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
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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.

<u>There is nothing that can be done</u> under this law <u>to track, control, or retrieve them</u> 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.
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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.
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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.

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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.”