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.

---

[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?

---

[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

---

[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/

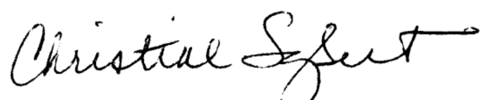
end up getting denied treatment, because this will always be the cheapest option… it's hard to financially fight," Packer said.

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, PharmD
1313 Water Oak Drive, Pasadena, Maryland, 21122
410.255.9540