N (%)[1]**	
Male (%)	87	(51.8)	763	(52.3)	71	(55.0)	112	(52.8)	169	(49.7)	324	(53.1)
Female (%)	81	(48.2)	696	(47.7)	58	(45.0)	100	(47.2)	171	(50.3)	286	(46.9)
Age												
18-34 (%)	0	(0.0)	9	(0.6)	2	(1.6)	2	(0.9)	2	(0.6)	3	(0.5)
35-44 (%)	2	(1.2)	28	(1.9)	3	(2.3)	7	(3.3)	5	(1.5)	11	(1.8)
45-54 (%)	9	(5.4)	85	(5.8)	10	(7.8)	21	(9.9)	21	(6.2)	24	(3.9)
55-64 (%)	24	(14.3)	275	(18.8)	21	(16.3)	52	(24.5)	68	(20.0)	110	(18.0)
65-74 (%)	50	(29.8)	441	(30.2)	46	(35.7)	47	(22.2)	101	(29.7)	197	(32.3)
75-84 (%)	54	(32.1)	394	(27.0)	37	(28.7)	61	(28.8)	91	(26.8)	151	(24.8)
85+ (%)	29	(17.3)	227	(15.6)	10	(7.8)	22	(10.4)	52	(15.3)	114	(18.7)
Median years (range)	74	(40-102)	72	(25-102)	69	(25-94)	69	(29-96)	71	(34-96)	73	(29-102)
Race												
White (%)	163	(97.0)	1,402	(96.4)	125	(96.9)	207	(97.6)	330	(97.9)	577	(94.9)
African American (%)	0	(0.0)	1	(0.1)	0	(0.0)	0	(0.0)	1	(0.3)	0	(0.0)
American Indian (%)	1	(0.6)	3	(0.2)	0	(0.0)	1	(0.5)	0	(0.0)	1	(0.2)
Asian (%)	2	(1.2)	21	(1.4)	4	(3.1)	2	(0.9)	2	(0.6)	11	(1.8)
Pacific Islander (%)	0	(0.0)	1	(0.1)	0	(0.0)	0	(0.0)	1	(0.3)	0	(0.0)
Other (%)	1	(0.6)	4	(0.3)	0	(0.0)	0	(0.0)	0	(0.0)	3	(0.5)
Two or more races (%)	1	(0.6)	7	(0.5)	0	(0.0)	0	(0.0)	0	(0.0)	6	(1.0)
Hispanic (%)	0	(0.0)	15	(1.0)	0	(0.0)	2	(0.9)	3	(0.9)	10	(1.6)
Unknown	*0*		*5*		*0*		*0*		*3*		*2*	
Marital status												
Married (including Registered Domestic Partner) (%)	72	(43.4)	668	(46.1)	60	(46.5)	94	(44.3)	156	(46.3)	286	(47.2)
Widowed (%)	32	(19.3)	319	(22.0)	29	(22.5)	44	(20.8)	85	(25.2)	129	(21.3)
Never married (%)	20	(12.0)	114	(7.9)	8	(6.2)	20	(9.4)	27	(8.0)	39	(6.4)
Divorced (%)	42	(25.3)	349	(24.1)	32	(24.8)	54	(25.5)	69	(20.5)	152	(25.1)
Unknown	*2*		*9*		*0*		*0*		*3*		*4*	

Characteristics	2018 (N=168)		Total (N=1,459)		1998-2002 (N=129)		2003-2007 (N=212)		2008-2012 (N=340)		2013-2017 (N=610)	
Education												
8th grade or less (%)	0	(0.0)	12	(0.8)	0	(0.0)	3	(1.4)	1	(0.3)	8	(1.3)
9th-12th grade, no diploma (%)	2	(1.2)	60	(4.2)	14	(10.9)	10	(4.7)	14	(4.2)	20	(3.3)
High school graduate/GED (%)	37	(22.4)	318	(22.0)	43	(33.3)	52	(24.5)	59	(17.6)	127	(21.1)
Some college (%)	36	(21.8)	306	(21.2)	23	(17.8)	47	(22.2)	80	(23.9)	120	(19.9)
Associate degree (%)	12	(7.3)	130	(9.0)	31	(24.0)	31	(14.6)	18	(5.4)	38	(6.3)
Bachelor's degree (%)	47	(28.5)	352	(24.4)	18	(14.0)	49	(23.1)	92	(27.5)	146	(24.2)
Master's degree (%)	17	(10.3)	158	(10.9)	not collected		13	(6.1)	42	(12.5)	86	(14.3)
Doctorate or professional degree (%)	14	(8.5)	108	(7.5)	not collected		7	(3.3)	29	(8.7)	58	(9.6)
Unknown	*3*		*15*		*0*		*0*		*5*		*7*	
Residence county/region[2]												
Multnomah (%)	31	(18.5)	319	(22.0)	26	(20.2)	46	(21.7)	80	(23.7)	136	(22.6)
Washington (%)	20	(11.9)	151	(10.4)	10	(7.8)	13	(6.1)	41	(12.2)	67	(11.1)
Clackamas (%)	19	(11.3)	148	(10.2)	12	(9.3)	33	(15.6)	28	(8.3)	56	(9.3)
Lane (%)	18	(10.7)	154	(10.6)	16	(12.4)	26	(12.3)	31	(9.2)	63	(10.4)
Marion (%)	15	(8.9)	154	(10.6)	22	(17.1)	25	(11.8)	24	(7.1)	68	(11.3)
Other northwest counties (%)	25	(14.9)	215	(14.8)	19	(14.7)	31	(14.6)	57	(16.9)	83	(13.8)
Southern Oregon (%)	20	(11.9)	206	(14.2)	17	(13.2)	25	(11.8)	61	(18.1)	83	(13.8)
Central Oregon / Columbia Gorge (%)	17	(10.1)	76	(5.2)	4	(3.1)	7	(3.3)	12	(3.6)	36	(6.0)
Eastern Oregon (%)	3	(1.8)	26	(1.8)	3	(2.3)	6	(2.8)	3	(0.9)	11	(1.8)
Unknown	*0*		*10*		*0*		*0*		*3*		*7*	
End of life care												
Hospice												
Enrolled (%)	152	(90.5)	1,285	(90.2)	107	(83.6)	185	(87.3)	301	(95.6)	540	(89.7)
Not enrolled (%)	16	(9.5)	140	(9.8)	21	(16.4)	27	(12.7)	14	(4.4)	62	(10.3)
Unknown	*0*		*34*		*1*		*0*		*25*		*8*	

Characteristics	2018		Total		1998-2002		2003-2007		2008-2012		2013-2017	
	(N=168)		(N=1,459)		(N=129)		(N=212)		(N=340)		(N=610)	
Insurance												
Private (%)	48	(32.4)	662	(49.6)	80	(63.5)	132	(62.6)	212	(66.7)	190	(35.8)
Medicare, Medicaid or other governmental (%)	99	(66.9)	656	(49.2)	44	(34.9)	78	(37.0)	99	(31.1)	336	(63.3)
None (%)	1	(0.7)	16	(1.2)	2	(1.6)	1	(0.5)	7	(2.2)	5	(0.9)
Unknown	*20*		*125*		*3*		*1*		*22*		*79*	
Underlying illness												
Cancer (%)	**105**	**(62.5)**	**1,107**	**(75.9)**	**102**	**(79.1)**	**178**	**(84.0)**	**274**	**(80.6)**	**448**	**(73.4)**
Lip, oral cavity, and pharynx (%)	2	(1.2)	30	(2.1)	3	(2.3)	3	(1.4)	5	(1.5)	17	(2.8)
Digestive organs (%)	27	(16.1)	291	(19.9)	24	(18.6)	53	(25.0)	64	(18.8)	123	(20.2)
Pancreas (%)	9	(5.4)	100	(6.9)	12	(9.3)	18	(8.5)	15	(4.4)	46	(7.5)
Colon (%)	7	(4.2)	86	(5.9)	7	(5.4)	16	(7.5)	20	(5.9)	36	(5.9)
Other digestive organs (%)	11	(6.5)	105	(7.2)	5	(3.9)	19	(9.0)	29	(8.5)	41	(6.7)
Respiratory and intrathoracic organs (%)	16	(9.5)	247	(16.9)	25	(19.4)	45	(21.2)	70	(20.6)	91	(14.9)
Lung and bronchus (%)	16	(9.5)	233	(16.0)	24	(18.6)	41	(19.3)	64	(18.8)	88	(14.4)
Other respiratory and intrathoracic organs (%)	0	(0.0)	14	(1.0)	1	(0.8)	4	(1.9)	6	(1.8)	3	(0.5)
Melanoma and other skin (%)	3	(1.8)	39	(2.7)	2	(1.6)	8	(3.8)	13	(3.8)	13	(2.1)
Mesothelial and soft tissue (%)	0	(0.0)	26	(1.8)	2	(1.6)	5	(2.4)	10	(2.9)	9	(1.5)
Breast (%)	10	(6.0)	102	(7.0)	10	(7.8)	20	(9.4)	27	(7.9)	35	(5.7)
Female genital organs (%)	7	(4.2)	84	(5.8)	10	(7.8)	11	(5.2)	20	(5.9)	36	(5.9)
Prostate (%)	5	(3.0)	63	(4.3)	8	(6.2)	12	(5.7)	12	(3.5)	26	(4.3)
Urinary tract (%)	6	(3.6)	42	(2.9)	5	(3.9)	6	(2.8)	9	(2.6)	16	(2.6)
Eye, brain, central nervous system (%)	12	(7.1)	47	(3.2)	5	(3.9)	5	(2.4)	5	(1.5)	20	(3.3)
Brain (%)	11	(6.5)	42	(2.9)	4	(3.1)	4	(1.9)	5	(1.5)	18	(3.0)
Eye and central nervous system (%)	1	(0.6)	5	(0.3)	1	(0.8)	1	(0.5)	0	(0.0)	2	(0.3)
Thyroid and other endocrine (%)	2	(1.2)	7	(0.5)	0	(0.0)	0	(0.0)	2	(0.6)	3	(0.5)
Ill-defined, secondary, and unspecified sites (%)	2	(1.2)	37	(2.5)	3	(2.3)	2	(0.9)	11	(3.2)	19	(3.1)
Lymphoma and leukemia (%)	10	(6.0)	65	(4.5)	3	(2.3)	7	(3.3)	21	(6.2)	24	(3.9)
Other cancers (%)	3	(1.8)	27	(1.9)	2	(1.6)	1	(0.5)	5	(1.5)	16	(2.6)

	2018		Total		1998-2002		2003-2007		2008-2012		2013-2017	
Characteristics	(N=168)		(N=1,459)		(N=129)		(N=212)		(N=340)		(N=610)	
Neurological disease (%)	**25**	**(14.9)**	**161**	**(11.0)**	**12**	**(9.3)**	**17**	**(8.0)**	**31**	**(9.1)**	**76**	**(12.5)**
Amyotrophic lateral sclerosis (%)	15	(8.9)	117	(8.0)	10	(7.8)	16	(7.5)	23	(6.8)	53	(8.7)
Other neurological disease (%)	10	(6.0)	44	(3.0)	2	(1.6)	1	(0.5)	8	(2.4)	23	(3.8)
Respiratory disease [e.g., COPD] (%)	**13**	**(7.7)**	**75**	**(5.1)**	**9**	**(7.0)**	**6**	**(2.8)**	**18**	**(5.3)**	**29**	**(4.8)**
Heart/circulatory disease (%)	**16**	**(9.5)**	**66**	**(4.5)**	**4**	**(3.1)**	**1**	**(0.5)**	**9**	**(2.6)**	**36**	**(5.9)**
Infectious disease [e.g., HIV/AIDS] (%)	**0**	**(0.0)**	**13**	**(0.9)**	**1**	**(0.8)**	**7**	**(3.3)**	**2**	**(0.6)**	**3**	**(0.5)**
Gastrointestinal disease [e.g., liver disease] (%)	**1**	**(0.6)**	**9**	**(0.6)**	**0**	**(0.0)**	**1**	**(0.5)**	**1**	**(0.3)**	**6**	**(1.0)**
Endocrine/metabolic disease [e.g., diabetes] (%)	**2**	**(1.2)**	**11**	**(0.8)**	**0**	**(0.0)**	**2**	**(0.9)**	**1**	**(0.3)**	**6**	**(1.0)**
Other illnesses (%)[3]	**6**	**(3.6)**	**17**	**(1.2)**	**1**	**(0.8)**	**0**	**(0.0)**	**4**	**(1.2)**	**6**	**(1.0)**
DWDA process												
Referred for psychiatric evaluation (%)	3	(1.8)	65	(4.5)	28	(22.8)	8	(3.8)	6	(1.8)	20	(3.3)
Patient informed family of decision (%)[4]	156	(94.0)	1,292	(93.7)	55	(94.8)	198	(94.3)	317	(93.5)	566	(93.4)
Patient died at												
Home (patient, family or friend) (%)	147	(88.6)	1,342	(92.4)	121	(93.8)	198	(93.4)	326	(96.7)	550	(90.3)
Assisted living or foster care facility (%)	12	(7.2)	72	(5.0)	4	(3.1)	11	(5.2)	10	(3.0)	35	(5.7)
Nursing home (%)	5	(3.0)	14	(1.0)	2	(1.6)	0	(0.0)	0	(0.0)	7	(1.1)
Hospital (%)	0	(0.0)	4	(0.3)	1	(0.8)	0	(0.0)	0	(0.0)	3	(0.5)
Hospice facility (%)	0	(0.0)	2	(0.1)	0	(0.0)	0	(0.0)	0	(0.0)	2	(0.3)
Other (%)	2	(1.2)	19	(1.3)	1	(0.8)	3	(1.4)	1	(0.3)	12	(2.0)
Unknown	*0*		*6*		*0*		*0*		*3*		*3*	
Lethal medication												
Secobarbital (%)	92	(54.8)	846	(58.0)	86	(66.7)	91	(42.9)	223	(65.6)	354	(58.0)
Pentobarbital (%)	0	(0.0)	386	(26.5)	41	(31.8)	120	(56.6)	117	(34.4)	108	(17.7)
DDMP1 (%)[5]	10	(6.0)	67	(4.6)	0	(0.0)	0	(0.0)	0	(0.0)	57	(9.3)
DDMP2 (%)[5]	54	(32.1)	78	(5.3)	0	(0.0)	0	(0.0)	0	(0.0)	24	(3.9)
Phenobarbital compound (%)[5]	2	(1.2)	65	(4.5)	0	(0.0)	0	(0.0)	0	(0.0)	63	(10.3)
Other (%)	10	(6.0)	17	(1.2)	2	(1.6)	1	(0.5)	0	(0.0)	4	(0.7)

Characteristics	2018	Total	1998-2002	2003-2007	2008-2012	2013-2017
	(N=168)	(N=1,459)	(N=129)	(N=212)	(N=340)	(N=610)
End of life concerns[6,7]						
Losing autonomy (%)	154 (91.7)	1,322 (90.6)	106 (82.2)	194 (91.5)	318 (93.5)	550 (90.2)
Less able to engage in activities making life enjoyable (%)	152 (90.5)	1,300 (89.1)	99 (76.7)	193 (91.0)	310 (91.2)	546 (89.5)
Loss of dignity (%)[8]	112 (66.7)	989 (74.4)	not asked	173 (81.6)	279 (82.1)	425 (69.7)
Losing control of bodily functions (%)	62 (36.9)	647 (44.3)	73 (56.6)	123 (58.0)	154 (45.3)	235 (38.5)
Burden on family, friends/caregivers (%)	91 (54.2)	654 (44.8)	44 (34.1)	88 (41.5)	132 (38.8)	299 (49.0)
Inadequate pain control, or concern about it (%)	43 (25.6)	375 (25.7)	28 (21.7)	64 (30.2)	65 (19.1)	175 (28.7)
Financial implications of treatment (%)	9 (5.4)	57 (3.9)	3 (2.3)	6 (2.8)	9 (2.6)	30 (4.9)
Health-care provider present (collected since 2001)	**(N=168)**	**(N=1,387)**	**(N=57)**	**(N=212)**	**(N=340)**	**(N=610)**
When medication was ingested[9]						
Prescribing physician	32	220	22	52	37	77
Other provider, prescribing physician not present	51	346	29	111	95	60
No provider	18	116	6	45	22	25
Unknown	*67*	*705*	*0*	*4*	*186*	*448*
At time of death						
Prescribing physician (%)	28 (16.8)	201 (14.7)	20 (35.1)	46 (22.1)	33 (9.9)	74 (12.4)
Other provider, prescribing physician not present (%)	37 (22.2)	352 (25.8)	37 (64.9)	110 (52.9)	111 (33.2)	57 (9.5)
No provider (%)	102 (61.1)	812 (59.5)	0 (0.0)	52 (25.0)	190 (56.9)	468 (78.1)
Unknown	*1*	*22*	*0*	*4*	*6*	*11*
Complications[9]	**(N=168)**	**(N=1,459)**	**(N=129)**	**(N=212)**	**(N=340)**	**(N=610)**
Difficulty ingesting/regurgitated	3	28	4	15	3	3
Seizures	0	2	0	0	0	2
Other	4	11	0	0	0	7
None	56	650	121	193	163	117
Unknown	*105*	*768*	*4*	*4*	*174*	*481*
Other outcomes						
Regained consciousness after ingesting DWDA medications	1	8	0	1	5	1

Characteristics	2018 (N=168)	Total (N=1,459)	1998-2002 (N=129)	2003-2007 (N=212)	2008-2012 (N=340)	2013-2017 (N=610)
Timing of DWDA event						
Duration (weeks) of patient-physician relationship						
Median	10	12	14	11	12	13
Range	1-1,108	0-2,138	0-1,337	0-1,477	0-1,905	1-2,138
Number of patients with information available	*165*	*1,449*	*128*	*212*	*339*	*605*
Number of patients with information unknown	*3*	*10*	*1*	*0*	*1*	*5*
Duration (days) between first request and death						
Median	43	47	43	43	49	50
Range	15-807	14-1,009	15-466	15-1,009	14-872	15-692
Number of patients with information available	*167*	*1,458*	*129*	*212*	*340*	*610*
Number of patients with information unknown	*1*	*1*	*0*	*0*	*0*	*0*

1 Unknowns are excluded when calculating percentages.

2 Other northwest counties: Benton, Clatsop, Columbia, Lincoln, Linn, Polk, Tillamook, and Yamhill.
Southern: Coos, Curry, Douglas, Jackson, Josephine, Klamath, and Lake.
Central/Columbia Gorge: Crook, Deschutes, Gilliam, Hood River, Jefferson, Sherman, Wasco, and Wheeler.
Eastern: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, and Wallowa.

3 Includes deaths due to arthritis, arteritis, sclerosis, stenosis, kidney failure, and musculoskeletal systems disorders.

4 First recorded in 2001. Since then, 55 patients (4.6%) have chosen not to inform their families, and 21 patients (1.7%) have had no family to inform. Information is unknown for 10 patients.

5 DDMP is a compound consisting of diazepam, digoxin, morphine sulfate, and propranolol. DDMP1 contains 10g of morphine sulfate; DDMP2 contains 15g. The phenobartital compound consists of phenobarbital, chloral hydrate, and morphine sulfate.

6 Affirmative answers only (“Don’t know” included in negative answers). Categories are not mutually exclusive.

7 The percentages in this section have been recalculated since the original report date of 2/28/2019. The original percentages did not include “don’t know” answers as a negative response.

8 First asked in 2003. Data available for 1,327 patients.

9 A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

Table 2. Number of DWDA prescription recipients, DWDA deaths, and attending physicians, 1998-2018

Year	Prescription recipients	DWDA deaths	Attending physicians
1998	24	16	n/a
1999	33	27	n/a
2000	39	27	22
2001	44	21	33
2002	58	38	33
2003	68	42	42
2004	60	37	40
2005	65	38	40
2006	65	46	41
2007	85	49	46
2008	88	60	60
2009	95	59	64
2010	97	65	59
2011	114	71	62
2012	116	85	62
2013	121	73	62
2014	155	105	83
2015	218	135	106
2016	204	139	101
2017	219	158	93
2018	249	168	103

Table 3. Primary location of practice, DWDA physicians, 2018

Region	Attending physicians		Consulting physicians	
	N	(%)	N	(%)
Metro counties (Clackamas, Multnomah, Washington) (%)	50	(48.5)	97	(52.7)
Coastal counties (%)	6	(5.8)	7	(3.8)
Other western counties (%)	36	(35.0)	61	(33.2)
East of the Cascades (%)	11	(10.7)	19	(10.3)
Unknown	0		2	

Table 4. Duration between ingestion and death, DWDA deaths, 2001-2018

Drug	Total	Unknown duration	Known duration		<1hr		1-6 hours		>6 hours		Median	Mean	Range	Regained consciousness[4]
Secobarbital (%)	778	397	381	(100.0)	285	(74.8)	69	(18.1)	27	(7.1)	25	139	2min - 83 hrs	5
Pentobarbital[1] (%)	384	156	228	(100.0)	188	(82.5)	31	(13.6)	9	(3.9)	20	97	1min - 104hrs	0
DDMP1[2] (%)	67	46	21	(100.0)	10	(47.6)	6	(28.6)	5	(23.8)	77	214	10min - 21hrs	0
DDMP2[2] (%)	78	37	41	(100.0)	12	(29.3)	19	(46.3)	10	(24.4)	120	230	13min - 21hrs	2
Phenobarbital (%)[3]	65	43	22	(100.0)	4	(18.2)	13	(59.1)	5	(22.7)	73	439	20min - 72hrs	0
Other (%)	17	3	14	(100.0)	6	(42.9)	6	(42.9)	2	(14.3)	68	192	10min - 14hrs	1

[1] Pentobarbital is no longer available in the United States.

[2] DDMP is a compound consisting of diazepam, digoxin, morphine sulfate, and propranolol. DDMP1 contains 10g of morphine sulfate; DDMP2 contains 15g.

[3] Phenobarbital is dispensed as a compound consisting of phenobarbital, chloral hydrate, and morphine sulfate.

[4] Patients who regained consciousness after ingestion are not considered DWDA deaths, and are not included in the other columns in this table.

NOTE: Table includes all reported durations, not just those from licensed providers. Complete information not available before 2001. Unknown values are excluded when calculating percentages.

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Special Article

A NATIONAL SURVEY OF PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA IN THE UNITED STATES

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ABSTRACT

Background Although there have been many studies of physician-assisted suicide and euthanasia in the United States, national data are lacking.

Methods In 1996, we mailed questionnaires to a stratified probability sample of 3102 physicians in the 10 specialties in which doctors are most likely to receive requests from patients for assistance with suicide or euthanasia. We weighted the results to obtain nationally representative data.

Results We received 1902 completed questionnaires (response rate, 61 percent). Eleven percent of the physicians said that under current legal constraints, there were circumstances in which they would be willing to hasten a patient's death by prescribing medication, and 7 percent said that they would provide a lethal injection; 36 percent and 24 percent, respectively, said that they would do so if it were legal. Since entering practice, 18.3 percent of the physicians (unweighted number, 320) reported having received a request from a patient for assistance with suicide and 11.1 percent (unweighted number, 196) had received a request for a lethal injection. Sixteen percent of the physicians receiving such requests (unweighted number, 42), or 3.3 percent of the entire sample, reported that they had written at least one prescription to be used to hasten death, and 4.7 percent (unweighted number, 59), said that they had administered at least one lethal injection.

Conclusions A substantial proportion of physicians in the United States in the specialties surveyed report that they receive requests for physician-assisted suicide and euthanasia, and about 6 percent have complied with such requests at least once. (N Engl J Med 1998;338:1193-201.)

THERE are strong arguments for and against easing the legal constraints on physician-assisted suicide and euthanasia in the United States. Public-opinion polls suggest that a majority of people favor legalization.[1] Currently proposed regulatory guidelines[2-5] may bear little relation to the range of clinical circumstances in which physicians care for patients who are near the end of life. Decisions about legislation and proposed safeguards should be responsive to the experiences of patients and doctors. We surveyed a representative sample of U.S. physicians with a high likelihood of caring for dying patients, in order to assess the prevalence of requests for assistance with suicide or euthanasia and of compliance with such requests.

METHODS

The survey was self-administered, anonymous, and conducted by mail. We drew a stratified probability sample of physicians from the American Medical Association's June 1996 master file of all physicians practicing in the United States. The sample included only doctors of medicine who were less than 65 years old or had graduated from medical school after 1960, if age was unknown. Physicians with office and hospital practices and those in the public and private sectors were included. The group of physicians from whom the sample was drawn represents approximately 40 percent of all practicing U.S. physicians under the age of 65 years. The sample was drawn from 10 specialties, selected on the basis of previous surveys[6,7] as those in which physicians are likely to receive requests from patients for assistance in hastening death. Physicians were eligible if they had at least one of the specialty codes as their primary, secondary, or tertiary specialty. A sample of 3102 physicians was selected. Specialists thought to be most likely to receive requests were oversampled.

For each specialty, the initial sample size, population size, sampling rate, and number of respondents are shown in Table 1. The numbers of respondents are based on the specialties reported on the completed questionnaires. Since the questionnaires were anonymous, there was no way to link this information to the original sample and the specialty codes from the master file. The number of respondents reporting family or general practice or other as their primary specialty was larger than the number initially selected in these specialties. The sample of respondents was weighted to account for these differences.

Questionnaire

The closed-ended questionnaire (available from the authors on request) was developed with the use of focus groups and cognitive interviewing[8] of physicians, some of whom had identified themselves as having received requests from patients for assistance in hastening death. The questionnaire was subsequently validated with the use of a "seeded sample" design in which physicians

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TABLE 1. SAMPLE SIZE, SAMPLING RATE, AND RESPONSE RATE ACCORDING TO SPECIALTY.

SPECIALTY	INITIAL SAMPLE	TOTAL POPULATION	SAMPLING RATE	RESPONDENTS	RESPONSE RATE*
	no.			no.	%
Family or general practice	192	52,448	0.004	197	103
Cardiology	197	4,603	0.043	110	56
Geriatrics	389	512	0.760	174	45
Infectious disease	393	919	0.428	175	45
Nephrology	383	936	0.409	190	50
Neurology	397	6,347	0.063	239	60
Hematology–oncology	387	3,764	0.103	275	71
Pulmonary disease	386	2,307	0.167	246	64
Internal medicine	191	80,378	0.002	96	50
Other†	187	1,700	0.110	200	107
Total	3102	153,914		1902	61

*Because of differences between self-reported specialty and selected specialty, some response rates are more than 100 percent.

†Other specialties included critical care medicine, critical care surgery, gynecology, and pain medicine. This category also included physicians who did not report a specialty.

known or thought to have engaged in physician-assisted suicide or euthanasia through their communication with one of the investigators were anonymously included. Two controls for each of these physicians were identified from the American Medical Association's master file on the basis of age, region of the country, city size, and specialty. The validation procedure showed that 20 of the 24 case physicians reported having engaged in either physician-assisted suicide or active euthanasia, as compared with 2 of 30 control physicians.

Assisted suicide was defined as "the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his or her own life." Active euthanasia was defined as "the practice of injecting a patient with a lethal dose of medication with the primary intention of ending the patient's life." Respondents were asked, "Was there an explicit request for assistance in dying, or was the request somewhat indirect?" "Explicit" and "indirect" were not further defined.

We mailed the questionnaire in August 1996. The cover letter explained that there were no codes that could be used to link a completed questionnaire to a particular respondent. This statement was reinforced by a detailed pledge of anonymity from the investigators, printed on the cover of the questionnaire. We instructed the recipients to return the enclosed reply postcard, which contained the respondent's identification number, separately from the completed questionnaire, in order to prevent telephone calls reminding the respondent to return the questionnaire. A $2 bill was enclosed as an incentive. Four weeks after the initial mailing, a second questionnaire, including a sharpened pencil, was mailed to physicians who had not returned the reply postcard. Four weeks after the second mailing, physicians who had not returned a postcard were telephoned to remind them to do so. Two weeks later, a second call was made, if necessary.

We received 1627 completed questionnaires (response rate, 52 percent). A third questionnaire was then sent to the 761 physicians who had not returned a postcard. This mailing included a $50 check made payable to the physician and a letter of endorsement from the American College of Physicians. There were 275 completed responses to the third mailing.

The study was reviewed and approved by the institutional review board of the Mount Sinai School of Medicine.

Sample Weights

The data from the completed questionnaires were weighted to account for the differences in selection probabilities among strata. The final weights reflected adjustments for differences between self-reported specialty and selected specialty, nonresponses, and differences in age and sex between physicians who completed the questionnaire and the overall population of licensed U.S. physicians. Unless otherwise stated, all results reported are weighted data.

Statistical Analysis

Multiple logistic-regression analysis[9] was performed to determine the relation between the characteristics of the physicians and their views and actions with respect to assistance in hastening death. First, we performed a single-variable analysis in which the specialty was compared with each predictor variable. All predictor variables for which P values were 0.15 or less in the single-variable analysis were examined jointly in the next step of model building. Variables that were no longer of even borderline significance ($P>0.10$) when the other variables were entered were eliminated from the model. Religious affiliation and specialty were forced into all models — religion in order to control for the effect of religious affiliation on frequency of prayer, and specialty because it was the stratification variable.

RESULTS

Characteristics of the Physicians

Of the 3102 physicians originally mailed a questionnaire, 81 were ineligible: 75 were not actively practicing medicine, and 6 were older than 65 years. We received 1951 questionnaires from eligible respondents, including some that were blank. There were 1902 completed questionnaires (response rate, 61 percent). The respondents to the third mailing, which included a financial incentive, did not differ significantly from the respondents to the initial mailings, in terms of demographic characteristics or responses to questions about participation in assisted suicide or lethal injection. Respondents and nonrespondents were similar with respect to age, sex, and region of the country, although there were some differences in the distribution of specialties ($P=0.001$ by the chi-square test), with a larger proportion of respondents who were infectious-disease specialists (16 percent, vs. 10 percent of the nonrespondents) and a smaller proportion who were general internists (9 percent vs. 15 percent). Table 2 shows the demographic and professional characteristics of the respondents.

Willingness to Provide Assistance

Eleven percent of the physicians (95 percent confidence interval, 9 to 12 percent) reported that under current legal constraints, there are circumstances in which they would prescribe a medication for a competent patient to use with the primary intention of ending his or her life; 36 percent (95 percent confidence interval, 34 to 38 percent) said they would prescribe a medication if it were legal to do so. Seven percent of the respondents (95 percent confidence interval, 4 to 10 percent) said that under current legal constraints, there are circumstances in which they would administer a lethal injection to a competent patient; 24 percent (95 percent confidence interval, 23 to 26 percent) said they would do so if the practice were legal.

Requests for Assistance

Of the respondents, 18.3 percent (unweighted number, 320) reported having received a request from a patient for medication to use with the primary intention of ending the patient's life (Table 3), with a median of three such requests since the physician entered practice. Fewer physicians (11.1 percent; unweighted number, 196) reported having received a request for a lethal injection, with a median of four such requests since the physician entered practice.

Compliance with Requests for Assistance

Only the 320 physicians who reported having received a request from a patient for a prescription for a lethal dose of medication were asked if they had ever written such a prescription. Sixteen percent of these respondents (unweighted number, 42), or 3.3 percent of the entire sample, reported that they had written a prescription for a lethal dose of medication, with a median of 2 such prescriptions (range, 1 to 25) since they entered practice; 59 percent of the patients used the prescriptions to end their lives.

All the respondents were asked whether they had ever given a patient a lethal injection (Table 3); 4.7 percent (unweighted number, 59) reported that they had done so, with a median of 2 instances (range, 1 to 150) in which they had administered lethal injections since entering practice.

TABLE 2. CHARACTERISTICS OF THE 1902 U.S. PHYSICIANS WHO RESPONDED TO THE SURVEY.*

CHARACTERISTIC	WEIGHTED VALUE	UNWEIGHTED VALUE
Age — % of respondents		
<45 yr	48	54
45–65 yr	49	43
Sex — % of respondents		
Male	77	76
Female	20	21
Percent of work time spent in direct patient care — % of respondents		
<76	17	24
76–100	83	76
Death of a patient in past 12 mo — % of respondents		
Yes	92	91
No	5	6
No. of patients who have died in past 12 mo		
Median (interquartile range)	10 (4–20)	14 (5–29)
Range	0–280	0–280
Patients with an estimated life expectancy of less than 6 mo — % of respondents		
None	8	9
<25%	85	71
≥25%	6	18
Region of practice — % of respondents		
Northeast	25	27
North Central	22	22
South	32	31
West	22	20
Religion — % of respondents		
Catholic	26	23
Other Christian	34	32
Jewish	14	17
Moslem	2	2
None	12	13
Other	9	9
Frequency of prayer — % of respondents		
Never	16	18
Less than weekly	20	24
Weekly	26	24
Daily	33	30

*Weighted values reflect estimated national rates in the surveyed specialties and unweighted values are the raw response rates. Some percentages do not add to 100 because of missing data.

Most Recent Request Honored

The 81 respondents (weighted proportion, 6.4 percent) who reported having acceded to at least one request for assistance with suicide or a lethal injection were asked to describe the most recent case (Table 4). Forty-seven percent of these respondents wrote a prescription for the purpose of hastening death, and 53 percent administered a lethal injection. The perceived reasons for the request were discomfort other than pain (reported by 79 percent of the respondents), loss of dignity (53 percent), fear of uncontrollable symptoms (52 percent), actual pain (50 percent), loss of meaning in their lives (47 percent), being a burden (34 percent), and dependency (30 percent). The reasons given for acceding to the request were severe discomfort other than pain (re-

TABLE 3. REQUESTS FOR PHYSICIAN-ASSISTED SUICIDE OR EUTHANASIA AND COMPLIANCE WITH REQUESTS.*

QUESTION	RESPONSE
Has any patient requested from you a prescription for medication to use with the primary intention of ending his or her own life? — % responding yes	18.3 (16.6–20.0)
Approximately how many patients have requested such a prescription from you?	
Since entering practice	
Median	3
Range	1–100
During the past 12 mo	
Median	1
Range	0–8
Has any patient ever requested that you inject him or her with a lethal dose of a medication? — % responding yes	11.1 (9.7–12.5)
Approximately how many patients have requested that you inject a lethal dose of medication?	
Since entering practice	
Median	4
Range	1–50
During the past 12 mo†	
Median	0
Range	0–6
Have you ever written a prescription for medication for a patient to use with the primary intention of ending his or her own life? — % responding yes	3.3 (2.5–4.1)
For approximately how many patients have you written such a prescription?	
Since entering practice	
Median	2
Range	1–25
During the past 12 mo‡	
Median	0
Range	0–3
Have you ever given a patient a lethal injection? — % responding yes	4.7 (3.7–5.6)
To how many patients have you given a lethal injection?	
Since entering practice	
Median	2
Range	1–150
During the past 12 mo§	
Median	0
Range	0–15

*Percentages are weighted. Medians and ranges are based on the responses of physicians who reported having received or acceded to at least one request since entering practice. Numbers in parentheses are 95 percent confidence intervals.

†Among physicians receiving at least one request for a lethal injection in the previous year, the median number of patients making such a request was 1, and the range was 1 to 6.

‡Among physicians who wrote at least one prescription for a lethal dose of medication during the previous year, the median number of patients who were given such a prescription was 1, and the range was 1 to 3.

§Among physicians who administered at least one lethal injection during the previous year, the median number of patients who were given a lethal injection was 4, and the range was 1 to 15.

ported by 78 percent of the respondents), the untreatability of the symptoms (72 percent), a life expectancy of less than six months (69 percent), and severe pain (29 percent).

Seventy-one percent of the physicians describing the most recent request for assistance in hastening death initially responded to the request by prescribing more analgesics (reported by 68 percent of the respondents), using less aggressive life-prolonging therapy (30 percent), discussing the request with colleagues (27 percent), prescribing antidepressants (25 percent), trying to dissuade the patient (22 percent), requesting a second opinion (18 percent), or obtaining a psychiatric consultation (2 percent).

The medications prescribed in lethal doses were opioids (in 75 percent of cases) and barbiturates (in 25 percent). The medications used for lethal injection were opioids (in 83 percent of cases) and potassium chloride (in 17 percent).

Of the 38 physicians who reported their most recent experience with a lethal injection, 43 percent administered it themselves, and 57 percent asked someone else to do so (a nurse in 57 percent of cases and another physician in 32 percent) or ordered an

TABLE 4. CHARACTERISTICS OF 81 PATIENTS WHO RECEIVED A PRESCRIPTION FOR A LETHAL DOSE OF MEDICATION OR A LETHAL INJECTION.*

CHARACTERISTIC	PRESCRIPTION	INJECTION
	weighted percent	
Person who made request†‡		
Patient	95	39
Family member or partner	5	54
Not specified	0	7
Request explicit	75	21
Request somewhat indirect	25	79
Patient's clinical status‡		
Experiencing severe discomfort	75	73
Dependent on others for personal care	68	55
Bedridden 50% or more of the time	57	55
Experiencing severe pain	54	24
Depressed	19	39
Confused 50% or more of the time	5	7
None of the above	2	15
Patient's sex		
Male	97	57
Female	3	43
Patient's age‡		
<18 yr	<1	<1
19–45 yr	28	17
46–75 yr	43	38
>75 yr	29	45
Patient's education		
<12 yr	<1	17
12–15 yr	29	60
≥16 yr	64	21
Don't know or don't remember	7	2
Life expectancy‡		
<24 hr	<1	59
1–6 days	26	37
1–3 wk	22	2
1–5 mo	50	2
6–12 mo	1	0
>12 mo	1	1
Patient hospitalized at time of request	5§	99
Family members or friends closely involved	83	95
Request reflected patient's wishes‡	100	100
Length of time physician had known patient		
<1 wk	0	8
1–4 wk	0	4
2–11 mo	12	26
≥12 mo	88	62
Request repeated‡	51	53
Immediate assistance requested	33	94
Second opinion obtained by physician‡	<1	32
Patient's primary diagnosis		
Cancer	70	23
Neurologic disease	6	17
Acquired immunodeficiency syndrome	6	16
Other¶	18	44
Someone else present at patient's death	98	65
Physician tried to dissuade patient from hastening death	34	11
Physician's comfort with role in assisting patient		
Very comfortable	58	83
Somewhat comfortable	24	5
Somewhat uncomfortable	18	6
Very uncomfortable	<1	6
Physician's willingness to comply with future requests of the same type		
Would definitely comply	39	28
Would probably comply	42	60
Unsure	18	5
Would probably not comply	1	1
Would definitely not comply	0	6

*The Oregon Death with Dignity Act specifies criteria for complying with requests from patients for assistance with suicide. The patient must be an adult with a terminal illness and a life expectancy of less than six months. The request must be made by the patient and must be voluntary. Procedural guidelines require that the initial request be repeated after 15 days, with an opportunity to rescind it, and that the physician obtain a second opinion, with a psychiatric evaluation if the disorder is causing impaired judgment.[10] We did not query physicians about all these criteria and could not determine whether all were met.

†If someone other than the patient made the request, we did not ask whether the patient later made the same request.

‡This involves one of the criteria specified in the Oregon Death with Dignity Act.

§Ninety percent of lethal prescriptions were given to patients who were at home, and 5 percent were given to patients in nursing homes.

¶Other diagnoses included end-stage heart or lung disease and multiorgan-system failure.

increase in the dose of an intravenous sedative or analgesic already being administered (in 11 percent of cases).

Characteristics of Patients Receiving Assistance

Although 95 percent of the requests for a prescription were made by the patients themselves, 54 percent of the requests for a lethal injection were made by a family member or partner (Table 4). Requests for a lethal injection were characterized as indirect rather than explicit in 79 percent of cases. Five percent of the patients who received prescriptions and 7 percent of those who received lethal injections were described as "confused 50% or more of the time," but we did not ask whether the patient was unable to communicate at the time of the decision to hasten death. Ninety-eight percent of the patients receiving a prescription were estimated to have less than six months to live, and 48 percent were estimated to have less than four weeks; 95 percent were not hospitalized at the time of the request. Ninety-six percent of the patients receiving a lethal injection were estimated to have less than a week to live, and 59 percent were estimated to have less than 24 hours; virtually all the patients died in the hospital. Most patients receiving either type of assistance had family or friends who were closely involved at the time of the request (83 percent of those receiving a prescription and 95 percent of those receiving a lethal injection). In every case of assisted suicide or

Table 5. Variables Predicting Willingness to Provide Assistance, Requests for Assistance, and Compliance with Requests.*

Variable	Prescription			Injection		
	No. of respondents	P value	Odds ratio	No. of respondents	P value	Odds ratio
Would provide assistance if it were legal to do so	747			502		
Religion		<0.001			<0.001	
Catholic			0.5			0.6
Other Christian			0.8			0.8
Jewish			1.6			1.7
None			1.3			1.2
Other†‡			1.0			1.0
Prayer		<0.001			<0.001	
Daily			0.3			0.3
Weekly			0.5			0.4
Less than weekly			0.7			0.6
Never‡			1.0			1.0
No. of patients seen/wk					0.056	
<50						0.7
50–100‡						1.0
>100						1.1
Have received request	319			195		
Specialty		<0.001			<0.001	
Region		<0.001			0.07	
West			1.8			1.5
North central			0.8			1.0
South			1.2			0.9
Northeast‡			1.0			1.0
Prayer		0.001			0.04	
Daily			0.4			0.7
Weekly			0.6			0.8
Less than weekly			0.4			0.5
Never‡			1.0			1.0
No. of patients seen/wk		0.02				
<50			0.7			
50–100‡			1.0			
>100			1.1			
Religion					0.04	
Catholic						2.1
Other Christian						2.1
Jewish						2.6
None						1.0
Other†‡						1.3
Age					0.04	
<45 yr‡						1.0
≥45 yr						1.4
Have complied with request	42			59		
Region		0.06			0.05	
West			2.2			3.0
North central			0.6			1.6
South			1.1			1.7
Northeast‡			1.0			1.0
No. of patients seen/wk		0.01				
<50			0.5			
50–100‡			1.0			
>100			0.2			
Religion					0.01	
Catholic						0.6
Other Christian						1.3
Jewish						2.7
None						2.2
Other†‡						1.0
Sex		0.03				
Male			5.0			
Female‡			1.0			
Prayer		0.05				
Daily			0.3			
Weekly			0.2			
Less than weekly			0.4			
Never‡			1.0			

*A multiple logistic-regression analysis was performed, with religious affiliation and specialty forced into all models. Variables with P values of less than 0.10 are reported.

†Because of small numbers, this category includes Moslem and other religions, as well as missing responses.

‡This was the reference category.

euthanasia, the physician believed that the request reflected the patient's wishes. The proportions of patients receiving a prescription who would have met the specific clinical and procedural criteria of the Oregon Death with Dignity Act[10] are shown in Table 4.

Predictors of Willingness to Provide Assistance and Provision of Assistance

Religious affiliation (Table 5) was associated with having given a lethal injection, as well as with the willingness to prescribe a lethal dose of medication or give a lethal injection. Catholic physicians were least likely and Jewish physicians or those with no religious affiliation were most likely to be willing to provide assistance or to have actually done so. Physicians who prayed less frequently were more willing to provide assistance or to have done so than physicians who prayed more frequently, except that frequency of prayer was not associated with lethal injection. The frequency of requests for a prescription was significantly associated with geographic region, with physicians in the West most likely to have received such requests. Doctors 45 years of age or older were more willing to give a lethal injection under current legal constraints (data not shown) and were more likely to have received such requests than younger doctors. Men were significantly more likely than women to have written a prescription for a lethal dose of medication.

Specialty was a significant predictor of both willingness to provide assistance under current law (data not shown) and the receipt of at least one request for assistance (Table 5). Pulmonologists, geriatricians, and general internists were most likely to be willing to give either a prescription for a lethal dose of medication or a lethal injection. Geriatricians and oncologists were more likely to have received requests for a prescription, whereas pulmonologists were more likely to have received requests for a lethal injection (Table 6).

DISCUSSION

We found that requests for assisted suicide or euthanasia are frequently made to physicians who practice in specialties in which they are likely to care for dying patients and that the decision to honor such a request is not rare in the United States. The prevalence of ever having acceded to a request for a prescription for a lethal dose of medication was 3.3 percent in our sample as compared with 7 percent in Oregon[7] in 1995, 13.5 percent among New England oncologists[11] in 1994, and 18 percent among Michigan oncologists[12] in 1993. The prevalence of ever having provided a lethal injection was 4.7 percent in our study, as compared with 4 percent in

Table 6. Willingness to Provide Assistance, Requests for Assistance, and Compliance with Requests, According to Specialty.

Variable		Specialty									
	All respondents	Family practice	Cardiology	Geriatrics	Infectious disease	Nephrology	Neurology	Hematology–oncology	Pulmonary disease	Internal medicine	Other
	percentage of respondents*										
Would write prescription for a lethal dose of medication if it were legal to do so	36	39	49	40	43	32	46	44	40	33	44
Would write prescription under current legal constraints	11	10	9	13	11	4	11	8	15	11	9
Have received request for assistance with suicide	18	15	12	26	21	9	9	25	18	21	12
Have written prescription for a lethal dose of medication	3.3	2	1	1	4	0	1	3	5	4	2
Would give lethal injection if it were legal to do so	24	28	28	25	31	21	32	27	31	23	28
Would give lethal injection under current legal constraints	7	7	2	4	5	3	7	2	9	8	5
Have received a request for a lethal injection	11	8	9	14	11	7	5	13	19	13	6
Have given a lethal injection	4.7	4	2	2	4	2	3	2	6	6	3

*Unweighted (raw) percentages are given for each specialty, with weighted percentages for all respondents.

Michigan[12] and 1.8 percent among oncologists in New England.[11]

Our study showed that several factors were associated with physicians' participation in hastening death, including region of practice, religion, and specialty. Repeated ballot measures and the attendant debate over the legalization of physician-assisted death in California, Oregon, and Washington may have led to a higher frequency of requests received by physicians in those states and may have influenced their willingness to honor the requests.[7,10] Whereas our study suggests that Jewish physicians are more likely to be willing to provide assistance than other physicians, two prior studies[13,14] have shown that Jewish (as well as Catholic) physicians are less willing than others to withdraw life support. Also, unlike prior surveys,[6,7,11,12] in which oncologists were the specialists most likely to receive requests for assistance with dying and most willing to provide such assistance, in our survey, other specialists were most likely to receive such requests and most willing to honor them.

We surveyed a national probability sample of physicians in a wide variety of specialties. Prior surveys have been limited to specialists who care for high-risk patients, such as oncologists[11,12] and specialists in the acquired immunodeficiency syndrome,[15] or to states where there has been considerable publicity associated with ballot measures (Washington and Oregon)[6,7,16] or Dr. Jack Kevorkian's repeated provision of assistance to patients (Michigan).[12,17] In addition, we assessed the validity of the survey instrument in eliciting honest answers about controversial and illegal acts by pilot testing in a group of physicians known to have participated in physician-assisted suicide or euthanasia.

Our results are limited to physicians in the selected specialties. To the extent that physicians in these specialties are more likely to receive requests for assistance with suicide or euthanasia, the prevalence estimates are higher than those for all practicing physicians. Conversely, to the extent that the respondents were reluctant to report illegal actions, we may have underestimated the actual frequency of physician-assisted death. Although the response rate in our study was more than 60 percent and was similar to that in other recent studies,[6,7,11,12,15] it is possible that the nonrespondents and the respondents differed.[18] Finally, although lethal injection was carefully defined as injection of a lethal dose "with the primary intention of ending the patient's life," some respondents may have confused this action with terminal sedation (i.e., the use of analgesic or sedative agents to induce unconsciousness and relieve suffering).

What are the implications of these data for the current debate over the legalization of physician-assisted death? First, a substantial number of physicians in the United States have received one or more requests for assistance with suicide or euthanasia. Educational efforts are needed to prepare physicians to explore the meaning of such a request[19] and to assess the patient's mental state and the adequacy of palliative care before responding to it. Second, legalization could lead to a large increase in the willingness of physicians to participate in the hastening of death and perhaps to an increase in its prevalence. Third, the majority of patients who request assistance with suicide appear to satisfy many of the criteria currently proposed as regulatory safeguards for this practice.[2,3,10,20]

Our findings with respect to lethal injection point to a different pattern of decision making. The finding that 54 percent of patients receiving a lethal injection did not make the request themselves suggests that physicians and family members felt compelled to intervene with a decision to hasten death. The majority of these patients had less than 24 hours to live, were experiencing severe discomfort or pain, and were in the relatively public setting of the hospital, with family members who were closely involved at the time of death. Sedation may have been used appropriately for refractory symptoms in the last hours of life, but in the absence of detailed descriptions of the circumstances surrounding these requests and actions, cautious interpretation is warranted. Although the fact that respondents reported these cases as examples of lethal injection suggests that their primary intention was to hasten death, the use of sedation for refractory symptoms in patients near death may have led some physicians to report actions intended to relieve suffering that were also intended to hasten death.[21]

Additional research on the circumstances in which doctors honor requests to hasten death should evaluate the possibility that better access to palliative care might obviate some of these requests[22,23] as well as clarify the practical implications of establishing regulatory guidelines. We evaluated physicians' practices during a time when medical education in palliative care was largely unavailable and such care was sporadically delivered.[23] The prevalence of requests for assistance in hastening death and of compliance with such requests may differ in communities where palliative care is easily accessible.

Supported by grants from the Greenwall Foundation, the National Institute for Nursing Research (1RO3NR03109), and the Gerbode Foundation. Drs. Meier and Morrison are Faculty Scholars of the Open Society Institute's Project on Death in America. Dr. Morrison is a Brookdale National Fellow.

The views expressed in this article do not necessarily reflect those of the University of Rochester or its Department of Medicine.

We are indebted to Jeri Mulrow for her work on sample design, selection, and weighting; and to Robert N. Butler, M.D., Joann Lynn, M.D., Kathleen Foley, M.D., Susan D. Block, M.D., and the Faculty Scholars of the Open Society Institute's Project on Death in America for their review and comments.

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LAW, ETHICS AND MEDICINE

Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ''vulnerable'' groups

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J Med Ethics 2007;**33**:591–597. doi: 10.1136/jme.2007.022335

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Received 10 July 2007
Accepted 10 July 2007

Background: Debates over legalisation of physician-assisted suicide (PAS) or euthanasia often warn of a ''slippery slope'', predicting abuse of people in vulnerable groups. To assess this concern, the authors examined data from Oregon and the Netherlands, the two principal jurisdictions in which physician-assisted dying is legal and data have been collected over a substantial period.

Methods: The data from Oregon (where PAS, now called death under the Oregon Death with Dignity Act, is legal) comprised all annual and cumulative Department of Human Services reports 1998–2006 and three independent studies; the data from the Netherlands (where both PAS and euthanasia are now legal) comprised all four government-commissioned nationwide studies of end-of-life decision making (1990, 1995, 2001 and 2005) and specialised studies. Evidence of any disproportionate impact on 10 groups of potentially vulnerable patients was sought.

Results: Rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured (inapplicable in the Netherlands, where all are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS. While extralegal cases were not the focus of this study, none have been uncovered in Oregon; among extralegal cases in the Netherlands, there was no evidence of higher rates in vulnerable groups.

Conclusions: Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.

If physician-assisted suicide (PAS) and/or voluntary active euthanasia were legalised, would this disproportionately affect people in ''vulnerable'' groups? Although principles of patient autonomy and the right to avoid suffering and pain may offer support for these practices, concerns about their impact on vulnerable populations speak against them. Warnings about potential abuse have been voiced by many task forces, courts and medical organisations in several countries where the issue is under debate. Box 1 presents some of these concerns.

We must take these concerns seriously, not only because they are repeated so often but because they are of such gravity. Would accepting or legalising physician-assisted dying at a patient's explicit request weigh more heavily on patients in vulnerable groups—the elderly, women, the uninsured, the poor, racial or ethnic minorities, people with disabilities, people with sometimes stigmatised illnesses like AIDS, and others? Would vulnerable patients be especially heavily targeted? Would these patients be pressured, manipulated, or forced to request or accept physician-assisted dying by overburdened family members, callous physicians, or institutions or insurers concerned about their own profits? This slippery-slope argument assumes that abusive pressures would operate on all seriously or terminally ill patients but would selectively disfavour patients whose capacities for decision making are impaired, who are subject to social prejudice or who may have been socially conditioned to think of themselves as less deserving of care. These pressures would result, it is assumed, in heightened risk for physician-assisted dying among vulnerable persons compared with background populations.

These are concerns both for those who oppose physician-assisted dying on moral grounds and for those who support it but are uneasy about the possible social consequences of legalisation. They are also concerns for proponents of legalisation who assume that the risks for vulnerable patients are heightened if these practices remain underground, as well as for those who favour legalisation but fear that vulnerable patients will be denied a privilege reserved for better-situated patients and that healthcare inequities already affecting vulnerable persons will be exacerbated. In short, slippery-slope concerns about vulnerable patients confront both those who do and those who do not find physician-assisted dying objectionable on moral grounds.

Of course, to observe that patients are members of potentially vulnerable groups is to assert neither that each such person or the group as a whole is actually vulnerable nor that people who are seriously or terminally ill but not considering physician-assisted dying are not vulnerable. But it is to recognize a special and appropriate concern about persons and groups seen as vulnerable because of impairment, disadvantage or stigmatisation.

Warnings of potential abuse rest on predictive claims, claims typically assuming that higher rates of death in this way suggest abuse. We do not attempt to evaluate putative criteria

Abbreviations: ALS, amyotrophic lateral sclerosis; ODDA, Oregon Death with Dignity Act; PAS, physician-assisted suicide

Box 1 '' Slippery-slope'' concerns about vulnerable patients in health policy statements on physician-assisted dying

''… no matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.''
New York State Task Force on Life and the Law, 1994[1]

''… the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals [Ninth Circuit] dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as ludicrous on its face.…We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations …''
US Supreme Court, joint opinion in *Washington v Glucksberg* (1997) and *Vacco v Quill* (1997)[2]

''Euthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. … If euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges … to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the ''slippery slope'' that many fear.''
Canadian Medical Association, 1998[3]

''Both society in general and the medical profession in particular have important duties to safeguard the value of human life. This duty applies especially to the most vulnerable members of society—the sick, the elderly, the poor, ethnic minorities, and other vulnerable persons. In the long run, such persons might come to be further discounted by society, or even to view themselves as unproductive and burdensome, and on that basis, ''appropriate'' candidates for assistance with suicide.''
''… the ramifications [of legalization] are too disturbing for the … value our society places on life, especially on the lives of disabled, incompetent, and vulnerable persons.''
American College of Physicians–American Society of Internal Medicine (ACP–ASIM), 2001[4]

''… the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns and that the practice might undermine patient trust and distract from reform in end of life care. The College was also concerned with the risks that legalization posed to vulnerable populations, including poor persons, patients with dementia, disabled persons, those from minority groups that have experienced discrimination, those confronting costly chronic illnesses, or very young children.''
American College of Physicians, 2005[5]

''… allowing physicians to participate in assisted suicide would 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 …''
''Euthanasia could also readily be extended to incompetent patients and other vulnerable populations …''
American Medical Association, 1996, 2005[6 7]

''In the BMA's view, legalizing euthanasia or physician-assisted suicide would have a profound and detrimental effect on the doctor–patient relationship. It would be unacceptable to put vulnerable people in the position of feeling they had to consider precipitating the end of their lives…The BMA acknowledges that there are some patients for whom palliative care will not meet their needs and wishes, but considers that the risks of significant harm to a large number of people are too great to accommodate the needs of very few.''
British Medical Association, 2003[8]

for whether assisted dying might seem ''appropriate'' for some vulnerable groups. Rather, we ask the prior question of whether there is evidence that where assisted dying is already legal, the lives of people in groups identified as vulnerable are more frequently ended with assistance from a physician than those of the background population. We can now begin to evaluate this factual issue by examining directly what is happening in the two principal jurisdictions—Oregon and the Netherlands—where physician-assisted dying is legal and data have been collected over a substantial period.

DATA AVAILABLE IN OREGON AND THE NETHERLANDS

In Oregon, nine annual reports issued by the Department of Human Services cover the period since the Oregon Death with Dignity Act (ODDA) took effect in 1997.[9] Three surveys of Oregon physicians and hospice professionals add information beyond that drawn from official reports.[10–12] In the Netherlands, four nationwide studies (the first of which is known as the Remmelink report) commissioned by the Dutch government used cross-sectional analyses of data from interviews, death certificates and questionnaires to cover all end-of-life decision making in the years 1990,[13 14] 1995,[15] 2001[16] and 2005.[17] Several smaller, focused Dutch studies provide additional data, as noted below. The Oregon data are from the 2006 report and cumulative study[9] and the Dutch data are from the 2005 nationwide study[17] unless otherwise mentioned. The Oregon Department of Human Services data include all legal cases reported under the ODDA; additional surveys have not uncovered extralegal or unreported cases.[10 12] The nationwide Dutch data cover cases reported to the authorities as required under Dutch guidelines as well as extralegal, unreported cases.

Box 2 provides the legal background, incidence and regulation of assisted dying in the two jurisdictions. The term ''physician-assisted suicide'' was used by Oregon in reporting its data for the first several years of legalisation, but it does not appear in the statute; Oregon now refers to ''death under the Oregon Death with Dignity Act''. The term ''physician-assisted suicide'' is used here to distinguish the form of physician-assisted

Box 2 Legal background, incidence and regulation of assisted dying in Oregon and the Netherlands

Oregon

- The Oregon Death with Dignity Act was passed as a ballot initiative in 1994; implementation was delayed by a legal injunction and the measure was returned to the ballot by the legislature and passed again in 1997; the Act became law on October 27 of that year. A federal challenge to the ODDA was rejected by the US Supreme Court in 2006. Oregon is the only US state to legalize PAS (now referred to as utilisation of the ODDA). Euthanasia remains illegal.
- A total of 292 people have died under the ODDA in the 9 years since its enactment; this is approximately 0.15% of people who have died during this period.
- The Act allows terminally ill Oregon residents to obtain from their physicians a prescription for lethal medication for the purpose of ending their lives if the following conditions are met:
  - The patient must be adult (18 years of age or older) and a resident of Oregon.
  - The patient must be capable (defined as able to make and communicate healthcare decisions).
  - The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.
  - The patient must be diagnosed by two physicians as having a terminal illness (defined as 6 months or less to live).
  - The patient must make two oral requests to his or her physician, separated by at least 15 days, and one witnessed written request.
  - If either physician believes the patient's decision may be influenced by a mental disorder, the patient must be referred for a mental health evaluation.
  - The patient must be informed by the prescribing physician of feasible alternatives, including comfort care, hospice care and pain control.
  - The prescribing physician must request, but may not require, the patient to notify his or her next of kin of the request.
  - The physician must report the prescription for lethal medication to the Oregon Department of Human Services (formerly the Oregon Health Division); and the Department must make available an annual statistical report of information collected under the Act.[18]
  - Pharmacies are required to report filling such prescriptions.
- Oregon's statute requires terminal illness but makes no reference to the patient's pain, symptoms or suffering. It does not indicate whether the prescribing physician must, may or may not be present at the patient's death. It stipulates that ending one's life under the Death with Dignity Act does not constitute suicide.

The Netherlands

- Voluntary active euthanasia and PAS have been openly practised and, in effect, legal since the 1980s under guidelines developed in the courts and by the Royal Dutch Medical Association. According to an exception in the criminal code enacted in 2002, physicians who perform euthanasia or provide assistance in suicide commit no offense if they follow the guidelines for ''due care''.
- Of the total annual mortality of 136 000 (2005), approximately 1.7% of deaths are by voluntary active euthanasia and 0.1% by physician-assisted suicide; another 0.4% involve life-ending acts without explicit current request (known as LAWER).
- The guidelines require that:
  - The patient must make a voluntary, informed and well-considered request.
  - The patient must be facing unbearable and hopeless suffering, either currently or in the immediate future and with no outlook for improvement.
  - The physician must agree with the patient that no reasonable alternative treatment that might reduce the suffering is available.
  - The physician must consult with another, independent physician.
  - The action must be performed with due care.
  - The action must be reported to the appropriate authorities.
- Since 1998, five regional committees appointed by the Ministry of Justice review all reported cases. If they decide that the physician's behavior met the requirements of due care, their decision is final.
- Dutch law does not require that the patient be terminally ill but does require that the patient be facing ''unbearable and hopeless suffering''. Advance directives requesting euthanasia in the event that the patient becomes comatose or demented are also legal. Both before and after statutory legalization in the 2002 law, a physician has been protected from prosecution if the guidelines are met.

dying legally permitted in Oregon from the wider range of physician-assisted dying in the Netherlands, namely, both physician-assisted suicide and voluntary active euthanasia.

This paper examines available data concerning the use of physician-assisted dying (PAS in Oregon; PAS or voluntary active euthanasia in the Netherlands) to determine whether there is evidence of disproportionate impact on vulnerable populations. Are the lives of people in vulnerable groups more frequently ended with a physician's assistance than those of other, less vulnerable people? The results presented (table 1) move from the most robust data to that which is partial, inferential or in other ways less secure. Detailed accounts of the statistical and other methods used in each source study are available in those studies, variously including information on response rates, survey questions asked, sample sizes, actual numbers, statistical power and confidence intervals, methods of calculation of rate ratios, detectable differences, changes over time, and methodology, design and analysis techniques. We recognize that substantial differences in the methodologies of the source studies make it impossible to determine with certainty the actual incidence of assisted dying in several of the vulnerable groups studied. Our question is whether the available data show evidence of heightened risk to persons in vulnerable groups.

IS THERE EVIDENCE OF HEIGHTENED RISK TO PEOPLE IN VULNERABLE GROUPS?

Findings based on robust data

The elderly: *no evidence of heightened risk*

In Oregon, 10% of patients who died by PAS were 85 or older, whereas 21% of all Oregon deaths were among persons in this age category. Persons aged 18–64 years were over three times more likely than those over age 85 years to receive assisted dying. In the Netherlands, rates of assisted dying were lowest in the people over 80 (0.8% in 2005), next lowest in the age range 65–74 years (2.1%) and higher below age 65 (3.5%). People over 80 formed 30% of the group of patients whose requests were refused and 13% of those whose requests were granted and carried out.[19]

Women: *no evidence of heightened risk*

In Oregon, 46% of individuals receiving assisted dying were women and women were not more likely than men to use assisted suicide. In the Netherlands, despite some fluctuation in different years of the nationwide studies, the rates tend to be slightly higher in men.

Uninsured people: *no evidence of heightened risk*

Three Oregon patients (1%) did not have documented health insurance, and in four cases, insurance status was unknown. In contrast, 16.9% of non-elderly adults in Oregon were uninsured[20] (persons 65 and older are insured by Medicare). In the Netherlands, virtually all patients are covered by mandated nationwide health insurance.

People with AIDS: *heightened risk found*

In 9 years in Oregon, a total of six persons with AIDS died under the ODDA; although the numbers are small (2% of the total of 292 ODDA deaths), persons with AIDS were 30 times more likely to use assisted dying than those who died of chronic respiratory disorders in the interview portions of the nationwide studies in the Netherlands, very few patients with AIDS had received a physician's assistance in dying. However, in an Amsterdam cohort of 131 homosexual men with AIDS diagnosed between 1985 and 1992 who had died before 1 January 1995, 22% died by euthanasia or PAS.[21]

Findings based on partly direct, partly inferential data

People with low educational status: *no evidence of heightened risk*

In Oregon, the likelihood of dying by PAS was correlated with higher educational attainment. Terminally ill college graduates in Oregon were 7.6 times more likely to die with physician assistance than those without a high school diploma. While no direct quantified data are available in the Netherlands about the educational status of patients receiving assisted dying, information in the 1990 study about professional status, associated with educational status, showed no special relationships to patterns of euthanasia or PAS.

The poor: *no evidence of heightened risk*

The Oregon data do not include direct measures of income, employment or assets, but death under the ODDA was associated with having health insurance and with high educational status, both indirect indicators of affluence. In the Netherlands, data inferred from the postal codes of the location in which the person was living before death showed that the overall rates of assisted dying were somewhat higher for people of higher socioeconomic status.[22]

Racial and ethnic minorities: *no evidence of heightened risk*

In Oregon, 97% of the 292 patients who had a physician's assistance in suicide were white; six of the non-white patients were persons of Asian descent, one was Hispanic and one was Native American. Although 2.6% of Oregonians are African-American, no African-American has received physician-assisted dying under the Act. Dutch mortality statistics do not include information about race or ethnicity; however, even the most vocal opponents of assisted dying in the Netherlands do not claim that it is imposed more frequently on stigmatised racial or ethnic minorities.

People with non-terminal physical disabilities or chronic non-terminal illnesses: *no evidence of heightened risk*

In one sense, virtually all patients who are seriously or terminally ill are to some extent physically disabled and chronically ill. Patients who are dying lose functional capacities and may be bedridden toward the end; in this sense, most patients who received assistance in dying in either Oregon or the Netherlands were chronically ill and (recently) disabled. Cancer, the diagnosis in about 80% of all cases of assisted dying in both Oregon and the Netherlands, is often identified as a chronic illness; so is amyotrophic lateral sclerosis (ALS), also a frequent diagnosis. Concerns about persons in vulnerable categories have focused, however, on pre-existing physical disabilities and chronic non-terminal illnesses.

Although the data from Oregon do not indicate whether a person had a disability before becoming terminally ill (defined as having 6 months or less to live), no one received physician-assistance in dying who was not determined by two physicians to be terminally ill—that is, no one received such assistance for disability alone. That some patients received lethal prescriptions that they did not ingest and lived longer than 6 months may represent limitations in prognostication, although clinicians caring for terminally ill cancer patients are likely to overestimate rather than underestimate survival.[23 24] In the Netherlands, assisted dying for disability alone would not be illegal in principle; a terminal diagnosis is not required by the Dutch guidelines, and a person who faces unbearable suffering, in his or her own view, and who has been offered all forms of treatment but has no hope of improvement may request assistance in dying. Estimates made by physicians of the amount of life forgone can be used to make an approximation of disability or chronic illness status: about 0.2% of patients receiving euthanasia or assistance in suicide were estimated to have forgone more than 6 months of life, or less than 10 of the approximately 2400 cases in 2005. Dutch general practitioners infrequently grant and frequently refuse assistance in dying to patients whose diagnosis is "old age/general deterioration" or "other" (this includes the category of patients with no terminal illness and no ALS or multiple sclerosis).[19] There is thus no evidence that physician-assisted dying poses heightened risk to people with disabilities who are not also seriously ill.

Minors and mature minors: *no evidence of heightened risk*

The Oregon ODDA requires that a patient be an adult (18 years of age or older) before assisted dying is granted; no cases of physician-assisted death were reported among minors. In the Netherlands, mature and relatively mature minors are understood to have some decision-making capacity and are not excluded under the Dutch guidelines, but because they are below the age of majority must be regarded as ''vulnerable''. Since death rates among minors in the Netherlands (0.4% of all deaths) were the lowest in any age group, it is difficult to reach statistically firm conclusions. In 2001, less than 1% of all deaths of persons aged 1–17 years were the result of euthanasia: no cases of PAS were found in this age group.

The Netherlands has recently developed a protocol for euthanasia in newborns with very serious deficits who have a hopeless prognosis and experience what parents and medical experts deem to be unbearable suffering; the decision is to be made in collaboration with the parents and requires their full approval. This is known as the Groningen protocol.[25] Such cases are infrequent—22 cases have been reported to district attorneys in the Netherlands during the past 7 years, and there are an estimated 10 to 20 cases annually among the somewhat

Table 1 Physician-assisted dying in potentially vulnerable groups in Oregon and the Netherlands: overview of data from Oregon reports and studies, and Dutch nationwide and focused studies

	Oregon—PAS patients 1998–2006			**Netherlands*— PAS/euthanasia patients 2005 (n = 2400)**		
Potentially vulnerable group	**Characteristic**	**No. (%)**	**Rate ratio**	**Characteristic**	**No. (%)**	**Rate ratio**
Findings based on direct data						
The elderly (age in years)	18–44	11 (4)	3.4	0–64	900 (38)	1.7
	45–64	83 (28)	3.2	65–79	950 (39)	1.7
	65–84	170 (58)	2.3	80+	550 (23)	1.0
	85 +	28 (10)	1.0			
	Median 70 (range 25–96)					
Women	Male	157 (54)	1.1	Male	1350 (56)	1.3
	Female	135 (46)	1.0	Female	1050 (44)	1.0
Uninsured people	Private insurance	180 (62)		Not applicable (all are insured)		
	Medicare or Medicaid	105 (36)				
	No insurance	3 (1)				
	Status unknown	4 (1)				
People with AIDS	HIV/AIDS†	6 (2)	30.3	HIV/AIDS‡	29 (22)	7.9
Findings based on partly direct and partly inferential data						
People with low educational status	<High school	25 (9)	1.0	Indirect data (via SES); no direct relationship		
	HS graduate	82 (28)	1.8			
	Some college	64 (22)	3.2			
	Baccalaureate or higher	121 (41)	7.6			
The poor (people with low SES)	Rate low¶			Low SES§	1400 (38)	1.0
				Moderate SES	1200 (33)	1.0
				High SES	800 (22)	1.2
				Institutions§	300 (8)	0.3
Racial and ethnic minorities	White	284 (97)	1.0	No data (Dutch mortality statistics are not kept by race)		
	African-American	0 (0%)				
	Hispanic	1 (<1%)	0.4			
	Native American	1 (<1%)	0.5			
	Asian	6 (2)	1.8			
	Other	0	0			
People with chronic physical or mental disabilities or chronic non-terminal illnesses	Not legal; no cases reported or identified			No data to calculate denominator; probably 10 cases or fewer per year		
Minors	Not legal; no cases reported or identified			1.6% of all deaths of minors aged 1–16 years		
Findings based on inferential or partly contested data						
People with psychiatric illness, including depression and Alzheimer disease	Not legal; no clear cases; three disputed cases among those given prescription (n = 456)			No data to calculate denominator; increased requests among cancer patients with depression; probably rare for psychiatric illness as main diagnosis; legal in Alzheimer disease with advance euthanasia directive but compliance rare		

*All estimates are based upon data about a sample of 9000 deaths from August to November 2005, unless indicated otherwise; 2005 data are used for simplicity. Data are roughly comparable for entire period studied. Also see van der Heide *et al*, 2007.[17]
†Referent is chronic lower respiratory disorder.
‡Estimate based upon prevalence study from early 1990s.
¶Indirect data (via educational level and insuredness).
§Estimates based upon 2001 nationwide study; also see Onwuteaka-Philipsen *et al*, 2003.[16]
LAWER, life-ending acts without explicit current request; PAS, physician-assisted suicide; SES, socioeconomic status.

over 1000 children born in the Netherlands who die during the first year of life, about 1% of newborn deaths.

Findings based on inferential or partly contested data

Patients with psychiatric illness, including depression and Alzheimer disease: *no evidence of heightened risk*

Approximately 20% of requests for physician assistance in dying came from depressed patients, but none progressed to PAS.[10] None of the 292 patients who died under the ODDA were determined to have a mental illness influencing their decision, though there have been three disputed cases among the 9-year total of 456 who received prescriptions.[26 27] Because not all patients who requested assistance were specifically evaluated by mental health professionals and because many cases of depression are missed in primary care, it is possible that some depressed patients received lethal prescriptions; it is also possible that a patient without a mental disorder at the time of receiving the prescription became depressed by the time they ingested it. There is, however, no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the ODDA.

In the Netherlands, about two-thirds of explicit requests for assistance in dying are not granted. In 31% of all requests not granted in the 1995 study, the physician gave the presence of psychiatric illness as at least one reason for not complying. Physicians in the interview portion of the 1995 Dutch nationwide study mentioned depression as the predominant symptom in patients who died by PAS or euthanasia in 3% of all cases, compared with ''loss of dignity'' in 60%, pain as an associated complaint in 45% and debility in 43%. In one study, cancer patients with depressed mood were four times more likely to request euthanasia, but how often the request was granted is unknown.[28]

In 1994, the Dutch supreme court ruled in the *Chabot* case, in which a psychiatrist assisted with suicide for a woman with intractable depression but without concomitant physical illness, that ''intolerable suffering'' might consist in mental suffering alone without somatic origins and not involving the terminal phase of a disease, though the court commented that such cases would be rare and that they require heightened scrutiny.[29] The 2001 Dutch interview study estimated that about 3% of all requests for euthanasia or PAS that physicians had received the previous year were from patients with predominantly psychiatric or psychological illnesses, but none were granted. In the Dutch 1995 nationwide substudy on end-of-life decision making in psychiatric practice, there appeared to be about two to five physician-assisted deaths on request per year, mostly but not always in patients with a concurrent serious physical illness, often in the terminal phase. Explicit requests for a physician's assistance in dying are not uncommon in psychiatric practice in the Netherlands, and a majority of Dutch psychiatrists consider assisted suicide for psychiatric patients acceptable in certain circumstances. However, this rather liberal attitude appears to be associated with quite reluctant practice: despite the fact that Dutch law would permit it, it occurs only very rarely.

Since 2002, the Netherlands has also recognised as legal advance euthanasia directives of patients with dementia, including Alzheimer disease. Although approximately 2200 demented patients with advance directives requesting euthanasia after the onset of dementia die annually having been treated by a physician who knows about this directive—indeed, in 76% of such cases, compliance with the directive was discussed—euthanasia is seldom performed.[30]

Table 2 summarises the comprehensive data provided in table 1.

THE COMPREHENSIVE PICTURE IN OREGON AND THE NETHERLANDS

The data from Oregon and the Netherlands are the most informative sources concerning legal physician-assisted dying, though they are not comparable in a number of respects: they cover different time periods, were obtained by different methods, and are of different strengths. Neither the Oregon nor the Dutch studies were corrected throughout for considerations of whether diagnoses that may make physician-assisted dying attractive are equally distributed in vulnerable and non-vulnerable groups. Clearly, more work needs to be done.

Where they do overlap, however, the studies are largely consistent. Where the data are robust, the picture in Oregon and the Netherlands is similar: in both jurisdictions, a smaller percentage of older people received assistance in dying than of younger patients; gender ratios were slightly higher for males over time; and assistance was not more common among the uninsured. Socioeconomic data of intermediate strength, usually inferred from other, more robust data, also suggest similar pictures in the two jurisdictions: recipients of assistance in dying were likely to be of equal or higher educational status and were less likely than the background population to be poor. Data that are robust in one jurisdiction but partly inferential and hence less secure in the other did not reveal cases in either

Table 2 Summary of evidence of heightened risk in physician-assisted dying in Oregon and the Netherlands

Potentially vulnerable group	Evidence of heightened risk	No evidence of heightened risk
Direct data		
The elderly		×
Women		×
Uninsured people		×
People with AIDS	×	
Partly direct, partly inferential data		
People with low educational status		×
The poor: people with low socioeconomic status		×
Racial and ethnic minorities		×
People with chronic physical or mental disabilities or chronic non-terminal illnesses		×
Minors		×
Inferential or partly contested data		
People with psychiatric illness, including depression and Alzheimer disease		×

data set of assisted dying associated with physical disability alone without concomitant serious or terminal illness. The rates of physician-assisted dying among mature minors, which is legal in the Netherlands, were too low to be statistically valid. Although the rates of request for physician-assisted dying may have been higher among patients with depression, it appears that most such requests did not culminate in euthanasia, even though such cases may be legal in the Netherlands if given heightened scrutiny; studies of patients in the process of making requests are needed to clarify the risk conferred by depression. Even where the data involve very few cases or are absent in one or the other jurisdiction, the picture appears to match: neither in Oregon nor in the Netherlands was there any report of assisted dying disproportionately practised among racial minorities. Thus, there is no evidence of heightened risk of physician-assisted dying to vulnerable patients in either legal or extralegal practice groups, with the sole exception of people with AIDS.

Thus, we found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups. The evidence available cannot provide conclusive proof about the impact on vulnerable patients, and full examination of practice in Oregon would require studies of the complexity, duration and comprehensiveness of the four Dutch nationwide studies. Nevertheless, the joint picture yielded by the available data in the two jurisdictions shows that people who died with a physician's assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges. This conclusion does not directly speak to the moral issues in physician-assisted dying; it does not argue whether physician-assisted dying would be more or less appropriate for people in some groups; and it does not show that people in vulnerable groups could not be disproportionately affected in the future or in other jurisdictions. It also does not show whether low rates of physician-assisted dying among vulnerable persons reflect a protective effect of safeguards or, rather, are evidence of unequal access to assistance. But it does show that there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying—concerns that death in this way would be practised more frequently on persons in vulnerable groups.

ACKNOWLEDGEMENTS

We are grateful to Katrina Hedberg, Mette Rurup, Hermann van der Kloot Meijberg and John Griffiths.

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Competing interests: None declared.

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JOURNAL OF PALLIATIVE MEDICINE
Volume 14, Number 4, 2011

DOI: 10.1089/jpm.2010.0425

Quality of Death and Dying in Patients who Request Physician-Assisted Death

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Abstract

Background: Physician-assisted death (PAD) was legalized in 1997 by Oregon's Death with Dignity Act (ODDA). Through 2009, 460 Oregonians have died by lethal prescription under the ODDA.
Objective: To determine whether there was a difference in the quality of the dying experience, from the perspective of family members, between 52 Oregonians who received lethal prescriptions, 34 who requested but did not receive lethal prescriptions, and 63 who did not pursue PAD.
Design: Cross-sectional survey.
Measurements: Family members retrospectively rated the dying experience of their loved one with the 33 item Quality of Death and Dying Questionnaire (QODD).
Results: There were differences reported in 9 of the 33 quality item indicators. Few significant differences were noted in items that measured domains of connectedness, transcendence, and overall quality of death. Those receiving PAD prescriptions had higher quality ratings on items measuring symptom control (e.g., control over surroundings and control of bowels/bladder) and higher ratings on items related to preparedness for death (saying goodbye to loved ones, and possession of a means to end life if desired) than those who did not pursue PAD or, in some cases, those who requested but did not receive a lethal prescription.
Conclusions: The quality of death experienced by those who received lethal prescriptions is no worse than those not pursuing PAD, and in some areas it is rated by family members as better.

Introduction

IMPROVING END-OF-LIFE CARE is a priority for health care in the United States. Researchers are refining measurements of the end-of-life experience and factors associated with better quality of care and quality of death and dying. Quality of death and dying is comprised of a variety of elements including symptom management, treatment in accord with patient wishes, psychological health, spiritual and existential well-being, social support, and the experience of death.[1,2]

Citizens in two states—Oregon (since 1997) and Washington (since 2009)—have legalized physician-assisted death (PAD) for terminally ill individuals. The Oregon Death with Dignity Act (ODDA)[3] allows a patient to request a lethal dose of medication from a physician for the purposes of self-administration. Since passage in 1997, 460 Oregonians have died under the terms of the ODDA. Experts have speculated that patients may be motivated to pursue PAD to avoid poor quality of dying caused by symptom distress and impaired physical function, psychological variables such as depression and hopelessness, lack of or conflicted social support, existential or spiritual distress, and perception of self as a burden.[4–9] It has been suggested that improved end-of-life care could address these needs and thus alleviate the desire for PAD.[4,8] Additionally, it has been postulated that presence of legal PAD might in fact result in a decline in the quality of end-of-life care for patients, as health care providers would prematurely consider PAD when faced with unmanaged symptoms[10] or as a response to the burden of the cost of care.[11] In contrast to these concerns, previous research with patients and physicians, social workers and nurses, and family members involved with patients who chose PAD identified the importance of a desire to control circumstances of death, die at home, maintain independence and avoid future physical symptoms as possible contributors to requests for PAD.[6,7,12,13] Whether access to a lethal prescription helps patients to meet these goals has not been investigated.

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Accepted November 16, 2010.

In this study we investigate the quality of death and dying of terminally ill Oregonians as perceived by family members, and consider whether those who receive a lethal prescription under the ODDA encounter end of life experiences that differ objectively and subjectively from those who requested PAD but were unable to access it, and those who never requested PAD.

Methods

To understand the perceived differences in quality of death, we asked participants to evaluate the end-of-life experiences of their loved ones in terms of physical symptoms, preparation for death, existential transcendence, connections to others, and overall quality of life and death by using the Quality of Death and Dying (QODD), a validated instrument.[14]

Participants for this study were recruited from agencies and organizations in northwest Oregon willing to participate: two large medical centers, three large hospices, the Amyotrophic Lateral Sclerosis (ALS) Association of Oregon, and Compassion and Choices of Oregon. Compassion and Choices of Oregon is an advocacy organization that provides information, support and referral to those who qualify for assisted death under the ODDA. Four of these organizations kept registries of those pursuing PAD and made the initial contact with family members of decedents who made an explicit request for PAD to a physician (whether or not the patient received a prescription). After being notified of the opportunity, family members contacted the research team if they wished to participate. Compassion and Choices of Oregon identified 180 eligible primary informants, of whom 38% participated. Family members from other referral sources were a convenience sample. Potential participants were excluded if the loved one died less than 4 months or more than 3 years before the study or if the organization was not confident that the family member was aware of the request for PAD. Comparison family members were a convenience sample recruited from the hospices, medical centers, and the ALS Association noted above. The data were collected between 2004 and 2007 and conducted by study research personnel and Dr. Goy. Details of recruitment have been previously described.[12,15]

This study was approved by the Institutional Review Board of the Portland Veterans Affairs Medical Center and the participating medical centers and hospices. All participants gave written informed consent to participate.

Measures

Quality of death and dying. The QODD is a retrospective, 33-item measure of the quality of dying and death for the time period immediately preceding the death from the perspective of family members.[14] The interviewer-administered instrument elicits family rating of the frequency and quality of the patient's experiences during the last 7 days of life, or during the last 30 days of life if the loved one was unconscious or unresponsive during the last 7 days of life. The QODD assesses the domains of symptom control, social connectedness, preparation for death, and transcendence, with several items in each domain as indicators of quality. This instrument has evolved over time with use and subsequent validation. Recent factor analysis has led the instrument's authors to recommend a 17-item version with the four conceptual domains noted above[16]; however, our study was conducted before this recommendation and we used the original version of the instrument which includes items to rate global quality of death and the moment of death.

Indicators of quality (items) in each domain were evaluated by family members on two aspects: whether and with what frequency an indicator was present; and to what extent the presence or absence of that indicator affected their loved one's dying experience. Frequency ratings are either on a 6-point Likert scale ($0 =$ none of the time; $5 =$ all of the time) or on a binary scale (yes/no) depending on the question. For example, family members are asked to rate "How often did (loved one's name) appear to be worried about strain on his/her loved ones?" or "Did (loved one) appear to find meaning and purpose in her/his life?" Family members are then asked to assess how this impacted quality with the question, "How would you rate this aspect of (loved one's name) dying experience" on an 11-point Likert scale ($0 =$ terrible experience; $10 =$ almost perfect experience). There are two global questions rating the quality of life in the last 7 days before death (or last 30 days under the conditions noted above) and at the moment of death on an 11-point Likert scale. Data from the 7-day and the 30-day versions of the QODD are combined.

Statistical analysis

Categorical data are presented as frequencies and proportions. Among the QODD continuous measures, many responses were not normally distributed. Because the sample size was large, $n = 147$, and each group size was relatively large ($n = 52$, 32, and 63, respectively), it was possible that nonnormality and asymmetry would not affect the analysis. Therefore, we analyzed the data with parametric (analysis of covariance and Student's t-test) and non-parametric tests (Kruskal-Wallis) to assure the reliability of the results. In all but 5 cases the parametric and non-parametric results agreed; of those that differed, significance values were close and trended in expected directions. As such, we report continuous measures as means with standard deviations (SD) and compared the three groups with analysis of covariance. Family education level and whether or not the patient was enrolled in hospice were included as covariates in these analyses to account for group differences on these variables. If significant differences were found, *post hoc* analysis was conducted using a Bonferroni adjustment. We used χ^2 analysis to examine group differences on dichotomously scored variables. Because of the large number of comparisons that were not hypothesis-based, alpha was set at 0.01. Items with p values between 0.05 and 0.015 are identified as trending toward significance. Data analysis was completed with the Statistical Package for the Social Sciences (SPSS Inc., Chicago, IL) version 17.

Results

We surveyed 147 family members regarding their assessment of their loved one's dying experience, including 84 family members of patients who requested physician assisted death. The final data set included three groups of Oregonians: 52 decedents who requested and received a lethal prescription to facilitate assisted death (including 32 who died of PAD); 32 decedents who requested but did not receive the requested prescription; and 63 decedents who never pursued or re-

Table 1. Characteristics of Family Members

Family member	*Loved one requested and received PAD* (n = 52)	*Loved one requested but did not receive PAD* (n = 32)	*Comparison family member* (n = 63)	*p value*
Relationship to patient, *n* (%)				NS[a,b]
Spouse/partner	33 (64)	17 (53)	37 (59)	
Daughter/son	15 (29)	9 (28)	17 (27)	
Other	4 (8)	6 (19)	9 (14)	
Gender, *n* (%)[a]				NS[a]
Male	17 (33)	10 (31)	13 (21)	
Female	35 (67)	22 (69)	50 (79)	
Family member ethnicity[a]				NS[a]
Caucasian	52 (100)	32 (100)	61 (97)	
Non-Caucasian	0 (0)	0 (0)	2 (3)	
Age (years), mean (SD)[c]	61.0 (13.3)	61.2 (12.2)	60.1 (14.2)	NS[d]
Educational achievement (years), mean (SD)	16.3 (3.4)	15.7 (2.3)	14.5 (3.2)	<0.05[d]
How long known patient (years), mean (SD)	40.0 (16.1)	44.2 (15.3)	38.6 (16.6)	NS[d]
Days between death and interview, mean (SD)	396.4 (274.4)	453.4 (264.2)	446.8 (210.1)	NS[d]
Religiousness (mm)[e]	31.3 (37.9)	27.3 (35.7)	58.4 (38.3)	<0.001[d]
Views on legalization of PAD[f]	1.1 (3)	1.1 (3)	2.4 (1.4)	<0.001[d]

[a] χ^2 test.
[b] NS, not significant.
[c] SD, standard deviation.
[d] Compared with analysis of variance.
[e] 0–100 mm scale where 0 = religion not important to me, and 100 = religion very important to me.
[f] Family members' views on legalization of PAD; scale 1 = strongly support, 5 = strongly oppose.
PAD, physician-assisted death; SD, standard deviation.

quested a prescription to facilitate PAD (comparison group). Most family members were well-educated spouses or children, who had known the decedent for close to 40 years (Table 1). Ninety-nine percent of respondents were Caucasian. Family members of those who requested PAD were overall supportive of legalization of PAD and less religious than comparison family members. Most decedents were enrolled in hospice and died of cancer (Table 2).

Table 3 presents measures of frequency and impact that were statistically significant or trended toward significance.

Symptom control

Twelve items measured the severity of six symptoms and their impact on the quality of dying including pain; ability to feed self; control over surroundings and over bowel and

Table 2. Characteristics of Decedents

Decedent	*Loved one requested and received PAD* (n = 52), n (%)	*Loved one requested but did not receive PAD* (n = 32), n (%)	*Comparison decedent* (n = 63), n (%)	*p value*
Gender				NS[a]
Male	32 (62)	16 (50)	36 (57)	
Female	20 (39)	16 (50)	27 (43)	
Hospice enrolled				<0.05
No	9 (17)	1 (3)	3 (5)	
Yes	43 (83)	30 (97)	60 (95)	
Terminal diagnosis				NS
Cancer	45 (87)	23 (72)	50 (79)	
ALS	3 (6)	1 (3)	6 (10)	
Other	4 (8)	8 (25)	7 (11)	
Place of death				NS
Home[b]	46 (90.2)	25 (80.6)	44 (69.8)	
Inpatient hospice	1 (2.0)	2 (6.5)	10 (15.9)	
Other	4 (7.8)	4 (12.9)	9 (14.3)	
QODD version				0.001
7 day	51 (98)	31 (97)	50 (79)	
30 day	1 (2)	1 (3)	13 (21)	

[a] NS = not significant, all comparisons χ^2 test.
[b] Includes own home, surrogate home, and other home.
PAD, physician-assisted death; ALS, amyotrophic lateral sclerosis; QODD, Quality of Death and Dying Questionnaire.

Table 3. Quality of Death and Dying in Patients Who Requested and Did Not Receive Physician-Assisted Death

Item	*Loved one requested and received PAD (1)*	*Loved one requested, but did not receive PAD (2)*	*Comparison decedent (3)*	p *value*	*Post hoc comparison*
	N = *52*	N = *32*	N = *63*		
Symptom control					
Control over surroundings,[a] mean (SD)[b]	3.8 (1.2)	2.6 (1.6)	2.3 (1.6)	0.000	1,2 $p < 0.01$ 1,3 $p < 0.001$
Control over surroundings, impact,[c] mean (SD)	7.6 (2.6)	6.0 (3.4)	5.5 (3.1)	0.006	1,3 $p < 0.01$
Ability to feed self,[a] mean (SD)	3.7 (1.8)	1.9 (1.9)	2.0 (1.9)	0.000	1,2 $p < 0.001$ 1,3 $p < 0.001$
Ability to feed self, impact,[c] mean (SD)	7.1 (2.8)	4.4 (3.1)	4.6 (3.0)	0.000	1,2 $p < 0.001$ 1,3 $p < 0.001$
Control bladder or bowels,[a] mean (SD)	3.1 (1.9)	1.8 (1.9)	2.2 (1.9)	0.008	1,2 $p < 0.05$
Control bladder or bowels, impact,[c] mean (SD)	6.0 (3.5)	3.8 (3.3)	4.7 (3.3)	0.015	1,2 $p < 0.05$
Energy to do things,[a] mean (SD)	1.1 (1.0)	0.6 (0.8)	0.8 (0.9)	0.011	1,2 $p < 0.05$
Energy to do things, impact,[c] mean (SD)	3.1 (2.6)	2.2 (2.3)	2.5 (2.6)	0.013	
Preparation					
Said goodbye to loved ones,[d] No. (%)	45 (87)	22 (69)	36 (57)	0.003	
Said goodbye to loved ones, impact,[c] mean (SD)	8.7 (2.3)	8.0 (2.4)	7.3 (2.9)	0.096	
Spiritual service before death,[d] No. (%)	4 (8)	6 (19)	22 (35)	0.002	
Spiritual service before death, impact,[c] mean (SD)	6.6 (2.1)	7.4 (2.3)	7.4 (2.4)	0.251	
Means to end life,[d] No. (%)	50 (96)	9 (28)	28 (44)	0.000	
Means to end life, impact,[c] mean (SD)	9.3 (1.9)	4.5 (3.6)	6.9 (2.3)	0.000	1,2 $p < 0.001$ 1,3 $p < 0.001$ 2,3 $p < 0.001$
Discussed end-of-life wishes,[d] No. (%)	49 (94)	29 (91)	54 (86)	0.342	
Discussed end-of-life wishes, impact,[c] mean (SD)	9.6 (0.9)	8.3 (2.7)	8.9 (1.6)	0.014	1,2 $p < 0.05$
Transcendence					
Worried about strain on loved ones[a] mean (SD)	2.8 (1.6)	1.9 (1.7)	2.4 (1.6)	0.033	1,2 $p < 0.05$
Worry strain on loved ones, impact,[c] mean (SD)	4.8 (2.9)	5.3 (3.0)	5.0 (2.6)	0.793	
Laugh and smile[a] mean (SD)	2.8 (1.2)	1.7 (1.2)	2.3 (1.3)	0.003	1,2 $p < 0.001$ 1,3, $p < 0.05$
Laugh and smile, impact,[c] mean (SD)	7.2 (2.7)	6.1 (2.9)	6.6 (2.9)	0.019	
Moment of Death					
Level consciousness at death[c]				0.012	
Awake	25 (48)	7 (22)	12 (19)		
Asleep	5 (10)	1 (3)	11 (17)		
Coma/unconscious	20 (38)	20 (63)	39 (62)		

[a] Scale 0 = none of the time, 5 = all of the time; compared with analysis of covariance; family education level and whether or not the patient was enrolled in hospice were included as covariates; post hoc comparison used a Bonferroni correction.

[b] SD = standard deviation.

[c] Scale 0 = terrible experience, 10 = almost perfect; compared with analysis of covariance; family education level and whether or not the patient was enrolled in hospice were included as covariates; post hoc comparison used a Bonferroni correction.

[d] Yes/no scale, reported as percentage 'yes,'" compared with Pearson's χ^2 missing data for these items range from 0%–< 10%.

PAD, physician-assisted death.

bladder; ability to breathe comfortably; and energy to do things. The three groups differed overall in control of surroundings, control of bladder and bowel, energy to do things, and ability to feed self, and *post hoc* analyses demonstrated that those who received a lethal prescription differed from the other two groups with better quality of dying related to control of surroundings and ability to feed self. Among those who requested PAD, those who received it had higher scores on control of bladder and bowel and energy to do things.

Connectedness

Indicators of connectedness were items measuring time spent with family and friends, attendance at important events, and physical expressions of affection. No items in the connectedness domain showed significant differences between the three groups.

Preparation

The domain preparation was measured by 18 items, including discussion of end of life wishes; clearing up bad feelings; use/avoidance of life support; having health care costs covered; visit from any religious advisor; spiritual service before death; having the means to end life if desired; funeral arrangements made; and goodbyes said.

Significant between-group differences were noted in having means to end life and discuss end-of-life wishes, spiritual services before death, and saying goodbye to loved ones. Those who received a lethal prescription were more likely to have said goodbye than those who did not pursue PAD, and were less likely to engage in a spiritual ceremony before death than those who did not pursue PAD.

Not surprisingly, the three groups differed on the item measuring possession of the means to end life if desired, and those who requested and received a lethal prescription were indeed more likely to be in possession of the means to end life than either those who requested but did not receive a lethal prescription or those who did not pursue PAD. Similarly, there were significant differences between all three groups in the family members' quality rating of the impact of possession of means to end life on the dying experience.

Transcendence

This domain included 12 items, including being unafraid of and at peace with dying; maintaining dignity; ability to laugh/smile; finding meaning in life; and worry about strain on loved ones. Significant between group differences were observed only in the item measuring ability to laugh/smile. Post hoc analysis revealed that those who received a lethal prescription were rated by family members as laughing/smiling more often in the final week of life than those decedents who requested a lethal prescription but did not receive it. There was a trend for those who requested but did not receive a lethal prescription to worry about their strain on loved ones.

Moment of death

Level of consciousness and presence of others was measured. There was a difference between the three groups in whether the loved one was awake, asleep, or in a coma in the moments before death.

Global ratings

Two items measured family members' perception of overall quality of death and dying: quality of life in the last 7 (or 30) days of life and quality of the moment of death. No differences between the groups were found on these items. In a separate analysis there was no difference in quality of life in the last 7 days of life for those who died by PAD (mean [SD] 4.1 [2.9]) versus those who received prescriptions but did not use them (mean [SD] 4.2 [2.6]). However, family members rated the quality of the moment of death as higher among those who took the prescription ($n = 32$; mean [SD] 9.6 [0.9]) compared to those who received a lethal prescription but did not take it ($N = 20$; mean [SD] 7.3 [3.2], $p < 0.001$).

Discussion

In this study we used the QODD to compare family perception of the quality of the dying experience between deceased Oregonians who pursued PAD and Oregonians who died of terminal illness without requesting PAD. We further distinguished between those who requested and received a lethal prescription for PAD and those who requested but did not receive the prescription. Domains evaluated by the instrument included symptom control, preparedness, connectedness, transcendence, and the moment of death. The main finding was that families perceived better quality of dying among patients who received lethal prescriptions when some physical symptoms were avoided and there was greater preparation for death.

Of the 33 different indicators of quality, significant between group differences were found in one or both aspects of 9 of the indicators. In domains of connectedness and transcendence there were very few differences between groups, and ratings of the moment of death and global ratings of quality of life did not differ, again indicating that those choosing PAD were similar to those not pursuing PAD in terms of quality of death.

In domains of symptom control and preparedness, however, significant differences were noted. Family members of those choosing PAD reported greater symptom control, particularly in regard to control over surroundings, better functioning, better energy, and better control of bowel and bladder. We previously found that at the time they expressed initial interest in PAD, Oregonians were motivated by worries about future discomfort, pain and other physical symptoms, but rated physical symptoms at the time of the request as relatively unimportant reasons for requesting a lethal prescription.[6] Our data suggest that PAD may meet that goal in some patients if they are able to avoid symptoms that contribute to "states worse than death."[17]

Those choosing PAD were in some ways more prepared for death in that they were more likely to have said goodbye to loved ones, yet less likely to have had a spiritual service before death than those who did not. Previous studies have demonstrated that as the importance of religion increases, interest in PAD lessens. Furthermore, there was a trend toward significance in the positive impact of discussion of end of life wishes on the dying experience with those who received a lethal prescription reported by family members as finding greater positive effect of end-of-life discussions on the dying experience than those who did not pursue PAD.

One limitation of this study is that family members retrospectively assessed the quality of their loved one's dying experience. It is unknown how closely family member assessment would correlate with the decedent's assessment. Research regarding the concordance of proxy respondents is mixed, with some authors reporting that proxy reporters are more accurate with observable indicators than with subjective indicators of quality[18] and that proxies tend to report lower quality of life than patients report for themselves.[19] However, given the frail nature of the patients and the potential burden of participating in end of life research, proxy respondents are viewed as an appropriate source of information on the final experiences of life.[1,18] Additional limitations were the low participation proportion among the aid in dying families and the comparison family members were a convenience sample. It is unknown how non-response might be associated with the views on quality of death and dying.

A strength of this study was the use of the QODD, an instrument designed to specifically assess the end of life experience of terminally ill patients. Given the overlap of the concepts of quality of life at end of life, quality of death and dying, and quality of care at end of life, this instrument specifically assesses the quality of the dying experience and helps to elucidate the experience for those choosing PAD. PAD is a controversial issue that draws moral and ethical arguments both for and against the practice. This study does not address those arguments. However, another concern regarding the legalization of PAD is that PAD would become a substitute for quality end of life care. Our study does not support that the choice for PAD reflects poor symptom management.[20] In fact, in the view of family members it does appear to meet patients' preferences for control and avoidance of a period of declining function. Insofar as family rating of the quality of a loved one's death is an indicator of end of life care, this study adds to the evidence that the choice to pursue PAD does not appear to be due to, or a reflection of, poorer end of life care. Nor is the quality of death experienced by those choosing PAD any worse than for those not pursuing PAD; in some areas it is rated as better by family members.

Acknowledgments

Funded by a grant from the Greenwall Foundation. This material is the result of work supported with resources and the use of facilities at the Portland VAMC in Portland, Oregon.

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

Author Disclosure Statement

No competing financial interests exist.

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SOUNDING BOARD

Lessons from Oregon in Embracing Complexity in End-of-Life Care

Susan W. Tolle, M.D., and Joan M. Teno, M.D.

Under the incentives of fee-for-service Medicare, the utilization trends among persons with chronic progressive medical illness include more care in the intensive care unit (ICU), more hospitalizations, and often late or no referrals to hospice care (Fig. 1).[1] These utilization patterns are strikingly different in Oregon, the second state to legalize an advance directive and the first state to legalize assisted dying. In response to this legislation, the Oregon Health and Science University Center of Ethics embraced a policy of neutrality as a public position on assisted dying while using the vote as a wake-up call to the medical community to improve end-of-life care more broadly.[2,3] The center has served as a convener of statewide education and supported the creation and dissemination of the Physician Orders for Life-Sustaining Treatment (POLST) Program.[4] The POLST Program allows patients with advanced illness and frailty and their health care professional to document patients' preferences regarding the use of life-sustaining treatment with medical orders that can be honored across settings of care.[5] The POLST form (see the Supplementary Appendix, available with the full text of this article at NEJM.org) is designed to ensure that patients' preferences to use or limit treatment are equally honored.[6]

Persons dying in Oregon are less likely to be hospitalized and more likely to use hospice services at home than are patients in Washington and the rest of the United States. We selected the state of Washington for comparison with Oregon because of its close proximity and comparable demographic features. Washington has similar liberal political views and racial composition of decedents, has an established POLST Program, and has also legalized assisted dying.[7] In 2013, nearly two thirds of Oregonians who died did so at home, whereas only 39.6% of persons in the rest of the United States who died did so at home. The rate of ICU use in the last 30 days of life in Oregon was 18.2%, as compared with 23.0% in Washington and 28.5% in the rest of the United States (Fig. 1). Patients who were hospitalized in the last month of life were more likely to be discharged home in Oregon than in Washington or the rest of the United States (73.5% in Oregon vs. 63.5% in Washington and 54.2% in the rest of the United States).

It is difficult to disentangle the reasons behind the differences in care at the end of life in Oregon as compared with other states, but we think that the differences in care reflect the complexity and intensity of the initiatives developed in coordination with the POLST Program. Although Washington also has an established POLST Program, it has not developed educational materials, coordinated cross-system conferences, conducted research, and maintained a statewide registry, as extensively as Oregon has done. In this article, we describe the policy changes and educational efforts to improve end-of-life care that were launched in Oregon at the levels of state government and local health systems (Table 1). (Fig. S1 in the Supplementary Appendix provides a timeline for the initiative in Oregon.) We will also outline some of the lessons learned from the successes in Oregon. Transforming care near the end of life requires a willingness to forgo the temptation of an easy fix by merely implementing the use of the POLST forms. Until we embrace the complexity of this social interaction, the need for multifaceted interventions, and the application of public health strategies, we will fail to make the needed improvements in care at the close of life.

Advance care planning and the use of POLST forms is important, but if patients' goals are not linked to actionable care plans that are supported by local health care systems and state regulation, many patients who wish to remain at home will die intubated in the hospital for all the reasons the current system fails them.[8,9] Consider

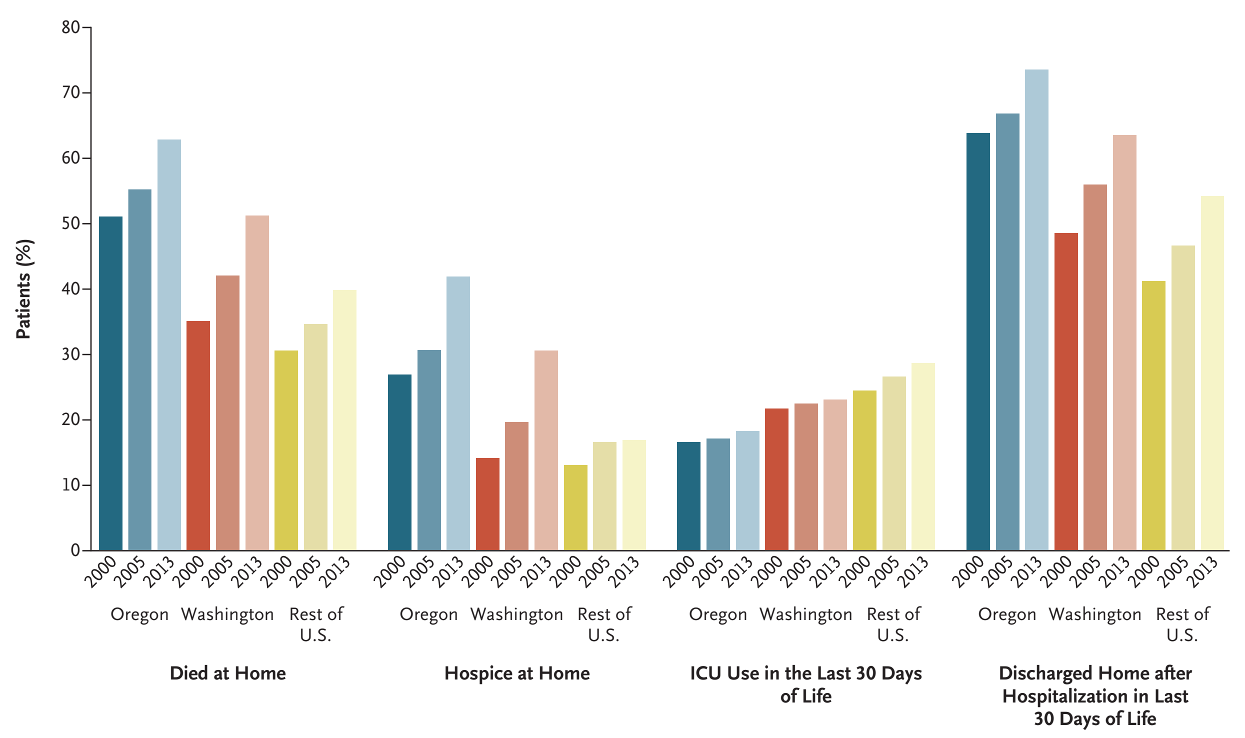

Figure 1. Deaths among Fee-for-Service Medicare Beneficiaries in Oregon, Washington, and the Rest of the United States.

The graph shows changes between 2000, 2005, and 2013 in the rates of death among fee-for-service Medicare beneficiaries in Oregon, Washington, and the rest of the United States (U.S.). Shown are the proportions of patients who died at home, who received hospice services at home, who received care in an intensive care unit (ICU) during the last 30 days of life, and among patients who were hospitalized during the last 30 days of life, the proportion who were discharged home.

the following composite case story, which illustrates the complexity, breadth, and depth of systems changes that are needed to ensure that patient preferences are consistently honored.

Edith, an 84-year-old white woman with oxygen-dependent chronic obstructive pulmonary disease, completed a POLST form after being counseled by her primary care physician. The form recorded her wishes that she would not be resuscitated or placed on mechanical ventilation. Despite having 24-hour care at home, she fell and fractured her hip. Emergency medical services (EMS) providers were called, and they accessed her POLST form from the Oregon POLST Registry. Edith was transported to a regional trauma center, where her condition deteriorated and there were concerns that she might need to be intubated. Per protocol, the trauma surgeon was notified of her POLST form specifying the do-not-resuscitate orders and the use of comfort measures only by accessing documentation in the POLST Registry that provided clear evidence of her wishes. Edith was cared for by the palliative care team in the emergency department with the use of opiates to relieve her pain and dyspnea, and she was transferred home with hospice services, where she died, comfortable and surrounded by her family. The key interventions in Edith's care that made her death at home possible included strategic interventions at four levels that are aimed at the individual person and their health care professional, the local health care system, cross health system collaboration, and state government (Table 1).

INTERVENTIONS AIMED AT INDIVIDUAL PERSONS

Extensive local media coverage, public education, and the experience of friends in her community made Edith and her family aware of their options for advance care planning and support for

Table 1. Key Interventions and Effects on Care of Patients.*

Level and Intervention	Application to Edith's Experience of Dying
Individual persons and their health care professionals	
Public education through media coverage and local community events	Raises Edith's awareness to complete a POLST form with her health care provider and discuss plans with daughter
Education of health care professionals about communication and completion of POLST forms	Facilitates sensitive communication and proper completion of the POLST form as well as creation of an action plan to honor the patient's preferences
State government	
Creation of Registry and enactment of regulation that allow EMS to honor POLST forms	Ensures that EMS is able to obtain Edith's POLST form and honor those wishes in the field
Quality monitors at the Registry in place to ensure the accurate completion of POLST forms	Ensures that POLST forms are completed correctly
Local health care system	
Change in culture to support health care professionals in counseling patients and the completion of the POLST forms	Values the time spent in the completion of the Edith's POLST form
Registry raises awareness to review the POLST forms in medical decision making; EMR of the health care system provides an alert that made the health care professionals aware of the patient's POLST form	Ensures that Edith's POLST form is available to the surgeon, who decides with Edith's daughter not to operate; in her medical record, EMR prominently provided an alert that the made all health providers aware of the patient's advance directive
Arrangement by local hospice for services for a dying person at home in transition from an acute care hospital	Ensures that Edith receives home hospice services that allow her to die at home, comfortable and surrounded by her family
Local champions and state coalition	
Ability to solve system and regulatory barriers nimbly and quickly	Champions played a key role in changing regulations to allow EMS to honor the POLST form and enhance hospice capacity to take admissions from the emergency department to home
Development of educational tools and identification of patients' stories	Enables design of educational interventions and hosting of regional conferences
Coordination of the implementation of systems change as a result of quality-improvement efforts	Promotes collaboration and conduct quality-improvement efforts across various settings of care

* Shown are key interventions, such as policy changes and educational efforts at various levels of local systems and government, to improve end-of-life care in Oregon and their effects on the care of a case-study patient (Edith). EMR denotes electronic medical record, EMS emergency medical services, and POLST Physician Orders for Life-Sustaining Treatment.

person-centered care. The Center for Ethics has hosted more than 200 conferences for health care professionals about ethics, palliative care, and communication skills.[10] The development of educational resources such as the *Understanding POLST* video and lay brochures made talking with her primary care professional a process rather than a single discrete event (Fig. S1 in the Supplementary Appendix).[11] Approximately 8 years before her death, Edith told her doctor that she wanted her daughter to be her surrogate. When Edith required oxygen support at home, her doctor encouraged her to complete an advance directive. At a visit 1 month before her death, Edith talked about never wanting to be intubated again, and she and her doctor completed a POLST form after she and her daughter watched the *Understanding POLST* video with a clinic social worker. Edith's primary care physician counseled Edith about her prognosis and treatment options, and through shared decision making they documented her treatment goals. The physician then worked with Edith's family to develop a plan that would allow her to remain at home with 24-hour care. The completion of her POLST form was not a single event but was part of a multistep process that was facilitated by her primary care team.[12] Key to Edith's care was that her EMS providers and all the members of her primary care team had been trained in how to record preferences for care accurately on the POLST form and in the importance of honoring those preferences.

INTERVENTIONS AT THE LOCAL HEALTH CARE SYSTEM AND STATE GOVERNMENT LEVELS

The process of creating and documenting POLST orders serves as a tool to record conversations regarding goals of care, but in isolation this process is not sufficient to ensure that Edith's wishes will be honored once she leaves her home. The creation of systems to ensure that health care professionals are aware of the directives and that EMS providers are able to honor those wishes is equally important. In Edith's case, the ability of EMS providers and the local health care system to obtain and honor her POLST form was key. In Oregon, state regulations allow EMS providers to follow the directives of a POLST form and to honor a person's wishes by not intubating or resuscitating the patient.[13] Similarly, although the physician who signed Edith's POLST form did not have admitting privileges at the trauma facility, Oregon Medical Board regulations ensured that the orders could be honored.[14] The trauma-system protocol enabled the POLST form to be obtained for the surgeon and other health care professionals to use in decision making.

In addition, Edith's physician was supported by a culture that valued team collaboration, and the health care team had participated in systems integration of educational materials to enhance patients' participation in goals-of-care planning, which optimized Edith's understanding and used the physician's time effectively. The electronic medical record (EMR) tagged the POLST forms, linking them to the patient-information header that alerts all the members of the health care system to the presence of the patient's POLST form.[15] A separate EMR tag confirmed the presence of the advance directive, and each form could be viewed with a single click, making her wishes clear as Edith moved from one care setting to another.

LOCAL CHAMPIONS AND STATE COALITION

Champions who are part of state coalitions can be nimble and help to address key leverage points in ensuring that patients' wishes are honored as transitions occur across care settings and that persons wishing to die at home have excellent palliation with hospice providers who are able to respond to the need for timely referrals. Education is important both within health systems and statewide, but local champions also play a vital role in removing system barriers, particularly in addressing barriers across care settings. The timeline in Figure S1 in the Supplementary Appendix shows a few of the dozens of interventions that have been facilitated by champions and coalition members. The development of educational tools and the removal of barriers are not enough. Even with an exemplary advance care planning process in place, if the patient and family do not have timely access to home hospice care, the advance care planning process may be of little value. If hospice had not been able to enroll Edith within 24 hours after her discharge, it would not have been possible for her to be discharged home from the emergency department observation unit.

Narrative stories are important in helping stakeholders understand the effect of each change in improving care, and these stories have proved to be vital to public education and media engagement. However, anecdotal case reports are not sufficient for the evaluation of success. We also need to track quality rigorously and to prevent unintended consequences. Oregon is currently using version 11 of the POLST form. Changes are made to the form by the statewide POLST Program coalition after extensive review to respond to new research data and changes in statutes or regulations and to address the use of new medical treatments. End-of-life champions in Oregon advocate broadly for improvements in best practices. When data showing that tube feeding did not extend life or enhance comfort in persons with advanced dementia,[16-19] broad and far-reaching public health efforts were implemented in the 1990s and were used to discontinue the practice. The effectiveness of these efforts is associated with remarkably low rates of tube-feeding use in Oregon, dating back to 2000.[20]

Finally, to sustain change from the beginning requires a stable financial base, leadership, and an administrative home. Although private philanthropy funded the development of the innovative POLST Program in Oregon, the Registry operations are now funded by the state, and the Oregon POLST Program is building an endowment to sustain operations. The Center for Ethics in Health Care, which administers the Oregon POLST Program and coordinates efforts to improve end-of-life care statewide, does not accept funding from health care industry sources. Important to the success of this work is the public trust that efforts are being made to honor patients' preferences and improve quality rather than to cut costs. The public trust can be damaged when incentives appear to have cost savings rather than patients' wishes as their primary goal (e.g., Liverpool Care Pathway of the Dying Patient and "death panels").[21]

Without a complex, multifaceted, and longitudinal set of interventions, Edith would have been intubated and would probably have died in an ICU, and the high rate of death at home with hospice in Oregon might look more like the rate in Washington (Fig. 1). Although Oregon has made great strides, our systems are far from perfect. One-click access to the POLST form in the EMR is not yet available in most hospitals. We are aware that finding Edith's POLST form was important to her achieving her wishes, but it was not sufficient. Replication of the experience in Oregon requires the development and adoption of interventions at every step in this complex medical and social interaction. With alignment of our health care systems incentives for value (i.e., quality and health care expenditures) over volume of services, fundamental change and improvement are within our reach. We must embrace the complexity, develop dynamic and multifaceted interventions, track the quality of care, and embed these interventions in the local and national health care culture, while avoiding incentives that might undermine the public trust and integrity of the process.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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DOI: 10.1056/NEJMsb1612511

DonnaSmith_FAV_SB701
Uploaded by: Smith, Donna
Position: FAV

Donna Smith Testimony in Support of SB701 End of Life Option Act

Good Afternoon, My name is Donna Smith and I am the Area Campaign Director for Compassion and Choices.

I want to thank Chairman Will Smith for his leadership on this issue as a sponsor last year and as the Chair of this committee. I would also like to thank Senator Waldstreicher for sponsoring the bill this year as well as the rest of the committee members for your support in some cases and others for your robust if not misinformed debate of this issue over the years.

As campaign director it has been my job to organize and expand the supporter base, to find subject matter experts to present on this issue, to present and educate legislators and the public on Medical Aid in Dying. I thought I had done a decent job for the last 5 years.

We have built a large coaliton of support
polls indicate 66% of Marylanders support this bill.
Our diverse coalition includes USM 2.5 million strong, Maryland Legislative Coalition, with over 30,000 members, ACLU 42,000 members, UU churches, 7000, American Aethist, American Humanist, UCC's Young Dems of Maryland and others

However, I have never provided testimony before today. I always thought there were so many others that needed to be heard and that it was my job to organize behind the scenes. We have the data and the statistics on our side, we have compelling stories from your constituents but unlike former years we now have supportive leadership?

We are two votes away from getting this bill passed. What else can we do?

I now realize I have not been doing my job. You see my job is to speak for those that no longer have a voice. To fight for those who cannot fight for themselves.

We have met here in this building for the last five years and every year I have lost supporters that spent their last days suffering in pain but fighting for this law. I'm sure you do not remember them but it is important for me to honor their memory and continue their fight and not let you forget who they were.

- Barbara Bergman and Dick Israel 2015
- Marlene King and her husband Pastor Eric King 2016 - Her last email to me was t remind me to remind her about an op/ed she wanted to write about supporting emd of life She was just getting out of the hospitalafter major sugery but told me that the journey continues and I should be encouragedand empowered she died 6 months later
- Her husband Eric who is a pastor in Baltimore testified in honor of his wife 1 year later
- David Kipping 2016
- "My David died at home on April 4th in Hospice care. During his final 2 weeks he was losing 5 lbs. per day. His normal weight for a man 5 ft. 11 in. was 142 lbs. The last time he had enough strength for me to weigh him he weighed 105 lbs. He probably weighed less than 100 at the time of death. (I weigh about 95 and I am 5'2"). "
- 2018 fellow legislator Wayne Norman
- 2019-Marci Rubin

These are only a small sampling of those we have lost we all have lost loved ones who would have loved to have this option at the end of life.

Some of them died horrible deaths, they suffered horribly at the end while we complained of the inconvenience of long hearings and hearing uncomfortable testimony. While we argued over comp[aratively trivial things Some of my supporters would have begged for the duration of their suffering and their families suffering to last only 13 hours.

I lose them every year without fail. I go to memorials and send flowers to their loved ones. These are just a few. How many more will die horribly while politics get played? How many families will suffer needlessly?

I challenge you to rise above your fears and discomfort about passing this bill. The End of Life Option Act does not cause more prople to die, they are already dying . It allows more people to die in peace. I urge you to pass SB701 and then go and talk to your fellow senators and convince them to pass it.

SusanSpock_FAV_SB701

Uploaded by: Spock, Susan

Position: FAV

Testimony Submitted by Susan Spock, Bethesda, MD on SB701, the End-of-Life Options Act for the Senate Judicial Proceedings Committee Hearing February 28, 2020

Dear Chair Smith and Members of the Committee,

Thank you for your time today. I have lived in Bethesda for 26 years, and my in-laws now live in Maryland too. I join with them and speak for myself in urging you to pass SB701. This bill is critical, allowing residents who face an imminent, agonizing death to decide for themselves when their suffering has become too much. This is a decision that should only be made by the person in pain. No one else's experience is relevant.

<u>In our family, the need for this bill is urgent</u>. My very dear mother-in-law, Ann Harrop, who approaches 92 with a keener mind than I have, was recently diagnosed with pancreatic cancer – one of the most deadly cancers, with excruciating pain at the end that cannot be fully alleviated with drugs. She is desperate for you to approve this legislation. She may die in the coming year – and the failure to pass this bill could be responsible for her immense suffering at the end of a full and caring life. She has submitted written testimony, as she could not be here today.

I am SAD, and I am ANGRY. I am tired of seeing a vocal minority impose its religious views on the 2/3 of Maryland's residents who support this bill.

The God of those who oppose it is not my God. I do not believe in a cruel God who would require us to endure so much when the time comes.

Who is to say that the opposition is correct in their view of God's will? Why is it hard to believe in a God who is infinitely merciful? In a God who has compassionately helped scientists develop pain killers and wants us – or expects us – to have the choice to use them in the face of a terrible, unbearable terminal disease?

Allow me and my mother-in-law our <u>constitutional</u> right to make our own religious choices – separate from the control of the State.

Please pass this bill, and do not substitute your judgment for that of other citizens. You will not have to feel their agony.

Thank you again for your consideration.

Susan Spock
5206 Albemarle ST
Bethesda, MD 20816

Susan Spock_fav_SB701
Uploaded by: SPOCK, SUSAN
Position: FAV

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Thank you again for your consideration.

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MichaelStrauss_FAV_SB701

Uploaded by: Strauss, Michael
Position: FAV

Testimony of Michael J. Strauss, MD, MPH
Support for SB701
The End-of-Life Option Act (The Richard E. Israel and Roger “Pip” Moyer Act)
February 28, 2020

I am Dr. Michael Strauss, a life-long Maryland resident and board-certified internist with a master’s degree in public health and epidemiology. I strongly support this bill.

I will use my time to address two points that opponents try to paint as defects in the bill, but which are not.

1. **There is simply no indication that drugs used for aid in dying are abused.**

There has never been a documented case of abuse of aid-in-dying medication, and there are several reasons for this. Most importantly, virtually all patients wait until the last minute to fill their prescriptions because of the drug’s cost and because a third of patients never need the drug. So, there is no unused drug lying around patients’ homes. Also, in recent decades there not been an illegal market for Seconal, until recently the most used medication. And now, increasingly, physicians prescribe a powder-mix of 4 lethal medications that together have no market for abuse. Opponents who raise unjustified fears of medication abuse are simply wrong. It’s a smokescreen that you should see through.

2. **While it is nearly impossible to accurately predict 6-month survival, it is a good and reasonable protection in the bill**.

Physicians estimate survival based on clinical experience, medical studies, and a patient’s particular circumstances. But research clearly show that mostly they OVERESTIMATE patient survival, and in only a small minority do they underestimate survival. Yet that misses the main point: The purpose of this criterion is to distinguish between those individuals who have a disease that is likely to end their lives in the near future, and those who do not. I want to emphasize that hospice uses the same criterion, but the bill has many additional patient protections. Yes, some outlive their 6-month prognosis, and that is good. It proves that patients are not pressured by their prognosis and only take the medication when their suffering is too great. The 6-month criterion is a well-established and reasonable criterion.

Taler_fav_sb701

Testimony of:

George Taler, MD
454 Arundel Beach Road
Severna Park, Maryland 21146

February 28, 2020

Good afternoon, Chair Smith, and members of the Senate Judicial Proceedings Committee.

My name is Dr. George Taler, I live in Severna Park in Anne Arundel County, but my practice is in Washington, DC and Baltimore Maryland. I am a geriatrician and all my patients have serious illnesses and disability. My team cares for >600 patients in their homes and in the hospital. Although these are the people most likely to request physician aid in dying, and I am prepared to honor those requests, none of the patients in my practice has asked in over 20 years, largely, I believe, because we have been able to meet our patients' needs and expectations, from lessons I have learned through the physicians' aid in dying movement.

I strongly support Senate Bill 0701, the End-of-Life Options Act, based on the effects that passage of the Death with Dignity Act had on the conversations people with serious illness had with their physicians and on the practice of medicine in Oregon. The results: Referrals for palliative care and hospice services increased dramatically, as did prescriptions for medications mostly used for symptom control. Fewer patients went to the hospital to die, and there was a commensurate increase in the numbers of people who died at home, in their own beds with their family beside them. In other words, the citizens of Oregon enjoyed better care, had a better care experience and at lower costs.

As a jurisdiction that has a special waiver with CMS, The Maryland All-Payer Model, we need to have that kind of societal change in the conversation between patients and their physicians, here, in our state. The End-of-Life Options Act is pivotal to that transformation.

I would like to thank the Committee for your support.

SueTavela_FAV_SB701
Uploaded by: Tavela, Sue
Position: FAV

February 22, 2020

Dear Senator,

The First Amendment to the Constitution starts with “Congress shall make no law respecting an establishment of religion or prohibiting the free exercise of religion.” Religions generally have rituals to mark major points in human life: birth, coming of age, marriage, and death.

My husband, John, and I were looking forward to having our second child late in 1971. A few months into the pregnancy, I started hemorrhaging. John got me to the hospital where they stopped it. Unfortunately, I started hemorrhaging again in the recovery room where I was in the process of dying according to my doctor. There was the most glorious light and I wanted with all my heart to walk into it, but there was a question asked of me. “Was I free to go?” I wanted to say “Yes!” but I knew I was not free; my husband was still recovering and getting to know the son who was born 2 weeks after he had left for Vietnam in 1968. Turns out that what I experienced is typical of near death occurrences.

John died in 2017, he suffered for over 12 hours because the night nurse was reluctant to start him on the morphine drops prescribed for pain by hospice. Even after he was receiving drops, he struggled on. Finally I said, “John if you want to live for any reason, do keep on, but if you are doing this for my sake only; let go.” He died almost immediately after that.

I am lucky to have found a faith that understands that I have little fear of dying, only fear of suffering and causing suffering. When aid in dying is lawful, if God’s path for me does not include help from a doctor, then what will be, will be. If I have a terminal illness and there is an option to have a doctor’s help in dying, I would opt for it. I would arrange to say my goodbyes to those I love and ask for their forgiveness and give them mine while realizing that what will be, will still be. However, having the hope of that bit of control would probably help me to live longer with the terminal illness. It probably would help many an elderly Vietnam Vet as well. John served in the Army Medical Service Corp in Chu Lai and got a bronze star. He was depressed when he came home but worked his way out of it. I recently found this statement in one of his last journals. “I’ve been dreaming about stacks of corpses again.” Great thanks go to those of you who passed SB521 last year. Please pass SB701 this year!

Bless you for taking the time to read this.

Sue Tavela

FrankArlinghaus.UNF.SB701

Uploaded by: Arlinghaus, Frank

Position: UNF

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.

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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.

MDPAS Frank Arlinghaus_UNF_SB701

Uploaded by: Arlinghaus, Frank
Position: UNF

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.

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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.

MDPAS Christina Bauman_UNF_SB701

Uploaded by: Bauman, Chistina

Position: UNF

3336 Texas Avenue
Baltimore, Maryland 21234

OPPOSE - SB 701

Honorable Senators

I have been a nurse in Maryland for the past 50 years and believe the sponsors/supporters of this bill have created an illusion that taking your own life is a dignified way to die. It is not. On the contrary, it would forever change the doctor/patient relationship, which is rooted in the oath, "do no harm" Any scenario given can be treated with palliative care, so dying is not something to fear. Do not force people to consider the value of their life, especially the weak, vulnerable, those alone or depressed, as they are at greatest risk.

This legislation was rejected 4 times by Marylanders who vote and who know that this bill before us again a 5th time, is driven by out of state, well-funded folks who do not vote in this state. The truth is that this is an attempt at social and verbal engineering to cut costs. I ask: how are you going to prevent insurance fraud and the slippery slope of insurance companies paying for poison verses a continuation of treatments? How do you monitor a drug take-back plan as Maryland struggles to fight the war on addiction? Who speaks for the mentally ill and the disabled? You are asking doctors to be judge, jury and now executioners of their patients! Where is their accountability and responsibility in all of this? The Hippocratic Oath still stands: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”

Personally, I have been blessed to care for both of my parents who died 3 years apart. I also lived with my sister (who had Down Syndrome) for the last three weeks of her life, and experienced the ultimate gift of comforting her, a 53-year-old, who had absolutely no idea what was happening to her, but she knew her sister and niece were by her side every step of the way, until she took her last breath. Her life was a blessing to our entire family, as is every life.

How wrong you would be to deprive anyone from those life-changing experiences, especially my children and grandchild who cared for her until she died.

I oppose any law that allows physician assisted suicide. Human life is precious. Our right to life is the first right we have. Without it, no other right is possible or matters. When scientists find a single-celled organism on another planet, they call it life. Human beings begin as 2 cells coming together at conception. We are called to help each other and protect each other. As elected officials and legislators, your duty is to protect life, not enable the snuffing out of it. That is a conflict of interest at its worst. I urge you to reject these efforts to codify the killing of our fellow brothers and sisters.

Sincerely,

Christina Bauman RN, BSN, M. Ed., C.A.S.E.

Cell: 443-695-0103

Mary Kathryn Bogdan_UNF_SB701

Uploaded by: bogdan, mary

Position: UNF

SB201—2020

Mary Kathryn Bogdan, RN, BSN, MA-CM, ALNC
of
Bogdan Associates, LLC

Position: Opposed

BACKGROUND

- Registered Nurse for over 40 years
- Background includes long-term care and end-of-life care (not termed "hospice" care)
- Background includes all areas of nursing
  Experienced with case review
- Former Chairperson for Ethics Committee of Maryland Nurses' Association
- RN membership active in Maryland Nurses' Association and Health Ministries Association

A patient who experiences insurmountable pain, overwhelming financial hardship or a disease that will result in further deterioration of the patient's health, is often unable to make reasonable and sound decisions that will, at that moment, improve their quality of life. When curative outcomes are not realistic, patients continue to require assistance with their quality of life and to help restore spirit.

When patients are offered the choice to end suffering by taking lethal medications (physician assisted suicide) or to have those lethal medications administered to them by a physician (euthanasia), a "ripple effect" results. Patients encouraged to take their own lives will not experience the support, love, and self-value they would otherwise receive from their loved ones, caregivers, and community. Families will never have the opportunity to provide the support, love, and care to their ill family member when a lethal injection is given — this behavior would be interpreted by the patient as abandonment. The community will deprived of the opportunity to join together in solidarity to provide the patient and the patient's family with recognition of that person's place in society and with a true perspective for all of the patient's legacy to be left behind.

The American Nurses' Association Position Statement on Ethics claims that patients should always have the right to make their own decisions, regardless of whether that means ending one's own life, or not. Medical Aid in Dying, including both euthanasia and physician assisted suicide, is not and never was inclusive in the language or accepted as a best practice in the healing arts. MAID, which this practice is now called, has devastating long-term effects on patients, their families, and the community-at-large. An example of this is a proposal the American Nurses' Association will soon present for inclusion in the Nursing Practice Act—that nurses will be allowed to administer these lethal medications to their patients.

What is missing here is every person's right, God-given and inalienable, to life, liberty, and the pursuit of happiness. Without life that is protected, the rest is just theoretic ideology.

Opposed

SB701/HB643 End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

Laura Bogley-Knickman, JD
Director of Legislation, Maryland Right to Life

SB701, the so-called "End of Life Option Act" is a euthanasia bill, that shelters doctors, hospitals and insurance companies from liability and creates a strong economic incentive for insurance companies to deny more costly life-saving treatments to patients in need. The bill allows another individual to administer lethal means (euthanasia) by making self-administration optional by using the word "may":

> "AID IN DYING" MEANS THE MEDICAL PRACTICE OF A PHYSICIAN PRESCRIBING MEDICATION TO A QUALIFIED INDIVIDUAL THAT THE QUALIFIED INDIVIDUAL *MAY* SELF–ADMINISTER TO BRING ABOUT THE QUALIFIED INDIVIDUAL'S DEATH."

For many of our most vulnerable citizens, without financial means or equal bargaining power, the "right to die" will become involuntary euthanasia or a ***"duty to die"***. Evidence from other states like Oregon and Washington supports this showing that the vast majority of patients who die from assisted suicide are Medicaid patients or people on publicly subsidized insurance.

STATE SANCTIONED ASSISTED SUICIDE IS A LICENSE TO KILL

- That is why 42 other states have repeatedly rejected assisted suicide laws.
- That is why the American Medical Association, after 3 years of intensive study and debate, voted overwhelmingly (>70% of delegates) last June 2019, to reaffirm its position against PAS, that it is

  "incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."

- That is why the National Council on Disabilities (an independent Federal Agency) issuing its report in October 2019, found that

  "the nation's assisted suicide laws are rife with danger to people with disabilities".

- That is why the bill's leading proponent, Compassion and Choices withdrew their support for their own bill last year after the Senate passed amendments to safeguard patients from abuse at the hands of doctors.

But I don't expect you to take my word for it. ***Hear the truth from Compassion and Choices in their own words....***

- **"..economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice."** Derek Humphry, founder of the Hemlock Society (precursor to Compassion and Choices).

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

  - Kim Callinan, CEO of Compassion and Choices, when asked about adding patient safeguards to the bill before the Maryland House of Delegates joint hearing February 15, 2019.

- Compassion and Choices also have tried to convince you that they are not asking you to legalize euthanasia. But this is exactly how the law is being implemented in other states and countries. In Quebec, Canada, 99% of deaths under the law were "euthanasia" and only 1% "assisted suicide" and 142 deaths were completely unaccounted for. In fact during the House hearing, Michael Strauss, the leading Physician promoting the bill, revealed the bill does permit others to administer the poison,

  "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."

Senator, Maryland citizens deserve your protection. Please don't trust insurance companies to do your job for you.

We ask you to afford Marylanders Equal Protection under the law and uphold current state law, keep Assisted Suicide in the Criminal Code where this Assembly firmly placed it, and vote "no" on Senate Bill 701 and House Bill 643. *Please vote like our lives depend on it – because they do.*

Sincerely,

Laura Bogley-Knickman, JD
Legislative Director
Maryland Right to Life

LauraBogleyKnickman.UNF.SB701
Uploaded by: BOGLEY-KINCKMAN, LAURA
Position: UNF

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Maryland Right to Life

MDPAS Marie-Alberte Boursiquot_UNF_SB701

Uploaded by: BOURSIQUOT, MARI-ALBERTE
Position: UNF

Oppose SB 701/House Bill 643

Dear Ladies and gentleman of the Maryland Senate

My name is Dr. Marie-Alberte Boursiquot. I am a board certified Internist and Fellow of the American College of Physicians. I have been in full time practice in the state of Maryland for over twenty years.

I am opposed to the "End of Life Option Act". I regret that another attempt is being made to legalize the act of suicide in the state of Maryland with the assistance of Physicians. Physicians are committed to the practice of medicine and the preservation of human life. The taking of one's life, even if a physician assists, is not medical care.

Almost exactly a year ago, the bill to legalize medically assisted suicide in the state of Maryland was defeated by you the state Senate. You, as a body, attempted to protect the public against Physician Assisted Suicide by imposing safeguards on this practice. As a result a major proponent of this bill, Compassion and Choices™ to be specific, withdrew its' support.

The American Medical Association (AMA), the largest association of physicians in the nation, reaffirmed its' opposition to this practice and reiterates that PAS "Is fundamentally incompatible with the physicians' role as healer". The American College of Physicians also affirms its' opposition to this practice.

Medicine is a noble profession. Medicalizing death does not address the needs of dying patients and their families.

There remain fundamental flaws in this bill which are not likely to ever be overcome with legislation such as:

- Promoting suicide instead of offering suicide prevention to those who are suffering from Depression.
- How does one determine whether a patient is being coerced to end their life?
- What happens if a suicide attempt fails?
- Under ordinary circumstances it would be considered a felony for a physician to falsely complete a death certificate. In this instance when a

patient commits suicide with the assistance of a physician, the physician is expected to falsely complete the death certificate and list an underlying medical condition as the cause of death.

It is my duty as a physician and you as legislators to safeguard the public and the patient-physician relationship. This duty applies most especially to the most vulnerable members of society such as:
- The sick
- The elderly
- The disables
- The poor
- Minorities
- Children

There is a clear prohibition to this practice in the Hippocratic Oath which translated reads: ".. Never to administer poison to anyone who'd ask for it nor to suggest such a course".

Most will agree that when a patient is suffering and seriously ill, their greatest concerns are for a loss of autonomy and the perception of being a burden to their loved ones and/or society. The promotion of PAS simply supports these feelings. As a member of a group, specifically minorities, that has been historically told that our lives are expendable, PAS simply underscores that sentiment.

When our citizens are at the vulnerable point in their lives of suffering from a medical condition we should be offering them the benefits of Palliative Care and not encouraging and assisting them to commit suicide. This is specialized medical care for people living with serious medical conditions. It stresses relief from symptoms and the stress of the illness.

It helps to improve the quality of life for both the patient and the family. The care is based on the needs of the patient, not on the patients' prognosis. It's covered by most insurance plans and can begin at the time of diagnosis and treatment.

On a personal note, my beloved mother suffered from Dementia for approximately ten years. It broke mine and my family's heart to watch her deteriorate from this illness. As a physician I knew what we could expect from this illness. We were grateful for every day of her life especially in her final five years in a nursing home. I don't know what we would have done without the compassionate care of the nurses, her physician, and medical aides. At no time were we ever advised to consider terminating her care. As she deteriorated, we simply reassessed her needs and addressed them accordingly.

When my mother could no longer eat, we accepted the placement of a feeding tube. We perceived everyday that we had her a gift. She remained with us long enough to celebrate hers and my father's sixtieth wedding anniversary last March. I am grateful for the ability to have spent Mother's day with her last year. She peacefully and naturally passed away last June 15th.

Naturally, if PAS were available and offered to us it would have offended us, we would have refused, and we would certainly not trust her physician and caretakers.

I reiterate that I am opposed to Physician Assisted Suicide. I sincerely hope that you will focus rather on addressing the needs of the patient and:

- Offer the outstanding Palliative and medical care that is already available in the state of Maryland.
- Focus on correcting the healthcare disparities which already exist towards minorities.
- Focus on assuring those who are disabled that they too are a valuable member of our society and worthy of receiving the superior medical care already available in our state.

Sincerely,

Marie-Alberte Boursiquot, M.D., F.A.C.P.

Deborah Brocato
Senate Bill 701
Opposed

Good afternoon,
I am here to encourage you to withdraw SB701, the End of Life Option Act.
This bill cannot be fixed because the very premise of the bill is wrong. For all intents and purposes, this legislation creates a right to suicide and a right to have others assist in that suicide. Suicide is not healthcare and should not be considered an option for those who are suffering.

Thirty-four years ago, my father used an industrial electric cord to hang himself. He suffered from alcoholism and depression. In his despair, he thought it would be better if he no longer lived. He was wrong. Our family became even more disjointed and anguished. If he had lived, each day was another day for him to conquer alcoholism and depression. Today, we have a better understanding of treating addiction and mental illness.

Sadly, every day, many people successfully commit suicide, and they do it without legislation telling them they have a right to do it and how to do it. According to the Centers for Disease Control and Prevention, suicide has been the tenth leading cause of death for the past ten years with a total of 47,173 deaths by suicide in 2017. That comes down to roughly 129 people committing suicide every single day of the year.

Twenty-three years ago, my mother died of cervical cancer. For the last 3 months of her life, she was bedridden, and my siblings and I cared for her at home. She had plenty of pain medicine and we used it to manage her pain. There is a difference between managing pain and overdosing someone to end their life. Every day mom lived was another day of hope. Every day, she hoped for a cure or a miracle. Near the end, she refused pain medicine because she wanted to be more awake until she died.

Supporters of this bill claim it is limited to those with a terminal diagnosis, but this legislation confers a new right, a right to suicide, toa certain group of people along with a right to have doctors assist in the suicide. Laws cannot give rights to only certain groups of people so we know this will expand to other groups who consider themselves terminal. The word “terminal” demonstrates how a law like this could be broadly expanded. It all depends on how and who is defining “terminal.” Supporters of this bill also claim that suicide is a healthy alternative.
Suicide is an end result of depression and despair.
Suicide is not a treatment solution for the suffering.

What our suffering fellow citizens need is a message of hope and caring. Until there were antibiotics, there were no antibiotics. Until there were chemotherapy drugs, there were no chemotherapy drugs. Until there was open heart surgery, there was no open-heart surgery. Every day, there are researchers, doctors and scientists working to find new cures, new medicines, new treatments. Every day that an ALS patient or a CF patient or an addict lives is another day they might see a breakthrough. We do not know the day when the right protein will be found to fight multiple sclerosis or the day when cervical cancer will be cured or the day when the right combination of therapy and medicine is found to successfully treat schizophrenia, depression and other mental illnesses.

All of these suffering people need to be reminded that medical advances happen every day. They deserve hope and appropriate treatment for their suffering, not a death solution.

This bill does not serve the best interests of the citizens of Maryland and needs to be withdrawn and shredded.

Thank you for your time.

MDPAS T. Brian Callister_UNF_S701

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Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
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Dear Honorable Senate Judicial Proceedings Committee Member,

I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act. Here are Six Important Reasons to Oppose Physician-Assisted Suicide.

First, contrary to what proponents say, legalizing assisted suicide actually **limits your choices and access to healthcare.** Physician Assisted Suicide (PAS) is not legal in Nevada, but I had two patents, one from California and one from Oregon, that needed life saving treatments, and the insurance medical directors in both cases denied the life saving treatments but readily offered assisted suicide. My patients would NOT have been terminal with treatment but were offered assisted suicide instead **– this does not expand choice – it reduces it.** Once assisted suicide becomes a medical option, **it is the cheapest option and provides an incentive for insurers to save money by denying treatment.** My two patients from Oregon and California, states that have legalized assisted suicide, were denied treatment and offered the lethal pills. Neither they, nor I, had requested the lethal drugs. **Assisted suicide is *not* about freedom, autonomy, or choice – it limits choice and reduces your healthcare options.** Compassion and Choices, which advocates for assisted suicide, has testified around the country that there is no verification of my story nor any "cause and effect", which is factually incorrect. Bill McMorris of the Washington Free Beacon reported an independent verification of this story on June 5th, 2017 (see *"Vegas Doctor Vouches for Former Colleagues Account in Assisted Suicide"*). Trying to legislate away this insurance company behavior is not a safeguard either as the insurance companies claim that there is no cause and effect. Just as they did in my cases, they will claim that their denial of a life-saving treatment while approving assisted suicide pills are unrelated.

It is important to remember that this same *"Compassion and Choices"*, the group that continues to push assisted suicide all across the country, was originally known as "The Hemlock Society" (they changed their name – probably because "hemlock" is a poison). The founder of the "Hemlock Society", Derek Humphrey, said in his book, ***"In the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice."*** (Derek Humphry and Mary Clement, Freedom to Die, St. Martin's Press (New York, 1998), page 313).

Second, the underlying premise that everyone will suffer horrible pain at the end of life is simply not true in 2018. *No one* has to die in pain in this day and age. If someone is suffering needlessly, frankly they need to change doctors. In fact, **"pain" is not even in the top five reasons for requesting assisted suicide, according to data in Oregon.** Only about twenty percent of all patients who utilized the assisted suicide law in Oregon ever mentioned "pain" or even a "concern about pain" as their reason for killing themselves. **The top three reasons listed in 20 years of Oregon data for assisted suicide are "loss of**

enjoyment in usual activities," "burden to family," and "loss of autonomy." These are important social issues indeed, but are they adequate rational to kill yourself?

Third, a physician's ability to predict life expectancy in terminal illness is often not accurate – the medical literature shows the average margin of error is 50-70 percent. Assisted suicide, like hospice, requires a physician to "certify" six months or less to live. Physicians are frequently wrong – I put people on hospice all the time, and I take them off all the time - after they have outlived their prognosis! Patients often live months and even years longer than we thought with a good quality of life. In Oregon, only 40% of the people that requested the assisted suicide pills and did not take them died within a year (40% died of natural causes within a year – not even six months – which means 60% were still living after a year!).

Fourth, assisted suicide puts too much power in a doctor's hands and corrupts the medical profession. **Having two doctors certify that the patient is terminal with six months or less to live is NOT a safeguard! We all know that doctors refer to likeminded doctors,** and they do the same with assisted suicide. The Compassion and Choices group will refer you to a doctor who routinely prescribes the deadly concoction. In Oregon, a majority of the cases of doctor assisted suicides were "helped" in finding a doctor who would prescribe lethal drugs by the pro-assisted suicide group Compassion and Choices.

Doctors exercise a lot of influence with their patients when important health decisions are being made. Jeanette Hall was considering doctor prescribed suicide in Oregon, but her doctor said no and encouraged treatment. Some **17 years later** she is an oft-cited opponent of assisted suicide. "If my doctor had believed in assisted suicide, I would be dead," she said.

Fifth, the "suicide contagion" that comes with legalizing assisted suicide is real: the CDC reported that after the Oregon assisted suicide law passed, general suicide rates in adults age 35-64 increased 49% in Oregon as compared to a 28% increase nationally. In addition, the U.S. Department of Veterans' Affairs reported that "the veteran suicide rate in Oregon was significantly higher than the national average" after Oregon legalized assisted suicide (31% higher than the national suicide rate for veterans).

Finally, doctor shopping and elder coercion will happen if assisted suicide becomes law. The Oregon experience has proven that it is easy to find a doctor who is happy to comply with an assisted suicide request with a like-minded colleague available to "certify" the request. Elder abuse is rampant in America. Nothing in the proposed assisted suicide law will prevent an interested party from looking for a doctor who will prescribe death if another doctor says "no," and no healthcare professional or witness is required to be present at the death. Such a situation is ripe for abuse.

I believe that the real story here is the confirmation of the risks surrounding legalization of doctor-assisted suicide – they are real and they are happening now. The loss of dignity and worth these patients and families suffer is not just limited to the residents of the states where assisted suicide is legal but is crossing state borders and permeating the attitude of the decision makers that determine the allocation of our health care resources. I hope this story raises concern for millions of patients and their families across the country that will have to fight their health care insurers for coverage of life saving treatments.

State legislators considering the issue of assisted suicide as public policy should take notice of these real world experiences and pay attention to the very real and negative impact it can have on patients and their families. Assisted suicide is an affront to human dignity on every level and should be vigorously opposed by all.

T. Brian Callister, MD, FACP, SFHM

T. Brian Callister is a board certified internal medicine specialist and hospitalist who is nationally recognized as an expert in both care transitions across the continuum and end of life care. He is the Governor of Nevada for the American College of Physicians and is a Professor of Medicine at the University of Nevada, Reno School of Medicine. Views expressed are those of Dr. Callister as an individual.

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Suicides in Oregon: Trends and Risk Factors – 2012 Report, Oregon Health Authority, Public Health Division, November 2012; and the CDC National Center for Health Statistics: Increase in Suicide in the United States, 1996-2010

ANITA CAMERON_UNF-SB701

Uploaded by: cameron, anita
Position: UNF

NOT DEAD YET
The Resistance

Anita Cameron's Testimony
Opposing Maryland SB 701
Friday, February 28, 2020

Committee Chair, and Members. Good afternoon. Thank you very much for allowing me to offer my thoughts to you today.

My name is Anita Cameron. I am a 54-year-old with multiple disabilities, two of which are degenerative, and one which will take my life. I am testifying in opposition to Senate Bill 701, the End of Life Option Act.

This bill is a physician assisted suicide bill. It is important to be up front and honest about what this is. Couching it in pretty language is disingenuous at best, and dangerous, at worst.

I am Director of Minority Outreach for Not Dead Yet, a national disability rights organization opposed to physician assisted suicide and euthanasia as deadly forms of discrimination against people with disabilities. I live in Rochester, New York, but work with people of color and marginalized communities around the nation.

My primary reason for opposition to this bill and others like it is that disabled BIPOC (Black, Indigenous and People Of Color) are at particular risk of being harmed by it.

Our health care system is inherently racist. Studies show that Blacks and people of color receive inferior medical treatment compared to Whites. We are less likely to receive adequate treatment for heart conditions, diabetes, cancer and chronic pain. Oregon has made it clear that a person whose condition becomes terminal because they don't receive healthcare they need would be eligible for assisted suicide.

The lives of people with disabilities are largely devalued by doctors and society, in general, particularly if we are living in poverty. The lives of BIPOC with disabilities are even more devalued due to racism and stereotypes about our communities.

Although assisted suicide requests in Oregon (which this bill and others are modeled on) are lower among Blacks and people of color, that doesn't mean that this won't change in more diverse areas, especially as healthcare faces cuts and assisted suicide becomes more acceptable due to well-funded efforts of groups like Compassion and Choices. In fact, though the numbers are small and increases are incremental, there has already been a rise in the number of assisted suicide requests from people of color in California and Colorado since their laws went into effect.

Another reason for my opposition is that doctors would be the gatekeepers of people's lives under this bill, and can decide for you about your quality of life. Anyone can request assisted suicide, but a doctor decides who gets suicide prevention and who gets suicide assistance. And since the top five reasons people request assisted suicide in Oregon are related to disability, like feelings of being a burden on others, it's clear that doctors see disability concerns as good reasons to prescribe lethal drugs.

Further, doctors often make mistakes about whether a person is terminal or not. In June, 2009, while living in Washington state, my mother was determined to be in the final stages of Chronic Obstructive Pulmonary Disease and placed in hospice. Two months later, I was told that her body had begun the process of dying. My mother wanted to go home to Colorado to die, so the arrangements were made. A funny thing happened, though. Once she got there, her health began to improve! Over ten years later, she is still alive, lives in her own home in the community and is reasonably active.

Because of the racist nature of our health care system and the tendency of doctors to devalue the lives of disabled and people of color, assisted suicide has no place in Maryland's healthcare system.

Please vote NO on SB 701.

MDPAS Diane Coleman_UNF_SB701

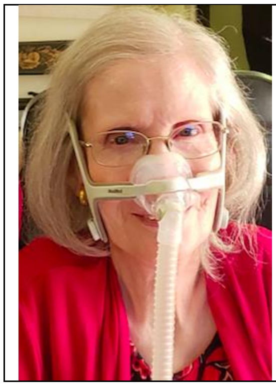
Uploaded by: Coleman, Diane

Position: UNF

NOT DEAD YET
The Resistance

Testimony of
Diane Coleman, JD
President and CEO of Not Dead Yet
Opposing SB 701 “End-of-Life Option Act”
Senate Judicial Proceedings Committee

February 28, 2020



I am submitting testimony as a person with an advanced neuromuscular condition. I’m also the founder and President of Not Dead Yet, a national disability rights group that opposes legalization of assisted suicide. I have personal experience with the uncertainty of terminal predictions by doctors, as well as the risks of assisted suicide laws for people who use breathing support or otherwise depend on ongoing treatments for serious chronic conditions. I will also discuss the Oregon data, which substantiates our concerns.

My Personal Story of Mistaken Prognosis

At the age of six I was diagnosed as having muscular dystrophy and my parents were told that I would die by the age of 12. A few years later I was re-diagnosed with spinal muscular atrophy (SMA), a progressive neuromuscular condition which has a longer lifespan. A few years ago, new DNA tests resulted in another revised diagnosis, a rarer neuromuscular condition. Regardless, since age eleven, I have used a motorized wheelchair.

I am now age 66. Beginning 18 years ago I have used breathing support at night. Over the years, the pressures required to sustain my breathing have increased. About five years ago, I went into respiratory failure. Since then I have used breathing support most of the day as well as at night. If I did not use this support, I would go into respiratory failure and die in a fairly short timeframe, far less than six months.

Throughout my adult life, I have worked full time, first as an attorney and then directing nonprofit disability related organizations. Over the last three years, I have continued to run Not Dead Yet, which has four staff and numerous volunteers across the country. I have spoken at conferences, published articles, submitted testimony in legislatures, and provided the day-to-day management an organization requires. I’m not saying this to be “inspirational”, but to make it clear that people like me can and do work, and/or do lots of other worthwhile and fun things, and should not be written off.

How Assisted Suicide Laws Endanger People Like Me

As a severely disabled person who depends on life-sustaining treatment, I would be able to qualify for assisted suicide at any time if I lived where assisted suicide is legal. As an Oregon official recently clarified in writing, any person who becomes terminal because they do not receive treatment, for any reason, would qualify for assisted suicide under an Oregon type law.[1] If the reason that I could not get treatment were an inability to afford insurance co-pays, I would be eligible for assisted suicide in Oregon. For over a year, my breathing support had a $500 per month co-pay which I had to pay out of pocket till my employer changed health plans.

If I became despondent, for example if I lost my husband or my job, and decided that I wanted to die, I would not be given the same suicide prevention as a nondisabled and healthy person who despaired over divorce or job loss. Where assisted suicide is legal, I would be treated completely differently due to my condition. By denying equal suicide prevention and other supports to people deemed “terminal”, assisted suicide laws are inherently discriminatory against old, ill and disabled people.

In these days of private managed care companies taking over Medicare and Medicaid, where providing expensive care has a tendency to reduce profits, we should at least question whether there is an inherent conflict of interest in having healthcare providers administrate a state sanctioned assisted suicide program. Anyone could ask for assisted suicide, but doctors are the gatekeepers with the power to decide who’s eligible.

What I’ve Learned From the Oregon Assisted Suicide Data

Oregon is held up as the model for other states. I’ve examined the Oregon state assisted suicide reports from a disability rights perspective, and want to share with you what I’ve learned.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there is “no evidence or data” to support any claim that these laws are subject to abuse, and that there has not been “a single documented case of abuse or misuse” in the 21 reported years. These claims are demonstrably false.

Regarding documented cases, please refer to a compilation of individual cases and source materials pulled together by the Disability Rights Education and Defense Fund entitled Oregon and Washington State Abuses and Complications.[2] For an in-depth analysis of several cases by Drs. Herbert Hendin and Kathleen Foley, please read Physician-Assisted Suicide in Oregon: A Medical Perspective.[3]

The focus of the discussion below is the Oregon Public Health Division data.[4] These reports are based on forms filed with the state by the physicians who prescribe lethal doses and the pharmacies that dispense the drugs. As the early state reports admitted:

"As best we could determine, all participating physicians complied with the provisions of the Act. . . . Under reporting and noncompliance is thus difficult to assess because of possible repercussions for noncompliant physicians reporting to the division."

Further emphasizing the serious limits on state oversight under the assisted suicide law, Oregon authorities also issued a release in 2005 clarifying that they have No authority to investigate Death with Dignity case.[5]

Nevertheless, contrary to popular belief and despite these extreme limitations, the Oregon state reports substantiate some of the problems and concerns raised by opponents of assisted suicide bills.

Non-Terminal Disabled Individuals Are Receiving Lethal Prescriptions In Oregon

The Oregon Public Health Division assisted suicide reports show that non-terminal people received lethal prescriptions every year except the first.

The prescribing physicians' reports to the state include the time between the request for assisted suicide and death for each person. However, the online state reports do not reveal how *many* people outlived the 6-month or 180-day prediction. Instead, the reports give that year's median and range of the number of days between the request for a lethal prescription and death. This is on page 13 of the 2018 annual report.[6] (The 2019 report is not yet available.) In 2018, at least one person lived 807 days; across all years, the longest reported duration between the request for assisted suicide and death was 1009 days. In every year except the first year, the reported upper range is significantly longer than 180 days.

The definition of "terminal" in the statute only requires that the doctor predict that the person will die within six months. There is no requirement that the doctor consider the likely impact of medical treatment in terms of survival. Unfortunately, while terminal predictions of some conditions, such as some cancers, are fairly well established, this is far less true six months out, as the bill provides, rather than one or two months before death, and is even less true for other diseases.

In addition, it should be noted that the attending physician who determines terminal status and prescribes lethal drugs is not required to be an expert in the disease condition involved, nor is there any information about physician specialties in the state reports.

Furthermore, as noted above, many conditions will or may become terminal if certain medications or routine treatments are discontinued – e.g. insulin, blood thinners, pacemaker, CPAP, etc. Any person who becomes terminal because they do not receive treatment for any reason, including lack of insurance coverage, including those caused by government budget cuts in Medicare and Medicaid, would qualify for assisted suicide under an Oregon type law.

Oregon reports that non-cancer conditions found eligible for assisted suicide has grown over the years, to include: neurological disease, respiratory disease, heart/circulatory disease, infectious disease, gastrointestinal disease, "endocrine/metabolic disease (e.g. diabetes)" and, in the category labeled "other", arthritis, arteritis, sclerosis, stenosis, kidney failure, and musculoskeletal systems disorders (pages 11 & 13).

The Only Certifiers of Non-Coercion And Capability Need Not Know the Person

Four people are required to certify that the person is not being coerced to sign the assisted suicide request form, and appears capable: the prescribing doctor, second-opinion doctor, and two witnesses.

In most cases over the years, the prescribing doctor is a doctor referred by assisted suicide proponent organizations. (See, M. Golden, Why Assisted Suicide Must Not Be Legalized,[7] section on "Doctor Shopping" and related citations). The Oregon state reports say that the median duration of the physician patient relationship was 10 weeks in 2018, and 12 weeks over all years (page 13). Thus, lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, Elder Abuse.[8])

The witnesses on the Oregon request form[9] need not know the person either. One of them may be an heir (which would not be acceptable for witnessing a property will), but neither of them need actually know the person (the form says that if the person is not known to the witness, then the witness can confirm identity by checking the person's ID).

So in Oregon, neither doctors nor witnesses need know the person well enough to certify that they are not being coerced.

In addition, as with the Oregon law, the definition of “capacity” in the Maryland bill allows third parties to communicate orally for the person to the doctors and witnesses, providing for the patient to be “communicating through a person familiar with a patient's manner of communicating.” This is especially dangerous for people with speech impairments, such as from a stroke or neurological disability.

No Evidence of Consent or Self-Administration At Time of Death

In about half the reported cases, the Oregon Public Health Division reports also state that no health care provider was present at the time of ingestion of the lethal drugs or at the time of death. Without an independent witness, there is no way to confirm whether the lethal dose was self-administered and consensual. The initial request for assisted suicide does not prove that the person wanted to go through with it, as shown by the reported decision by many not to do so.

Therefore, although “self administration” is touted as one of the key “safeguards”, in about half the cases, there is no evidence of consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know. The request form constitutes a virtual blanket of legal immunity covering all participants in the process.

Essentially, proponents of legalizing assisted suicide have taken what is fundamentally a third party legal immunity statute and marketed it deceptively as a personal rights statute. This deception relies on the common misconception that suicide is illegal, which it is not.

Pain Is Not the Issue, Unaddressed Disability Concerns Are

The top five reasons doctors give for their patients’ assisted suicide requests are not pain or fear of future pain, but psychological issues that are well understood by the disability community: “loss of autonomy” (91%), “less able to engage in activities” (89%), “loss of dignity” (74%), “losing control of bodily functions” (44%), and “burden on others” (45%) (page 12).

These reasons for requesting assisted suicide pertain to disability and indicate that over 90% of the reported individuals, possibly as many as 100%, are disabled at the time of their assisted suicide request.

Three of these reasons (loss of autonomy, loss of dignity, feelings of being a burden) could be addressed by consumer-directed in-home long-term care services, but no disclosures about or provision of such services is required. Some of the reported reasons are clearly psycho-social and could be addressed by disability-competent professional and peer counselors, but this is not required either. Moreover, only 4.5% of patients who request assisted suicide were referred for a psychiatric or psychological evaluation, despite studies showing the prevalence of depression in such patients.

Basically, the law operates as though the person's reasons don't matter, and nothing need be done to address them.

Conclusion

The Oregon assisted suicide data demonstrates that people who were not actually terminal received lethal prescriptions in all 21 reported years except the first, and that there is little or no substantive protection against coercion and abuse. Examples of abuses have surfaced through mainstream media and professional journals, but not through the superficial and unmonitored physician self-reporting system used by the state. Moreover, reasons for requesting assisted suicide that sound like a "cry for help" with disability-related concerns are apparently ignored. Thus, albeit minimal, the data substantiates serious problems with the implementation of assisted suicide laws.

For all these reasons, I urge you to vote no on the Maryland assisted suicide bill. The dangers of mistakes, coercion and abuse are simply too high, not only for people like me, but for everyone.

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[1] https://www.washingtontimes.com/news/2018/jan/11/diabetics-eligible-physician-assisted-suicide-oreg/; https://drive.google.com/file/d/1xOZfLFrvuQcazZfFudEncpzp2b18NrUo/view

[2] https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf

[3] https://dredf.org/wp-content/uploads/2012/08/Hendin-Foley-Michigan-Law-Review.pdf

[4] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[5] https://dredf.org/wp-content/uploads/2012/08/Oregon-DHS.pdf

[6] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

[7] https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/

[8] http://www.nejm.org/doi/full/10.1056/NEJMra1404688

[9] http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/pt-req.pdf

MDPAS Katie Collins-Ihrke_UNF_SB701
Uploaded by: Collins-Ihrke, Katie
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MACIL

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Lori Magruder,
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Lidiya Belyovska,
Executive Director

Statement to the Senate Judicial Proceedings Committee
Re: Senate Bill 701 – "End-of-Life Option Act"
Friday, February 28th, 2018
OPPOSE

The Maryland Association of Centers for Independent Living (MACIL) includes seven nonprofit organizations designed, governed and staffed by people with disabilities. We are part of a nationwide network of Centers for Independent Living providing the following core services: Information and Referral; Advocacy; Peer Support; Independent Living Skills training and Transition Services. Centers for Independent Living are resource and advocacy centers that promote independent living and equal access for people of all ages with all types of disabilities residing in Maryland.

MACIL is opposed to SB 701 the End-of-Life Options Act.

Under the proposed legislation, individuals can request physician-assisted suicide if a doctor has diagnosed them with a terminal illness and six months or less to live. This type of prognosis is nearly impossible to accurately predict. Individuals who have been injured in accidents or acquire serious illnesses are often viewed by health care providers as not having a quality of life so therefore are deemed terminal. Diagnoses of terminal illness are too often wrong, leading people to give up on treatment and lose good years of their lives.

People with spinal cord injuries, traumatic brain injuries, or diagnosed with ALS or Muscular Dystrophy, can be viewed as individuals who are terminal. To offer end of life options to individuals facing these diagnoses is counterproductive to encouraging them to learning to live their lives in a different way. Centers for Independent Living believe all individuals with disabilities can live a life of quality. People needing significant support for regular life activities can still live fully integrated and independent lives in their own homes with long term supports and services. Steps that could address the person's concerns with home care services to relieve feelings of burdening family, should be explored with the individual rather than assisted suicide and Centers for Independent Living can assist with this.

An additional concern on this legislation is that it does not require doctors to give patients a screening for depression before providing physician assisted suicide. People who want to die often have treatable depression or possibly need better palliative care. In addition, individuals facing a significant illness or new disability likely need suicide prevention information and connections to others who live in similar situations. Individuals facing a new way of life need support in understanding and dealing with a loss of autonomy and dignity, loss of control of bodily functions. These are all disability issues dealt with in the disability community daily.

MACIL feels there are no alternatives for death and the unintended consequences of this legislation can never be undone.

MDPAS Jim Dausch_UNF_SB701

Uploaded by: Dausch, Jim

Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act. Good afternoon. My name is Jim Dausch, and this is Jean, my wife of nearly 48 years.

This is our story:

In 2009, the neuromuscular specialists at Hopkins gave Jean a diagnosis of ALS. By late 2010, she lost the ability to speak clearly or to walk unaided. By 2011 she was using a walker then a wheelchair. After that, and following a visit to Lourdes in late summer 2010, there was no further development of the condition, and by now, the doctors believe that she may have a very rare variant of ALS called Primary Lateral Sclerosis, which cripples and affects speech but doesn't kill. However, there is no way to test for this. ALS has been known to go into prolonged remission and then come back. For us, the challenge and uncertainty remain.

At the Hopkins ALS Clinic, we learned of the palliative measures, devices, services and support that would be available to enable us to meet the challenges that lay ahead. When we got the initial diagnosis in 2009, Jean said to me "I'm not scared and I don't want you to be." We agreed that, whatever was coming, we'd go through it together, and for me, that also included the ALS Ice Bucket Challenge. The last 11 years, despite everything, have been the closest in our marriage. The support of family and friends, and of the dedicated Hopkins professionals, has been helpful beyond words. The idea of suicide, to avoid the ravages of ALS, never entered the picture. Life, even with ALS, is too precious.

MDPAS Father John J. Dillon_UNF_SB701

Uploaded by: Dillon, Fr. John

Position: UNF

HB 643/SB 701

The Rev. John J. Dillon

Pastor of St. Francis of Assisi Catholic Church

Archdiocese of Washington

Position: **OPPOSED**

Good afternoon, my name is Fr. John J. Dillon and I am the pastor of St. Francis of Assisi Catholic Church in Derwood, MD, located in Montgomery County. My parish is comprised of about 1,500 faith-filled families who live largely in the communities of Derwood, Rockville and Gaithersburg, MD.

I come to you today to submit testimony in opposing HB 643/SB 701, the End-of-Life-Option Act. In my ministry as a Catholic priest, one of my key roles is to serve as the on-call priest for Casey House, the only all-hospice, acute care inpatient medical facility in Montgomery County. In that capacity, I am often called to offer the Sacrament of the Anointing of the Sick to patients very near death; this is a holy rite in the Catholic Church whereby the requestor receives the Holy Spirit's peace and courage to bear the challenges of their last hours on Earth. Yet, I go to Casey House to provide more than a sacrament. I am also there to pray with the individual and his or her family, offer him or her comfort, and, in some cases, simply remind the patient of the mercy and compassion of Jesus Christ with my presence.

When I arrive at Casey House or any hospital where I'm called, I never know into what type of situation I am walking. If a patient is conscious, then I introduce myself and we may pray together. I ask the patient if he or she really wants the Anointing of the Sick and I try to be sensitive to what I am observing. If a person is agitated, I try to speak very calmly to him and her and tell the patient that the Lord is in our midst. To trust in His mercy.

As I accompany these patients to the end of their journeys on Earth, I've witnessed that people often feel like they are worthless or a burden. They often feel this way because they have seen the sacrifices their family members and friends have given and they feel ashamed that they are weak and cannot reciprocate the care they are receiving. But this is not so. They are precious in God's eyes and in the eyes of their family members and loved ones, who care for them and do so, out of love for them. But these patients, near the end, need this reassurance and this reminder that their lives are valuable and worthy, despite their human condition.

The End-of-Life-Option Act, physician-assisted suicide – whatever name you call it, the effect of this proposed policy is the same: it devalues the lives of people in our state, people who may be wracked with pain, but could also be filled with anguish and guilt at how their human condition has impacted the lives of their loved ones. The antidote to this is not providing these patients with life-ending drugs, but offering them emotional, spiritual and physical comfort in the last hours, days, weeks and months of their lives.

This bill concerns me gravely for many reasons, but mostly because it can go well beyond trying to give people a choice in when they leave this Earth. It could encourage our most vulnerable people – individuals with disabilities, mental illness and other special needs – to take their own lives. It could allow for insurance companies to pressure individuals to take a cheaper, life-ending drug, rather than extend their lives with more expensive medication prolonging their lives. It could compel doctors and health care workers to take part in an act that they oppose doing for ethical reasons. The bill changes the entire equation of how we view life in this state. It would move us to a place where we begin believing that some people's lives are more valuable than others – and that is a dangerous place to be.

I want to close with this: I sincerely hope we are in a position where someone listening to me, a Catholic priest with the sole purpose of guiding my parishioners closer to Jesus Christ, will be listened to. We need to listen to where all residents of this state stand on this bill. And we must be careful about listening to outside pressure groups arguing for legislation, which in the end, can be very corrosive and destructive to us as a society.

Thank you.

MDPAS Kevin Donovan_UNF_SB701

Uploaded by: DONOVAN, KEVIN

Position: UNF

G. Kevin Donovan, M.D., M.A.

SB 701 Testimony - Feb. 28,2020

Ladies and gentlemen, thank you for the opportunity to speak with you today about SB 701. This is not the first time that the Maryland assembly as considered such a bill nor is it the first time that I've spoken against it. I hope this body will share in the wisdom of its predecessors, and not allow this to become the law of the land. This is been a difficult issue for all concerned, and you will hear specific problems with the proposed bill - but not from me. I don't think tweaking the bill will solve the problems. I don't think there is a right way to do the wrong thing.

To be a lawmaker shares some of the features of being a physician: we have responsibilities to those individuals that we care for or represent, but we must always be cognizant that our actions will affect large segments of society as well. In your case, to pass a law is to set a societal standard for **all** those who will be affected by it. And make no mistake- this law will have repercussions for far more patients, far more people, than those few that it is intended for. You will be told the truth, that this law is intended as much as a comfort as it is a curative. In states such as Oregon, only a tiny minority of the people seek a lethal prescription, and many never actually use it. Today I want you to consider that much larger majority of your constituents, my patients, who have no declared need for such a law, no intention of ever using it, and a well-founded fear of it. You have heard and will hear, from representatives of the disabled who rightly fear this bill, but this fear and danger applies not just to them. They are just the canaries in the coal mine. There is a frightening list of those who will be placed at risk: the physically disabled, the mentally disabled, the elderly, the unfriended, the indigent, those who have never had adequate access to the healthcare system and are afraid of being shut out of access near the end of their lives as well. I am a medical doctor and an ethicist, and now spend much of my professional time with those near the end-of-life. Many are now concerned, rightly concerned, about how laws such as this create a new category for persons - persons whose lives may be looked at as less valuable, less worthy of preserving even as those lives dwindle, whose quality-of-life may be judged by others by this new criteria as meriting an early exit. Imagine how these patients feel when faced with such a proposal? Too many want to live, but want to live better lives, not to end them. In the absence of adequate services to the disabled, healthcare to the indigent, or palliative care to those near the end-of-life, this bill is premature. It represents a failure of societal support to those most in need. Instead, it places them in a new category, those whom society would allow or even encourage to choose death. We've seen other cultures take this route, both in the past and currently. We have seen the justification for it easily expand the list for whom it is intended. This is inevitable. If we feel driven by compassion to end the lives of those who suffer, where should we draw the line? Where can we draw the line? If it is the most compassionate choice that our society has to offer, how can we deny it to those not immediately included in this bill? After all, people can suffer without being terminally ill. People can suffer psychological anguish without being in physical pain. Should this choice be limited? Soon the so-called safeguards will be recast as barriers, barriers to be overcome by a society and the legislature that has redefined death as something not just to be accepted in due time, but to be promoted ahead of its time. And it will be promoted for those who are not seeking it, who are unable to seek it because of their psychological state, their dementia, or the fact that they are still children. These are not speculative problems. They are inherent in the justifications for such a bill, and they are being promoted already in Canada, which is only had such laws in the past four years, as well as Belgium and the Netherlands which have had them for decades.

Moreover, how can we struggle to reduce the number of suicides among our young people and our veterans, yet promote self killing for others? It doesn't work - it sends a mixed message, and that message has led to increased suicides elsewhere when such laws are instituted.

And last but not least, as a physician I would beg you not to distort the best practices of medicine, the trust relationship that we strive to build with our patients. Physicians are devoted to healing. Killing is not healing. Giving someone a deliberate lethal overdose is killing, not the practice of medicine. Even the notorious Dr. Kevorkian, a pathologist who typically only saw patients after their demise, did not seek to define euthanasia or assisted suicide as a medical act. He thought little independent clinics could be set up, and technicians taught how to do this. I would point out that physicians are not taught in medical school how to effectively prescribe a lethal overdose. I don't like Dr. Kevorkian's solution either, any more than most of you would want to work in such a clinic, especially if you're familiar with the concept of Soylent Green. If you would have an aversion to such a solution, I ask you to trust your instincts and your good sense. Changing the law to create a category for assisted suicides is unwise, unnecessary and ultimately uncontrollable. It fails to serve the greater good.

G. Kevin Donovan, MD, MA
Director,Pellegrino Center for Clinical Bioethics
Professor,Georgetown University Medical Center

Dyer_UNF_SB701

Uploaded by: Dyer, John

Position: UNF

Written Testimony of John J. Dyer IV

Senate Bill 701

End of Life Option Act

I OPPOSE the End of Life Option Act

February 28, 2020

My Name is John Dyer and I have been a lifelong resident of Maryland, even while serving on Active Duty in the Military. My family and I currently own a home at 11602 Hunters Run Drive Cockeysville MD.

The following reasons are my personal testimony as to why I request you also Oppose Senate Bill 701.

First, in 2004, following the birth of our oldest daughter in 1998 and after 3 subsequent miscarriages in 1999, 2000 and 2001 we decided to pursue the adoption of a child. Circumstances lead us to adopt a 1-year old little girl we named Olivia from Russia on November 30, 2004. Olivia like many of these children from Russia suffers from Fetal Alcohol Syndrome Disorder which has led to her being diagnosed with multiple mental disabilities. She also has learning disorders as well. She suffers from anxiety very low self-esteem and makes statements that she wants to take her own life.
Because of this my Jackie and I are very concerned about her mental health and she is already on multiple prescribed medications.
I Oppose Senate Bill 701 in this instance because I have a disabled daughter with mental illness and in no way do I want the State of Maryland to make it easier to have a legal mechanism to end her own life at her own hand or by a medical providers hand once she becomes an adult in a few short years. **(The Senate Bill 701 reads she "may" take the drugs which also means she MAY NOT which means someone else would administer the poison which is actually Euthanasia NOT Assisted suicide.)**

Second, Since March of 2018 my siblings and I have been involved with the medical care of both of my now 90-year-old parents Kitty and john Dyer 3rd. My mother in particular survived colon cancer 2 years ago and she suffers with heart failure and her and my father both take multiple medications. They too are life long residence of Maryland and last Labor Day they were presented with the Key to Ocean City by Mayor Meehan since they met there in 1951 and they have spent many days there opening there little townhouse on the bay to innumerable family and friends since 1972. Unfortunately for my parents since last fall 2019 they have 5 combined Emergency Room Visits between the two of them. My Mother for infections, swelling and open sores in her legs and my Father for a hand infection. Four of those for my Mother. Since I have been the sibling that most often goes with them to the ER, I can personally attest that is very difficult to get the medical providers, be they primary care Dr's, Home Nurses, Wound Care

Centers etc., to provide adequate if any pain medication. I sense that there is a real fear that they will put their license in jeopardy if they prescribe any medication that has any level of opioid in it. No matter how legal. IN FACT, during my Mother's last visit to the ER NO pain medication was provided to her to alleve her suffering. None.

I Oppose Senate Bill 701 in this instance because I feel that if this law is passed, Maryland's medical providers will be more inclined to prescribe the poison pills to end an elderly person's suffering because it will be legal and there will be plenty of legal and political protection for their licenses to prescribe these pills in lieu of an adequate pain pill for citizens like my parents.

Additionally, I hear that this is a matter of the heart and so-called compassion for the suffering and that is why the poison pill needs to become legal in Maryland. I disagree I contest this is a matter of the head and I would rather use my brain instead of my heart to fight for the proper care of my Parents then just to say it is somehow more compassionate to provide them the choice of a pill that will end their lives.

Third, 22+ of our Nation's Veterans are taking their own lives each day. Already over 1000 at this writing. As a veteran like my Father both of us serving over 30 years in the Maryland Air National Guard and the Air Force I am very concerned about making it easier here in Maryland for a Veteran to take their own life. Instead of this I would rather our efforts be focused on legislation to help them save their lives.

In fact, I am personally involved as a volunteer in a local chapter of the Military officers of America and for the 3rd year in a row we are hosting a fundraiser for an organization called "pws4vets". Organizations like this are making a REAL life saving difference in providing highly trained services dogs to our struggling Veterans. I chose the Pooch over the Poison Pill.

I Oppose Senate Bill 701 in this instance because there are proven ways like paws4vets to help our Veterans and to protect them from the seductive call of Suicide. Why would we choose to fight against this great organizations by making it easier for our Veteran's to end their own lives her in Maryland.

Respectfully Submitted,

John J. Dyer IV
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MDPAS Katie Glenn_UNF_SB701

Uploaded by: Glenn, Katie

Position: UNF

Written Testimony of Katie Glenn
Government Affairs Counsel, Americans United for Life
Against Senate Bill 701, the Richard E. Israel and Roger "Pip" Moyer Act
Submitted to the Maryland Senate Judicial Proceedings Committee
February 28, 2020

Dear Chairman Smith and Members of the Committee:

I serve as Government Affairs Counsel of Americans United for Life (AUL), America's original and most active organization advocating for life-affirming support and protections for the most vulnerable members of our communities. Established in 1971, AUL has dedicated nearly 50 years to advocating for everyone to be welcomed in life and protected in law. In my practice I specialize in life- and health-related legislation, and I am testifying as an expert in constitutional law generally and in the constitutionality of end of life-related laws specifically. I appreciate the opportunity to provide testimony against Senate Bill 701, the Richard E. Israel and Roger "Pip" Moyer Act, which would legalize suicide by medical means in Maryland.

I have thoroughly reviewed Senate Bill 701 ("the Act") and it is my opinion that the Act goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable persons at greater risk, and fails to protect the integrity and ethics of the medical profession.

Suicide by Physician Places Already-Vulnerable Persons at Greater Risk

Maryland has a responsibility to protect vulnerable persons—including people living in poverty, elder adults, and those living with disabilities—from abuse, neglect, and coercion. Considering the risk posed to these vulnerable individuals, legalizing assisted suicide can be considered neither a "compassionate" nor an appropriate solution for those who may suffer depression or loss of hope at what may be the end of life.

Indeed, contrary to the prevailing cultural narrative, the reason why people consider seeking assistance in their suicide is neither pain nor fear of pain. In the last 15 years, pain and fear of pain have never been in the top five reasons cited by those seeking assisted suicide in Oregon;[1] the latest data from

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[1] Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY (Feb. 15, 2019) [hereinafter OREGON 2018 DATA SUMMARY], https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf.

Washington State reveal the same concerns.[2] As bioethicist Ezekiel Emanuel has noted, "the main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . . In this light, assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."[3]

Emanuel is not alone. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved prescription suicide, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[4] The most vulnerable among us—such as the poor, the elderly, the terminally ill, the disabled, and the depressed—are equally worthy of life and even more in need of equal protection under the law, and state prohibitions on promoting or enabling suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[5] Speaking to this disparate treatment, Dr. Kevin Fitzpatrick wrote, "When non-disabled people say they despair of their future, suicide prevention is the default service we must provide. Disabled people, by contrast, feel the seductive, easy arm of the few, supposedly trusted medical professionals, around their shoulder; someone who says 'Well, you've done enough. No-one could blame you.'"[6]

There has been discussion of a "suicide contagion," or the Werther Effect.[7] Empirical evidence shows media coverage of suicide inspires others to commit suicide as well.[8] One study, which incorporated assisted-suicide statistics, demonstrated that legalizing assisted suicide in certain states has led to a rise in overall suicide rates—assisted and unassisted—in those states.[9] The study's key findings show that after accounting for demographic, socioeconomic, and other state-specific factors, physician-assisted suicide is

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[2] Wash. State Dept. of Health Disease Control and Health Statistics Div., WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (Mar. 2018) [hereinafter WASHINGTON 2018 REPORT], https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf.

[3] Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, N.Y. Times (Oct. 27, 2012), https://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/.

[4] 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.).

[5] *Glucksberg*, 521 U.S. at 731–32.

[6] Kevin Fitzpatrick, *Assisted Suicide for Disabled People – Democracy in Britain?*, Euthanasia Prevention Coalition blog, June 23, 2015, available at http://alexschadenberg.blogspot.com/2015/06/assisted-suicide-for-disabled-people.html.

[7] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOVERNMENT (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/.

[8] *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 RES. 137 (2004).

[9] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015) https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf.

associated with a 6.3% increase in overall suicide rates.[10] These effects are even greater for individuals older than 65 years of age—14% increase.[11] And so suicide prevention experts have criticized assisted-suicide advertising campaigns, writing that a billboard proclaiming "My Life My Death My Choice," which provided a website address, was "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal."[12]

The Supposed Safeguards Are Ineffective in Practice

Despite the so-called "safeguards," opening the door for suicide by physician also opens the door to real abuse. For example, SB 701 requires that there are two witnesses to the request for life-ending medication, but only one must be a disinterested party, at least in theory. There is no requirement that the second witness be completely disinterested, meaning an heir and his best friend, roommate, or significant other would satisfy the two-witness requirement, easily circumventing the alleged safeguard designed to protect the patient from pressure, coercion, or abuse.

Additionally, the Act's mental health assessment requirement is practically nonexistent. The patient is referred to counseling for a mental health assessment only if the physician believes the individual "may be suffering from a condition that is causing impaired judgment or otherwise does not have the capacity to make medical decisions." Then, the patient is provided the medication if the counseling physician "determines that the patient is not suffering a psychiatric or psychological condition including, but not limited to, depression, that is causing impaired judgment."

This safeguard is ineffective for two reasons. First, the Act fails to define "impaired judgment" at all. This means that even if individual is suffering from depression, that in and of itself might not preclude the individual from being prescribed and utilizing life-ending medication. Second, there is no requirement that the counselling involve meeting more than once. As the most recent statistics from Oregon show, only 3 of the 168 patients who died from ingesting end-of-life drugs in 2018 were ever referred for a psychiatric evaluation.[13] Similarly, in Washington, only 10 of the 251 individuals who died in 2018 were referred for a psychiatric evaluation.[14] One study from Oregon found that "[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[15] This is problematic because the Act only requires the provider making this determination be a "licensed psychiatrist or psychologist" not the primary care physician or a physician with a prior relationship with the individual who has an

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[10] *Id.*

[11] *Id.*

[12] *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/.

[13] OREGON 2018 DATA SUMMARY, *supra* note 1.

[14] WASHINGTON 2018 REPORT, *supra* note 2.

[15] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, Am. J. Psychiatry 157:4, 595 (2000) https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.157.4.595.

understanding of his or her history and needs. For these reasons, it is difficult to argue this "safeguard" in SB 701 will accurately assess an individual's mental health.

In addition, the Act assumes the physicians are able to make the correct diagnosis that a patient is has an incurable and irreversible disease which will "result in death within six months." But this fails as a safeguard as terminality is not easy to predict. Current studies have shown "experts put the [misdiagnosis] rate at around 40%,"[16] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[17] 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.[18] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care,"[19] and Arthur Caplan, the director of the Center for Bioethics at the University of Pennsylvania, considers a six month requirement arbitrary.[20] Even the Oregon Health Authority admitted, "[t]he question is: should the disease be allowed to take its course, *absent further treatment*, is the patient likely to die within six months? . . . [Y]ou could also argue that even if the treatment [or] medication could actually cure the disease, *and the patient cannot pay for the treatment*, then the disease remains incurable."[21]

Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on physician-enabled suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as to the principles articulated in the Hippocratic Oath to "keep the sick from harm and injustice" and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[22] Likewise, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of life. The AMA states that "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."[23] In fact, the

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[16] 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

[17] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, The Local, Apr. 24, 2014 (reporting the doctor was not held accountable for his negligence).

[18] Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

[19] *See id.*

[20] *See id.*

[21] Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan. 2018 (emphasis added), available at https://www.masscitizensforlife.org/oregon-health-authority-reveals-hidden-problems-with-the-oregon-assisted-suicide-model.

[22] 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).

[23] AMA CODE OF MEDICAL ETHICS OP. 5.7 (Physician-Assisted Suicide), https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf.

AMA states the physician must "aggressively respond to the needs of the patients" and "respect patient autonomy [and] provide appropriate comfort care and adequate pain control."[24] And in June of 2019, the AMA reaffirmed its position against suicide by physician by a vote of 65-35.[25]

Furthermore, SB 701 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. It opens the door for physicians to be forced to violate medical ethics, such as the Hippocratic Oath to "do no harm," as well as their moral convictions or religious beliefs against taking one's own life or assisting another to end her life. Even though the Act includes language stating that a physician may "refuse to participate" in suicide by physician, it does require that the physician provide a referral to a physician who will act on the request. Many healthcare providers find referral a violation of their moral, ethical, or religious beliefs because they still feel complicit in the ultimate act. SB 701 as currently written insufficiently protects the conscience rights of Maryland healthcare providers.

The U.S. Supreme Court has stated "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[26] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for physician-assisted suicide, he pointed out: "Virtually 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.'"[27]

The Majority of States Affirmatively Prohibit Medical Suicide

Currently, the majority of states—at least 37 states—prohibit assisted suicide and impose criminal penalties on anyone who helps another person end his or her life. And since Oregon first legalized the practice in 1996, "about 200 assisted-suicide bills have failed in more than half the states."[28] In *Washington v. Glucksberg*, the United States Supreme Court summed up the consensus of the states: "In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life."[29]

This longstanding consensus among the vast majority of states is unsurprising when one considers, as the Court did, that "opposition to and condemnation of suicide—and, therefore, of assisting suicide—

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[24] *Id.*

[25] Steven Ertelt, AMA Votes to Retain Longstanding Opposition to Assisted Suicide, LIFESITENEWS.COM (June 10, 2019), https://www.lifenews.com/2019/06/10/ama-votes-to-retain-longstanding-opposition-to-assisted-suicide

[26] *Glucksberg*, 521 U.S. at 731.

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

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

[29] 521 U.S. 702, 710 (1997).

are consistent and enduring themes of our philosophical, legal and cultural heritages."[30] Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide in the U.S. Constitution, finding instead that there exists for the states "an 'unqualified interest in the preservation of human life[,]' . . . in preventing suicide, and in studying, identifying, and treating its causes."[31]

Thus, Maryland should reject Senate Bill 701 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable individuals such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession. Thank you.

Sincerely,

Katie Glenn, Esq.
Government Affairs Counsel
Americans United for Life

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[30] *Id.* at 711.
[31] *Id.* at 729–30.

MDPAS Sheryl Grossman_UNF_SB701

Uploaded by: GROSSMAN, SHERYL
Position: UNF

Testimony to the Senate Judicial Proceedings Committee
Re: Senate Bill 701—"End of Life Options Act"
Friday, February 28, 2020

OPPOSE

Mr. Chairman, Senators, and fellow citizens, I am here today to oppose Senate Bill 701, the "End of Life Options Act".

Hello, my name is Sheryl Grossman. I come before you today, as I have before, to urge you to oppose SB 701, the End of Life Options bill.

As someone born with a very rare genetic condition, who meets the criteria for "terminal" under this bill, I am telling you this bill is harmful to disabled people.

When the average person on the street says they want to harm themselves, we rush crisis intervention services and follow up mental health care to them. Why should people who are labeled as having 6 months or less to live be treated differently? Why? Because this bill buys into the age-old notion that a life with limitations is less worthy of life.

We know that the top two reasons that people request a lethal prescription are the fear of loss of function and the fear of being a burden physically and financially on others. Add to that the health disparities that exist for many disabled and multiply marginalized people and we get a perfect storm where the cost cutting of insurance companies in the form of denied coverage meets the stereotypes that lead us disabled folks to believe that assisted suicide is a viable choice, sometimes, the only option.

This bill does not do anything to protect people from being coerced into making this decision. It requires a consultation with a physician, but if they get someone like the psychiatrist I had who actually suggested turning up my pain meds, or turning off the chemotherapy because she just didn't understand why I would want to keep living in and out of hospitals for the rest of my life, then it is hard to make a different decision. And one of the bill's star witnesses last year, Dr. Strauss, testified that it is possible that a caregiver can put the meds in someone's drink. There is no requirement that the physician be present when the dose is taken. And the cause of death is listed is the underlying disease process, not the actual cause of death, assisted suicide.

Maryland is the home of Johns Hopkins, one of the best medical systems in the US. and people come here and like me, move to Maryland, for the life saving care it provides. The state of Maryland should be in the business of helping save our lives, so please, kill this bill, don't make it easier to kill us. Thank you.

I am including a list of Disability Organizations that oppose physician-assisted suicide:
https://notdeadyet.org/disability-groups-opposed-to-assisted-suicide-laws

Additionally, please see this link to a study put out recently by the National Council on Disability: https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf

JosephHamilton.UNF.SB701

Uploaded by: Hamilton, joseph

Position: UNF

Joseph Hamilton

Opposed SB701 Feb., 2020

Honorable Senators,

In the Bible, in the book of Genesis, we are told people are special. We are not just another animal. What makes us unique is our ability to love and be loved. We can also use our unique gift of free will for good or bad.

When our emotions work against us and make us sad or depressed or hopeless, our community should not add to our misery. Rather, we need to encourage and comfort those who are hurting and vulnerable. It does take more effort to care for someone than to just leave them.

I know of a young girl who lived in Ma., who could not move; even her head. Nevertheless, she became so popular that my friend had to take over setting up meeting times for her so as to help control the many people coming to her for help. These people wanted to talk to Audrey because she had the gift of miracles. She would intercede for your intensions and God would answer in profound ways! Though totally immobile, God used her to help many, many people.

Our dignity does not come from other people's attitude or opinion about us. Our life is a gift from God. God knows us and wants us from the moment of our conception and throughout eternity. Our body is made for community. It is the community's responsibility to support and encourage our body, mind, and spirit.

Assisted suicide is the EXACT OPPOSITE of what we are called to do as a civilized society! Let us seek ways to comfort and ease pain and encourage rather than spend money on our selfishness. “Death with dignity” is an oxymoron! Death is not dignified. Life is! We must seek ways to promote and honor life as we encourage others; no matter their circumstance. From the moment we are conceived, we require nurturing support. We must change our attitude promoting what has been called a “culture of death” and seek ways to promote a “culture of life” in which all people are held in higher esteem.

It costs more money to nurture life than to just “pull the plug.” But, in the broader economic scope of life, there’s more money to be gained through promoting life, liberty, and the pursuit of happiness. We must not focus on selfish immediate gain. Instead, let’s initiate new and better ways to comfort and ease the pain of those in need.

Maryland Psychiatric Society__UNF_SB701

Uploaded by: Hanson, Annette
Position: UNF

February 20, 2020

The Honorable Senator William C. Smith, Jr
Senate Judicial Proceedings Committee
2 East Miller Senate Office Building
Annapolis, MD 21401

RE: Oppose – SB 701: End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

Dear Chairman Smith and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) is a state medical organization whose physician members specialize in the diagnosis, treatment, and prevention of mental illnesses including substance use disorders. Formed more than sixty years ago to support the needs of psychiatrists and their patients, MPS works to ensure available, accessible and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branch of the American Psychiatric Association covering the state of Maryland excluding the D.C. suburbs, MPS represents over 700 psychiatrists as well as physicians currently in psychiatric training.

MPS opposes Senate Bill 701: End-of-Life Option Act (SB 701). Since this bill was first introduced in 2015, MPS has extensively deliberated the legislation within the organization through several listserv discussions, a member survey, and a four hour pro-con debate sponsored jointly with the Maryland somatic physician's organization, Med Chi. In addition to reviewing the legislation each year, MPS has considered information contained in the American Psychiatric Association's (APA’s) resource document on assisted suicide and other literature as cited in the footnotes to this testimony.

MPS recognizes that this is a divisive issue and that some of our members disagree with the organization's position. Those members have been encouraged to contact their elected officials to contribute their thoughts and we welcome consideration of both sides of this serious policy.

MPS maintains its opposition to SB 701 based on three general areas of concern.

1. Suicide Contagion

Promotion of this bill, and assisted suicide laws generally, transmit a dangerous message to vulnerable Maryland citizens. According to the Centers for Disease Control (CDC), at any given point in time 4% of people are experiencing suicidal thoughts. One-sixth of those individuals will attempt suicide (1.4 million Americans), and 3% will die.[1] Translated into Maryland numbers, this means that 242,000 people are presently thinking of killing themselves, 40,333 will attempt suicide, and 1210 will die.

Suicide clusters and contagion are well established phenomena with documented connections to media coverage and publicity.[2] The CDC and the World Health Organization both promulgate guidelines for the media coverage of high profiles suicides.[3] These guidelines advise against the portrayal of self-destruction as a "brave," or "romantic," and discourage reports which idealize suicidal behavior. They also caution against explicit discussion of suicide methods. These recommendations were developed in part due to a study which demonstrated that deaths by helium asphyxiation increased by more than 400% in New York following publication of the book Final Exit in 1991.[4]

Proponents of assisted suicide laws violate these public health recommendations when they describe self-destruction as a "graceful" or "beautiful" expression of personal autonomy.[5] To date there have been no well-designed studies to clarify the relationship, if any, between adoption of assisted suicide laws and states rates of un-assisted suicide. However, following the highly publicized death of Brittany Maynard in 2014 the number of assisted deaths by lethal medication in Oregon nearly doubled, from 71 in 2013 to 132 in 2015. In a letter to the Colorado Springs *Gazette*, Dr. Will Johnston documented the

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case of a young man who was inspired to research suicide methods online after being impressed by, and admiring, Brittany Maynard's suicide video.[6]

Here in Maryland, two people with serious mental illness have sought psychiatric help to die on the basis of their mental illness. One was a resident of the Maryland state hospital system and made a request for lethal medication on the day the 2019 bill failed in the Senate.[7] Another was a resident of the Eastern Shore with schizophrenia who contacted several forensic psychiatrists for a capacity assessment in order to apply for euthanasia in Switzerland.[8]

Adoption of this law carries serious implications for people with mental disorders who would demand equality under the law. People with serious and treatment-resistant eating disorders could qualify, since qualification is based upon prognosis rather than diagnosis.

2. Safeguard Failures

MPS considers the statutory safeguards to be inadequate. Furthermore, the safeguards historically have been ignored without consequences to the negligent physicians.

Between 1998 and 2012, a total of 22 Oregon physicians were referred to the Board of Medical Examiners for non-compliance with the provisions of the Death with Dignity Act. None could be sanctioned due to the "good faith" protections of the law, even when required witness attestations were missing. No attempt has been made by Oregon, or any independent researchers, to document unreported cases in Oregon since the entry into force of the DWDA. The true reporting rate in Oregon is therefore unknown.[9]

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Similarly, in the first year of the Colorado law all prescribing physicians attested that they followed the law even when 42 cases were missing the consultant's evaluation, 22 had no written request, and nine of 69 cases were not reported at all by the physician.[10]

In 2016, the Des Moines Register investigated ten years of data in Washington and Oregon, and found that in 40% of cases the reports were missing key data. Failure to submit required reports, or to hold physicians accountable for reporting failure, is a substantial weakness of this legislation.[11] Even if all required documents were accounted for, there has been no study to date to confirm the accuracy and specificity of these statutory safeguards.

In Maryland, one physician was willing to violate our state's criminal prohibition. The late Dr. Lawrence Egbert admitted to participating in the assisted suicide deaths, by helium asphyxiation, of six non-terminally ill Maryland residents. Three of those patients had co-existing clinical depression. Dr. Egbert's actions were discovered purely by accident. Nonetheless, Dr. Egbert was never charged or prosecuted in Maryland. Dr. Egbert admitted in an interview with the Baltimore Sun that he had been involved in 15 suicides in Maryland and 300 nationwide.[12]

If Maryland is unwilling to enforce criminal prohibitions, the enforcement of statutory safeguards is even less likely. Connecticut's Division of Criminal Justice acknowledged that the statutory construction of their legislation would have prohibited prosecution for murder.[13]

3. Implications for the Practice of Psychiatry

This legislation has the potential to significantly complicate the practice of psychiatry in Maryland, for both the treating clinician and when functioning as an evaluator of

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There is no provision to correct an error if lethal medication is given to a patient who has concealed his or her psychiatric history from a prescribing physician. A treating psychiatrist who discovers an error would have no legal means to take custody of or dispose of the medication given to a patient. There is no procedural mechanism to challenge a faulty or erroneous capacity assessment.

A psychiatrist charged with assessing capacity must also rule out the possibility of coercion. In order to do this, the evaluator must be at liberty to interview any individual with relevant information. Under this law, a coerced individual could refuse permission for the evaluator to speak with anyone who has knowledge of the coercion.

SB 701 allows the patient to ingest the medication at the time and place of his or her choosing. Thus, a participating facility could require an inpatient psychiatric unit to allow ingestion on the ward in violation of ward suicide prevention policies. This would be particularly detrimental on units designed for the treatment of eating disorders or in geriatric units, where it would be most likely to occur. People with mental illness also develop co-occurring serious medical conditions such as diabetes; since the law does not require the patient to accept any treatment, this condition would qualify as "terminal" if the individual refuses insulin.[14] California's health department regulations mandate that state psychiatric facilities must carry out assisted suicides within their units under certain conditions (9 CCR §4601).[15]

Conclusion

Several additional deficiencies have been identified by other opponent groups, and the Maryland Psychiatric Society endorses these concerns. These include:

1. No requirement for decisional capacity at the time of ingestion

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5. Detrimental psychological effects on the involved medical professional
6. No requirement for a doctor to notify a power of attorney or guardian that a prescription has been requested
7. Potential federal civil rights violations if the eligible person is institutionalized in a correctional facility or state hospital where prevention of suicide is an affirmative obligation.
8. The lack of mental health screening instruments validated in this population for this purpose
9. No mandatory reporting or whistleblower protection for healthcare providers aware of negligent or malicious prescribers

For all the reasons above, MPS asks the committee for an unfavorable report of SB 701. If you have any questions with regard to this testimony, please feel free to contact Dr. Annette Hanson at hanson1072@gmail.com.

Respectfully submitted,
The Legislative Action Committee for the Maryland Psychiatric Society

Extra References:

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MDPAS Annette Hanson_UNF_SB701

Uploaded by: Hanson, Annette

Position: UNF

February 20, 2020

The Honorable Senator William C. Smith, Jr
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2 East Miller Senate Office Building
Annapolis, MD 21401

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The Legislative Action Committee for the Maryland Psychiatric Society

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MDPAS Kristen Hanson_UNF_SB701

Uploaded by: Hanson, Kristen
Position: UNF

Maryland Senate Judiciary Proceedings Bill HB0643 & SB0701

Kristen Hanson's Testimony

Community Relations Advocate, Patients Rights Action Fund

Members of the committee, my name is Kristen Hanson and I represent the Patients' Rights Action Fund, a national, secular, non-partisan organization opposed to the legalization of assisted suicide.

On Dec. 30, 2017, my husband, JJ Hanson, passed away from terminal brain cancer. He was only 36 years old.

JJ was a Marine Corps war veteran and volunteer fireman who served New York state under two Democratic Governors. JJ believed in personal autonomy and freedom.

Yet, JJ also understood that it is the duty of a fair and just society to protect its most vulnerable members. That's why he devoted his final days to fighting the legalization of assisted suicide.

After a seizure unexpectedly sent JJ to the hospital in 2014, we were told that he only had four months to live. Three different doctors told us there was nothing we could do.

Thankfully, we didn't listen and JJ had great success with treatment. He lived 3.5 good years following his diagnosis. During that time our son created priceless memories with JJ and we welcomed a second son into the world.

But if assisted suicide was legal, JJ could have had the lethal drugs with him during his fifth month of treatment when he questioned if we'd all be better off without him, fearing he was a burden to us.

Thankfully, JJ didn't end his life. But if he had suicide pills, he might have taken them. And you can't undo that.

Twenty years of data from Oregon show the main reasons patients request assisted suicide are disability-related concerns. Pain and suffering, or even concern about it never makes it into the top five reasons, but last year's report showed 54% of patients chose it out of fear of being a burden.

Assisted suicide laws abandon vulnerable patients like JJ who can experience depression at any point following their illness. Once patients receive the prescription, they're on their own. There's no requirement for a doctor to follow-up with them.

Please focus your efforts on improving access to hospice and palliative care, which truly addresses patients' concerns at the end of life instead of removing society's care at a time when it's needed most.

Thank you.

Board of Physicians_UNF_SB 701

Uploaded by: Hawk, Wynee

Position: UNF

Maryland
DEPARTMENT OF HEALTH

Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

February 28, 2020

The Honorable William C. Smith, Jr.
Chair, Judicial Proceedings Committee
2 East
Miller Senate Office Building
Annapolis, MD 21401

RE: SB 701 – "End-of-Life Option Act (Richard E. Israel and Roger 'Pip' Moyer Act)" – Letter of Concern

Dear Chair Smith:

The Maryland Board of Physicians (the "Board") is submitting this Letter of Concern for SB 701, entitled "End-of-Life Option Act (Richard E. Israel and Roger 'Pip' Moyer Act)."

SB 701 sets forth the circumstances under which, and the procedure by which, an individual may request aid in dying. A "qualified individual" is defined in the bill as one who is an adult, has the capacity to make medical decisions, is a resident of Maryland, has a terminal illness, and has the ability to self-administer medication.

The process involves the licensed physician who has primary responsibility for the medical care of the individual making the request. Among other requirements, this physician, or "attending physician," shall ensure that the individual is a qualified individual, makes an informed decision, and has voluntarily requested aid in dying. The attending physician also is responsible for determining that the individual has a terminal illness and documenting certain information in the qualified individual's medical record.

The Board has concerns that the bill does not clarify if any civil or criminal liability is incurred by a health care provider for failing to comply with certain provisions of Health-General Article, §5-6A-01 *et seq,* such as improperly diagnosing a patient. Is a health care provider's failure to cooperate in good-faith compliance with Health-General Article, §5-6A-01 *et seq* deemed a criminal violation of §3-102 of the Criminal Law Article that subjects the provider to particular criminal penalties? In addition, the bill does not specifically address who, or what entity, is responsible for resolving matters concerning compliance with the Health-General provisions and determining whether or not the provider acted in good-faith compliance with the subtitle. For example, who investigates a complaint? Is a criminal law enforcement agency responsible for determining compliance with and enforcing these provisions? Is it the Board? What is the meaning of an act in "good-faith" compliance? This term is not defined in the bill.

The Board also is concerned regarding the following provision under §5-6A-09:

> *(C) RECORDS OR INFORMATION COLLECTED OR MAINTAINED UNDER THIS SUBTITLE ARE NOT SUBJECT TO SUBPOENA OR DISCOVERY AND MAY NOT BE INTRODUCED INTO EVIDENCE IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING, EXCEPT TO RESOLVE MATTERS CONCERNING COMPLIANCE WITH THIS SUBTITLE OR AS OTHERWISE SPECIFICALLY PROVIDED BY LAW.*

If it's decided that the Board is the agency, or one of the agencies, that will be tasked with investigating complaints alleging failure to comply with the requirements of the subtitle or involving other standard of care concerns, the Board must have the ability to subpoena medical records as part of its investigation. This provision could preclude the Board from investigating complaints involving standard of care issues or other potential violations of the Medical Practice Act related to certain actions by physicians in an end-of-life matter, and would adversely affect the Board's efforts and mission to protect the health and safety of Maryland citizens.

In addition, the bill does not specifically address the potential role of physician assistants (PAs). Under Health Occupations Article (H.O.), Title 15, PAs may be delegated the dispensing of prescription drugs, under certain circumstances, by a supervising physician who possesses a dispensing permit. *See H.O. §15-302.2.* The Board is concerned that the bill lacks clarity about whether the dispensing of medications prescribed for aid in dying may be delegated by a permit holder to a PA.

Finally, the Board believes there are inconsistencies in the use of certain terms throughout the bill, which – in turn – may cause confusion for the public and practitioners about certain provisions.

Thank you for your consideration of this information. If you have questions or need additional information, please contact Wynee E. Hawk, 410-764-3786.

Sincerely,

Christine A. Farrelly

Christine A. Farrelly
Executive Director

cc: Members of the Judicial Proceedings Committee
Webster Ye, MDH

MDPAS Allison Johnson_UNF_SB701

Uploaded by: Johnson, Allison

Position: UNF

Rev. Allison Johnson, U.S. Army Master Sergeant (Ret)
Associate Pastor, First Baptist Church of Glenarden
Master of Arts (Religion), Trinity Evangelical Divinity School, Deerfield, IL
Master of Human Relations, University of Oklahoma
Breast Cancer Survivor with a Double Mastectomy

To the Honorable Legislators of the Great State of Maryland:

I humbly request you NOT pass SB 701. As a Christian Ethics Instructor, I and those I teach believe in the sacredness of life.

I dare say most of you would argue that capital punishment is barbaric and inhumane. In 2013 we struck down capital punishment in Maryland, becoming the 18th state to do so. Here we are in 2020 among 18 states poised to approve physician assistant suicide under the guise of compassionate choice, and safeguards that will be discarded before the ink is dry from the Governor's pen. A primary argument for the elimination of Capital Punishment is the racist and disparate outcome for people of color, and those economically disenfranchised. How is this any different? We struck down capital punishment, and we now want to approve Physician-Assisted Suicide, which will quickly become Euthanasia. Like Capital Punishment, this will ultimately have a disparate effect on ***my*** community.

Make no mistake SB 701 is written to allow for wide interpretation on purpose, so that in the future, waiting periods can be deleted, the definition of chronic pain can extend to such things as diabetes and depression, and "may self-administer," will come to mean let the doctor inject me like we use to strap prisoners to gurneys and administer lethal drugs to end their life. How is Physician-Assisted Suicide any different in its real consequences?

In 2016, my mother spent 17 days in hospice care. Her treatment was dignified and respectful, and that worthy of a woman who loved her God, six children, and community. I may not be able to say the same for my father-in-law, who is currently in an assisted living situation in the state of California.

As an Associate Pastor and Ethics Instructor, I know:

1. **All human beings are created in God's image**, Genesis 1:26-27
2. **All human life is sacred**, Genesis 9:3-6
3. **All human life has intrinsic value regardless of life stage or condition**

Please do not pass or table this bill; **throw it out**. Stand against racism and for the least among us.

Thank you,

Allison Johnson

Rev. Allison Johnson, MHR, MAR
4868 Champlain Court
Waldorf, MD 20602

MDPAS Laura Jones_UNF_SB701

Uploaded by: JONES, LAURA
Position: UNF

SB 701/ HB 643
"Richard E. Israel and Roger "Pip" Moyer"
End-of-Life Options Act
OPPOSED - VOTE NO

Laura Jones
508 Post Oak Road
Annapolis, MD 21401
410-246-5166

Thank you for allowing me to express my opposition to SB 701

The people wearing the sticker that says – "My Life, My Death" think this is a personal choice that does not effect anyone else but that is simply not true. If you pass this law, it would have an impact on my family.

My mother-in-law has melanoma that spread to her lymph glands. She was given 6 months to live and like most people, she was afraid of what the future would hold. More than once she said she just wanted to die, esp. after one of her friends died. She couldn't see a reason to go on living. That is one problem with this bill. The patient could get the prescription when they are not depressed, but later something could happen that puts them into despair.

If this becomes law and she gets the lethal drugs, she could commit suicide simply because she is having a bad day. Thankfully, she does not have this option , and even though she was diagnosed with less than 6 months to live and continues to fight cancer, she is still with us, 4 1/2years later.

My concern is not only for my mother-in-law. During this same time our teenage daughter developed anxiety and depression. Her high school counselor informed us she planned to kill herself by overdosing on pills. As a result, we sought help for her and we were told to put all our medications under lock and key.

If you pass this law, it would pose an immediate threat to my mother-in-law and my daughter. How would I protect my daughter from access to my mother-in-law's medication? If my mother-in-law ends her life because she is depressed and feeling low, how I can explain to my daughter that she should not do the same thing?

Can a law be good for one person and bad for another?

(Hold up Picture)Attached to my written testimony is a copy of this story from our local newspaper, The Capital, that glorified the suicide of a woman in CA with ALS. This woman sent out invitations to her own death party that was held at sunset overlooking the beach with her closest friends.

This story makes me physically ill as I remember my daughter telling me how she wanted her funeral. Some kids dream about the best way to die and it does not help when the news makes suicide look like some great thing.

Vote against SB 701 to protect my daughter from danger, my mother-in-law from bad days, and the people in Maryland from a law which forces all of us to consider suicide as a medically approved healthcare option when we are terminally ill.

The Sunday Capital

Health&Fitness

D3
SUNDAY
Aug. 28, 2016

CAPITALGAZETTE.COM

A graceful means to an end

Terminally ill woman had one rule: No crying

By Lindsey Bever
The Washington Post

Her death, much like her life, would be a work of art.

Betsy Davis sat in her bedroom in Ojai, a valley town surrounded by the California mountains.

Her caregivers routinely placed her iPad on her lap, and she would type, slowly poking the keypad with her pinkie.

This time, she was writing an invitation for her farewell party.

"First, you are all very brave for sending me off on my journey," she wrote in a July email to family members and friends. "Thank you so much for traveling the physical and emotional distance for me. These circumstances are unlike any party you have attended before, requiring emotional stamina, centeredness, and openness. I strongly encourage you all to connect with every person at the party — this will not only benefit you but me as well."

Three years earlier, Davis had been diagnosed with ALS, or Lou Gehrig's disease, a merciless illness that renders muscles unusable and speech unrecognizable.

Davis did not want to experience death the way the disease typically demands, her family and friends said; she wanted to celebrate her life — eating favorite foods, listening to favorite music and reliving favorite memories with those who meant the most to her — then slip away surrounded by love and support.

"There are no rules," she wrote. "Wear what you want. Speak your mind. Dance, hop, chant, sing, pray ... but do not cry in front of me. Okay, one rule. But it is important to me that our last interactions in this dimension are joyful and light. If you need to cry, there will be designated crying areas ... or just find a corner."

But, she told them, "I AM allowed to cry."

"One of the symptoms of ALS is uncontrollable laughing/crying. So, in effect, I'm not crying because of you, but merely because my neurons are having a meltdown. However, if I laugh, it probably is because of you."

ALS, which stands for amyotrophic lateral sclerosis, is a neurodegenerative disease that afflicts some 20,000 Americans at any given time, according to the ALS Association. On average, those who have been diagnosed with ALS are expected to live two to five years, the association says.

In recent years, terminally ill patients like Davis have drawn attention to the much-debated issue of right-to-die legislation. Currently, four states have death with dignity laws: Oregon, Washington, Vermont and California, whose End of Life Option Act took effect in June.

California's new law states that the patient must be at least 18 years old, terminally ill and expected to die within six months. The patient must also be mentally capable of making the decision to die and physically capable of self-administering the aid-in-dying drug, according to the law.

Davis, a 41-year-old artist with wavy red hair, freckled skin and an appreciation of beauty, had to use a wheelchair, having lost muscle control in her legs. She was struggling to use her hands, to speak, to swallow.

She decided it was time, her family and friends said, and she set the date for a two-day celebration at her Ojai home.

"What she really wanted was for everyone to reconnect," said her sister Kelly Davis, adding, "I think she knew what she was doing; she was creating a support group."

On the weekend of July 23-24, more than 30 people came from across the country for what Davis called her "rebirth." They arrived at a home filled with mementos from her life: artwork, books, clothing and keepsakes from her worldwide travels, such as desert sand from Jordan and incense from Japan.

Each item had a blue Post-it note stuck to it with a name of a friend she wanted to pass it down to.

Davis asked her friends to try on her clothes and take items they wanted, Kelly Davis said. Some men in the group tried on her dresses, Kelly Davis said, and modeled them to make her laugh.

They listened to Brit pop and indie rock, including New Order and the Pixies.

They watched a film, "Dance of Reality," by Chilean director Alejandro Jodorowsky.

They huddled together on her porch, where friends played the harmonica and the cello.

And, at times, some of them stepped away and cried.

Kelly Davis said it was "really remarkable how joyful everything was," but that, every so often, she would have a "reality check" about how the party would end.

"I would look at my watch and say, 'In five hours, my sister will no longer be living,' " she said, crying. "You just have to accept it. You just have to acknowledge it and move on."

That Sunday night, as the sun started to set, Davis headed toward a hillside outside her home with her family and friends to watch the sky turn pink.

First, Davis told her father that he had always been her hero, Kelly Davis said. And she told her sister, who is a journalist, "Don't stop trying to make the world a better place."

Betsy Davis' caregivers helped her slip into a blue-and-white kimono that she had bought during a bucket-list trip to Japan. A family friend drove her up the hill in his new Tesla.

There, her family members and closest friends sat in chairs under a white canopy facing California's setting sun.

Her caregivers helped her onto a bed, where she would soon take a cocktail of morphine, pentobarbital and chloral hydrate mixed into a coconut milkshake to "mask the taste," her sister wrote in the Voice of San Diego.

One by one, friends who could bear it said their goodbyes.

It was the only time all weekend Davis cried, her sister said.

With only her physician and her family by her side, Davis chugged the concoction, lay down and, almost immediately, slipped into a "peaceful" sleep, a four-hour coma before her eventual death, her sister said.

Kelly Davis called it "a surreal moment" to witness.

"I sat with her about an hour," she said. "I felt like after an hour, she was gone, that her spirit was gone."


NIELS ALPERT/AP PHOTOS

Family and friends take ALS sufferer Betsy Davis, center, to a friend's new Tesla for a ride up a California hillside to end her life at her farewell party.


Kestrin Pantera plays her cello at the weekend going-away party for Davis in July.

MDPAS Tom Jones_UNF_SB701

Uploaded by: JONES, TOM

Position: UNF

Oppose - Senate Bill 701

End-of-Life Option Act (Richard E. Israel and Roger “Pip” Moyer Act)

Presented to the Senate Judiciary Committee

February 28, 2020

By **TOM JONES**
508 Post Oak Rd, Annapolis, MD 21401
410-224-4807

This is the fourth year Laura and I have testified before this committee, describing how this bill would impact people with suicidal family members. In our previous testimonies, we also heard supporters argue the bill does not have a suicide contagion effect, describing how other factors create states that are part of a “suicide belt” and quoting a paper by Doctors Jones and Paton, which they claim shows no increase in suicides for models with “state specific trends.”

This seemed inaccurate to me, so in 2018 I read this article and could not draw the same conclusion. The study Dr. Jones and Paton conducted actually subtracted out the impact of a large number of suicide contributors to suicide rates, ranging from unemployment to whether medical marijuana was legal. After these “suicide belt” adjustments were made, the study found a **6.3% increase in total suicides after PAS was legalized**. I also contacted the authors to ask about the impact on their study of “state specific trends.” I have attached the response of Dr. David Paton to my written testimony but I will highlight his opening. He says, “I agree that it would not be accurate to claim on the basis of our paper that there is no correlation between physician assisted suicide (PAS) laws and non-assisted suicide rates. Indeed, I believe such a claim would be misleading.”

In Maryland, what does it mean to have 6.3% more suicides? On average it’s roughly 37 additional suicides, every year That’s another 74 parents, like Laura and me, that will lose a child**; i**t’s also roughly 89 siblings, deprived of a lifetime of companionship with their sister or brother, and on average it’s over a thousand friends and acquaintances that will know the tragedy of losing a friend. I remind you this human toll is taken **every year**

If you are like Laura and I, and have known the exhaustion of waking up night after night, checking to see if your child was still alive or drove to work with anxiety so intense you felt like throwing up, because you did not know how the day would end, **you know that 6.3% is a huge number**. If you have ever had a sibling or a close friend or relative commit suicide and know the pain of regret, of wondering “What could I have done?”, **you know that 6.3% is a huge number**.

Assisted suicide is not just an individual decision. Assisted suicide increases overall suicide rates and claiming otherwise is misleading. Unfortunately there are many families like mine in Maryland today. In 2018 I knew of 3 young adults who committed suicide in Annapolis alone. This law could have a definite negative and potentially devastating impact on families like Laura and mine. I ask you, please vote No on SB701.

From: David Paton <David.Paton@nottingham.ac.uk>
Subject: RE: Physician Assisted Suicide - Need Your Help!
Date: March 3, 2017 at 6:23:28 AM EST
To: Thomas Henry Jones <trieste@prodigy.net>
Cc: Laura Jones <tomhj@prodigy.net>

Dear Tom,

Thank you for your email about our paper in the Southern Medical Journal.

I agree that it would not be accurate to claim on the basis of our paper that there is no correlation between physician assisted suicide (PAS) laws and non-assisted suicide rates. Indeed, I believe such a claim would be misleading.

In the first place, our paper finds no evidence that, as some have suggested, PAS laws might bring about a reduction in non-PA suicide rates. Further, we find strong evidence that PAS laws increase total suicide rates (PAS and non-PAS combined).

Next, some of our models provide evidence that PAS laws lead to a statistically significant increase in non-PA suicide rates. In other models (e.g. the model including state-specific trends), although the point estimate still suggests that non-PA suicide rates increase, the increase is not statistically significant. In other words, in these models, we cannot rule out the possibility that there was no change in non-PAS rates. As you suggest, including the state-specific trends might overfit the model – once we include the trends, there is very little residual variation with which to identify any effect from assisted suicide. This means that the statistical tests with this specification are liable to suffer from low-power. That is, even if there is a real effect on non-PA suicides, there is a relatively low probability that our model will pick it up as being statistically significant. As an aside, the fact that the effect of PAS on total suicides (i.e. PAS and non-PAS combined) is positive and significant even in the models with state-specific trends is a very strong result.

To summarise, in all our models the estimated effect of PAS laws on non-PA suicides is positive but the effect is only statistically significant in some cases. Given this, I think it is fair to say that we find some evidence that PAS increased non-PA suicides but that the case is not proven beyond reasonable doubt.

However, it is important to remember that, even if the true effect of PAS on non-PA suicides was zero, this would not, necessarily mean there is no suicide contagion. One of the arguments for PAS has been that some people who would otherwise have committed suicide now take advantage of PAS. To the extent that this is true, then non-PAS should decrease. If non-PAS does not decrease, then it is reasonable to infer that suicide contagion has taken place and balanced out any switching from non-PAS to PAS. Even in the model with state-trends, we find no decrease in non-PAS. So, as long as there were some people who did switch from non-PAS to PAS, then the model with state trends is still consistent with there being suicide contagion.

On your other question, we did experiment with allowing the effect of PAS to vary over time, but opted for the static model as there are so few PAS states in the sample and only Oregon with enough data points to do anything sensible with divergence over time. We thought it was just asking too much of the data.

We are currently in the middle of updating the research using the two extra years of data that are now available (2014 & 2015). The analysis is not yet complete but early indications are that the results in the SMJ paper hold up well and, if anything, are strengthened.

I hope this is helpful but please let me know if anything needs clarifying further.

Yours sincerely,

David

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From: Thomas Henry Jones [mailto:trieste@prodigy.net]
Sent: 28 February 2017 12:30
To: director@bioethics.org.uk; Paton David <lizdp@exmail.nottingham.ac.uk>
Cc: Laura Jones <tomhj@prodigy.net>
Subject: Physician Assisted Suicide - Need Your Help!

Dr Jones/Dr Paton

My wife and I are currently leading a grass roots campaign to defeat passage of a physician assisted suicide (PAS) bill in the state of Maryland in the United States. In addition to our concern about how this bill could impact the old and vulnerable in our society, we are both very concerned about the impact of physician assisted suicide on suicide contagion, as on of our children struggled for years with suicidal tendencies. We are preparing for a Senate Hearing next Tuesday and I was hoping I could get some insight on a paper you published on the subject in time for next week.

The supporters of the bill are citing your paper published in the Southern Medical Journal to bolster their arguments that PAS does not lead to suicide contagion. My reading of your paper shows lead me to believe that you were attempting to disprove an assertion that PAS lead to lower suicide rates. You modeled and removed a large number of contributors to increased suicide rates, my belief is this was done to make sure people could not dispute your analysis showing there is no decrease in suicides where PAS is legal. My concern is that the state trend variable that was not identified with a specific cause has the potential of over fitting the data and removing the impact of suicide contagion. I think your analysis method is great to disprove decreases in suicides caused by PAS but when using the state trend variable (which the bill's supporters do) I don't think it is accurate to claim there is not a correlation between PAS and non-assited suicide rates. Could you comment on whether my observation is valid?

Another question, the 6.3% increase in non-assisted suicide rates you found before removing state trends, is a static value. Data from Oregon tends to show a divergence from national suicide rates (i.e. the difference grows with time. Was there a reason you modeled suicide rates as a constant over the time period?

Thanks much for any help or insight you can provide.
Tom Jones
443-924-0360

"How far you go in life depends on your being tender with the young,
compassionate with the aged, sympathetic with the striving and tolerant
of the weak and the strong. Because someday in your life you will have been
all of these." - George Washington Carver

MDPAS John Keown_UNF_SB701

Uploaded by: Keown, John

Position: UNF

GEORGETOWN UNIVERSITY
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20 February 2020

The "End of Life Option" Bill

Maryland legislators should reject the "End of Life Option" Bill, for two main reasons.

1. The bright-line prohibition in the criminal law and in professional medical ethics on the intentional killing of patients, and on intentionally assisting patients to kill themselves, reflects a foundational ethical and legal principle: the inviolability of human life. That principle is grounded in a recognition that **everyone, regardless of illness, life-expectancy, age, disability, gender, race, religion or sexual orientation shares an intrinsic and ineliminable dignity and equality that makes it wrong for physicians intentionally to kill patients or help patients kill themselves.** (This does not mean patients' lives must be preserved at all costs: it is proper for physicians to withhold or withdraw treatments which are futile or too burdensome or refused by patients, even if it is foreseen that death will come sooner.)

One of the several expert committees that have concluded that the prohibition on PAS and VE should be upheld was the eminent House of Lords Select Committee on Medical Ethics. It observed:

> **That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.**[1]

By contrast, laws that permit PAS or VE are grounded on the notion that there are *two* categories of patient: those with lives 'worth living' and those who would be 'better off dead'. Such laws invite fundamentally **discriminatory** judgments.

The superficially attractive argument that PAS or VE is required by respect for patient 'choice' is specious. Laws and proposed laws for PAS and/or VE do not allow them for *any* patient who autonomously wants them: they allow them only for *some* patients who want them (such as the 'terminally ill' or those 'suffering unbearably'). So: PAS or VE are not fundamentally about choice but about the judgment that the requests of *some* patients should granted because it is thought *by others* that they would be 'better off dead'. No wonder that disability groups are at the forefront of opposition to PAS and VE. They see more clearly than many that any such judgment is discriminatory. And those with disabilities are not the only ones who would likely find themselves being judged to have lives less 'worth living' than others, or not 'worth living' at all. Other disadvantaged people, including those who cannot afford healthcare, would also be at heightened risk.

The judgments that would be permitted by the Bill are not only discriminatory; they are **arbitrary.**

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[1] Report of the Select Committee on Medical Ethics (House of Lords, Paper 21-I of 1993-4) para 237.

- Why PAS only for those with a "terminal illness" (the Bill's definition of which is vague)? Why not for those with MS, or ALS, or arthritis, especially when those with a "terminal illness" may not be suffering at all whereas those with a non-terminal condition may face many years of severe suffering? (The Bill does not require that the patient be suffering, and the two most common reasons for accessing PAS in Oregon are not suffering but "losing autonomy" and being "less able to engage in activities making life enjoyable".[2])
- Why lethal prescriptions but not lethal injections, especially if the patient is unable to self-administer the poison?
- Why a hastened death only for those who request it? Why not for those who may be suffering but who are (like those with dementia or severe learning disabilities) incapable of making a request?

Supporters of proposals like the End of Life Option Bill have yet to produce cogent answers to any of these questions. This Bill would, then, be merely a first step. Sooner or later, whether as a result of a legislative or a judicial decision recognizing that the proposed limitations are 'discriminatory' restrictions on the newly-established 'right to die', the law will be extended to allow VE and then euthanasia without request. The Dutch realized years ago, when they relaxed their laws, that it made no sense to permit PAS but not VE, or to limit them to the 'terminally ill'. And since then the Dutch have, logically, extended their law to permit euthanasia for babies born with disabilities.

2. Even *if* PAS or VE were defensible in principle, **effective legal control would prove impossible.** Several expert committees that have considered the case for legalization, like the House of Lords Select Committee and the New York State Task Force on Life and the Law,[3] have rejected PAS and VE because of the risks of abuse, especially to vulnerable groups. How, for example, are doctors to *know* that a person (whom they may only just have met) is competent and that their request is truly voluntary, not the result of clinical depression or family pressure, or the fear of being a burden, or a misguided fear of dying in pain? This is especially so when patients can (as the vast majority do) access a hastened death without being examined by physicians with expertise in either psychiatry or palliative treatment.

Moreover, the evidence from those relatively few jurisdictions which allow PAS or VE reinforces concerns about effective control. The Netherlands legalized both over thirty-five years go. Despite the legal requirement that physicians end life only at the request of the patient and that they report all cases, official Dutch surveys have disclosed that physicians have, with impunity, failed to report thousands of cases, and have given lethal injections to thousands of patients without request. The law allows even purely mental suffering as a ground for PAS and VE, and in 2016 the government supported further relaxation of the law to allow assisted suicide for even healthy elderly folk with a "completed life".[4]

The evidence from Oregon, where no comprehensive surveys like those in the Netherlands have been carried out, is far more limited and is certainly insufficient to substantiate any claim that its law has

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[2] See Oregon Health Authority, 'Death with Dignity Act: 2018 Data Summary', Table 1. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.

[3] New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (New York, NYSTF: 1994)

[4] See John Keown, Euthanasia, Ethics and Public Policy (Cambridge University Press, 2nd edition 2018), ch. 17.

provided effective control. We simply do not know how many physicians have practised PAS outside the law, or how reliable the reports filed by physicians with the Oregon Health Authority have been. As the analysis of the Oregon statute by Professor Alexander Capron, the leading health lawyer, rightly concluded, **the Oregon law's safeguards are "largely illusory"**.[5]

Moreover, Oregon's minimal ex post 'review' procedure is weaker even than that in the Netherlands, and both jurisdictions rely on self-reporting by physicians. Which physician is going to report that he or she has broken the law? And one Oregon study, which found that some patients accessed lethal drugs under the Act even though they were depressed, concluded: "the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug."[6] This is hardly surprising, given that ordinary physicians lack expertise in diagnosing and treating depression. The End of Life Option Bill is modelled on the Oregon Act and suffers from similar, serious flaws. It is not surprising that such Bills have been repeatedly rejected elsewhere.

The real challenge facing Maryland, from which legalizing PAS would be a dangerous distraction, is to provide quality end-of-life care and social support to all, especially the poor, the disabled and the marginalized.[7]

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[5] Alexander M Capron, "Legalizing Physician-Aided Death" (1996) 5 (1) *Cambridge Quarterly of Health Care Ethics* 10.

[6] Linda Ganzini et al, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross-sectional survey" (2008) 337 *British Medical Journal* a1682.

[7] I write this note in my personal capacity, not on behalf of the Kennedy Institute or Georgetown University. Three of my books which explore the issues are: Euthanasia Examined (Cambridge University Press, 1995); Debating Euthanasia (with Emily Jackson; Hart Publishing, 2012); Euthanasia, Ethics and Public Policy (Cambridge University Press, 2nd edition 2018).

MDPAS Mark S. Komrad_UNF_SB701

Uploaded by: KOMRAD, MARK

Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act. I am a psychiatrist and medical ethicist on the faculty of Johns Hopkins School of Medicine. I want to explain to you why you should not legalize Physician Assisted Suicide in Maryland.

The 2300-year-old history of medical ethics is grounded in the core ethical foundations established at the dawn of medicine — the Hippocratic values "professed" by physicians as a covenant-based community of values. The Hippocratic Oath says: "I will give nobody a poison, nor counsel any others to do so." This is the root of the mighty tree from which the House of Medicine was built, this value persisting as societies and their demands have come and gone. To this day, the World Medical Association, the AMA and many other major medical organizations continue this ethical stance against physician-assisted suicide and euthanasia.

Legalizing assisted suicide empowers one class of human beings (ironically, physicians) to literally take the life of another. It turns suicide from a freedom into it right. No country has been able to constrain these practices to the extreme end of life and over time have inevitably expanded to euthanasia by injection and looser criteria for eligibility. Some did it rapidly, others, like Oregon, are now slowly beginning this inevitable drift.

In Oregon there is no way to distinguish between encouragement and coercion by those who "support" terminally-ill loved ones taking lethal drugs prescribed to cause death. There are no regulations to keep lethal prescriptions from being diverted. There is evidence of a contagious increase in ordinary suicide, subsequent to legalizing assisted suicide, as the message that "some suicides are OK" suffuses society.. New legislation is being pursued there now to move to more active euthanasia by injection and to make prognostic criteria for eligibility more vague. The law even allows patients whose conditions are not considered "terminal" to make themselves so, by choosing to refuse life-sustaining treatments — diabetics stopping their insulin, for example.

Canada, Belgium and the Netherlands went straight to euthanasia, which is vastly preferred in those countries to assisted suicide by prescription. In 2017 the rate of euthanasia in Canada increased by 1/3 between the first and second half of the year. In Ontario, it is unethical and illegal for physician conscientious objectors to refuse to refer a patient for possible euthanasia evaluation, if they won't provide it themselves.

In Belgium and the Netherlands, where these practices have evolved over 18 years, and 4% of all human deaths are by physicians' injections, the slope has slipped to include eligibility for those with nonterminal illnesses, psychiatric conditions, young children, and uncomfortable lifestyles. There are strong advocacy efforts, with governmental support, to de-medicalize the criteria for such procedures by allowing those who are "tired of living" or feeling that their life is "complete" to ask for euthanasia, with the hopes of developing a "suicide pill" that can be obtained without a medical evaluation or prescription — a high sanctification of autonomy. Organ donation by those seeking euthanasia is encouraged as a "virtue opportunity." The slippery slope is real.

The profound changes to a civilized society produced by such laws are unnecessary and undesirable. The suffering and disabled should have even more access to the very latest, state -of-the art palliative care, without it being economically or morally short-circuited by institutional killing promoted as a seductive virtue — referring to it as "dying with dignity" or self-determination. The so-called "choice" that is offered to the suffering to end their lives is a pseudo-choice, filtered through a physician's own values, or chosen because of narrowed choices in others ways--economics, social support, healthcare, etc. It is unjust, and therefore impossible, in a democratic society, to limit these procedures to some — like the terminally ill — but refuse it to others — like those with chronic physical and psychiatric disabilities. Yet, it signals that chronic disability and its sufferings might constitute a "life not worth living." It is an unfair and confusing public health message to designate one category of people who are helped to suicide, but others who are actively prevented from doing so with psychiatric care. Medicalizing suicide out-sources to the medical establishment the moral responsibility for a taboo about taking one's own life by suicide,

reducing the moral deterrence to suicide and lowering the threshold of acceptability for all suicide. It takes the protected and vital ethos of health care professionals away from their millennia-old Hippocratic commitment to be providers of comfort, hope, and healing, to become providers of death, not just supporters of the dying.

TEN REASONS TO OPPOSE SUCH LAWS:

1. They contradict public health messages to prevent suicide, which becomes forbidden for some, but not others.

2. These laws imply that illness, dependency & debilitation are lives not worth living. Bad message for the disabled.

3. There are always inadequate safeguards against coercion & diversion.

4. Everywhere this is law we see unequivocal slippery slopes to euthanasia, inclusion of mentally ill, linking to organ donation, etc. LEARN from the living laboratories of places where this is legal

5. Outsourcing suicide to physicians lowers barriers to suicide in general. Data shows effect of such laws on raising ordinary suicide rates.

6. Suicide is a freedom, not a right

7. The Hippocratic Oath and the subsequent history of medical ethics has consistently excluded killing in the House of Medicine, which is critical for patients' vulnerable trust that their physician will not administer death.

8. The U.S and world's major medical associations hold that assisted suicide is UNETHICAL: The AMA, the American Psychiatric Association, The World Medical Association, many others.

9. The state-of-the-art of palliative care is a profoundly effective way to provide "death with dignity," but is inadequately accessed

10. The patient doesn't really "choose"—the Dr. does-it comes down to the individual Dr.'s choice about who is eligible.

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Maryland Catholic Conference_UNF_SB701

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Position: UNF

MARYLAND
CATHOLIC
CONFERENCE

ARCHDIOCESE OF BALTIMORE ✝ ARCHDIOCESE OF WASHINGTON ✝ DIOCESE OF WILMINGTON

February 28, 2020

Senate Bill 701
End-of-Life Option Act
(Richard E. Israel and Roger 'Pip' Moyer Act)

Senate Judicial Proceedings Committee

Position: OPPOSE

The Maryland Catholic Conference offers this testimony in OPPOSITION of Senate Bill 701 (SB 701). The Catholic Conference represents the public policy interests of the three (arch) dioceses serving Maryland, the Archdioceses of Baltimore and Washington and the Diocese of Wilmington, which together encompass over one million Marylanders.

SB 701 would allow doctors to legally prescribe a lethal dose of controlled substances at the request of a patient who has been deemed “capable of making a medical decision” and who has received a terminal diagnosis. The Conference joins many in the faith community who oppose this legislation, not only because it violates the most basic tenet of our belief in the sacredness of life, but also because of the many dangers this legislation poses to vulnerable populations.

In a time where opioid-related overdose deaths continue to increase in Maryland, it seems woefully misconstrued to encourage the passage of legislation that would legalize a means of ending one’s life by prescribing a large dosage (typically 100 pills) of barbiturates or a compound mixture (usually morphine sulfate, Propranolol (Inderal), Diazepam (Valium), Digoxin) that a patient would self-administer.

In addition, we have many concerns about the bill which are shared by numerous other groups, including countless physicians, mental health providers, hospice nurses, pharmacists, disability rights groups, advocates for senior citizens, and others. From the perspective of the Church, however, we wish to convey our deep dismay about the message this legislation sends to those who might feel that their illness and the care they require is nothing more than a burden to their families and the rest of society. Passage of this bill will undermine societal support for communities that are currently prone to higher suicide attempt rates – young adults, adolescents, and the military community.

At the heart of our ministry to the sick, the disabled, the elderly, and those without access to adequate medical care is recognition of the Gospel call to embrace the lives of those most in need of our love, care, and compassion. There is no life that we consider not worth living, no person who does not deserve to be valued. While some may view this legislation as a response to the understandable fears about pain and loss of "dignity" that someone diagnosed with a terminal illness might face, we insist firmly that the answer to those fears should be a demand for medical treatment that provides adequate pain management and excellent palliative or hospice care. A terminally ill patient requesting a prescription to commit suicide deserves to be surrounded by compassion, not handed a large quantity of lethal drugs to take his or her life.

The Maryland Catholic Conference respectfully urges an unfavorable report on SB 701.

Maryland Catholic Conference_UNF_SB701

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The Maryland Catholic Conference respectfully urges an unfavorable report on SB 701.

MDPAS Steve Levenson_UNF_S701

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Position: UNF

Statement to the Senate Judiciary Proceedings Committee and House Health and Government Operations Committee
Re: SB0701 / HB643
"END OF LIFE OPTIONS ACT"
OPPOSE
Friday, 2/28/20
Steven A. Levenson, MD, CMD

ISSUE	Proponents' Claims	**REBUTTAL**
1. Why am I testifying for the 4th time against this legislation?	- This bill is exactly the same as previous ones, because it is good as it is - Opponents are just trying to use scare tactics and are ignoring the facts. - Proponents say momentum is building and it is time to climb on board. They will just keep coming back until it is passed.	- There are many valid and serious concerns about this legislation, which go far beyond the focus on the right to die. - Proponents and sponsors have not addressed major concerns to any meaningful extent; instead, these have repeatedly been brushed off or dismissed as unimportant.
2. What is this legislation all about?	- Proponents say people should have the right to choose how and when they die - They allege this is needed to give people the right to "die with dignity" - Five years after first introducing almost identical legislation, it is still often portrayed as a "right-to-die" versus "right-to-life" type of issue.	- For several decades, existing legislation such as the 1993 Health Care Decisions Act and 2010 MOLST legislation have given citizens wide latitude to decline medical care and die with dignity (see www.marylandmolst.org) - This bill does not repeal, reform, or otherwise improve upon existing laws. - The only thing that this proposed legislation does is to authorize people to take a lethal overdose of medications so that they can die within hours. - Most of the proposed legislation is designed to limit inquiries and finesse the overdose death so that it doesn't look like suicide.
3. How can people who are ready to die do so without a lethal overdose?	- Proponents say this legislation is needed to allow a quick and painless death.	- As I have presented over the past 5 years, studies have shown that most individuals can die with dignity in a reasonably short time, by using existing means. - With the safeguards and waiting period in this legislation, it takes just as long or longer to die under this bill as without it.
4. How many people	- Even though not many have used it in any jurisdiction, more will do so	- Only a very small fraction of the total population and of all those who have

have actually used this legislation?	with time.	died in states and countries where these laws exist have used the provisions. - While repeatedly emphasizing the bill's alleged "safeguards," proponents have blamed those same safeguards repeatedly for inhibiting its use by patients and doctors, and have watered them down in several states (e.g., Oregon, Colorado). - Proponents don't acknowledge that the real reason for limited use is that this is a bad and unnecessary idea that the vast majority of people don't want and won't use. - Studies have shown repeatedly that many of those who take their lives are not bedridden or suffering severely; instead, they have mostly "existential" concerns.
5. What medications are given to patients to hasten death?	- The medications allow a quick and painless death and don't have complications.	- Physician assisted deaths involve taking massive overdoses of familiar high-risk medications that rapidly cause loss of consciousness and death. - These medications do not always work quickly and there are sometimes complications. - They are not something that we want floating around. - Despite what the bill might say, nothing meaningful can be done under this law to track, control, retrieve, or dispose of these medications if they are not used.
6. How long does it take to die after taking these drugs?	- Proponents often repeat that dying by overdosing is a more "dignified" way to die than other methods.	- As with any drug overdose, not everything goes smoothly and sometimes it goes significantly awry. - Among those who take these massive doses of these drugs, most become unconscious within a few minutes and die within 1-2 hours. - A few take longer and a few have survived, for whatever reason. - It may be quicker than most other methods–when it goes right–but there is nothing inherently more "dignified" about it.
7. When do people who get lethal prescriptions use them?	- Proponents say that people should have the right to decide when they are ready to die.	- Most people who have chosen to receive the fatal doses of medications waited many weeks to months, if not years, to use them. - In many cases, no one really knows what those people died of or what becomes of the medications or whether they even used them.
8a. What has to happen correctly in order for	- Proponents say not to worry! There has never been a problem in any	- 5 major things must be done right in all cases: 1) accurate diagnosis, 2) accurate prognosis, 3) correct decision-making capacity determination, 4) adequate

things to go right under this proposed legislation?	state at any time	explanation and understanding of alternatives, 5) correct determination of freedom from coercion. - The physician is supposed to encourage the individual to participate in hospice and prepare an advance directive, but neither is required. - The physician must verify that the individual is making an informed decision. - The physician must complete required documentation.
8b. Is it really true that there and there has never been a problem anywhere with these laws?		- Given all the things that have to go right, and the strong evidence about current odds in everyday practice about these things being done right, it is absolutely not credible to claim that nothing has ever gone wrong. - In many instances, results are unknown, largely because the law limits record keeping, investigation, and discovery.
9. What is the reality about the alleged safeguards in this legislation against its misuse?	- Proponents allege that the bill has many safeguards and there has never been a problem related to these laws in multiple states across several decades.	- The safeguards are largely unenforceable and results are often unknown, because the law limits record keeping, investigation, and discovery. - Once the prescription is written, the recipient doesn't have to tell anyone or have anyone present or notified when he or she takes the lethal dose. - Only some of the deaths are witnessed by anyone, including a medical practitioner. - Around the country, proponents have been bragging about all the safeguards and then subsequently watering down the safeguards (e.g., Colorado and Oregon), blaming them for limited use of the legislation.
10. Who among medical practitioners supports the right to die by ingesting large doses of prescribed medications?	- There is a growing movement among physicians to support this legislation.	- Proponents say that a majority of physicians have climbed on board to support physician assisted death. - Many individual physicians and respected physician organizations still oppose this legislation on various grounds. - The American College of Physicians ACP (attached), representing 150,000 Internal Medicine physicians), and the American Medical Association (AMA) have published statements unequivocally opposing physician assisted death. - It is highly unlikely that physicians who may support the concept in the abstract are aware of the detailed concerns that this legislation raises. - Using doctors to try to legitimize some very questionable propositions is of

		great concern.
11. Is this suicide, or not?	Proponents say that it's not suicide, because the law mandates doctors to say that the patient died of their illness.	- Ingesting a large overdose of lethal medications for the purpose of dying as quickly as possible is completely consistent with the definition of suicide. - A law that requires doctors to fabricate parts of the death certificate hides the truth, sets a bad example, and gives out seriously conflicting messages. - Suicide is a major concern around the country, and in Maryland. - Recent research strongly suggests that many people who are already taking drug overdoses are actually trying to kill themselves (see article at end of this PDF).
12. Summary	Proponents say, "Everyone else is doing it, so we should too."	*- This complex and convoluted proposed legislation is built on a foundation of half truths, falsehoods, and deception.* *- There isn't any problem that this legislation "fixes," unless we consider wanting to die in a really big hurry a problem in need of fixing.* *- Part of the AMA position statement on medical ethics sums up the whole thing very well: "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."* *- Alleged safeguards are largely mythical because the legislation effectively blocks disclosure, discovery, and investigation.* *- This legislation opens a can of worms about suicide and drug overdoses that have the potential to impact the entire population.* *- It applies to only a tiny handful of people.* *- It is not worth all the problems and complexities associated with this legislation so that a few individuals can choose the day they die.* *- The legislation basically not only promotes–but mandates–falsification of death certificates, with multiple problematic consequences.* *- For the vast majority of people, we still have to accomplish the goals of alleviating suffering and dying in a dignified manner, by applying existing laws and regulations–which we can and must do better.*

Details of Statement to the Senate Judiciary Proceedings Committee
and House Health and Government Operations Committee
Re: SB0701 / HB643 "END OF LIFE OPTIONS ACT"
Friday, 2/28/20
Steven A. Levenson, MD, CMD

OPPOSED

Why am I, as a physician, testifying once again in opposition to this bill?

Key Points

- I have *extensive personal experience* as a doctor and in the legislative and policy arena on these topics.
- I have identified *numerous serious issues with this legislation*, as detailed in this testimony.
- I believe that *proponents* of the legislation *have ignored or avoided addressing these issues* satisfactorily.
- I conclude that *this legislation has serious negative implications* for Maryland and should be rejected.

I am a Maryland physician with 41 years of practice in long-term and postacute care settings across Maryland. I am known throughout the United States in the medical community for my expertise in the issues and arguments raised by this bill.

Over time, I have dealt extensively in my everyday work with all of the complex issues raised by this proposed legislation.

I have been involved in great depth in helping develop and implement laws and regulations that have helped Maryland's citizens to exercise their rights to control their destiny, direct their healthcare, limit medical interventions, and die with dignity (e.g., 1993 Health Care Decisions Act and 2011 MOLST legislation)

I have served on the Governor's End-of-Life Council in various forms for 2 decades

Besides my extensive experience as a doctor, I have spent years reading and evaluating the medical and general literature about physician assisted death and the reports of all states and countries that have legalized it.

For the fourth time in 5 years, legislation is being introduced to allow people with advanced illness to take a lethal dose of prescribed medication in order to die quickly. AS in past years, I am here again to oppose this legislation.

Five years ago, when this legislation was first introduced, I delved extensively into the issues surrounding physician-assisted death. What I found caused great concern. Five years later, to my dismay, I find the same issues and the same lack of substantive answers to valid concerns.

I have come to realize that there are a lot of issues beneath the surface that have not been sufficiently acknowledged or addressed

Each year, the proponents of this legislation have left the bill essentially the same, made the same arguments, and tried to convince legislators that their arguments are based on "truth and evidence," while opponents are just trying to use scare tactics and ignoring the facts.

What does this law give us that we don't already have?

- Maryland's *citizens already have great support and latitude for their health care decisions* under current laws and regulations, and *they can die with dignity* when the time comes.
- This *proposed legislation does not* repeal, reform, or otherwise *improve upon existing laws and regulations*.
- The only thing this *proposed legislation* adds is that it *legalizes taking one's own life by ingesting a massive overdose of medications* and dying (usually) within the next several hours to days.
- *Reading* existing laws and regulations *helps us understand* this reality.

Proponents of this legislatioin allege that this law is needed to allow people to control their destiny, end unrelieved suffering, and die with dignity.

Actually, Maryland's laws and regulations already give its citizens great latitude and support in expressing their wishes about their health care, making decisions, conveying their choices, having medical practitioners respect their wishes, an having a dignified death when the time comes.

These enabling laws and regulations have improved citizens' decision making dramatically over the last 30 years.

The Maryland Health Care Decisions Act has been around for 27 years (1993) and the MOLST enabling legislation has existed for 9 years.

I have always found it very helpful to be familiar with existing laws and our Maryland experience over the past 3 decades before accepting conclusions about what we lack and what else is needed.

The only significant new thing about this law is that it authorizes individuals to request and take a lethal overdose of medications with major side effects, prescribed by a physician for the express purpose of dying within several days.

Who has used the law?

- Only a *very small fraction* of the total population and a tiny percentage of all those who have died in various states where these laws exist have made use of the provisions.
- In at least once case, *proponents blamed this on* the same *procedural safeguards* that they have promoted as allegedly necessary to prevent abuse.
- Studies have indicate repeatedly that *many of the people who take their lives* have not been and are not bedridden or are not suffering severely; instead, they *have mostly "existential" concerns*.

It is alleged that this law is essential to allow people to relieve severe suffering.

However, in countries and states that have passed this legislation, only a very small fraction of the total population and a tiny percentage of all those who have died in various states where these laws exist have made use of the provisions.

For example, in Washington DC, an April 2018 newspaper article noted that in the year after Washington DC passed its physician assisted death law, not a single patient had used it and only 2 doctors had registered to be able to prescribe the medications.

Of note, the article adds that "Officials with the national advocacy group Compassion and Choices blame local health officials for creating what they consider a cumbersome process that dissuades doctors from participating."

Of course, this comes from the same group that has emphasized all the alleged safeguards in the proposed legislation as a way to supposedly limit unauthorized and inappropriate actions. It also suggests another possibility (not widely discussed by proponents); namely, that maybe this is just a bad and unnecessary idea.

As in the past, most individuals who have selected physician-assisted death have either had cancer or a progressive neurological illness.

However, reports from the various states still indicate that many of those who request and ingest a fatal dose of medications have primarily "existential" concerns, such as loss of autonomy, dignity, and being a burden on family and friends. Only a minority of individuals had inadequate pain control or were very concerned about it.

Reasons for requesting and ingesting lethal doses of medication appear to still be consistent with the 1999 Oregon report that stated: "The primary factor distinguishing persons in Oregon selecting physician-assisted suicide is related to the importance of autonomy and loss of control."

Another Oregon report stated further: "At death, patients who chose physician assisted suicide were significantly less likely than controls to be completely disabled and bedridden."

"79 percent of persons who chose physician-assisted suicide did not wait until they were bedridden to take their lethal medication."

Is this legislation needed to allow people to die when they are ready to?

- *Proponents say that people should have the right to decide* when they are ready to die.
- *Under existing laws, they already can decide when they are ready to die*, except they cannot now choose to die on a specific day.
- The question is *whether it is worth all the problems and complexities* associated with this legislation *so that a few individuals can choose the day they die*.
- *Most people* who chose to receive the fatal doses of medications *waited many weeks to months*, if not years, to use them.
- In many cases, *no one really knows* what those people died of or what becomes of the

medications or whether they even used them.

Proponents say that people should have the right to decide when they are ready to die.

However, existing legislation allows them to do that, with dignity and reasonably quickly.

As to how long people waited between first requesting medication and their death, the lag time was quite variable.

For example, over 17 years in Oregon, the waiting period between first request and death in Oregon was between 15 days and as long as 2 3/4 years . Half of all participants waited at least 48 days.

As I have presented in the past, studies have shown that individuals who choose to stop eating and drinking can die peacefully within 10-14 days.

Therefore, with rare exception, the restrictions and waiting periods in the legislation make the delays as long as, or longer than, current approaches.

In reality, because people who get a fatal prescription do not have to tell anyone and the law precludes meaningful discovery and investigation, often no one really knows what those people died of or what has become of the medications, or whether they even used them.

What medications are given to patients to hasten death?

- Physician assisted deaths involve taking *massive overdoses of familiar high-risk medications* that rapidly cause loss of consciousness and death.
- Because these are *lethal doses of scarce, expensive, and risky medications*, they are not something that we want floating around.
- Despite what the bill says, it is *highly likely that lethal drugs will not all be returned and disposed of properly if they are not used* by the patient.
- *Nothing meaningful can be done* under this law to track, control, or retrieve them from those who never used them

There is surprisingly little discussion in the literature about the drugs that are used for physician assisted death. But it hasn't changed much over time.

Essentially, physician assisted deaths involve taking massive overdoses of familiar high-risk medications that rapidly cause loss of consciousness and death. At least some are familiar medications that were once used commonly in medical practice, but fell into disfavor due to serious risks and side effects (primarily, barbiturates such as pentobarbital and secobarbital.

Because these drugs have become scarce and expensive, other medications have been added or substituted.

The problem is, because they are lethal doses of scarce, expensive, and risky medications, they are not something that we want floating around.

Like other versions of this legislation, this bill says that anyone in possession of these medications after a patient's death must turn them in for proper disposal.

However, compliance is totally voluntary. Since only some patients with the lethal prescriptions actually use them, and since patients do not even have to tell anyone else what they are doing, it is highly likely that an unknown number of these lethal drugs remain indisposed even after patients' deaths.

There is nothing that can be done under this law to track, control, or retrieve them from those who never used them. That is a significant percentage of people who request them.

How long does it take to die after ingesting these medications?

- Among those who take these massive doses of these drugs, most become unconscious within a few minutes and *die within 1-2 hours*.
- *A few take longer* and *a small handful have survived*, for whatever reason.
- Through the years, in a significant percentage of patients who have these drugs in their possession, *what happens* has been *unknown and unwitnessed*.

Most people who take these massive doses of these drugs die within 1-2 hours. A few take longer and a small handful have survived, for whatever reason.

For example, in Oregon, after taking the medications, half the individuals became unconscious within 5 minutes (range 1-38 minutes). Everyone who took the medication became unconscious within 38 minutes. Information was unknown about 352 (41%) of patients

Nonetheless, since so many of these deaths occur unwitnessed, the evidence is that no one really knows exactly what happens to these drugs in a large percentage of patients who obtain them.

What–if anything–is more dignified about physician-assisted death?

- *Proponents often repeat that dying by overdosing is a more "dignified" way to die* than other methods.
- However, while *it is quicker* than most other methods–*when it goes right*–there is nothing inherently more "dignified" about it.
- *As with any drug overdose*, *not everything goes smoothly* and sometimes it goes awry significantly.
- *Current laws allow for dying in a way that is equally or more dignified*, compared to dying by taking an overdose.

Proponents often repeat that this is a more "dignified" way to die than other methods.

However, other than being quicker than most other methods, there is nothing inherently more “dignified” about it.

While many die quickly, others take longer, some vomit while others have to receive additional medications so they won’t vomit, and a small handful even have survived to have to go through the whole thing all over again.

As with any drug overdose, not everything goes smoothly and sometimes it goes awry significantly.

That doesn’t sound particularly dignified.

In reality, a great many other individuals die dignified deaths, supported by existing laws and regulations, that are equally or more dignified than dying by taking an overdose.

Should we believe the assertion that this legislation has not been a problem elsewhere?

- Proponents *allege that there has never been a problem* related to these laws in multiple states across several decades.
- *In many instances, results are unknown*, largely because the law limits record keeping, investigation, and discovery.
- *Patients do not have to tell anyone* what they have done or what they are going to do with the medications, and when.
- *Official state reports* from Oregon have noted that *it is impossible to detect or collect data on issues of noncompliance* with any accuracy, and that under-reporting and noncompliance are difficult to assess.
- Evidence from the medical literature is that there is *significant error in doing the key processes* needed in this law (for example, determining decision-making capacity, correctly predicting prognosis).
- *Referral to a mental health professional* is optional and *occurs only rarely*.
- Under this law, such *mistakes are largely undetectable* and cannot be readily investigated.
- *Advocates* of the legislation have already *complained about too many safeguards* impeding participation.

Proponents of this bill allege that other states and nations that have passed such laws over the past several decades have essentially had only positive results and no major problems or violations.

In fact, these laws are all written similarly. Very few individuals have used them, very few practitioners have participated, and results are unknown in many instances.

The legislation contains significant barriers to disclosure, discovery, and investigation.

The law basically allows people to go through the process without telling anyone else. Only some of the deaths are witnessed by anyone, including a medical practitioner.

Among the statements in the annual Oregon reports are the following:

"We cannot detect or collect data on issues of noncompliance with any accuracy."
"Under-reporting and noncompliance is . . . difficult to assess because of possible repercussions for noncompliant physicians reporting to the division."

As I have testified in past years, 5 key things must happen correctly in order to protect patients as they go through the process:

- accurate and complete diagnosis to enable accurate prognosis determination
- accurate determination of prognosis
- accurate, relevant, and understandable discussion with the patient
- accurate determination of decision making capacity
- accurate determination of absence of undue influence or coercion

In this regard, there is unmistakable evidence in the medical and other literature (see attachments) that the steps and detailed procedures needed in this law (for example, determining decision-making capacity, correctly predicting prognosis) often are done incorrectly and lead to inaccurate results.

The problem here is that such mistakes are largely undetectable and cannot be identified and investigated, and the end result is death from an overdose. The legislation's provisions make meaningful investigation and disclosure extremely difficult, if not impossible.

One alleged safeguard is a referral to a mental health professional regarding capacity to decide and to help determine freedom from coercion. However, a safeguard is only good on paper if it is not used. This one has only rarely been used across settings For example, over a number of years, only 5.9 percent (44/754) were referred in OR and 3.5 percent (33/937) in Washington state.

The physician is charged with the responsibility to ensure that the patient is not being coerced and is acting freely. In reality, it is hard to conceive of how physicians have the time, inclination, or means to verify this. All they can really do is take the patient's word for it. That is rather superficial, at best.

Thus, taking all of these factors into account, the chances of everything going right consistently are more like 60-75 percent and nowhere near 100 percent.

Thus, for many reasons, there are a lot of great unknowns about these laws and their impact and complications. Patients can go through the entire process without telling or asking anyone else. Other than having an alleged terminal illness, they don't have to give a reason for wanting to die in this manner.

Although I have reviewed and presented these questions and concerns over time when this bill has come up, I still cannot seem to identify in my follow-up reviews any meaningful responses to them. Instead, they appear to just be dismissed.

In Washington, DC, not a single patient had used the law in the year after Washington

DC passed its physician assisted death law, and only 2 doctors had registered to be able to prescribe the medications. As noted above, an April 2018 article stated that "officials with the national advocacy group Compassion and Choices blame local health officials for creating what they consider a cumbersome process that dissuades doctors from participating"

So, on the one hand we are told that this legislation should be passed because it contains numerous safeguards. In the next breath, it seems that the safeguards are blamed for limited participation.

Telling us that "there's never been a problem with similar laws anywhere" is essentially impossible to believe or trust. What it really means is that the laws have been written and implemented so that we know relatively little about what really happens and whether it happens as it should have.

To me, the mere fact that proponents of this legislation keep saying this year after year should tell us immediately that we must dig deeper and read between the lines about everything we hear about this proposed legislation.

Who among medical practitioners supports the right to die by ingesting large doses of prescribed medications?

- Proponents say that a majority of physicians have climbed on board to support physician assisted death.
- *Many individual physicians and large physician organizations still oppose* this legislation on various grounds.
- *Most physicians have never been given the details* or shown the many issues that this legislation raises, as discussed in this testimony.

Proponents claim that substantial and growing number of physicians support physician assisted death.

Since the last time this bill was introduced in Maryland, The American College of Physicians ACP (attached), representing 150,000 Internal Medicine physicians, published a statement unequivocally opposing physician assisted death

The Maryland State Medical Society (Med Chi) has polled its physicians but actually does not appear to have told them about most of the issues raised in this testimony. They only posed the question generally and with little detail about the issues. When I inquired about this, I was ignored.

Again, while some physicians support the right to die by overdose, many still do not, and very few actually participate.

What does current legislation allow?

- Under current legislation, patients have broad latitude and many options before and at the time of a terminal illness.
- Details can be readily found online.

Under current legislation, a person can choose at any time to forego any and all medical interventions, including life-sustaining treatments, without the complicated procedures and hazards of this proposed legislation.

Evidence from an Oregon study, which I have cited in my testimony over the years, is that the vast majority of individuals who stop eating and drinking can die comfortably within two weeks.

Short of this, many options are available for people to choose how much treatment they want, for how long they want it, when they want it to stop, and when they would like to shift into palliative mode.

All of this can be readily found online at www.marylandmolst.org and other website that discuss Maryland's laws and regulations related to health care decision making, advance directives, and end-of-life options.

What problem– if any–does this legislation fix?

- The only thing this proposed legislation does beyond existing laws is allow people who want to die quickly to request and take medication that will make them unconscious within a few minutes and die from minutes to days later.
- The many procedural steps in this law result in it potentially taking as long or longer to die under this legislation as it does under existing laws.

The only thing this legislation does that existing laws do not is allow people who want to die by their own hand to request and take medication at any time that will make them unconscious within a few minutes and die from minutes to days later.

When we consider the many procedural steps in this law, necessary to prevent illegal acts, there is compelling evidence that for many individuals, it actually takes as long or longer to die under this legislation as it would to do so under existing laws.

As the Oregon report notes, if there was a better job of informing people of their end-of-life options, it is likely that even fewer people would pursue assisted suicide. "Often, once the provider has addressed patients' concerns, they may choose not to pursue PAS."

What problems does this legislation potentially cause?

- *The proposed legislation creates many actual and potential problems*, now and later on.
- It *basically promotes falsification of death certificates*, with multiple problematic consequences.

The proposed legislation creates many actual and potential problems, now and later on, as follows:

- It opens a can of worms that has the potential to impact the entire population.

- The process is complex and convoluted.
- The alleged safeguards are primarily on paper and are actually often not used or not enforceable.
- The legislation precludes adequate investigation and disclosure, so there is no practical way to confirm whether required procedures were done correctly and whether the patient met the criteria and was not coerced.
- It is not possible to keep track of what happens, or to investigate if there is a problem, or even to know when to investigate.
- In truth, we are giving people lethal doses of medications and we often don't have any idea what becomes of those lethal doses.
- In reality, patients die by taking a massive drug overdose. This fits the definition of suicide, but the proposed law sidesteps the issue and tells physicians to falsify the death certificate.
- Since death certificates are the basis for many things, including public health morbidity and mortality dats, it results in falsification and complications in many different directions, besides public health and compliance with the law.

Truthfulness of the death certificate

- *Saying that all of these patients died of their illness (and authorizing it as such on the death certificate) is invalid*, as it is true of only some of them, and the exact number is unknown.
- *In many cases, no one knows* when or how the patient died or whether or when they took the medications.

Since prognostication is inexact and some of those who requested lethal medication did not take it, and some of those who died did so under unknown circumstances, saying that all of these patients died of their illness (and authorizing it as such on the death certificate) is invalid.

The Oregon report states openly that some died by ingesting lethal medication and some died because of their illness. Therefore, there is a difference between death by ingesting a medication and death by the underlying disease or condition.

If a patient requests these drugs and then does not have to tell anyone what they are doing and many deaths in people who request these drugs are unwitnessed, then how does anyone know what a lot of these people die of?

Isn't this suicide?

- *Ingesting a large overdose of lethal medications for the purpose of dying as quickly as possible is completely consistent with the definition of suicide.*
- *It is highly problematic that a law would both promote that action and seek to call it something else than what it is, regardless of the nobility or righteousness of the intent.*

Ingesting a large overdose of lethal medications for the purpose of dying as quickly as possible is completely consistent with the definition of suicide.

Definition: Medical Definition of suicide. 1: the act or an instance of taking one's own life voluntarily and intentionally. https://www.merriam-webster.com/dictionary/suicide

If the typical time between ingestion and death is 25 minutes (range 1 min-104 hours), then clearly death occurs as a direct result of taking the medication, and not of dying of the illness.

This legislation simply avoids the entire question of suicide.

The act of taking a lethal dose of medication prescribed specifically for its inevitable fatal consequences completely fits the definition of suicide.

However, the legislation is written to define taking your own life by a prescribed medication specifically as not suicide, even though taking your life by any other means (including deliberately overdosing on a medication not specifically prescribed for that purpose) still is suicide.

If the legislature wants to legalize suicide, then it should take on the whole issue and deal with its implications.

It is of great concern that the legislature would pass a law that ignores the obvious and promotes falsification of death certificates, just because some think that it is a noble cause.

SUMMARY

- Like others, I have many strong and valid reasons to oppose this legislation.
- It is confusing, convoluted, and creates as many problems as it allegedly solves.
- Other than allowing people to take a drug overdose that causes them to die rapidly, it offers nothing that cannot be done by applying existing laws and regulations.
- It opens a huge can of worms that we are not ready to deal with.
- It takes far too much on faith and allegation while at the same time making it very difficult to determine whether and how it is actually being applied consistent with alleged safeguards.
- It asks physicians to prescribe lethal doses of medications so that patients can die by a deliberate drug overdose.
- It authorizes physicians in many cases to fabricate causes of death and falsify death certificates.
- It applies to only a tiny handful of people.
- For the vast majority of people, we still have to accomplish the goals of alleviating suffering and dying in a dignified manner, by applying existing laws and regulations–which we can and must do.

Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD. Attitudes of Oregon psychiatrists toward physician-assisted suicide. *Am J Psychiatry* 1996;153:1469-1475.

Ref ID: 224
Keywords: Attitude of Health Personnel/Ethics,Medical/Euthanasia/Family Practice/Female/Humans/Male/Mental Competency/Mental Disorders/psychology/Middle Aged/Oregon/Personal Autonomy/Psychiatry/Referral and Consultation/Social Values/Suicide,Assisted/legislation & jurisprudence/Surveys and Questionnaires/Terminally Ill/Trust/Vulnerable Populations/Wedge Argument/Withholding Treatment

Abstract: OBJECTIVE: After passage, in November 1994, of Oregon's ballot measure legalizing physician-assisted suicide for terminally ill persons, the authors surveyed psychiatrists in Oregon to determine their attitudes toward assisted suicide, the factors influencing these attitudes, and how they might both respond to and follow up a request by a primary care physician to evaluate a terminally ill patient desiring assisted suicide. METHOD: An anonymous questionnaire was sent to all 418 Oregon psychiatrists. RESULTS: Seventy-seven percent of psychiatrists (N = 321) returned the questionnaire. Two-thirds endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for a medication whose sole purpose would be to allow a patient to end his or her life. One-third endorsed the view that this practice should never be permitted. Over half favored Oregon's assisted suicide initiative becoming law. Psychiatrists' position on legalization of assisted suicide influenced the likelihood that they would agree to evaluate patients requesting assisted suicide and how they would follow up an evaluation of a competent patient desiring assisted suicide. Only 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide. CONCLUSIONS: Psychiatrists in Oregon are divided in their belief about the ethical permissibility of assisted suicide, and their moral beliefs influence how they might evaluate a patient requesting assisted suicide, should this practice be legalized. Psychiatrists' confidence in their ability to determine whether a psychiatric disorder such as depression was impairing the judgment of a patient requesting assisted suicide was low

Ganzini L, Goy ER, Miller LL, Harvath TA, Jackson A, Delorit MA. Nurses' experiences with hospice patients who refuse food and fluids to hasten death. *N Engl J Med* 2003;349:359-365.
Ref ID: 110
Keywords: Age Factors/Aged/Aged,80 and over/Attitude to Death/Caregivers/Death/Dehydration/Drinking/Family/psychology/Fasting/Female/Hospices/Humans/Male/Middle Aged/Nursing Staff/Oregon/Suicide,Assisted/statistics & numerical data/Surveys and Questionnaires/Treatment Refusal
Abstract: BACKGROUND: Voluntary refusal of food and fluids has been proposed as an alternative to physician-assisted suicide for terminally ill patients who wish to hasten death. There are few reports of patients who have made this choice. METHODS: We mailed a questionnaire to all nurses employed by hospice programs in Oregon and analyzed the results. RESULTS: Of 429 eligible nurses, 307 (72 percent) returned the questionnaire, and 102 of the respondents (33 percent) reported that in the previous four years they had cared for a patient who deliberately hastened death by voluntary refusal of food and fluids. Nurses reported that patients chose to stop eating and drinking because they were ready to die, saw continued existence as pointless, and considered their quality of life poor. The survey showed that 85 percent of patients died within 15 days after stopping food and fluids. On a scale from 0 (a very bad death) to 9 (a very good death), the median score for the quality of these deaths, as rated by the nurses, was 8. On the basis of the hospice nurses' reports, the patients who stopped eating and drinking were older than 55 patients who died by physician-assisted suicide (74 vs. 64 years of age, P<0.001), less likely to want to control the circumstances of their death (P<0.001), and less likely to be evaluated by a mental health professional (9 percent vs. 45 percent, P<0.001). CONCLUSIONS: On the basis of reports by nurses, patients in hospice care who voluntarily choose to refuse food and fluids are elderly, no longer find meaning in living, and usually die a "good" death within two weeks after stopping food and fluids

Does This Patient Have Medical Decision-Making Capacity?

Laura L. Sessums, JD, MD
Hanna Zembrzuska, MD
Jeffrey L. Jackson, MD, MPH

Context Evaluation of the capacity of a patient to make medical decisions should occur in the context of specific medical decisions when incapacity is considered.

Objective To determine the prevalence of incapacity and assessment accuracy in adult medicine patients without severe mental illnesses.

Data Sources MEDLINE and EMBASE (from their inception through April 2011) and bibliographies of retrieved articles.

Study Selection We included high-quality prospective studies (n=43) of instruments that evaluated medical decision-making capacity for treatment decisions.

Data Extraction Two authors independently appraised study quality, extracted relevant data, and resolved disagreements by consensus.

Data Synthesis Incapacity was uncommon in healthy elderly control participants (2.8%; 95% confidence interval [CI], 1.7%-3.9%) compared with medicine inpatients (26%; 95% CI, 18%-35%). Clinicians accurately diagnosed incapacity (positive likelihood ratio [LR+] of 7.9; 95% CI, 2.7-13), although they recognized it in only 42% (95% CI, 30%-53%) of affected patients. Although not designed to assess incapacity, Mini-Mental State Examination (MMSE) scores less than 20 increased the likelihood of incapacity (LR, 6.3; 95% CI, 3.7-11), scores of 20 to 24 had no effect (LR, 0.87; 95% CI, 0.53-1.2), and scores greater than 24 significantly lowered the likelihood of incapacity (LR, 0.14; 95% CI, 0.06-0.34). Of 9 instruments compared with a gold standard, only 3 are easily performed and have useful test characteristics: the Aid to Capacity Evaluation (ACE) (LR+, 8.5; 95% CI, 3.9-19; negative LR [LR–], 0.21; 95% CI, 0.11-0.41), the Hopkins Competency Assessment Test (LR+, 54; 95% CI, 3.5-846; LR–, 0; 95% CI, 0.0-0.52), and the Understanding Treatment Disclosure (LR+, 6.0; 95% CI, 2.1-17; LR–, 0.16; 95% CI, 0.06-0.41). The ACE was validated in the largest study; it is freely available online and includes a training module.

Conclusions Incapacity is common and often not recognized. The MMSE is useful only at extreme scores. The ACE is the best available instrument to assist physicians in making assessments of medical decision-making capacity.

JAMA. 2011;306(4):420-427 www.jama.com

CLINICAL SCENARIO

One of your patients, a 72-year-old woman, comes to you for a preoperative evaluation for a total hip replacement. Her medical history includes early-stage Alzheimer disease. At a recent clinic visit, her husband noted his wife seemed more forgetful, and on examination, her Mini-Mental State Examination (MMSE) score was 21 out of 30 points. Today, you ask the patient what she understands about the risks and benefits of the planned procedure. She smiles and tells you it will fix her hip. When you give her information about risks and alternative treatment options, and query about her understanding, she continues to smile and replies, "It'll be okay." You wonder whether she has the capacity to make the decision to proceed with the operation.

WHY IS THE CLINICAL EXAMINATION IMPORTANT?

Patients are assumed to have capacity to make medical decisions unless proven otherwise,[1] and many clinicians lack formal training in capacity evaluation. The practical consequence is that clinicians regularly fail to recognize incapacity[1-8] and generally question a patient's capacity only when the medical decision to be made is complex with significant risk, as in the case presented herein, or if the patient disagrees with the physician's recommendation.[9]

The criteria for valid consent to medical treatment vary from state to state but are based on common law and have 3 elements. The patient must (1) be given adequate information regarding the nature and purpose of proposed treatments, as well as the risks, benefits, and alternatives to the proposed therapy, including no treatment; (2) be free from coercion; and (3) have medical decision-making capacity.[10] The standards for whether a patient meets this last element also vary from state to state but are generally based on evaluating

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Rising rates of hospice discharge in U.S. raise questions about quality of care

By Peter Whoriskey and Dan Keating
August 6, 2014

washingtonpost.com

At hundreds of U.S. hospices, more than one in three patients are dropping the service before dying, new research shows, a sign of trouble in an industry supposed to care for patients until death.

When that many patients are leaving a hospice alive, experts said, the agencies are likely to be either driving them away with inadequate care or enrolling patients who aren’t really dying in order to pad their profits.

It is normal for a hospice to release a small portion of patients before death — about 15 percent has been typical, often because a patient’s health unexpectedly improves.

But researchers found that at some hospices, and particularly at new, for-profit companies, the rate of patients leaving hospice care alive is double that level or more.

The number of “hospice survivors” was especially high in two states: in Mississippi, where 41 percent of hospice patients were discharged alive, and Alabama, where 35 percent were.

“When you have a live discharge rate that is as high as 30 percent, you have to wonder whether a hospice program is living up to the vision and morality of the founders of hospice,” said Joan Teno, a Brown University hospice doctor and researcher and the lead author of the article published in the Journal of Palliative Medicine. “One part of the reason is some of the new hospice providers may not have the same values — they may be more concerned with profit margins than compassionate care.”

Two types of improper practices emerge

A patient must have a life expectancy of six months or less to enroll in hospice care, according to Medicare rules. Hospice treatment focuses on providing comfort to the terminally ill, not finding a cure.

While judging life expectancy is inexact, the rising rates of live discharge in the U.S. in recent years has raised concerns that the rapidly changing industry has become rife with one of two types of improper practices.

First, some hospices appear to be forsaking patients when their care becomes expensive. Hospices bill by the day, so added tests and treatments can cut into their profits. Researchers found, for example, that 1 of 4 patients who leave hospice alive are hospitalized within 30 days.

Some hospices “abandon their end stage residents to the nearest hospital ER and have the legal representative sign the [hospice] revocation papers — all to save money and avoid intensive continuous care at the end of life,” W.T. Geary Jr., medical director at the Alabama Department of Public Health, said in an e-mail.

In what researchers described as a particularly alarming pattern, more than 12,000 patients in 2010 were released alive from hospice, entered a hospital and within two days of leaving the hospital were re-enrolled in hospice. Those are the kind of abrupt transitions that can be disruptive and confusing for the dying, and which hospice care is supposed to transcend.

“The concern is that hospices could be discharging people to avoid expensive care, such as a CAT scan or an MRI — and that they are trying to game the system," Teno said.

More than just financial harm is noticed

The other problem driving up the numbers of people leaving hospices alive is the practice of hospices enrolling patients who aren't actually dying.

The federal government in recent years has sought to recover more than $1 billion from hospices that, according to attorneys, illegally billed Medicare for patients who weren't near death.

The new research supports the idea that many of the patients released alive from hospice are far from death: More than one-third of patients who were released alive from hospices did not re-enroll in a hospice and were still alive six months after being released.

While the federal government has filed numerous lawsuits to recover the money spent on hospice patients who weren't dying, the harm is not just financial.

Hospice care often exposes patients to different, more powerful drugs, including morphine and other potent painkillers. In some cases, those medications led to the death of patients who were not otherwise dying, families say.

"My mother was not dying, just old and in a lot of pain," said Shalynn Womack, a writer in Tennessee whose mother entered a hospice with the diagnosis of "failure to thrive."

After receiving what Womack called a "toxic cocktail" of drugs, her mother passed away. Womack has since testified to a Tennessee legislative committee about what she considers to be the dangers of enrolling patients in hospice who aren't dying.

"Putting her in hospice was putting her in harm's way," Womack said.

Roseann Gillespie and her daughter, Shalynn Ford Womack, are shown on Roseann's 90th birthday on Oct. 11, 2011, six months to the day before she entered hospice for respite care. (Photo by Nova Ford/Photo by Nova Ford)

Changing nature of hospice population among factors

In December, The Washington Post reported a rapid growth in live discharge rates, based on an analysis of more than 1 million patient records over 11 years in California — a state that, by virtue of its size, offers a portrait of the industry.

More recent Medicare statistics show a similar trend nationally: Between 2000 and 2012, the overall rate of live discharges increased from 13.2 percent of hospice discharges to 18.1 percent in 2012.

The forthcoming study, to be published in the Journal of Palliative Medicine, is based on an analysis of more than 1 million records of Medicare patients across the U.S. during 2010, and provides more detail on the variance of rates between hospices and states. It found that more than 182,000 hospice patients were discharged alive. More than 400 hospices released more than one in three of their patients alive.

A spokesperson for the National Hospice and Palliative Care Organization, the industry trade group, declined to comment on the findings because they have not seen the research.

In the past, industry advocates have argued that the national rise in live discharges stems from the changing nature of the hospice population. A larger portion of hospice patients today have ailments that are harder to predict, such as dementia. That, they say, could explain why more patients are exiting hospice care alive.

This explanation, however, does not appear to explain the vast differences between states that the researchers found.

For example, the live discharge rate was 41 percent in Mississippi but only 17 percent in neighboring Arkansas; it was 35 percent in Alabama but only 16 percent in neighboring Tennessee.

Becoming a commercial enterprise in the industry

The new paper also finds substantial differences between older hospices and newer ones.

In recent decades, what began as a movement to improve the end-of-life experience has become more of a commercial enterprise. In 2000, only 30 percent of hospices were run by for-profit companies, while the rest were operated by community organizations, religious groups and government agencies. By 2012, the proportion of for-profit companies had nearly doubled, to 6o percent, according to Medicare figures. Moreover, many hospices are relatively new, largely because the number of for-profit hospices has tripled, rising from 672 in 2000 to 2,196 in 2012.

At small for-profit hospices open five years or less, the live discharge rate averaged 32 percent, according to the research. That compares with 14 percent of older for-profit companies.

“That is a very striking difference,” said Melissa Aldridge, associate professor at Icahn School of Medicine at Mount Sinai, who has proposed that a hospice’s live discharge rate be considered as a measure of quality. “What we have found is that smaller, newer hospices had higher rates of live discharge. The ability to deal with a patient who’s having a crisis at home — to be able to send a team out there — may be more difficult for smaller hospices.”

Those patients end up going to the emergency room, Aldridge said, “and that’s usually not what someone on hospice wants. They usually want to be at home.”

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Physicians should focus on providing more compassionate, comprehensive end-of-life care, ACP president says.

This week, the American College of Physicians (ACP) reaffirmed its opposition to the legalization of physician-assisted suicide and placed renewed emphasis on the professional responsibility to improve the care of dying patients.

Citing ethical arguments and clinical, policy, legal, and other concerns for its positions, the ACP's paper is published in the Annals of Internal Medicine, along with two editorials and a related review article.

Jack Ende, MD, president of the ACP, spoke with HealthLeaders about the paper's implications for physicians and leaders. The transcript below has been lightly edited.

HealthLeaders: Why did the ACP decide to reiterate its position on this issue now?

Jack Ende, MD: The "now" question can be answered in a couple of ways. One is that we've had a policy paper out since 2001, and the issue continues to get addressed as our ACP ethics manual is continuously updated.

Since 2001, there has been a fair amount of legal activity: Seven states, Washington D.C., and Canada have legalized physician-assisted suicide, and it's up for discussion in several other states and districts.

Related: Physician-assisted Suicide and the ICU

The other reason is the perception that the care we're providing for terminally ill patients is not as good as it could be, and perhaps physician-assisted suicide is sort of a compromise.

For these reasons, the ethics committee decided that it was worth review.

Related: Few Docs Discuss Advance Care Planning

HLM: Does the underlying issue have more to do with improving palliative and end-of-life care?

Ende: There is a link. We have studies showing that most patients don't know what palliative care is; yet when they hear about it, it's the type of care they would want for themselves and their loved ones.

Yet when you're practicing medicine, there are many places that still do not support hospice and palliative care. These are services that are not as available as they should be or covered by insurance plans as widely as they should be.

We have a long way to go in really getting hospice and palliative care built in as an expected and necessary part of the medical system.

Related: 5 Ways to Improve Palliative Care

HLM: What kind of feedback are you anticipating in response to this paper?

http://www.healthleadersmedia.com/physician-leaders/acp-renews-stance-against-physician-assisted-suicide

Ende: We're likely to hear, "What about patient autonomy? Isn't our guiding principle that patients should get what they ask for?" And our response is that patient autonomy is extremely important, but there are limits to autonomy, and it is not our sole principle.

We are more focused on munificence—doing what is best for the patient—and non-malfeasance or never doing harm.

The second question is, "Well, what do you do?" And I think the paper does a good job outlining 12 conversation points that physicians may want to address with patients and their families when they're asked about physician-assisted suicide.

They include providing reassurance that the physician will be there for the patient's entire journey, understanding what the patient's goals are, and trying to meet those goals in ways that patients will appreciate.

And once that's done, I think the request for physician-assisted suicide will be less pressing.

HLM: What's most important thing for healthcare executives to understand about this issue?

Ende: There are three critical points:

- First, be aware that the Supreme Court has said that nobody has a right to commit suicide. States can legalize physician-assisted suicide, but it's not seen as a right.
- Second, assisting somebody in suicide is not part of the caring process. It's not part of why doctors take oaths, and it's not part of what we should be doing. So there is a concern about medicalizing death.
- Third, there is the concern that regarding physician-assisted suicide as a well-accepted may take us away from what we should be doing, which is providing compassionate, comprehensive care, which includes hospice care and palliative care and assisting patients through a much more comfortable, natural dying process—one that retains the physician-patient relationship and also retains the physician's ethical standing.

Debra Shute

Up to a third of opioid overdose deaths might be suicides, Johns Hopkins researcher concludes

baltimoresun.com/health/bs-hs-suicide-by-opioid-20200110-k76hksubcbcm7lrrej2pnleaky-story.html

By Meredith Cohn

Tens of thousands of people fatally overdose each year on opioids and other drugs. Sometimes medical examiners label them accidents, and sometimes they don't know what to call them.

But where humans waver, a computer program using a kind of artificial intelligence finds that many are likely suicides — possibly a third of them, according to a study by a Johns Hopkins School of Medicine researcher who partnered with a Utah high school student.

The information could bring sharper focus to the scope of epidemics of both opioid abuse and suicides, as well as the need for resources.

"If we're trying to prevent deaths in the community, we have to figure out why people are dying," said Dr. Paul Nestadt, the Johns Hopkins assistant professor of psychiatry and behavioral sciences who was one of the study's authors.

"If people are dying by accidental overdose, the best interventions — naloxone availability and treatment in the community for addiction — are different from those for suicide, like the availability of hotlines and antidepressants," he said.

There have been other attempts to identify the suicides hidden in the overdose numbers. This study, recently published in the journal Suicide and Life-Threatening Behavior, backs up some of those findings. The Hopkins research, however, may be the first attempt to use so-called machine learning to verify the estimates.

Under the model, the researchers entered information about overdose deaths in Utah from 2012 to 2015 into an algorithm. The data included age, sex, race, history of mental illness, and stressors like job loss, Nestadt said. The algorithm, taught to recognize the importance of risk factors, combined the data to determine the probability that a case was a suicide.

Few overdose cases nationally are labeled suicides because, absent a suicide note, examiners are often unsure of the drug user's intent. That's led to overdose cases largely being called accidents or "undetermined."

Overdoses quadrupled over two decades to about 70,000 in 2017, mostly due to opioids that include prescription painkillers and illicit heroin and fentanyl. Suicides have risen by about a quarter to 47,000 in about the same time frame.

“There are two epidemics, suicide and opioids,” said Dr. Ian Rockett, who has been researching the undercounting of suicides for a decade. “They tend to be treated separately, when there is considerable overlap.”

Rockett, who was not involved in the computer study, said it may have found a way to ascertain more accurate suicide numbers among the overdoses, making it important.

The study, which could end up influencing policy nationwide, grew out of a science fair project by a freshman at West High School in Salt Lake City. Daphne Liu was working on a project involving machine learning, and someone in Utah’s health department suggested she tap statewide overdose data.

The idea resonated with her; her brother had lost a friend to a drug overdose.

Daphne Liu, now a junior at West High School in Salt Lake City, worked with Dr. Paul Nestadt, a Johns Hopkins School of Medicine researcher, to refine and publish her machine learning study that found a third of overdoses were likely suicides. (Handout/For The Baltimore Sun)

Liu uncovered the likely suicides. In 2018, her project won first place in the National Institute on Drug Abuse’s Addiction Science Award. Nestadt read about the award and contacted Liu’s science teacher to suggest that they work together to refine and publish the findings.

Liu, now a high school junior, said the researchers hoped to continue modifying the algorithm to evaluate fatal overdoses from other states, which could make the data more useful. In Utah, about 20% of overdose cases had an undetermined manner of death. Next up may be Maryland, where 80% of cases were labeled undetermined, by far the highest number of any state.

“The biggest thing I hope comes of this is awareness,” Liu said. “We’re already told the suicide rates are super high. But that’s not the whole picture. ... It’s up to policymakers to decide what to do with it.”

Rockett said more detailed autopsies may be needed to find the suicides among overdose cases. The gold standard would be “psychological autopsies” in which family, friends, coworkers and others are interviewed, a practice that originated in the 1950s in California but was largely abandoned because of the expense, said Rockett, professor emeritus in West Virginia University’s Department of Epidemiology.

“Suicide gets neglected by investigators for practical reasons,” Rockett said. “The trouble is, though, if you’re not measuring suicides accurately then you’re not preventing them.”

He said the computer study had limitations, many noted by the researchers themselves. The model is only as good as the data, and many states don’t collect good information on the lives of each overdose case, Rockett said.

He also said the computer didn’t review cases that were labeled accidents, assuming that they were labeled properly, and examiners likely missed suicides in this category.

Further, some cases may be more nuanced, Rockett said, with drug users not intending to die that day but still intending to harm themselves.

Still, he said, the computer study provided useful information and could help draw attention to rising overdose suicide cases that may be under public radar.

Another researcher, Michael Schoenbaum, said the computer may be overreaching, and that Utah specifically may not be a good proxy for other states.

But Schoenbaum, a senior adviser for mental health services, epidemiology and economics at the National Institutes of Mental Health, said strict death certificate labels may not matter so much when it comes to treatment. Suicides and accidental overdoses are both “deaths of despair,” he said.

“If someone presents today with an accidental injury, tomorrow they may be a suicide risk, and we need to be more proactive in finding people with any combination of risk,” he said. “The outcome you want for patients is not being dead.”

That is an area of agreement on a controversial subject, said Dr. Maria Oquendo, president of the American Foundation for Suicide Prevention and a past president of the American Psychiatric Association.

Her own review of research in 2018 concluded that at least 30 percent of all overdose deaths were likely suicides, though the number could be closer to 40 percent. Her findings took into account emergency department data that included interviews with overdose survivors about their intent.

Oquendo, chair of the University of Pennsylvania’s psychiatry department, said efforts are underway to improve the data, including development of national reporting standards for medical examiners, coroners and others who categorize overdose deaths. Computer modeling could help.

There is value in getting the data right because there are proven life-saving interventions, she said.

“It’s definitely worth knowing,” she said. “It’s definitely worth trying to save a life.”

Finding people before they overdose is key, researcher and clinicians say. They suggested, among other efforts, universal screening in emergency departments and elsewhere for those who have considered suicide. Then seeking treatment and taking steps such as eliminating pills, alcohol and firearms from the homes of those deemed at risk.

Dr. Kenneth Stoller, director of the Johns Hopkins Broadway Center for Addiction, agrees that treatment works for people with addictions and mental health disorders, and there is overlap.

He said those with substance use disorders often live on a continuum between wanting to live to wanting to die. Their feelings can waver depending on whether they are intoxicated or in withdrawal and in the throes of depression, for example.

Mental health disorders and addiction are both diseases of the brain that are “very tied together in a very dangerous way,” he said.

He said treatment generally involves medication and counseling, as well as compassion and empathy.

As for labeling overdose deaths as suicides or accidents, Stoller said he wasn’t sure those buckets were enough.

“When I get a chance to ask patients who survive their drug use, they tell me it’s about escaping," he said. "Whether someone wanted to escape permanently or absolutely wanted it to be temporary, or somewhere in between, it may be tough to tell.”

BJC_UNF_SB701

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Position: UNF

BALTIMORE
JEWISH
COUNCIL

Senate Bill 701– End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

Judicial Proceedings Committee
February 28, 2020

OPPOSE

Background: Senate Bill 701, if enacted, would repeal the State's ban on physician-assisted suicide. It would allow a patient's attending physician to determine if a person is terminally ill and decide whether the patient requires a psychological exam. If the patient meets the criteria, is over 18 years of age, and is a Maryland resident, they may request a prescription for life-ending drugs. The patient must request three times: request 1 is oral; request 2 is in writing and signed by the individual and two witnesses, one of whom may not work for the patient, be a relative, or in any way benefit by the death of the patient; request 3 is oral, at least 15 days after the initial oral request and at least 48 hours after the written request. At least one of the requests must be made in private with the doctor. The bill also requires a second opinion from a specialist or someone with "experience" to confirm the patient has a terminal illness and whether he or she requires a psychological exam. The patient must self-administer the prescription. Any pharmacist, doctor, or healthcare facility need not participate if they object, and there is no penalty for non-participation. If the patient takes the medication and dies, he or she is declared dead by *natural causes* on the death certificate.

Written Testimony: The Baltimore Jewish Council (BJC) has a long-standing policy position opposing assisted suicide. The policy position was adopted in 1997 and reaffirmed in 2015. While we understand that this is a personal issue for many people in Maryland, on significant life-impacting principles that are deeply rooted in Jewish heritage, doctrine and tradition, the BJC is directed by our Jewish spiritual leadership. We believe that all life is sacred and that we are all created in the image of God. Suicide is a violation of Jewish law, as is assisting in a suicide. We are extremely supportive of end-of-life planning, such as advanced directives, and withholding or withdrawing impediments to the natural process of dying.

With this in mind, the Baltimore Jewish Council asks for an **unfavorable** report on SB 701.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of the Associated Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

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Member of the Jewish Council for Public Affairs

MDPAS Joseph Marine_UNF_SB701

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Position: UNF

Joseph Marine, MD
Testimony to Senate Judicial Proceeding Committee
February 28, 2020
Re: Senate Bill 701 - "End of Life Option Act"
OPPOSE

Senator Smith and Honored Committee Members:

Good morning. My name is Joseph Marine. I am a cardiologist practicing with Johns Hopkins Medicine in Baltimore with over 15 years of experience caring for thousands of patients throughout the state of Maryland. As part of my job, I am responsible for overseeing cardiology patient quality and safety efforts for my health system. I am also a member of the American Medical Association, the American College of Physicians, and the Baltimore City Medical Society, all of which oppose the legalization of assisted suicide. The views expressed here are my own.

The End of Life Option Act represents shockingly dangerous and misguided public policy, which violates many basic principles of patient safety, and which does nothing to address the real needs of Maryland patients with advanced illnesses and disabilities.

Assisted suicide is not medical care. It has no basis in medical science, practice, or tradition. In states that have passed assisted suicide laws, very few physicians are willing to participate.[1] The lethal drugs used in assisted suicide have never been scientifically tested, and the US FDA has never approved any drugs for this purpose. The drug recipes for assisted suicide have been invented by the Euthanasia Movement, not the health professions.

Furthermore, we know that doctors practicing assisted suicide in other states have been performing uncontrolled, unregulated, and unethical experiments on human beings using combinations of cheaper drugs. This is because almost any drug, given in a high enough dose can serve as a poison. Tragically, these experiments have caused some patients to scream in pain and to take over 2 days to die.[2] This is not medical care, this is a disgrace.

We know that in other states with assisted suicide, some patients have taken up to 4 days to die, and that the drugs have failed to kill some patients.[3] We know that every other country with assisted suicide using pills has almost entirely abandoned it in favor of intravenous euthanasia because of complications and failure in up to 20% of patients.[4] The State of Oregon, which has had assisted suicide for 20 years, admits that in the 80% of cases with no witnesses to consumption of drugs, they have no idea if complications occurred.[3] Without witnesses, no one can know whether the drugs were self-administered or whether some patients were assisted to die in some other way.

We know that in states with assisted suicide, patients have lived up to 3 years after receiving a prescription, in violation of the law which requires a 6 months prognosis, with no accountability or consequences for the physician.[3] We also know that at least 20% of US patients referred for hospice care survive their 6 month prognosis, and that doctors are even more inaccurate in prognosis in other settings.[5] All this means that we cannot know how many wrongful deaths are occurring in other states under this law.

We know that patients who qualify for PAS under this law have a 50-75% incidence of clinical depression, and that at least 1 patient, received a prescription in Oregon despite a history of severe depression and suicidality.[6-8] Yet in 2018, less than 2% of Oregon patients received a formal mental health evaluation - virtual proof that the law is being violated.[3]

The law can be routinely violated because it relies entirely on self-reporting, with broad legal immunity given to physicians, protection of records from discovery and subpoena, no witnesses to consumption of drugs, falsification of death certificates, and no routine audits, investigations, or supervision by an independent safety monitoring board.

The End of Life Option Act provides a new license for doctors to violate basic principles of medical ethics and to kill vulnerable patients with broad legal immunity and with no real oversight or accountability. It does not give any patients any new rights at all, and it takes away many basic legal protections.

What Maryland patients with advanced illnesses need is more support and greater access to excellent palliative and hospice care programs. We have some of the best health care in the world right here in Maryland. We should use it and not undermine our health care system with assisted suicide.

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MDPAS Michael P. May_UNF_SB701

OPPOSITION TO SB 701
A MONUMENT TO THE DOCTRINE OF UNINTENDED CONSEQUENCES

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For yet another year, well-intentioned legislators have attempted to make physician assisted suicide the law in Maryland, joining other states who have passed similar legislation, with disastrous consequences. This year's bill continues that tragic and heartbreaking effort. Decades ago, Archbishop Fulton J. Sheen wrote *Life Is Worth Living*. Somehow our society has regressed, rejecting that fundamental precept, notwithstanding the hallowed words of our Declaration of Independence: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness." The bill additionally ignores the United Nations Universal Dclaration of Human Rights: "Everyone has the right to life, liberty and security of person."

The bill implies that suicide may be chosen by people of sound mind. Of course, no one can agree on the meaning of the term "sound mind." Extremely busy physicians, many trained in specialties other than psychiatry, somehow must decide if a person who wishes to commit suicide possesses a so-called sound mind in rejecting the fundamental human instinct of self-preservation. If the physician suspects an unsound mind, whatever that means, or the consulting physician has the same suspicion, one or both may refer the individual to a mental health professional, not necessarily even a physician, to determine if the patient's suicide desire is rational. The bill does not provide the health care providers with any guidance.

Similarly, this year's bill attempts to guard against coercion or undue influence. The doctor must talk to the patient alone – unless the patient needs an interpreter. The doctor receives no guidance as to what questions to ask to discern coercion or undue influence. Indeed, the bills provide no guidance on how to distinguish coercion or undue influence from a mere conversation about assisted suicide. In the final analysis, a doctor's determination as to whether a patient seeks to commit suicide as a result of coercion or undue influence amounts to the physician's best guess.

To add to the conundrum, patients considering or requesting physician assisted suicide would naturally seek out a physician whose opinion favors assisted suicide. Indeed, states with assisted suicide laws already on their books have only a small percentage of physicians who engage in the practice. The greatest majority try to help their patients, not kill them. Thus, the doctor ostensibly screening for coercion or undue influence has a predisposition to find that neither exist, notwithstanding the fact that generally the doctor knows nothing of the patient's family dynamics. To put matters another way, no patient would tell the doctor that a friend or a family member forced, bullied, tricked or coerced him or her into requesting the pills that will cause death, not even immediately, but sometimes days after ingesting them. The screening therefore becomes a cynical illusion designed to foster, support and promote suicide.

The bill discriminates between persons with terminal illnesses who only have a few months to live and those with lifelong illnesses and no idea how long they will live. Only the former are "entitled"to commit suicide – if their prognosis is that they will die within 6 months, although no doctor has a crystal ball to enable him or her accurately to predict when the patient would actually die of natural causes.

Oregon, a "pioneer"in the assisted suicide movement, allows people with depression to end their lives through assisted suicide. That, of course, undermines agencies offering support to people with depression.

In reality, it is impossible to determine how long someone will live or to predict how a particular person will respond to a terminal illness. Thus, a doctor could prescribe life ending poison for a person, only to have the person live beyond the six-month window and ingest the suicide pills later. The current bill makes that a distinct possibility. In Oregon, there have been lapses of almost 3 years between the time the patient received the poison and the time the patient took it.

Insurance companies could deny access to expensive medical treatment while covering suicide options. Already, the current bills effectively invalidate incontestability provisions in life insurance policies, a clear violation of the Contracts Clause of the United States Constitution. Moreover, insurance companies have a fiduciary relationship to their shareholders or, in the case of mutual companies, to their policyholders. One could certainly make the argument that fulfilling that fiduciary obligation requires the companies to save money by denying access to certain treatments while effectively encouraging suicide by telling the patient or policyholder that the company will pay for suicide but not for treatment. After all, that would save the company money, and that sort of phenomenon has already surfaced in Oregon.

In Maryland, hospitals generally receive reimbursement, not on a per patient basis, but on a lump-sum formula. They therefore must budget resources. That scenario raises the question of whether hospitals with limited resources would provide quality care to a patient who is not expected to live or would begin to limit end-of-life options offered to terminal patients.

The bill eviscerates, indeed contradicts, the concept of health care. Doctors must preserve lives. Facilitating death at a patient's own hand hardly accomplishes that. Instead, it undermines any trust between the doctor and the patient who can no longer be sure that the doctor is helping him or her to live or die. On the other hand, if the doctor does not offer a suicide option to a terminally ill patient, the doctor could be maligned for allegedly prolonging a patient's pain. The doctor has a choice – between the devil and the deep blue sea.

There additionally appears to be a persistent correlation between assisted suicide and divorce. Judge Gorsuch writes that in each year except 2000, as his Winter 2004 article in the Wisconsin Law Review notes, "Divorced persons have represented over 24% of all assisted suicides in Oregon, well in excess of their representation in the population of all deaths due to similar underlying illnesses." He also noted that over time, Oregon physicians became increasingly unlikely to refer their patients for psychiatric or psychological consultation before providing them with an imprimatur to kill themselves.

Statistics tend to show that in the United States, the duration of the physician-patient relationship and assisted suicide cases is exceedingly short. Thus, the doctor vetting, and eventually approving, a patient for assisted suicide does not know the patient well and may not know the patient's family at all. Sadly, the bill practically guarantees that will be the case because assisting patients to kill themselves remains anathema to most physicians.

Gorsuch writes of the cases of "Helen"and Ms. Chaney in Oregon. Helen was a breast cancer patient in her mid 80s. Both her regular physician and a second doctor refused to help her kill herself. Her husband then called Compassion in Dying. That organization's medical director spoke to her and later explained that she was "frustrated and crying because she felt powerless." She was neither bedridden or in great pain. In fact, she enjoyed aerobic exercises until 2 weeks before contacting Compassion in Dying. She was also still performing housework. The organization recommended a physician to Helen, and that doctor referred her to a specialist of some kind, as well as to a psychiatrist who saw her only once. She got the lethal prescription. Her family told a newspaper reporter that Helen was worried that further care would threaten her financial assets.

Ms. Cheney, an 85-year-old widow, went to the doctor with her daughter who was a retired nurse. The daughter thought that the initial physician was dismissive, so she and her mother got another referral for a doctor within the same HMO, Kaiser Permanente. The second doctor referred Ms. Cheney to a psychiatrist who found that she "did not seem to be explicitly pushing for assisted suicide and that she lacked the very high level of capacity to weigh options about it." She accepted that assessment, but the daughter became angry. The HMO then suggested a 2nd psychiatric evaluation and agreed to pay for it. The 2nd mental health professional, a psychologist according to Judge Gorsuch, found that the daughter might have been "somewhat coercive" but that Ms. Cheney was competent to make the decision to kill herself. She then received the lethal prescription, and the drugs were placed under her daughter's care. Eventually she went to a nursing home temporarily to give her daughter a break. When she returned home, she said that something had to be done about her declining health and that she did not want to go back to the nursing home. She said she wanted to use the pills in her daughter's custody. Her daughter consented, and Ms. Cheney took the pills and died.

Of course, both stories are heartbreaking. People died needlessly – at their own hands. Moreover, one necessarily wanders what would have happened had family members urged against the request to die? What would have happened if the family members had offered care? Should patients be permitted to shop around for doctors who will go along with the desire to commit suicide? What if the HMO had not referred Ms. Cheney to a 2nd doctor? What if Compassion in Dying had not referred Helen to one of its stable of physicians chosen to help people kill themselves?

The bill guarantees a horrifically discriminatory and disproportionate effect on the elderly, African-Americans, the poor and the disabled. In fact, things are so bad in Holland that many old people insist on written contracts assuring against involuntary euthanasia before they will admit themselves. One necessarily wonders if Oregon's extremely homogeneous population, roughly 90% white, made it a pioneer. The *Detroit Free Press*, in 1994, found that while 53% of whites sampled in Michigan could envision assistance in committing suicide, only 22% of African-Americans could.

The *New England Journal of Medicine* reported that female, African-American, elderly and Hispanic cancer patients are all less likely than similarly situated non-minorities to receive adequate pain-relieving treatment that might obviate or eliminate a patient's perceived need to resort to suicide. In 1994, the Journal reports, minority cancer patients were 3 times less likely than non-minority patients to receive adequate palliative care. Only 48% of African-Americans received medicines designed to slow the progress of AIDS, compared to 63% of whites. Only 58% of African-American patients received treatments for preventing AIDS -related pneumonia while 82% of whites got the treatment.

Clearly this year's bill will, once again, have a highly disparate, disproportionate and deleterious effect on the most vulnerable members of our society: our poor, our elderly and our minorities. Certainly no enlightened legislative body, much less the members of the committees, can countenance, much less promote, such horrific carnage.

The bill contradicts our most fundamental values. It also starts to propel us, as a society, down that proverbial slippery slope to the day when the government decides that a person's life no longer has meaning, no longer has inherent value, that the person can no longer make a contribution, that the person is a liability, an albatross, that the person must therefore die.

Almost three centuries ago, Goethe wrote *The Sorrows of Young Werther*. The protagonist, devastated by unrequited love, killed himself. The book became an instant phenomenon. It sparked an appalling rash of copy cat suicides. So many occurred that some jurisdictions forbade the wearing of blue coats and yellow pants, as Werther did in the book, because so many young people were killing themselves.

The current bill permits adults to decide to kill themselves under certain circumstances with the assistance of a physician. The age of majority in this state is 18. Can anyone say that an 18-year-old has reached full emotional development? Is the 18-year-old immune from influences that would not affect someone older or more mature? Could an 18-year-old engage in a copy cat suicide?

One must also ask why the bill mandates that the death certificates of those who would engage in physician assisted suicide should attribute their deaths to the underlying condition that purportedly formed the basis of the request. That requirement implicitly acknowledges that a doctor's assisting a patient to commit suicide is wrong. If helping people kill themselves were right, if obtaining medications, actually poisons, to kill oneself were right, there would be no reason to avoid the truth, that a person died at his or her own hand with the assistance of a physician who took an oath to care for people, not kill them.

Under no circumstances should this committee permit the bill it is considering to emerge from committee, a Leviathan rising from the sea, destroying people and ultimately destroying a society founded on life, liberty and the pursuit of happiness.

Michael P. May
February 20, 2020

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OPPOSITION TO SB 701
A MONUMENT TO THE DOCTRINE OF UNINTENDED CONSEQUENCES

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Of course, both stories are heartbreaking. People died needlessly – at their own hands. Moreover, one necessarily wanders what would have happened had family members urged against the request to die? What would have happened if the family members had offered care? Should patients be permitted to shop around for doctors who will go along with the desire to commit suicide? What if the HMO had not referred Ms. Cheney to a 2nd doctor? What if Compassion in Dying had not referred Helen to one of its stable of physicians chosen to help people kill themselves?

The bill guarantees a horrifically discriminatory and disproportionate effect on the elderly, African-Americans, the poor and the disabled. In fact, things are so bad in Holland that many old people insist on written contracts assuring against involuntary euthanasia before they will admit themselves. One necessarily wonders if Oregon's extremely homogeneous population, roughly 90% white, made it a pioneer. The *Detroit Free Press*, in 1994, found that while 53% of whites sampled in Michigan could envision assistance in committing suicide, only 22% of African-Americans could.

The *New England Journal of Medicine* reported that female, African-American, elderly and Hispanic cancer patients are all less likely than similarly situated non-minorities to receive adequate pain-relieving treatment that might obviate or eliminate a patient's perceived need to resort to suicide. In 1994, the Journal reports, minority cancer patients were 3 times less likely than non-minority patients to receive adequate palliative care. Only 48% of African-Americans received medicines designed to slow the progress of AIDS, compared to 63% of whites. Only 58% of African-American patients received treatments for preventing AIDS -related pneumonia while 82% of whites got the treatment.

Clearly this year's bill will, once again, have a highly disparate, disproportionate and deleterious effect on the most vulnerable members of our society: our poor, our elderly and our minorities. Certainly no enlightened legislative body, much less the members of the committees, can countenance, much less promote, such horrific carnage.

The bill contradicts our most fundamental values. It also starts to propel us, as a society, down that proverbial slippery slope to the day when the government decides that a person's life no longer has meaning, no longer has inherent value, that the person can no longer make a contribution, that the person is a liability, an albatross, that the person must therefore die.

Almost three centuries ago, Goethe wrote *The Sorrows of Young Werther*. The protagonist, devastated by unrequited love, killed himself. The book became an instant phenomenon. It sparked an appalling rash of copy cat suicides. So many occurred that some jurisdictions forbade the wearing of blue coats and yellow pants, as Werther did in the book, because so many young people were killing themselves.

The current bill permits adults to decide to kill themselves under certain circumstances with the assistance of a physician. The age of majority in this state is 18. Can anyone say that an 18-year-old has reached full emotional development? Is the 18-year-old immune from influences that would not affect someone older or more mature? Could an 18-year-old engage in a copy cat suicide?

One must also ask why the bill mandates that the death certificates of those who would engage in physician assisted suicide should attribute their deaths to the underlying condition that purportedly formed the basis of the request. That requirement implicitly acknowledges that a doctor's assisting a patient to commit suicide is wrong. If helping people kill themselves were right, if obtaining medications, actually poisons, to kill oneself were right, there would be no reason to avoid the truth, that a person died at his or her own hand with the assistance of a physician who took an oath to care for people, not kill them.

Under no circumstances should this committee permit the bill it is considering to emerge from committee, a Leviathan rising from the sea, destroying people and ultimately destroying a society founded on life, liberty and the pursuit of happiness.

Michael P. May
February 20, 2020

February 14, 2020

Hon. William C. Smith, Jr.
Maryland Senate Committee on Judicial Proceedings
Miller Senate Office Bldg., 2 East Wing
11 Bladen St.
Annapolis, MD 21401

Re: S.B. 701, End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

Dear Chairman Smith:

My name is Stephen L. Mikochik. I am a Professor Emeritus of Constitutional Law at Temple Law School in Philadelphia and a visiting professor of Jurisprudence at Ave Maria Law School in Naples, Florida. Before joining the Temple faculty, I was an attorney with the Civil Rights Division, U.S. Department of Justice, where I enforced Section 504 of the Rehabilitation Act of 1973, prohibiting discrimination against persons with disabilities in programs receiving federal financial assistance. I have authored several articles on assisted suicide and have presented testimony on the impact proposed end-of-life legislation would have on persons with disabilities.

I write to clear up several misconceptions about S.B. 701:

First, despite claims to the contrary, the Bill is not aimed at avoiding pain at the end of life. Nothing in the criteria it lists for receiving a lethal drug requires the presence of insufferable pain (or for that matter, any pain at all) as a qualifying condition. This is not surprising since "[medical] technology [makes] the administration of pain-relieving drugs sufficient, except for a very few individuals for whom the ineffectiveness of pain control medicines can mean, not pain, but the need for sedation[.]" *Washington v. Glucksberg*, 521 U.S. 702, 791-92(Breyer, J., concurring in the judgements) (relying on the amicus curiae briefs of the National Hospice Organization and the American Medical Association).

Second, despite claims that it does not authorize active euthanasia, Section 5-6A-11, (D)(1), the Bill actually blurs the line between assisted suicide and euthanasia. Though a patient qualifying for a lethal drug must have "the ability to self-administer medication[,]" Section 5-6A-01(P)(5), the term "self-administer" means only the "act of taking medication[.]" Section 5-6A-01(R). "Taking medication" is broad enough to include merely the patient swallowing or ingesting what someone else feeds directly, which would constitute euthanasia not assisted suicide.

Third, despite claiming the opposite, Senate Bill 701 already includes persons with disabilities. People with disabling conditions that can cause death within six months, but only if treatment were removed, are terminal for purposes of the proposed legislation. Section 5-6A-01(S). Thus, their eligibility would not rest "solely" on "disability, or a specific illness[,]" Section 5-6A-04(A)(2); and they could thus receive a lethal prescription.

Fourth, rather than protecting vulnerable people, Senate Bill 701 provides a legislative blueprint for crime. The written form for requesting the lethal drug only requires the attending physician to determine that the patient's condition will, "more likely than not," result in death within six months. Section 5-6A-03(C). Someone financially interested in the patient's death (say, the beneficiary of a life insurance policy) can communicate to the attending physician, if needed on the patient's behalf, the patient's decision to request the lethal drug. Section 5-6A-01(D)(3). The same interested person can be a witness to the patient's written request for the lethal drug, Section 5-6A-03(B)(1)(ii), and can be the agent authorized to procure it from the dispensing pharmacist. Section 5-6A-07(B). That same person can serve if needed as an interpreter for the patient when the patient and attending physician privately discuss whether the patient is feeling coerced or unduly influenced. Section 5-6A-07(A)(5). The same interested person can be the only witness present when the lethal drug is taken, as objective observers are not required. Since the drug commonly used in assisted suicide is water soluble, the interested person can mix it in an unsuspecting patient's drink.

Further, the attending physician is not required to evaluate the patient's competency at the time the lethal drug is taken, even though weeks or months may have passed since the prescription was written. The attending physician can complete the death certificate, Section 5-6A-07(C), on the hearsay of such interested person regarding the circumstances of the patient's death since the physician's presence is not required when the lethal drug is taken. For the death certificate and other record-keeping purposes, and for all "other purposes governed by the laws of the State, whether contractual, civil, criminal, or otherwise," the patient's death must be listed as from natural causes. Section 5-6A-11. Thus, family members may never know that the patient died from a lethal drug rather than from the underlying medical condition. Further, coroners may not routinely investigate deaths certified from natural causes. Thus, no one will have reason to inquire into the circumstances surrounding the patient's death. Finally, even though the patient's insurance policy does not cover death from suicide, the same interested person can still recover if named as a beneficiary since the policy must treat the patient's death as from natural causes. Section 5-6A-12(C).

Maryland's interest, however, "goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and societal indifference." *Glucksberg*, at 732 (citation and internal quotations omitted). When the State safeguards the able-bodied from suicide but facilitates it for the sick and disabled, it signals unmistakably that such people's lives are less worthy of protection. Those who argue instead that dignity is affirmed when such people are given the right to choose to make themselves dead underestimate how devalued they are in society; how internalized such attitudes can become; how attractive the hint to leave can then appear. Finally,
those who argue that assisted suicide is no prelude to euthanasia forget that every principle tends

"to expand itself to the limit of its logic," *Glucksberg*, at 733 n. 23 (quoting Justice Cardozo, *The Nature of the Judicial Process* 51 (1932)), and that unwelcome guests who "can't take a hint" are eventually helped to leave.

For all these reasons, I urge your Committee to reject Senate Bill 701.

Respectfully submitted,

Stephen L. Mikochik

Stephen L. Mikochik

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cc: Maryland Senate Committee on Judicial Proceedings

Robert Nelson.UNF.SB701

Uploaded by: NELSON, MINISTER BOB

Position: UNF

SB0701–Oppose

Testimony by Robert Nelson to the Judicial Proceedings Committee

February 28, 2020

My name is Robert Nelson, Minister of Pastoral Care at Living Word International Christian Church in Silver Spring.

I'm here today to testify in opposition to SB0701, the "End-of-Life Option Act."

I believe that every life is precious and is a gift from God. Dr. Peter Saunders, CEO of the Christian Medical and Dental Association covering over 60 countries, states,

> "The Bible tells us that human beings are unique amongst God's creatures in being made in the image of God (Genesis 1:26) and it is on this basis, after the flood, that God introduces to all humankind the death penalty for murder (Genesis 9:6,7). The prohibition against killing legally innocent people is later formalized in the sixth commandment, 'You shall not murder' (Exodus 20:13; Deuteronomy 5:17). Euthanasia clearly falls within this Biblical definition. There is no provision for compassionate killing, even at the person's request and there is no recognition of a 'right to die' as all human life belongs to God (Psalms 24:1). Our lives are not actually our own. Suicide and assisted suicide is therefore equally wrong."[1]

Dr. Paul McHugh, former psychiatrist in chief at Johns Hopkins Hospital said,

> "scientific publications from oncologists … who study patients with painful cancers, reveal that … most cancer patients want help

> with the pain so they can continue to live. Suicide is mentioned only by those patients with serious but treatable depressive illness, or by those who are overwhelmed by confusion about matters such as their burden on loved ones and therapeutic options. These patients are relieved when their doctors attend to the source of their psychological distress and correct them."[2]

My own personal experience is that estimates of length of life with a terminal disease are inexact. My Mother was given "two to six months" to live; she died at home three years later being lovingly attended to by my Dad. In 2013 my wife of 42 years was diagnosed with an aggressive cancer and I was present when she died very peacefully with palliative care in the hospital.

All life is precious from the moment of conception until the last breath of a natural death. I believe and have seen hundreds of times that the Lord does miraculously heal. I have heard of reports of people even being raised from the dead. Let's not get in the way of Divine intervention and healing.

Please vote in opposition to SB0701.

Bob Nelson
Minister of Pastoral Care
Living Word International Christian Church
bnelson@lwicc.org

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[1] Dr. Peter Saunders, *Euthanasia: What Does the Bible Say?* LifeNews.com, November 13, 2013.

[2] Dr. Paul McHugh, *'Death with Dignity' Claims Another Victim, The Wall Street Journal*, May 25, 2013.

SandyNettina.UNFSB701

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Oppose - Senate Bill 701
End-of-Life Option Act

Presented to the Judicial Proceedings Committee
February 28, 2020

I respectfully oppose this legislation for multiple reasons, two of which I will explain to you here. My first point is that this legislation is not necessary. We have true medical options that are effective and far safer for end of life care. Why not expand on palliative care programs to improve the negative scenarios about death. Second, this legislation is inherently discriminatory, and would only expand the flaws in our health care system and culture that are discriminatory toward the poor and minorities.

Premeditated, intentional ending of one's life is not health care. The fact that this option is being introduced as a health care treatment, prescribed by physicians, is far outside of the standard of care that all health care professionals train for and are held to. Assistance with ending of one's life should not be offered as a medical treatment. There are effective, proven, mainstream treatments available to care for the physical and emotional distress and other symptoms of end stage and terminal illness. We also have advance directives and the Maryland MOLST form which give people choices about their end of life experience.

I am passionate about the care of people faced with very serious diagnoses. As a nurse practitioner for over 30 years, I have designed my practice to provide palliative care in the home and utilize hospice services for a wide range of cases. I provide individualized care, bringing in other health resources, to meet the physical and emotional needs of people facing death. I provide treatment, education, and support with comfort medications and other symptom controllers, administered by family members and monitored by health care professionals to improve the quality of life, right up to the time of natural death. I also refer for home hospice care where a whole professional team is available to them for comfort and support. I have found individualized palliative care and hospice services to meet all of my patients' varied needs, no matter how intense or complex. And despite what studies cite as one of the main reasons for seeking aid in dying, families and loved ones, in my wide experience, do not feel the dying person is a burden.

Despite the great strides we have made in Maryland and in this country to increase health care coverage, there is still racial and economic disparity in health care access. Our health care system is inherently flawed so that it is more difficult for poor people to receive the same quality of care as people of greater economic means. Unfortunately, allowing for people to opt into ending life with a lethal dose of medication will be seen as desirable for people who have been made to feel undesirable. This act, fully sanctioned by the state, will become a cultural norm. What a shift in culture that will be for us in Maryland, when there is already cultural bias against the weak and vulnerable—the poor, minorities, those with disabilities, the elderly, and the mentally ill. Do you want to make that happen? Even if it was not your intent, it will happen by unintended consequences.

Sincerely,

Sandra Nettina CRNP

Sandra M. Nettina
2760 Wynfield Road
West friendship, MD 21794 (home and office)

MDPAS Elizabeth Puleo_UNF_SB701

Uploaded by: Puleo, Elizabeth

Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

My name is Elizabeth Puleo and I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act.

Lou Gerhig, the baseball player, once said "I might have had a tough break, but I have an awful lot to live for." As you aware of ALS, also known as Lou Gerhig’s disease is a disease in which one is robbed of their physical functions while still being mentally intact and resulting in death. When I was 3 years old, my dad was diagnosed with ALS and lived for almost eight years with the disease despite the fact doctors told him he only had two years to live. He didn’t choose when he died but he died with dignity at home surrounded by our loving family.

Two years after his diagnosis, at age five, I developed brain cancer. Within the span of three years, I underwent two major surgeries to remove the tumor. Six weeks after my second brain surgery, the tumor grew back. Radiation was my only option for survival. I spent that summer undergoing radiation treatments, not how many seven year olds spend their summer. By that September, I started to experience side effects from the radiation. The radiation destroyed my cancer but I became physically disabled. Within four months, I could not walk, crawl or do anything on my own. Doctors told my parents, "take her home, love her, she'll be dead in a couple weeks". Unwilling to accept that prognosis, I started to receive therapy. I retaught myself to walk and how to live again. So here I am, over 20 years later and showing no sign of death anytime soon, guess those doctors were wrong.

I oppose this bill because I believe everything happens for a reason and that suffering is part of the human experience. If my dad just gave into death two years after being diagnosed, he would’ve never seen me struggle with cancer and conquer it. Watching him slowly deteriorate with each day was not easy but seeing him fight to the end inspired me to continue working hard and stay determined despite the obstacles I faced. At the same time, if he had chosen death, I would not have the cherished memories I do of my dad. One of my greatest memories of my dad is having to feed my dad because he could not use his hands. Just imagine, a five year old feeding her father potato chips, grease and saliva mixed on your hand. At the time, I thought it was gross but now I cherish those memories because it was our time together and something no one can take from me.

If I had chosen death and given up at age 8, I would have missed out on many wonderful things! Yes, I admit there are days when everything seems to fall apart, when life is challenging, and I struggle to see the positives but it is at those times that I keep pushing forward and remind myself that every day is a new beginning. I oppose the Physician Assisted Suicide because every life matters and we never truly know what the future holds.

For the past 6 years, I've testified against this bill. I have listened to the many arguments for it and against it. Yet my position on this bill still stands. When I'm having a bad day, my mom tells me to take a look in your rearview mirror. So many times, I focus on being a burden to those around me and think of only my suffering, that I fail to see the perspective of others. Earlier this year, I was helping with a high school youth group. My legs were shakier than normal on that day and when I stood up to grab something, my foot failed to pick up and fell face forward into the chair in front of me. I ended up with a small cut above my eyebrow that required stitches. Thankfully that was the extent of my injuries but needless to say I was embarrassed and felt like a burden. While waiting at the ER, I wondered why things like this happen to me and how better the world would be if I took myself out of the equation. Throughout that week, my phone kept ringing with concerned messages and calls. The following Sunday, one of the high schoolers approached me, saying how much I inspire him and how me being there every week encourages him to overcome the challenges he faces. Funny thing is, I never spoke to him until that day and didn't even think he knew my name. Take a look at your rearview mirror.

There are days when I feel like a burden and I hate being physically disabled. But then there are moments like that.

Some people may say those who are disabled or terminally ill are a burden to society. When considering this bill, please keep in mind the families and friends who would be impacted by this legislation. Think of the memories of loved ones it might affect and all the good this bill might take away from our society.

MDPAS Rabbi Daniel Rose_UNF_SB701

Uploaded by: ROSE, RABBI DANIEL
Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

I am a rabbi in the Jewish community who works extensively with the terminally ill and their families, both as the rabbi of a synagogue and as a hospice chaplain. Based on my experiences in this work, I am writing today in opposition to House Bill 643 and Senate Bill 701, both entitled An Act Concerning the End of Life Options Act. This bill would allow the prescription of self-ingested medication to end one's life. I strongly encourage you not to pass this bill.

I advocate against this bill, first of all, as a religious Jew. The principle that life has value no matter how productive or how limited is a sacred value for me and my community. We must not accept the notion that we can place a value on life based on its quantity or its quality. Judaism has always taught that our lives are a sacred charge, gifts we must use and appreciate; it is never in our hands, or our family's or physician's hands, to decide to end them. The Almighty blows the breath of life into us and only the Almighty decides when to take it away.

But I also ask you not to pass this bill as someone who spends time every day with the terminally ill. Someone who is a hospice patient has, by definition, been given a diagnosis of less than six months to live, the kind of people this bill would allow to take their own lives. And I have learned a great deal about the way people experience life when they know it is limited.

I have learned from the family of Miriam, a once vivacious and active woman who had become severely limited by Alzheimer's disease. When I first met her family, they were sure their mother would never want to live this way and wanted to provide very little to help her continue living. But over time, they came to see the pleasure she had in being spoon-fed by her children, or the joy on her face when her grandchildren came to visit. They came to treasure those encounters and were happy that she continued living for as long as she did. There is special meaning at the end of life that does not exist before. How could we take that away? The pain, guilt and regret that haunts the family of a suicide victim is no less present when it is committed by someone who is ill.

I have also learned that the families of those at the end of life can be under a great deal of psychological and financial stress. This stress is even more acute for diseases like dementia which last for years and have no clear end in sight. In our own hospice, we have seen a marked increase in suicide and suicidal ideation – not only among terminal patients, but among their caregivers. I am gravely concerned that those who are ill and compromised will feel pressure to take their own lives rather than create a burden for the families.

There was a report last year in The Guardian about the experiences of physicians in The Netherlands, where euthanasia has been legal for over a decade. One anecdote involved a patient whose wife would constantly harangue him to commit physician-assisted suicide, calling him a coward for not doing so. His physician, responsibly, refused to administer the life-ending medication. But one day his physician returned from a vacation to find that her patient was dead. His wife had convinced a different physician to carry it out. “I am a doctor”, his physician said, “and yet I can’t guarantee the safety of my most vulnerable patients.”

I have also learned the tremendous value of hospice care. The expertise and compassion of a hospice team can provide relief from almost all forms of distress at the end of life. This is why the National Hospice and Palliative Care Organization does not support this legislation: we know how to provide comfort and dignity in a way that honors life. And I must add something every hospice professional knows: predicting how much time a person has left is a terribly inexact science. Patients of mine who were supposed to have weeks left to live are still going strong, two years later, time that has been filled with meaning, friendship and joy. A law based on our ability to predict a six-month prognosis is a deeply flawed proposition.

The proponents of this bill insist that it is needed so that people do not have to suffer from untreatable pain. We must never minimize any person’s suffering. But the fact is that this claim is simply a red herring. Oregon’s own statistics tell us that pain is not even one of the top four reasons given by patients who commit assisted suicide. Far more common is a desire to avoid being a burden and a fear of losing independence. Let us be clear: a vote for this bill is not a vote to free people from pain. It is a vote that tells the people of Maryland that you may kill yourself to avoid relying on others for help, that burdening others to help us when we need it is so terrible that death is a perfectly acceptable alternative and your doctor will help you achieve it. What message does this telegraph to our young people, to those struggling with mental illness, to the disabled?

Finally, I note with confusion that this bill is purported to be an expression of progressive values. A progressive approach would be to listen to those vulnerable populations who are asking us to protect them. A progressive approach would be never to risk that someone could take advantage of the disabled, or the mentally ill, or the religious people in our state. A progressive approach would send a message to our young people that seeking help is always better than taking your own life and that suffering does not mean that life is not worth living. To reject this bill, and in so doing, to extend society’s protection to its most vulnerable members until the end of their lives – that would truly be an act that supports death with dignity.

I urge you to report unfavorably on Senate Bill 701.

Rabbi Daniel Rose

Rabbi Ariel Sadwin__UNF_SB701

Uploaded by: SADWIN, RABBI ARIEL

Position: UNF

בס"ד

Agudath Israel of Maryland
אגודת ישראל במרילנד
PROTECTING ADVOCATING SERVING

MARYLAND SENATE JUDICIAL PROCEEDINGS COMMITTEE

FEBRUARY 28, 2020

SENATE BILL 701

END-OF-LIFE OPTIONS ACT - RICHARD E. ISRAEL AND ROGER "PIP" MOYER ACT

TESTIMONY OF RABBI ARIEL SADWIN

OPPOSE

Agudath Israel of America and its Maryland office speaks on behalf of the Orthodox Jewish community on matters of government affairs and public policy. For the last 85 years, Agudath Israel has been the voice for "culturally sensitive health and end-of-life advocacy and counseling" for American Orthodox Jewry.

The Orthodox Jewish community of Maryland firmly and unequivocally opposes Senate Bill 701 – the Richard E. Israel and Roger "Pip" Moyer End-of-Life Options Act.

While the merits of the issue at hand have been debated for more than two thousand years, classical Jewish tradition teaches us that **all** human life is sacred without any exception. Any laws that are enacted to undermine the sanctity of human life, sends a message that is profoundly dangerous for all of society.

It is of the most basic principles of Jewish law and ethics, that "man does not possess absolute title to his life or body", for that belongs to the Almighty G-D. We firmly believe that recognition of that fact has served as one of the pillars of civilized societies throughout all of the generations. That pillar is now in peril.

There are far too many people who suffer from terrible and dreadful illness, and we all know so many who have been affected by their suffering. Both proponents and opponents have shared many personal examples of loved ones who have suffered terribly for reasons man will never be able to comprehend. And while it may seem for some that they are better off dead than to remain alive, that is not a statement that ***any of us*** can firmly state.

However, to sanction a way for any person to hasten death prematurely… to that we are firmly opposed.

Our community is emphatically supportive of advanced medical directives – where a person and their family can set their treatment preferences and when to decide when and how to cease treatment to fight illness, etc., but that isn't the item being debated in this bill.

The Holy Talmud relates instances where a person is in the throes of death. It clearly and emphatically rules that one is even forbidden to lay a hand on that individual, lest he be involved in hastening the moment of death.

It is G-D himself who determines when we are to be born and when we are to die. It is not our doctor who takes the place of G-D to make those decisions. It is not our family members who make those decisions. And it is not ourselves.

On a very personal note, rarely does a day go by when I don’t think about a person who had a profound impact on my own life, our family rabbi growing up in Silver Spring. He had just turned 60 when he was diagnosed with the ever-dreadful pancreatic cancer. After surgery and extensive treatment, the disease went into remission, only to return with a vengeance not long after. All of the treatment that he had sustained while he was still strong had taken a deadly toll on his body. All the while he continued to persevere and tried to remain as active and involved in the community as he was physically capable, and *beyond.*

In his own holy words delivered in his last public appearance, he said that if he was going to die it would be “with his boots on”, i.e. still living life to its fullest – in as meaningful a way as possible. Now, several years later, an entire community of hundreds of households still draws strength from the way that man lived….and, how he died.

We request that you report unfavorably on Senate Bill 701.

Thank you.

MDPAS Lois Snyder Sulmasy_UNF_SB701

Uploaded by: SNYDER SULMASY, LOIS
Position: UNF

Annals of Internal Medicine POSITION PAPER

Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper

Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH*; for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians

Calls to legalize physician-assisted suicide have increased and public interest in the subject has grown in recent years despite ethical prohibitions. Many people have concerns about how they will die and the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Some have advocated strongly, on the basis of autonomy, that physician-assisted suicide should be a legal option at the end of life. As a proponent of patient-centered care, the American College of Physicians (ACP) is attentive to all voices, including those who speak of the desire to control when and how life will end. However, the ACP believes that the ethical arguments against legalizing physician-assisted suicide remain the most compelling. On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient–physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities regarding other issues and the physician's duties to provide care based on clinical judgment, evidence, and ethics. Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. The ACP remains committed to improving care for patients throughout and at the end of life.

Ann Intern Med. doi:10.7326/M17-0938 **Annals.org**
For author affiliations, see end of text.

How we die, live, and are cared for at the end of life is important, with implications for individuals, their families, and society. The 1997 report *Approaching Death: Improving Care at the End of Life*, by the Institute of Medicine (IOM), documented inadequate end-of-life care in the United States (1). The investigators of SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment; 2000) agreed (2, 3). The emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining—physically, emotionally, and financially—for patients and their families. Many people have concerns about death. At the end of life, some patients receive unwanted care; others do not receive needed care (4–6). Some end-of-life concerns are outside of medicine's scope and should be addressed in other ways. Although medicine now has an unprecedented capacity to treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle with getting it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revisiting these issues in 2014, the IOM's *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* reported that challenges remain in delivering quality end-of-life care to a growing and diverse elderly population, especially with regard to access to care, communication barriers, time pressures, and care coordination (7). Inadequate reimbursement and other disincentives also are barriers to palliative and hospice care.

Hospice and palliative care may ease apprehension about the dying process. Such care requires improving access to, financing of, and training in palliative care; improving hospital, nursing home, and at-home capabilities in delivering care; and encouraging advance care planning and openness to discussions about dying. Of note, 90% of U.S. adults do not know what palliative care is; however, when told the definition, more than 90% say they would want it for themselves or family members if severely ill (4).

Within this context of challenges in providing palliative and hospice care, a few U.S. jurisdictions have legalized physician-assisted suicide. This paper presents the position of the American College of Physicians (ACP) on the topic. The ACP recognizes the range of views on, the depth of feeling about, and the complex-

See also:

Related article 1
Editorial comment 2

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* This paper, authored by Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH, was developed for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Individuals who served on the Ethics, Professionalism and Human Rights Committee at the time of the paper's approval were Carrie A. Horwitch, MD, MPH† (*Chair*); Omar T. Atiq, MD† (*Vice Chair*); John R. Ball, MD, JD†; Nitin S. Damle, MD, MS†; Pooja Jaleel, BA†; Daniel B. Kimball Jr., MD†; Lisa S. Lehmann, MD, PhD†; Ana María López, MD, MPH†; Paul S. Mueller, MD‡; Alexandra Norcott, MD†; Sima Suhas Pendharkar, MD, MPH†; Julie R. Rosenbaum, MD†; Molly B. Southworth, MD, MPH†; and Thomas G. Tape, MD†. Approved by the ACP Board of Regents on 27 March 2017.
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ity of this issue. This executive summary is a synopsis of the ACP's position. See the **Glossary** for definitions and the **Appendix** for the full position paper.

METHODS

This position paper was developed from September 2015 to March 2017 on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper; the paper was then reviewed by members of the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, Council of Subspecialty Societies, Patient Partnership in Healthcare Center and Advisory Board, and other committees and experts. The paper was revised on the basis of comments from the aforementioned groups and individuals, reviewed again by the full leadership, and then revised further. Finally, the ACP Board of Regents reviewed the paper and approved it on 27 March 2017. Financial support for this project is exclusively from the ACP operating budget.

BACKGROUND AND BRIEF RATIONALE

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). This issue also has been considered every few years in the *American College of Physicians Ethics Manual*, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient–physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients on the basis of the ethical principles of beneficence (that is, acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient autonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient judges to be inconsistent with his or her goals and preferences. Death follows naturally, after the refusal, as a result of the underlying disease (9).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering (10). Proponents view physician-assisted suicide as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort, that physicians should not participate in intentionally ending a person's life, and that physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter (12, 13).

Both sides agree that patient autonomy is critical and must be respected, but they also recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient–physician partnership. Only by this balancing of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write an illegal prescription, or breaches confidentiality to protect public health. It also undergirds the physician's duty not to engage in futile care (such as care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering. Both proponents and opponents of physician-assisted suicide wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other principles reflects ethical arguments about the nature of the patient–physician relationship—a relationship that is inherently unequal because of power differentials and the vulnerability of illness—physicians' duties, and the role of the medical profession in society. A fuller consideration of this ethical balance, intent and

Glossary

Suicide: The act of killing oneself intentionally.
Physician-assisted suicide: Physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).
Euthanasia: The act of intentionally ending a life to relieve pain or other suffering (e.g., lethal injection performed by a physician).

causation in acts near the end of life, medicalization versus personalization of death, and the ethics and implications of physician-assisted suicide are presented in the Appendix.

POSITION STATEMENT

The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and management of pain and other symptoms, and support for families. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

CONCLUSION

Society's goal should be to make dying less, not more, medical. Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life. On the basis of substantive ethics, clinical practice, policy, and other concerns, the ACP does not support legalization of physician-assisted suicide. This practice is problematic given the nature of the patient–physician relationship, affects trust in that relationship as well as in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities on other issues and the physician's duty to provide care based on clinical judgment, evidence, and ethics. Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter.

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Acknowledgment: The authors and the ACP Ethics, Professionalism and Human Rights Committee thank the many reviewers of the paper for helpful comments on drafts and Kathy Wynkoop for administrative assistance.

Financial Support: Exclusively from the ACP operating budget.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M17-0938.

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APPENDIX AND EXPANDED RATIONALE: ETHICS AND THE LEGALIZATION OF PHYSICIAN-ASSISTED SUICIDE—AN AMERICAN COLLEGE OF PHYSICIANS POSITION PAPER

Framing the Issues: Care Near the End of Life

We all will die. How we die—and live at the end of life—is important, with implications for individuals, their families, and society. How we are cared for at the end of life matters.

The groundbreaking 1997 report *Approaching Death: Improving Care at the End of Life*, by the IOM, documented inadequate end-of-life care in the United States (1). In 2000, the SUPPORT investigators agreed (2, 3). Although the cultural norm of fighting disease aggressively is the right approach in many cases, the emphasis by medicine, as well as society, on intervention and cure sometimes comes at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining—physically, emotionally, and financially—for patients and their families. Many of us have concerns or apprehensions about how we will die. Indeed, some patients receive unwanted care at the end of life, whereas others do not receive the care they need (4–6). Although medicine now has an unprecedented capacity to treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle to get it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revisiting these issues in 2014, the IOM report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* found that challenges remain in delivering quality end-of-life care to a growing and diverse elderly population, especially regarding access to care, communication barriers, time pressures, and care coordination (7). Inadequate reimbursement and other disincentives also create barriers to palliative and hospice care.

Appendix Table. U.S. Jurisdictions Where Physician-Assisted Suicide Is Legal

Where	When	How
Oregon	1997	Voter-approved ballot initiative
Washington	2008	Voter-approved ballot initiative
Montana	2009	Court decision*
Vermont	2013	Legislation
California	2015	Legislation
Colorado	2016	Voter-approved ballot initiative
District of Columbia	2016	Legislation

* A patient's request for physician-assisted suicide can be an affirmative defense for a physician who participates.

Wide agreement exists that hospice and palliative care may ease apprehension about the dying process. Such care requires improving access to, financing of, and training in palliative care; improving hospital, nursing home, and at-home capabilities in delivering care; and encouraging advance care planning and openness to discussions about dying. Of note, 90% of U.S. adults do not know what palliative care is, but when told the definition, more than 90% say they would want it for themselves or family members if severely ill (4).

Access to state-of-the-art symptom control remains limited for all dying patients. Of particular concern, evidence of ethnic and racial disparities in access, outcomes, and communication is increasing (5, 6). Many patients fear they will not receive appropriate end-of-life care when they need it. Others are concerned about being a financial, physical, or other burden on their family, losing autonomy or control, or being placed in a long-term care facility. Some are alone or lonely; loneliness has a mortality risk similar to that of cigarette smoking, yet its health implications are underappreciated (16). Many persons approaching death are clinically depressed or have other psychiatric comorbid conditions, and some contemplate suicide (17, 18). According to Wilson and colleagues, "the expression of a desire for death by a terminally ill patient should raise a suspicion about mental health problems; by itself, however, it is not definitively diagnostic of one" (17). This desire fluctuates over time (19, 20) and may be related to inadequate symptom management. Medicine can and should ameliorate many of these problems; some, however, are outside the scope or goals of medicine and should be addressed in other ways.

As challenges in providing palliative and hospice care continue, a few jurisdictions have legalized physician-assisted suicide (see the **Glossary** for definitions and the **Appendix Table** for U.S. jurisdictions with physician-assisted suicide laws). The ACP recognizes the range of views, depth of feeling, and complexity of the issue of physician-assisted suicide.

Revisiting Physician-Assisted Suicide

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). The issue also has been considered every few years in the *American College of Physicians Ethics Manual*, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient–physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

The Context

Physician-assisted suicide is medical help with a patient's intentional act to end his or her own life (for example, an individual taking a lethal dose of medication prescribed by a physician for that purpose). It is ethically, legally, and clinically different from patient refusal of life-sustaining treatment through the withdrawal or withholding of treatment. Physician-assisted suicide also differs from euthanasia, an act in which a physician intentionally terminates the life of a patient (such as by lethal injection), the purpose of which is to relieve pain or other suffering (8). Dictionaries define suicide as intentionally ending one's own life. Despite cultural and historical connotations, the term is neither disparaging nor a judgment. Terms for physician-assisted suicide, such as aid in dying, medical aid in dying, physician-assisted death, and hastened death, lump categories of action together, obscuring the ethics of what is at stake and making meaningful debate difficult; therefore, clarity of language is important.

Although suicide and attempted suicide have been decriminalized in the United States, assisting a suicide remains a statutory offense in most states. Euthanasia is illegal everywhere in the United States. In New Mexico, a lower-court decision authorized physician-assisted suicide, but it was struck down; like all appellate courts, the New Mexico Supreme Court ruled that there is no right to physician-assisted suicide. Elsewhere in the world, in 2015, the Parliament of the United Kingdom voted down a physician-assisted suicide bill, 330 to 118, and Canada legalized both physician-assisted suicide and euthanasia. In 2016, the Parliament of South Australia rejected a bill on euthanasia. Physician-assisted suicide and euthanasia are legal in the Netherlands, Belgium, and Luxembourg; euthanasia is legal in Colombia; and Switzerland has decriminalized assisted suicide.

Principles of Medical Ethics and Arguments, Pro and Con

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients based on the ethical principles of beneficence (acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient autonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient considers unduly burdensome and inconsistent with his or her health goals and preferences. Death follows naturally after the refusal, due to the underlying disease (9).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering. The decision to intentionally end one's life is regarded as intensely private and therefore should not be prohibited (10). Seeking physician-assisted suicide is most frequently associated with concerns about loss of autonomy and control, decreasing ability to participate in enjoyable activities, and loss of dignity, rather than pain or other symptoms (21, 22). For persons who seek this type of control, palliative and hospice care are not the issue—they often are already receiving those services. In Oregon, the state with the most experience, 1327 persons have obtained prescriptions for lethal doses of medications under the law since 1997; 859 died after taking the medication. Of 105 deaths during 2014, 68% occurred in persons older than 65 years, 95% were white, 56% were men, 48% were persons with a baccalaureate degree or higher, and 69% had cancer (21). More recent justifications present physician-assisted suicide as a personal choice, avoiding discussion of important medical ethics considerations (11).

Proponents of physician-assisted suicide view it as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). In support of legalization, they also argue that some patients receiving a lethal prescription ultimately do not use it. In addition, some maintain that physician-assisted suicide already occurs where it is illegal (23), so legalization would result in standardization, transparency, and monitoring.

Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort and that physicians should not participate in intentionally ending a person's life (12). Physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter

(13). Pronouncements against physician-assisted suicide date back to Hippocrates.

Opponents agree that patient autonomy is critical and must be respected but recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient–physician partnership. Only by such a balance of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write illegal prescriptions, or breaches confidentiality to protect public health. It also undergirds the duty that physicians not engage in futile care (for example, care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

Death certificate requirements under physician-assisted suicide laws ask physicians to list the cause of death as the underlying illness, not the new pathology caused by ingestion of a lethal dose of medicine (24), which seems inconsistent with the physician's duty of honesty. Moreover, although individual physicians may decline to participate, conscientious objection to physician-assisted suicide does not address the fundamental ethical objections to it.

The suffering of dying patients may be great; it is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering; attempting to do so ultimately leads to bad medical care (25). Good medicine demands compassion for the dying, but compassion also needs reason (26). Both proponents and opponents wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other ethical principles reflects arguments about the nature of the patient–physician relationship, physicians' duties, and the role of the medical profession in society. In fact, one may argue that making physicians arbiters of assisted suicide is a return to paternalism and not a power physicians should want (27), that "the legalization of physician-assisted suicide does not empower patients; it empowers physicians" (28).

Legalization of physician-assisted suicide also raises social justice issues. Society and the medical profession have duties to safeguard the patient–physician relationship and human dignity. These duties apply especially to the most vulnerable members of society: the sick, the elderly, children, the disabled, the poor, minorities, and others. Some individuals might view themselves as unproductive or burdensome and, on that basis, as candidates for assisted suicide, especially if a physician raises it or validates a request. Physician-assisted suicide laws have been associated with a 6% increase in total suicides (15% in those older than 65 years) in the states where physician-assisted suicide is legal, controlling for state-specific time trends (29, 30). Although a recent study did not find vulnerable groups being pressured to accept physician-assisted suicide, it did raise questions about a lack of data on complications and on how many physicians may have assisted without reporting (31). Vulnerable communities and individuals raise strong concerns that legalization leads to attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living (32, 33). National disability groups are opposed to physician-assisted suicide (32, 34). One article reported various opinions among focus group participants (35). Finally, advocating for physician-assisted suicide where there is no general right to health care and access to hospice and palliative care services is limited, especially in an era of health care cost containment, is ironic (8).

Ethics and the Nature of the Patient–Physician Relationship

The ACP's main concerns in this debate are ethical ones. The patient–physician relationship is inherently unequal. Physicians have specialized medical knowledge, training, experience, and prescribing powers that patients do not. Illness makes patients vulnerable (including physicians who are patients [36, 37]). Patients disrobe, are examined, and disclose intimate information to their physicians. The physician must earn the patient's trust, preserve his or her confidentiality, and act as a fiduciary. Physicians publicly profess that they will act for the benefit of their patients, putting patients' welfare and best interests first and helping them cope with illness, disability, suffering, and death. The physician has a duty to respect the dignity and the cultural and spiritual uniqueness and traditions of every patient (9).

Physician-assisted suicide and euthanasia were common during the time of Hippocrates, leading to their specific prohibition in the Hippocratic Oath (38). Together with the prohibition of sexual relationships between physicians and patients and the duty to maintain patient confidentiality, the Oath provides a context for a therapeutic alliance to prevent the exploitation of patient relationships.

The Hippocratic Oath, of course, is not followed word for word today; however, it has been analyzed and applied over time in light of its fundamental principles. Acting in the best interests of the patient and recognizing the special nature of the patient–physician relationship, principles and prohibitions set ethical boundaries to prevent misunderstandings and misuse of medical authority. These boundaries encourage patients to be open and honest regarding intimate health matters in a safe space, in the context of a trusted relationship.

Physicians can influence patients, even in ways physicians may not appreciate. Patients seeking physician-assisted suicide may seek validation to end their lives. Indeed, studies have shown that socially isolated, vulnerable persons seek social support and contact through visits with their physicians (16). Physicians may influence patients based on their own fears of death and disability (39). Evidence also suggests that many physicians who participate in physician-assisted suicide are adversely affected by the experience (40). Some commentators question whether assisted suicide needs to be physician assisted and whether others might provide assistance instead (41).

The Ethics of Refusal of Treatment and Providing Symptom Control: A Closer Look at Intent and Causation

For decades, the consensus has been that after a careful weighing of patient autonomy, beneficence, nonmaleficence, and societal interests, a patient may forgo life-sustaining treatment. Although Hippocratic writings explicitly proscribe euthanasia and physician-assisted suicide, they deem treatment abatement ethically appropriate in patients who are "overmastered by disease" (42). Although some lower courts have questioned the importance of this distinction (43), the U.S. Supreme Court has distinguished the refusal of treatment from suicide (44, 45). Withdrawal of treatment based on patient wishes respects the patient's bodily integrity and right to be free of unwanted treatment. Physician-assisted suicide and euthanasia are interventions done with the intent to end the patient's life (46, 47). This distinction is ethically and legally important (9).

Some argue that withdrawing treatment on the basis of patient wishes—an omission, such as forgoing a mechanical ventilator in a patient with respiratory failure—and prescribing a lethal dose of medicine for the patient's use—a commission—are equivalent, because they both are acts that lead to the patient's death. However, commission (doing something) versus omission (not doing something) is not alone determinative. Withdrawing ventilator support is an act, but the act merely removes an intervention that prevented a preexisting illness from running its course. The aim of the act is not to terminate the patient's life (47). Intent and causation are critical factors in distinguishing physician-assisted suicide from withdrawal of life-sustaining treatment.

Death may be accelerated if a patient requests withdrawal of a life-sustaining treatment and that request is carried out. However, the patient could have refused the treatment when it was originally offered; therefore, he or she may request its withdrawal after it is started. If not for the intervention to which the patient consented, death would have occurred as a result of the underlying disease. As the International Association for Hospice and Palliative Care, citing the European Association for Palliative Care, stated, "Withholding or withdrawing ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments does not constitute euthanasia or PAS [physician-assisted suicide] because it is not intended to hasten death, but rather indicate the acceptance of death as a natural consequence of the underlying disease progression" (48).

The intent of treatment refusal is freedom from an unwanted intervention. A natural death follows due to the underlying disease (in fact, imposing unwanted treatment is a bodily invasion and is considered unethical and an illegal battery). In contrast, if a person disconnects a ventilator without patient consent and the patient subsequently dies, that person has acted wrongly. In both instances, the patient dies after withdrawal of life-sustaining treatment, but in very different ways under ethics and the law. Death by medication overdose is not a natural death due to an underlying medical condition.

Research advances have introduced new life-sustaining technologies into clinical practice. For example, many patients have life-sustaining devices, such as pacemakers, implantable cardioverter-defibrillators, and ventricular assist devices. Physicians inevitably encounter patients whose underlying disease no longer is being treated effectively by the device or who have a terminal illness the device cannot treat (such as cancer). Desiring a natural death, patients or their surrogates may request withdrawal of therapies delivered by these devices. In these situations, the death that follows is due to the underlying heart disease or other comorbid conditions (49, 50). Physicians should honor these requests. However, without a firm line drawn between withdrawal of life-sustaining treatment and physician-assisted suicide, or because of confusion between the two, some physicians might consider discontinuation of these therapies as intentional killing and refuse to implement such requests. Patients and families often, but not always, see the line.

Intent and causation also are critical factors in providing pain or symptom relief. Competent provision of symptom control is an ethical duty (9). Patients often fear the prospect of unrelieved pain. Some physicians withhold pain medication because of ungrounded concerns that higher doses may accelerate death through respiratory suppression or that the patient may become addicted to the medication. Appropriate pain relief, however, rarely results in either (51, 52), and patients and families need to understand this (52). Under the rule of double effect, strong ethical support exists for increasing pain medication for terminally ill patients if the intent is to relieve pain, even if it might shorten life (9, 53, 54).

The rule of double effect holds that an action undertaken with the intent of achieving a benefit is morally acceptable even if it has a harmful side effect, provided that the harmful side effect is not intended, the side effect is not the cause of the benefit, and the benefit outweighs the harm. Vigorous management of pain and symptoms, such as dyspnea and nausea, at the end of life is ethical, even if the risk for shortening life is foreseeable, if the intent is to relieve those symptoms. The beneficial effects are pain and symptom control; the rare but potential harmful effect is respiratory suppression, but it is not intended. If the intent was to cause death, or to cause death to relieve pain, it would not be permissible. Likewise, it would not be in keeping with the rule of double effect to use pain control to "treat" loneliness, depression, being tired of living, or existential suffering.

Law and Ethics: U.S. Supreme Court Decisions on Assisted Suicide

Although the language of rights is sometimes invoked, there is no right to physician-assisted suicide in the United States. In fact, in landmark decisions, the U.S. Supreme Court overruled 2 lower courts that had found a constitutional right (45, 55). The lower-court rulings differed in important ways. In *Compassion in Dying v. Washington* (56), the U.S. Court of Appeals for the Ninth Circuit had held that persons have a right to choose how and when they die. As applied to the limited circumstance of the competent, terminally ill adult who wants a physician's prescription for a lethal dose of medication, the Washington State criminal statute banning physician-assisted suicide was found unconstitutional as a violation of the Due Process Clause of the 14th Amendment, which says a state may not "deprive any person of life, liberty, or property without due process of law."

In contrast, in *Quill v. Vacco* (43), the U.S. Court of Appeals for the Second Circuit specifically declined to "identify a new fundamental right." It said a New York law was unconstitutional on much narrower grounds, as a violation of the Equal Protection Clause of the 14th Amendment, because competent patients at the end of life were being treated differently: Some patients could refuse life-sustaining treatment and thereby accelerate death, but others were prohibited from seeking prescriptions from physicians to hasten death. The Equal Protection Clause says that no state shall "deny to any person within its jurisdiction the equal protection of the laws."

The U.S. Supreme Court found both lower-court decisions unpersuasive. Instead, it found refusal of treatment and physician-assisted suicide to be very different. Refusal of treatment, the Court concluded, means being free of the bodily invasion of unwanted medical treatment—a right to be left alone, not a right *to* something. This is a "negative right"—a form of right of which Americans have many—and differs from a positive right to secure assistance to kill oneself and control the manner and timing of death. Lending support to the rule of double effect, Justice Sandra Day O'Connor pointed out in her concurring opinion that vigorous pain control for the dying is ethical and available: " . . . a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death." This would include what some refer to as palliative sedation or terminal sedation, although a more accurate term would be double-effect sedation.

The U.S. Supreme Court ruled that there is no constitutional right to assisted suicide and that states may prohibit it. However, the Court also left open the possibility that individual states could legalize it.

Slippery Slopes

Although the ACP's fundamental concerns are based on ethical principles, research suggests that a "slippery slope" exists in jurisdictions where physician-assisted suicide and euthanasia are legal. In the Netherlands, requests are granted for patients whose "medical condition" is categorized as "tired of living." Many patients report "loneliness" and "psychological suffering" as symptoms (57). One study found that persons receiving euthanasia or physician-assisted suicide in the Netherlands for psychiatric disorders were mostly women with complex and chronic psychiatric, medical, and psychosocial histories, and disagreement about patient eligibility among physicians was not unusual (58, 59). In Oregon, referrals for psychiatric evaluations have been infrequent (60); in 2014, only 3 of 105 persons who died under the law were referred for formal psychiatric or psychological evaluation. In a study from Belgium, death by euthanasia increased from 2% in 2007 to 5% in 2013. Similarly, approvals of euthanasia requests increased from 55% in 2007 to 77% in 2013 (61). An editorial said these trends were "worrisome" and "require that [the slippery-slope concern] be taken very seriously" (62).

A recent review found that safeguards and controls in jurisdictions where physician-assisted suicide and euthanasia are legal are not always followed (63), and concerns have been raised about underreporting (31). Subtle long-term changes in attitudes are difficult to detect. For example, although only a small number of persons have requested physician-assisted suicide in Oregon, as noted earlier, questions arise regarding whether that fact lessens these and other concerns.

Limiting physician-assisted suicide to the terminally ill is said to be a safeguard, but prognostication raises practical concerns. Laws such as Oregon's require a consultation from a second physician to confirm the diagnosis and prognosis. However, predicting how long a terminally ill patient will live or to what extent cognitive capacity will be impaired by disease or injury often is difficult. In addition, many patients do not have long-standing relationships with physicians who know them well. Furthermore, current safeguards are likely to be challenged. Restricting physician-assisted suicide to terminally ill adults with decision-making capacity raises legal concerns about arbitrary discrimination (64). Fairness, it may be argued, would require granting access to decisionally incapable and non–terminally ill persons. Also, because some patients cannot take pills, arbitrary discrimination could be asserted, unless the practice is broadened from physician-assisted suicide to euthanasia.

Dying Well: Moving From Medicalization to Personalization of Death

Is a medicalized death a good death? Have we already gone too far down a path in which dying patients receive unwanted technology in the intensive care unit while their family members are regarded as "visitors"? Is the solution medicalization of death through medication overdose? Physician-assisted suicide is not a therapy. It runs counter to the goal of the patient rights movement to empower patients to experience a more natural death.

Medicalizing death does not address the needs of dying patients and their families. What is needed is care that emphasizes *caring* in the last phase of life, facilitating a natural dying process, and humanizing institutions that are used only when those settings are unavoidable. The 3 Wishes Project shows how even simple, nontechnologic approaches in the hospital intensive care unit can improve care, ease dying, enhance dignity, and give voice to patients and families while deepening the sense of vocation among clinicians (65). The 3 Wishes researchers said the project

> . . . aimed to integrate palliative care and spiritual care into critical care practice. Eliciting and honoring wishes fostered a community of caring, promoting patient- and family-centeredness as a core component of palliative care. It encouraged the verbalization and realization of unmet spiritual needs, whether secular or faith-based. Our findings underscore the drive that we all have to search for meaning, memories, and closure in anticipation of death while helping to create preparedness, comfort, and connections during the dying process (65).

In "A Modern Ars Moriendi," a physician recounts the death of her rancher father, noting the challenges they faced trying to refuse hospital treatment. Ultimately, his wishes were met by going home and changing the "focus from life-prolonging technology to life-enriching community" (66). Earlier hospice care, avoiding the intensive care unit in the last month of life, and experiencing death at home are associated with family perceptions of better care for cancer patients (67). Studies have found regional variations in end-of-life care, with "little relationship to patient preference," but some evidence of lower-intensity care when the primary care physician is more involved in care (68). Longitudinal relationships should be valued and supported by health care systems and payers.

Home is where most patients want to die (69), and even the discontinuation of ventilators (70) or implantable cardiac devices (71) can be done compassionately and effectively at home with hospice care. This approach is more patient centered and a better use of resources when hospital care is not truly necessary. This is the control the medical profession can and should give patients and their families. Dying well requires science and an art of caring for the dying.

Medicine's Role in a Societal Decision

The ACP recognizes that some patient cases will be medically and ethically challenging, that autonomy-based arguments in support of legalization of physician-assisted suicide are compelling, and that some might find physician-assisted suicide justifiable in rare circumstances. Patients have the ultimate authority over their lives, but whether physicians should assist them in carrying out suicide is another matter.

Despite changes in the legal and political landscape, the ethical arguments against legalization of physician-assisted suicide remain the most compelling. We are mindful that ethics is not merely a matter for a vote. Majority support of a practice does not make it ethical. Medical history provides several cautionary examples of laws and practices in the United States (such as racial segregation of hospital wards) that were widely endorsed but very problematic.

Furthermore, the ACP does not believe neutrality on this controversial issue is appropriate. The medical profession should not be neutral regarding matters of medical ethics (9). The ACP is not neutral on practices that affect the patient–physician relationship and trust in the profession, such as laws that restrict or mandate discussions with, or certain recommendations for, patients. According to the *American College of Physicians Ethics Manual*, physicians have a duty to come forward, to "clearly articulate the ethical principles that guide their behavior in clinical care, research, and teaching, or as citizens or collectively as members of the profession. It is crucial that a responsible physician perspective be heard as societal decisions are made" (9).

A few patients want to control the timing and manner of death; many more are fearful of what living the last phase of life with serious illness will be like. To the extent that the debate about legalizing physician-assisted suicide is a dilemma because of the failings of medicine to adequately provide comfort and good care to dying patients, medicine should do better. Legalized physician-assisted suicide medicalizes suicide (72). Physician-assisted suicide is not a private act but a social one, with effects on family, community, and society.

Responding to Patient Requests for Assisted Suicide

Etymologically, to be compassionate means to "suffer with" another person; remaining with a dying patient is the essence of nonabandonment (73). When the patient's suffering is interpersonal, existential, or spiritual, care coordination is necessary, and the roles of the physician are to remain present; provide compassionate care; and enlist the support of social workers, psychologists, hospice volunteers, chaplains, and family in addressing sources of suffering that are beyond the scope of medical care.

Regardless of jurisdiction, physicians may encounter patients who request physician-assisted suicide (or express fear of suffering with death). Patient concerns and reasons for the request should be discussed thoroughly. As for all patients nearing the end of life, the physician should:

1. Be present (74), listening to the patient and keeping dialogue open, exploring the reasons for the request, trying to understand its meaning and seeking alternative solutions where possible.
2. Affirm that he or she will care for and not abandon the patient, accompanying and advising the patient through the journey of end-of-life care (studies suggest "the desire to hasten death is future focused and appears to be related to fear of distress and not coping, rather than with current levels of distress or coping ability" [75]).
3. Discuss patient goals of care and the nature of curative and comfort care, explaining a both/and approach to disease-oriented and palliative care as well as an either/or approach and asking, for example, how do you hope I can help you?
4. Facilitate advance care planning and an understanding of surrogate decision making, as desired by the patient.
5. Ensure that the patient is fully informed of the right to refuse treatments and what that entails.
6. Discontinue or do not start medications and interventions that interfere with the patient's values, goals, and preferences.
7. Assess and treat the patient's pain and other distressing physical and psychological symptoms.
8. Assess and optimize patient function through a whole-patient focus.
9. Coordinate, as desired by the patient, the efforts of other members of the health care team, and use community-based resources to address financial, emotional, and spiritual burdens on the patient and family.
10. Prepare the patient and family for what they can expect as illness progresses, addressing uncertainty together and ensuring that the patient and family have informed expectations, including, for example, an understanding that advanced illness often entails a natural loss of appetite and thirst.
11. Regularly assess the patient's status and decision-making capacity.
12. Arrange hospice care at home if that is the patient's preference, being cognizant that palliative and hospice care expertise should be used as early as is indicated. Many patients in the United States receive such care too late or not at all.

Requests for physician-assisted suicide are unlikely to persist when compassionate supportive care is provided (76, 77). However, providing this care may be challenging, especially in today's time-pressured health care environment. It requires us to reflect and act on " . . . the original purpose of physicians' work: to witness others' suffering and provide comfort and care . . . the privilege at the heart of the medical profession" (78).

Physicians should consult with colleagues in caring for the patient and family but also seek support for themselves. According to Kearney and colleagues, "Self-care is an essential part of the therapeutic mandate" (79). Collegial support also reinforces better care of the patient and family. Describing a phone conversation with a colleague about the shared care of a patient, a physician reflects that it was, "A call whose sole but worthy purpose was to say, 'I feel powerless, and I know you do, too, so let's talk this over.'" Yet, it " . . . allowed two physicians to share . . . and reconcile to the inevitable. All too often, we announce our triumphs but camouflage our losses, as if the death of a patient represents a personal failure. In hindsight, acknowledging the impending loss enabled appropriate palliation for the patient and timely pastoral care for her husband . . . " (80).

The need to ensure the central role of families in care; provision of consistent, high-quality care; and education, training, and support of physicians were identified as overarching themes in a series of reports on end-of-life care recently issued by the British Medical Association (81). The British Medical Association and Australian Medical Association both reaffirmed opposition to legalization of physician-assisted suicide and euthanasia in 2016.

Conclusion

The art of medicine is arguably most needed as patients live out the last phase of life. Society's goal should be to make dying less, not more, medical. The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all persons can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and the management of pain and other symptoms, and support for family. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter. Throughout patients' lives, including as they face death, medicine must strive to give patients the care, respect, and comfort they deserve.

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February 25, 2020

Senate Judicial Proceedings Committee
Miller Senate Office Building
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Annapolis, MD 21401

Re: Senate Bill 701 and House Bill 643-- "End-of-Life Option Act"

Dear Honorable Senate Judicial Proceedings Committee Member,

The American College of Physicians (ACP) writes to you to express our opposition to Senate Bill 701 and House Bill 643 ("End-of-Life Option Act"). ACP is the largest medical specialty organization and the second-largest physician group in the United States with over 154,000 members. Our Maryland Chapter has 2600 members. As physicians, we oppose these bills because they will harm patients, the patient-physician relationship, and trust in medicine. They are also discriminatory toward our most vulnerable patients.

Physician-assisted suicide (PAS) bills use terms like "aid-in-dying" that are confusing and obscure what is at stake when physicians are asked to help bring about a patient's death. This is very different than the patient's right to refuse treatment which we strongly support. ACP does not support legalization of physician-assisted suicide (our position paper is attached) and we again reaffirmed this in our *Ethics Manual* (seventh edition, 2019). The American Medical Association and the World Medical Association have also strongly reaffirmed their opposition to physician-assisted suicide.

We are deeply sympathetic to the concerns and fears patients and their families have at the end of life. The physician must fulfill her or his ethical obligations and always act in the best interests of the patient as healer, comforter, and trusted advisor. Often, lack of awareness of the care that physicians and others can provide to dying patients and fears that patients will not have access to this care drive interest in PAS. It doesn't have to be that way. Research shows many individuals do not know what palliative care is but when it is described, they overwhelmingly respond that they would want it if they were severely ill. Palliative and hospice care have not received the attention PAS has received. We can do better.

We need to ensure that all patients know they will be well cared for at the end of life, not medicalize suicide. The highest priorities for the care of dying patients should include the alleviation of pain and other symptoms, a team approach to care, and strong support for the patient's right to refuse treatment, including life-sustaining treatment. Patients often fear pain at the end of life, but physicians have an ethical obligation to treat pain with competence and compassion. Vigorous management of pain at the end of life is ethically acceptable even when the risk of hastening death is foreseeable, if the intent is to relieve pain: the *ACP Ethics Manual* states that "…the physician may appropriately increase medication to relieve pain, even if this action inadvertently shortens life" and this has been consistently supported by US courts.

We note the irony of legalization of PAS given continuing disparities in access to and delivery of health care. Patients, especially those in minority communities and the disabled, have deep concerns about legalization and the message it sends about the value of their lives and their ability to get the palliative and hospice care they want. Vulnerable communities raise extremely valid points that legalization leads to "attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living" as we discuss in our paper. The pressures on individuals to not be a "burden" are real.

Physician-assisted suicide is not medical therapy. We hope you will join ACP in advocating that those who seek suicide with a physician's help instead be provided with the care and compassion that can alleviate suffering and reaffirm our commitment to all patients. The best medical care for patients throughout life, including the last phase of life, requires our full attention. In this way, physicians can fulfill their ethical responsibilities and give dying patients and their families the care, compassion, and comfort they need and deserve. No Marylander, or any other American, should have to fear an undignified or pain-filled life or death.

Thank you for the opportunity to comment. Please let us know if you have any questions.
Sincerely,

Mangla Sood Gulati, MD, CPPS, FACP, SFHM

The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

MDPAS Tom Steffens_UNF_SB701

Uploaded by: STEFFENS, TOM
Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act. Good Morning. My name is Tom Steffens. I am a former Navy Seal and a retired Rear Admiral.
My purpose today is to highlight the negative impact legalizing assisted suicide will have on our Veterans.
As you know, suicide among active duty and veterans is off the scale.
The national average for civilians is 16 suicides per 100,000.
For Veterans it is 30 per 100,000.
And the suicide rate for women veterans is TWICE that of their civilian counterparts.

Every veteran group that I have talked to about assisted suicide has had the same reaction. WHAT ARE WE DOING? What did we fight for?

So, I leave you with THREE TAKEAWAYS.

First, our state veterans programs and our civilian veterans organizations (like the Navy SEAL Foundation or AMVETS) fight every day to bring vets back into community and prove to them their lives matter – something millions of vets with PTSD and TBI struggle with everyday .

If we legalize assisted suicide it sends a CLEAR and OFFICIAL SOCIETAL MESSAGE that all lives are NOT important. That can't stand.

Secondly it says**: SUICIDE is OK!** But of course we know that every soldier suicide comes with nothing but pain and agony for the family, his friends, her platoon mates and for the society as a whole. It's not compassionate, it's horrible.

Finally, as proof of these impacts, in Oregon where assisted suicide has been legal for 20 years, the veteran suicide rate is 25 % higher than the national average. Those are real lives, real families, and real defenders of our way of life.

I know you see the far reaching and unintended impacts of legalization and
ask you to turn your time, power and authority to provide even better treatment and care for all our citizens. Not to kill them.

Thank you for your time and God bless you for YOUR SERVICE. I share your oath.
I know what you're doing is NOT easy.

MDPAS Christine Sybert_UNF_SB701

Uploaded by: Sybert, Christine

Position: UNF

Statement to the Senate Judicial Proceedings Committee
Re: Senate Bill 701 – "End of Life Option Act"
Thursday, February 27th, 2020
OPPOSE

As a pharmacist, I took an oath and promised to consider the welfare of humanity and relief of suffering my primary concerns. People suffering from terminal illnesses certainly do suffer… as do their families. I have seen this in my 25 years as a clinical pharmacist. However, legalizing physician-assisted suicide is not acceptable medical care. As one patient admitted, it is the coward's way out. It leaves the door open for abuse and coercion, especially with the risk of labeling those who are elderly and disabled as lacking dignity and functionality, and hence eligible for government-sanctioned physician-assisted suicide. There is also a possibility for **drug diversion**, something that Maryland is already struggling too much with!

Medicine is an art, a practice, not an exact science. Often, patients who are given a 6-month life expectancy go on to survive several years. Many of them also continue to live with an acceptable quality of life. However, we must be careful not to equate functionality and quality of life with dignity.

Oregon's latest report on the "Death with Dignity" Act lists the top concerns patients have with end-of-life issues.[1] ***All are all based on fear.*** Losing autonomy (91.7%), less able to engage in activities making life enjoyable (90.5%), loss of dignity (66.7%), and burden on family, friends/caregivers (54.2%) were the top reasons. (Noteworthy was that inadequate pain control or concern about it was low, only 25.6%.) So the driving force behind seeking physician assisted suicide is fear. Fear of what life will bring and fear to take responsibility for one's own actions… hence seeking to call it something besides suicide or assisted suicide.[2] A story about Robert Good, who was a patient suffering from throat cancer, posted on the Compassion & Choices website, illustrates these fears perfectly.[3] He and his life partner, Eve Syapin, discussed the aspects of his terminal illness. "Death With Dignity gives an individual the dignity to go knowing he hasn't done anything wrong," Robert said. "He alleviated his pain and suffering and maybe shortened his life, but when you get to the point where there is no quality — what's the point?" Eve discussed her fear of seeing him suffering, stating, "One way or another, it's [his death from cancer] going to happen, and I'd rather see him go in peace." Robert offered his own opinion. "I think I'm a chicken shit," he said. "A big coward, and that's why I have an option." Yet, in the end, he chose not to use the lethal dose of secobarbital that he had stored on the shelf. "The doctor is right. It doesn't hurt to die," Robert told Eve. "It's OK." She said, "Then he went real peaceful." Fear was the driving force behind Robert's desire to have a lethal dose of secobarbital available, yet he found that it wasn't even necessary. And so did Eve. Shouldn't we be offering people better palliative and supportive care? Help them to face death, not with fear and despair and as an escape from life, but rather as the natural event that it is.

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[1] https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year21.pdf
[2] Maryland Senate Bill 701 "End-of-Life Option Act"
[3] https://www.goskagit.com/news/award-winning-coverage-his-final-choice/article_eb7a11c2-803f-11e1-8dd0-001a4bcf887a.html

Physician-assisted suicide is not a "natural cause" of death, and it is dishonest to consider naming it anything otherwise. We have an innate desire to survive, to fight to live. While it is natural to die, it is unnatural to *want to* die. Anyone who wants to die, and seeks sanctioning from the state to permit them to do so, is suffering from a mental disorder of depression or hopelessness. The terminally ill population is already psychologically vulnerable, as evidenced in a prospective study of 92 terminally ill cancer patients at Memorial Sloan-Kettering Cancer Center. Breitbart et al found that "***among patients who were neither depressed nor hopeless, none had high desire for hastened death***, whereas approximately one fourth of the patients with either one of these factors had high desire for hastened death, and nearly two thirds of patients with both depression and hopelessness had high desire for hastened death" (emphasis added).[4] Why should we not focus on providing better hospice, palliative, and supportive care for those who suffer with a terminal illness, rather than encourage them to "jump off the bridge"? Proponents of this legislation would say they are simply trying to provide "autonomy" and end-of-life "options" for those who are suffering. Don't fall for these euphemisms… even though the patient is "self-administering" the medications, let's call it what it is: government-sanctioned euthanasia for the terminally ill.

This legislation will serve to increase the suicide rate. The latest CDC data indicates that there were 630 suicides in Maryland in 2017 (up from 586 in 2016), for an age-adjusted rate of 9.8 per 100,000.[5] While this is less than the national average (14.0%), shouldn't our efforts be to reduce the number of suicides even further, not promote it? If you doubt that passage of these bills will encourage nonassisted suicides, consider what Drs. Jones and Paton found when they evaluated the rates of suicide in the first four states that legalized physician-assisted suicide compared to twenty-five states with suicide data that have not. If physician-assisted suicide were to be beneficial, you would expect to find a reduction in total suicides and a delay in those that do occur, since patients will feel that they have more control over their life… and their deaths. On the contrary, there was a significant (6.3%) increase in total suicides and no reduction in the rates of nonassisted suicides. "***The introduction of physician-assisted suicide seemingly induces more self-inflicted deaths than it inhibits***" (emphasis added).[6] If the anticipated increase in suicides of 6.3% from passage of this legislation is included, then an additional 40 all-cause suicides (including assisted) will occur with a new total of 670 suicides. Is this the medical care we want to provide to Marylanders?

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[4] Breitbart W, Rosenfeld B, Pessin H. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. JAMA 2000;284:2907-2911.

[5] Kochanek et al. Deaths: Final Data for 2017. National Vital Statistics Reports. US Department of Health and Human Services. Vol. 68 No. 9, June 24, 2019. Page 53.

[6] Jones DA and Paton D. How Does legalization of physician-assisted suicide affect rates of suicide? Southern Medical Journal. 2015;108:599-604.

No healthcare provider is required to be in attendance. This puts the patient at risk for side effects. The barbiturates secobarbital and pentobarbital are the top two drugs prescribed for lethal overdoses.[7] Both are DEA schedule C-II medications. These are given in 9 gram or 10 gram doses, respectively, which is 90-100 times the recommended dosages of 100mg at bedtime to aid in sleeping. Nausea and vomiting are common with these overdoses, so a medication called metoclopramide is often prescribed to be taken one hour before the lethal dose is to be taken in an attempt to reduce this side effect from the overdose. In addition, the contents of 90 capsules of secobarbital must be opened up before being taken, as the patient may pass out before consuming the full overdose. Both medications should be mixed with juice to mask the bitter taste. Additionally, morphine – an opiate – was used more commonly in Oregon in 2017-18 than in the past due to price increases from drug shortages and European Union bans on importing the barbiturates to the U.S. because of E.U. prohibitions on their use for capital punishment.[8] With all these drugs, death occurs by respiratory arrest. The intention is to die, but what happens if the patient doesn't die right away? In Oregon, the range of onset of death after taking the overdose is 1 minute to 4.3 days, and in 2018, one patient even awoke after the overdose![9]

Drug diversion is also a concern. Over one-third of the lethal prescriptions written in Oregon in 2018 were not used, either because the patient changed their mind, they died before committing suicide, or the ingestion status was unknown. What happens to these "leftover" prescriptions? They are supposed to be disposed of "lawfully" once filled, but there is also a great possibility that some will be diverted. As the rest of medicine is trying to reduce the prescriptions written for controlled substances – especially opiates, why would Maryland want to legalize a practice that leaves dangerous medications unaccounted for?

The American Medical Association[10] and the American College of Physicians[11] continue to oppose physician-assisted suicide because of the ethical issues and confusion that can occur with physicians participating in a patient's death.

In the healthcare insurance industry, a dead patient is the most cost-effective patient of all. Will insurance companies notify patients once they are diagnosed as terminally ill that physician-assisted suicide is an option for them? Yes. It happened to at least one woman in California. [12] After initially approving her chemotherapy treatments, within one week of California's passing the assisted suicide legislation, Stephanie Packer, a 32-year old wife and mother of four, received a letter from her insurance company denying her chemotherapy coverage. When trying to obtain clarification, she was told that they would pay $1.20 for her end-of-life prescription. "As soon as this law was passed, patients fighting for a longer life

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[7] Fass J, Fass A. Physician-Assisted Suicide: Challenges for Pharmacists. Am J Health Syst Pharm. 2011;68:846-849.
[8] https://www.deathwithdignity.org/faqs/
[9] https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year21.pdf
[10] https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide
[11] https://www.acponline.org/acp-newsroom/opposition-to-legalization-of-physician-assisted-suicide
[12] http://www.catholicnewsagency.com/news/insurance-denied-her-chemo-treatment-but-it-covered-drugs-for-suicide-46828/

end up getting denied treatment, because this will always be the cheapest option… it's hard to financially fight," Packer said.

What if a family is in a situation where finances are tight, medical bills are piling up from caring for the sick patient, who is now declared terminally ill. It could lead to coercing of the terminally ill and disabled into thinking that they, and their family, are better off dead. This coercion may not be picked up in the 15-20 minute office appointment that the patient has with their physician. Yes, some safeguards have been entered in the bill, but those with dishonest intentions can find a way to work around them. Is this an acceptable risk to take?

The lack of a requirement to notify next of kin raises several issues. Those who are terminally ill often fear "becoming a burden" (54.2% in Oregon did in 2018). This bill allows them to commit suicide without ever discussing their fears with their family, fears that may be completely unfounded. The opportunity to serve others, especially parents or grandparents who have given much to the children and grandchildren over the years, often provides a meaningful exchange and fond memories after the loved one has passed away. If that is snatched from them, then they are denied that chance to serve and care for their loved one, all because of a misunderstanding that was enabled by this law.

Does relief of suffering mean avoid suffering at all costs? How many of us have suffered something tragic… yet after getting through that time period, you reflect back and realize that some of your greatest lessons and accomplishments were as a result of what seemed a tragedy at the time?

In closing, I would like to quote Monica Canetta, a teacher & columnist, "***What matters in life is not 'doing something' but allowing oneself to be loved.***" Those who are terminally ill offer an opportunity for all of us to care for them and show them our love. Don't let a few voices claiming to offer false "compassion" and "choices" take that opportunity away from us.

Christine Sybert

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MDPAS Nancy Weisman_UNF_SB701

Uploaded by: WEISMAN, NANCY

Position: UNF

Nancy Weisman, Ph.D.
February 27, 2020

Please **REJECT** SB701, HB643 Physician Assisted Suicide!

This law is about ending life, not improving life up to the very end.

Physician assisted suicide provides no “relief” that is not already available, as the soaring suicide statistics show. Suicide is difficult to prevent and far too easy to accomplish without assistance.

Relatively few people apply for PAS and, even fewer actually use it. But everyone is harmed by the social approval for suicide explicit in the law - that is what makes it so **destructive** - reaching everyone, everywhere. Sanctioned suicide affirms suicide as a reasonable answer to life’s problems. Though the law specifies only the problem of terminal illness, we know from sad experience that the social signaling is far broader. It cannot be excluded as a factor driving suicide rates up.

As a psychologist, I’ve been trained to respond to suicidal thoughts and actions as cries for help - and we can help. Most people **will find meaning, purpose and joy in their lives after suicidal despair**. Even for those with terminal illness and little time left, therapies devised by palliative psychiatrists like William Breitbart and studied by psychologists like Annette Stanton help patients find hope and purpose in the time remaining to them. Not only is this valuable, perhaps invaluable, to the patients themselves, it **benefits their families and the entire community.** Perhaps it benefits the children most of all. The emotional consequences of a completed suicide for the family and community are devastating and long lasting. Our children are watching and listening. We must let them know that **we are there for them** - suicide creates, not solves, problems.

Please consider three malignant consequences of this legislation: **Contagion**, **Progression**, and **Collateral Damage**.

Incidents of suicide without assistance increase once legislation like this is passed, as if it were **contagious.** Oregon’s general suicide rate increased by over 40% after the legislation passed. Then, there is **progression**. In Belgium, they have gone from “assisting death” for the terminally ill to the healthy old to the depressed and, recently, to children - children with chronic disease. One was 11 years old with cystic fibrosis, euthanized just a few years before the treatment became available. The children die by the hand of the state at the request of their parents'. What is the impact on the family? On classmates?

And the impact is even broader and takes place "under the radar" in emergency rooms, ICUs, and nursing homes. The **collateral damage** to patients, doctors, and the practice of medicine.

Here are two examples of the confusion and damage already affecting doctors and medical care:

1) From the New England Journal of Medicine: A young doctor saved a toddler, beaten so badly her life was in danger - this happened twice. Though the baby's mother and grandmother were happy and grateful, the doctor titled her essay, "Will you forgive me for saving you?" The doctor worries, "Did I save you for a good life? Are you glad I did it?" This doctor is wondering if it would have been better let the baby die.
   - In this case, the doctor has done her job and done it well - if she also called Child Protective Services - but she thinks she's responsible for the unknown future.
2) From the Washington Post: A man arrived in the ER having been found in cardiac arrest. The young doctor and her team restored circulation - an uncommon achievement. Rather than proceed to stabilize him and send him up to the ICU for whatever the future might bring, the doctor halted the team and met with his wife and grown daughter. She told them, "His life of holding hands, his life of living is gone." "I needed them to understand that this wasn't their decision to shoulder. It was their time to respect… the man they loved." **His future was uncertain -** *until,* she told them something she could not yet know, and they ceased helping him live and let him die.
   - Here she did not do her job. She made a judgement call beyond her expertise. The signs she mentioned are not definitive. She ordered no further tests. It seems she thought healing was too limited a role. She thought she could tell the future.

Doctors need to know that their job is to heal. When they've done that they've done well. Their responsibility lies in the realm of the known and the possible - burn out is a consequence of ignoring human limitations.

Physician Assisted Death spreads a **contagion** of suicide, **progress**es to include ever more ***vulnerable*** people, and **damages** medicine, as well as communities, families, and individuals by its endorsement of **despair**.

Please ***don't let Maryland go there***. PLEASE stop this bill.
Thank you.

Nancy Weisman
8916 Ridge Place
Bethesda, MD 20817

1. Terry McGowan. NEJM, July 5, 2018,p.8
2. Cindy Winebrenner, Washington Post, February 5, 2017

MDPAS Edward Willard_UNF_SB701

Uploaded by: Willard, Edward
Position: UNF

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401
February 28th, 2020

Good afternoon, thank you for allowing me to speak in front of you. I am Edward Willard, in years past I had the honor of representing advocacy organizations for citizens with disabilities. This session, because of the wonderful phase in life called retirement I am in front of you as a private citizen of Maryland. I am also a member of the Maryland Against Assisted Suicide Coalition.

Probably most of you remember my testifying last session due to some medical professionals who devalued my life by my Cerebral Palsy I almost died the summer of 2017. Had my Mother not been in the right place at the right time, my family would have had to bury me.

Working in the disability field thirty years I Know how professionals often need to use terms and terminology to soften things. That for me is no longer necessary, therefore, I will use terms that others want to sugar coat.

Last Session being my first time working on legalized euthanasia for people with disabilities, I started asking myself these types of questions. If I tell people I am in pain, will this lead to conversations about putting me down? If getting out of pain means laying me down once or twice a day, will this become a measurement of work by others? Would medical professionals question if my pain is too much for others to handle, the type of Cerebral Palsy I have does get progressive and more pain comes with that. Therefore, would doctors suggest euthanizing me would be an option? and with the new norm in Washington DC, would Medicare deem me too expensive to pay for ongoing treatment, yet for a one time cost we will pay for my euthanasia? Besides a higher risk of more hospitalizations, the need for specialized therapy and costly equipment, and having a G-tube for primary nutrition my formula itself is two thousand dollars a month. So yes, I often times get frightened for my life being ended not by my choice.

Several supporters of this bill would say there are safeguards to be put in place to avoid these dangers for citizens with disabilities. Let’s be honest, there is absolutely no way to guarantee safeguards would not be gone around, or more importantly ways to monitor situations where safeguards have been ignored and gone around.

I close today by sharing in researching other states and countries in my former job. I read an article from the Netherlands, due to a gentleman who had significant mental health issues, they claimed everything was tried to help the gentleman to calm down and not be in so much distress, it was decided to end his life with medication. The most haunting and horrifying thing is, a few days before the procedure was going to happen a case manager described the setting as the gentleman sitting calmly relaxed on his couch watching television. I would venture to say the gentleman had no or little understanding of what was going to happen. But the case manager knew and perhaps was going to be present when the procedure took place. to this day it haunts me what if the day of he was yelling and screaming, because he didn't know what was about to happen, or he knew precisely was happening. I leave you with that vision.

HPCNMD_Peggy Funk_Info_SB0701

Uploaded by: Funk, Peggy

Position: INFO

Hospice & Palliative Care Network
OF MARYLAND

Letter of Information
HB643/SB701: End of Life Option Act (Richard E. Israel and Roger “Pip” Moyer Act)
Contact: Peggy Funk, Executive Director 410.891.5741

HB643/SB701: *End of Life Option Act (Richard E. Israel and Roger “Pip” Moyer Act),* has been introduced to the Maryland legislature. After discussion, the consensus of the Hospice & Palliative Care Network of Maryland (HPCNM) Board of Directors is that **the Network takes no position on this bill. However, HPCNM offers the following information concerning this proposed legislation:**

- ***Patients facing life-limiting illness and their families need honest information*** *about prognosis* ***early and frequently after their diagnosis.*** Armed with adequate information, patients have more access and choices for better pain management, palliative care, and enrollment in hospice. Patients are always encouraged to document their wishes to ensure their end-of-life decisions are well-known.

- ***Hospice care provides terminally ill patients and their families with compassion, comfort, and security that can replace suffering, desperation, and loneliness***. With timely hospice referrals, hospice can afford patients and their families the opportunity of reducing physical and emotional pain while making tender memories. Much individual growth and love can occur in the last months of life when symptoms are controlled and support is present, providing death with dignity for patients and closure for grieving families. However, fewer than half of eligible patients receive hospice care, and a third of those that do are referred in their final days of life-too late to enjoy many of the benefits of comfort, emotional counseling, volunteer friendship and spiritual care.

- ***A cultural shift needs to happen that emphasizes hospice care as “Affirming Life”.*** Hospice is not “brink of death”, or “when there is no hope” care. Patients redefine hope for themselves when they have honest information, realistic expectations, and the compassionate support of a team of professionals who are experts in relieving distress.

- ***Hospice and palliative care professionals believe in respect for patient decisions.*** It is not our job to judge a legal decision that a patient makes regarding how they want their life to end. Hospice and palliative care professionals provide expert physical, emotional and spiritual symptom management and relief with all available means, but never through intentional hastening or causing of death.

About Hospice & Palliative Care Network of Maryland (HPCNM)
HPCNM is the Association for hospice providers and palliative care partners across the state of Maryland. The mission of the Hospice & Palliative Care Network of Maryland is to lead and advance quality hospice and palliative care by serving as an advocate and resource for all Marylanders. HPCNM envisions a Maryland where individuals and families facing serious illness, death, and grief always receive expert hospice and palliative care services. In 2018, Hospice providers served 24,000 patients in the state of Maryland. Visit our website at www.hnmd.org.

Updated 2/24/2020