Statement to the House Health and Government Operations and Judiciary Committees
Re: House Bill 933 – "End-of-Life Option Act"
Friday, March 10, 2023
UNFAVORABLE

As a pharmacist, I took an oath and promised to consider the welfare of humanity and relief of suffering my primary concerns. People with terminal illnesses certainly do suffer… as do their families. I have seen this in my 25 years as a clinical pharmacist, and I do understand why some might think this bill is a good idea. However, there are numerous issues with this bill, and, in general, legalizing assisted suicide is not acceptable medical care or good public policy. Of note, in 2019, the American Medical Association (AMA), after two years of debate, voted 392-162 (71%) to maintain its opposition to assisted suicide.[1] The poll you may have heard of from MedChi, Maryland's AMA chapter, was a small 2016 Surveymonkey.com questionnaire with responses from only 1.5% of Maryland's 30,000 licensed physicians (n=455); of those few, 53% did not approve changing MedChi's position from opposition to approval on assisted suicide.[2] Public surveys are misleading, as they ask generalized questions about opinions on"aid-in-dying" while failing to mention details or flaws in the legislation template. Many patients are shocked and change their opinion when I have explained to them why it is bad medicine.

Overview

- Conscience protections missing
- Drug diversion potential
- Illegal human experimentation
- Vulnerable populations at risk
- It offends me
- Increased nonassisted suicide rates
- Opening Pandora's box
- Public opinion vs. flawed legislation
- Autonomy?

Conscience protections missing

There is a lack of conscience protections for pharmacists who object to participating in assisted suicide.

[1] https://www.medpagetoday.com/meetingcoverage/ama/80384
[2] http://www.medchi.org/Portals/18/files/Law%20&%20Advocacy/Initiatives%20Page/MedChi%20Survey%20on%20Assisted%20Suicide.pdf?ver=2016-08-09-111636-707

Drug diversion potential

Drug-involved overdose deaths in the U.S. are rising (up 16% in 2021 over 2020).[3] Several of the medications in these cocktails are identified as culprits in 33% of these deaths: prescription opiates, benzodiazepines, and tricyclic antidepressants.

- Oregon (2021) - DDMA and DDMA-Ph were used predominantly (96%)
- These are equivalent to:
  - Digoxin 0.25mcg tablets = #400
  - **Diazepam 10mg tablets = #100** (a benzodiazepine)
  - **Morphine 30mg tablets = #500** (an opiate)
  - **Amitriptyline 100mg tablets = #80** (a tricyclic antidepressant)
  - Phenobarbital [when used] 100mg tablets = #50

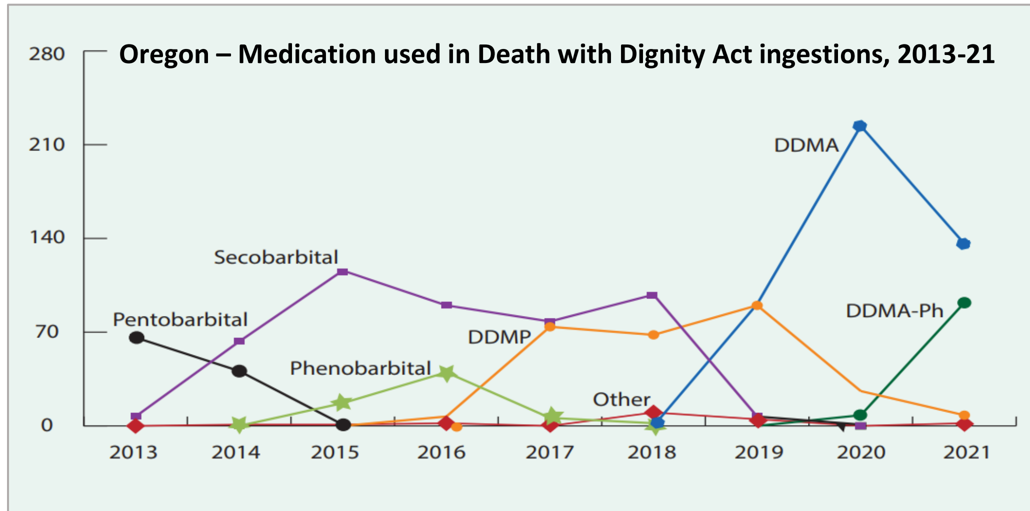
No accountability is required once these prescriptions are written or filled. No ID is required for picking up or receiving the prescriptions. This leaves these large lethal doses potentially accessible to non-patients and could contribute to rises in drug-involved overdose deaths.

- Oregon 2021 – 38% of the prescriptions were not used.[4]
- Washington 2021 – 27% were not used or had an unknown status.[5]

Illegal human experimentation

In my role as a clinical pharmacist, I coordinate drug studies at my hospital and serve on our Institutional Review Board (IRB), which reviews all protocols to make sure that they meet Good Clinical Practice (GCP) guidelines established by the Food & Drug Administration (FDA). The primary job of the IRB is reviewing the Informed Consent forms to make sure patients will be fully notified and aware of the risks and benefits of participation in the study, that the information provided to them is in writing, and that they have signed the consent form before any experimentation takes place. Additionally, the lack of oversight from clinicians is appalling. No medical provider is required to be in attendance at the ingestion. The side effects being reported – horrible taste, painful burning, nausea, vomiting, prolonged deaths (sometimes days) – are not benign. It is not always a peaceful passing, and some patients even survive the overdoses. And, this is limited data because no healthcare provider or witness is required to be there.

[3] https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
[4] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf
[5] https://doh.wa.gov/you-and-your-family/illness-and-disease-z/death-dignity-act/death-dignity-data



If we ever tried to treat patients with experimental drug regimens -- which is exactly what these concoctions are, and they change year-to-year – and with so little informed consent or concern for our patients' wellbeing, the FDA would shut us down for violation of GCPs and not properly protecting our patients… and they would be right to do so!

Vulnerable populations at risk

Maryland is a Total Cost of Care state with Centers for Medicare and Medicaid Services (CMS) and 30% of Marylanders are on Medicare or Medicaid. Hospitals have a fixed amount of revenue for the year and therefore there are major incentives to cut costs. According to Derek Humphry, the founder of the Hemlock Society, which is now called Compassion & Choices, he stated that "economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice."[6] To paraphrase him, a dead patient is the cheapest patient. What does that mean to Maryland's vulnerable populations? The disabled, the elderly, the socioeconomically disadvantaged, minorities? What choice will they have? None. Those in power will make the choices for them. It is happening already to patients with non-CMS insurance.[7] People are being denied healthcare that could help them survive but are instead being offered assisted suicide as a medical "treatment" that their insurer will pay for. A choice that these patients did NOT request. This legislation will lead to an erosion of trust in the medical professions, especially in vulnerable populations.

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[6] Humphry, Derek and Mary Clement. *Freedom to Die*, St. Matin's Press (New York), 1998, p. 313.
[7] Callister, T Brian. "7 important reasons to oppose physician-assisted suicide." Updated 4/27/21.
https://www.rgj.com/story/opinion/voices/2021/04/27/7-important-reasons-oppose-physician-assisted-suicide-callister/7261231002/

It offends me

This legislation is offensive. Why? Life has infinite value. Assisted suicide, however, attacks that value by permitting some people in some circumstances to sometimes commit suicide. Human beings are relational, and no suicide happens in a vacuum. On average, one suicide affects an estimated 135 other lives.[8] Therefore, this legislation is offensive to me and to all human beings. Preventing that affront to all humans supersedes any individual's autonomy. Furthermore, what does this legislation say to those already suffering with suicidal ideation or past suicide attempts? How can we logically try to prevent suicide in 99.995% of people yet approve it for a tiny minority (0.005%, estimated n=300/6,000,000 Marylanders) and believe that it will not influence the rest of society? The fact is that is does influence more than just the very small number of people who might kill themselves with this "option." The next section will show that it has already begun…

Increased nonassisted suicide rates

This legislation will serve to increase the suicide rate. The latest CDC data indicates that there were 585 suicides in Maryland in 2020 (thankfully, a decrease from 2019 which had an all-time high of 657), for an age-adjusted rate of 9.2 per 100,000.[9] While this is less than the national average (16.1%), 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 assisted suicide compared to twenty-five states with suicide data that have not. If 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).[10] If the anticipated increase in suicides of 6.3% from passage of this legislation is included, then an additional 37 all-cause suicides (excluding assisted ones, however, due to falsified death certificates) will occur with a new total of 622 suicides. Is this the "medical care" we want to provide to Marylanders?

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[8] Cerel et al. How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior. 2019; 49:529-534. https://doi.org/10.1111/sltb.12450

[9] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[10] Jones DA and Paton D. How does legalization of physician-assisted suicide affect rates of suicide? Southern Medical Journal. 2015;108:599-604. https://pubmed.ncbi.nlm.nih.gov/26437189/

Opening Pandora's box

Proponents have demonstrated that they will not stop with this legislation. This is only the outside of Pandora's box, and if we allow it to be opened, it will lead to all types of problems. Not immediately, but, eventually, yes. The proof? Five of eleven jurisdictions (45%) where assisted suicide has been legalized have already passed and/or are proposing legislation to remove "barriers."

- Oregon (legalized in 1998) – first change took 21 years: 2019 - waiver of waiting periods allowed; 2023 proposing removing residency requirements
- Vermont (2013) – after 9 years: 2022 - removed physical presence requirement for requests, prescribing doctor need never physically examine the patient in person, and removal of final 48-hr waiting period; 2023 - seeking to remove residency requirements
- California (2016) – after only 6 years, first change: 2022 - reduced waiting period to 48 hours
- Washington (2009) – took 14 years for first attempt to change: 2023 - seeking to allow NPs and PAs to be prescribers and mailing of lethal prescriptions
- Hawai'i (2019) – just four years to first attempt: 2023 - seeking to add Advance Practice RNs and NPs as prescribers, wanting to reduce waiting period to 5 days or waive altogether for some patients

If the legislative template is not working in Oregon, California, Vermont, Washington, or Hawai'I, why propose the same legal safeguards here? It is because the goal is to sway public opinion into accepting this offensive bill as a "reasonable choice." How long before current safeguards in the bill are re-labeled as "obstacles and barriers" and removed in Maryland? As the saying goes, the way to boil a frog is to slowly increase the temperature, and it will not notice the danger until it's too late.

Public opinion vs. flawed legislation

When people are asked generally about the topic, this seems like a compassionate thing. Why would we not want to ease someone's suffering? But here's the thing – we already can. Maryland has outstanding palliative and hospice care, but many are not even aware of what it is or how it can help. Plus, what public opinion poll questions do NOT mention are the serious issues in the bill:

- redefines the term "suicide" and prohibits stating truthfully what these actions are
- falsification of death certificates is specifically mandated
- it gives the doctor writing the prescription broad legal immunity which means no accountability for their actions
- medical records are protected from discovery and subpoena
- no long-term relationship is required to exist between the prescribing doctor and patient
- there is no requirement to notify next of kin
- no witnesses are required when the overdose is taken
- no routine audits, investigations, or supervision by an independent safety monitoring board are required

Contrary to what you may hear, not everyone thinks this is a good idea. In 2019 (the last year proponents really pushed this legislation because COVID rightly focused the world on *saving* lives, not ending them), of the 13 states that considered assisted suicide legislation, only 2 passed it. That means 11 rejected it, including Maryland. Utah even passed legislation to definitively make it illegal.

Autonomy?

This bill is not really about offering "a choice" or autonomy. I have heard proponents say they have a right to die. That is true, and patients already have that option now and without this legislation. There is no requirement for anyone to continue medical care that they do not want. As for attempting to control the date or time of death, that already lies within their hands as well. The vast majority (75%) of the tiny number of people who killed themselves in 2021 (in Oregon and Washington) using assisted suicide were cancer and ALS (Lou Gehrig's disease) patients. They don't need permission from the government – or a firearm or starvation – to end their lives. They already have access to powerful drugs in their medicine cabinets, and in amounts that would allow them to commit suicide peacefully. Opiates and benzodiazepines especially when combined with alcohol, can produce respiratory depression and death – most of the time within a few hours. The person falls asleep and never wakes up.

Therefore, if the minority of people who might make use of this (0.005%) already have the right to die, the right to commit suicide (it's not illegal, after all), and have access to the drugs to do so, why the need for this bill? The true goal of this bill is to destigmatize suicide by changing the definition of what "intentionally taking your life" means and change public opinion about assisted suicide… through government sanctioning of it and physicians and pharmacists legitimizing it through participation.

Summary

Please don't fall for the euphemisms of "medical aid-in-dying" or "death with dignity" that proponents are attempting to use to mask the truth. This is assisted suicide, and it is bad medicine and poor public policy.

I urge you to report "unfavorable" on this bill. Thank you.