HB933
"End of Life Options Act"
OPPOSSED – VOTE NO

Tom Jones
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Since 2016 I have testified against the legalization of physician assisted suicide (PAS) in Maryland alongside my wife, Laura. Initially we were concerned that legalization of this practice would cause an increase in suicide rates among people with mental illness, an issue that was very important to us as we had a teenage daughter struggling with mental illness and suicidality at the time. Additionally, we were concerned that once passed, additional legislation and court actions would broaden the legislation to allow PAS to be applied to people with non-terminal illnesses, including mental illness. The passage of time has shown these concerns to be valid.

It has been known for years that the suicide rate in Oregon increased after PAS was legalized and is currently 19% above the national average. Recently, several peer reviewed studies have concluded that legalizing PAS increases the overall suicide rate. In 2015, Doctors Jones and Paton released a paper that compared suicide rates in states that had legalized PAS with those who had not and concluded that after removing all economic and societal contributors to suicide rates, states with legalized PAS had a suicide rate that was 6.3% higher. An additional study by Dr. Jones in 2022 using the larger data sets of European countries found that legalization of PAS resulted in increased suicide rates (assisted and non-assisted) and rises in "intentional self-initiated death," particularly among women.

Over the last several years there has been a steady broadening accessibility to PAS. There have been efforts in multiple states to reduce waiting times, allow PAS subscriptions by tele-medicine and allow non-physicians to provide PAS prescriptions. Oregon has expanded PAS to cover non-terminal illnesses such as diabetes and arthritis and most troublingly, both Colorado and Oregon have allowed patients suffering with Anorexia to take their lives by PAS. This is exactly the type of broadening Laura and I were afraid of when we first started testifying and it follows the patterns of every other government that has legalized assisted suicide or euthanasia. Euthanasia for psychological conditions in both Belgium accounts for 2% of all euthanasia deaths. Nearer to home, our cultural and geographic sibling, Canada, just decided to delay broadening their PAS laws to include mental illness but this has been described as a "when, not if" decision.

I know that the legislature of Maryland takes the issue of mental health seriously and I thank you for your passage last year of SB94 and other mental health provisions. SB845 presents a risk to people with mental illness and if passed, opens the door to being amended or challenged in the courts to broaden its applicability to people without terminal conditions. There are no amendments that can make this bill safe from later changes that are already underway in many states. The only safe option is to never open the Pandora's box at all. I ask you to please vote NO on HB933.

NOTE: I am attaching as part of my written testimony an e-mail correspondence between Dr. Paton and myself. Dr. Paton's article is frequently misquoted by PAS supporters to claim there are no increases in suicides when PAS is legalized. The e-mail chain captured on the following page captures his response to my questioning this interpretation of his findings.

From: **David Paton** David.Paton@nottingham.ac.uk
Subject: RE: Physician Assisted Suicide - Need Your Help!
Date: March 3, 2017 at 6:23 AM
To: Thomas Henry Jones trieste@prodigy.net
Cc: Laura Jones tomhj@prodigy.net

Dear Tom,

Thank you for your email about our paper in the Southern Medical Journal.

I agree that it would not be accurate to claim on the basis of our paper that there is no correlation between physician assisted suicide (PAS) laws and non-assisted suicide rates. Indeed, I believe such a claim would be misleading.

In the first place, our paper finds no evidence that, as some have suggested, PAS laws might bring about a reduction in non-PA suicide rates. Further, we find strong evidence that PAS laws increase total suicide rates (PAS and non-PAS combined).

Next, some of our models provide evidence that PAS laws lead to a statistically significant increase in non-PA suicide rates. In other models (e.g. the model including state-specific trends), although the point estimate still suggests that non-PA suicide rates increase, the increase is not statistically significant. In other words, in these models, we cannot rule out the possibility that there was no change in non-PAS rates. As you suggest, including the state-specific trends might overfit the model – once we include the trends, there is very little residual variation with which to identify any effect from assisted suicide. This means that the statistical tests with this specification are liable to suffer from low-power. That is, even if there is a real effect on non-PA suicides, there is a relatively low probability that our model will pick it up as being statistically significant. As an aside, the fact that the effect of PAS on total suicides (i.e. PAS and non-PAS combined) is positive and significant even in the models with state-specific trends is a very strong result.

To summarise, in all our models the estimated effect of PAS laws on non-PA suicides is positive but the effect is only statistically significant in some cases. Given this, I think it is fair to say that we find some evidence that PAS increased non-PA suicides but that the case is not proven beyond reasonable doubt.

However, it is important to remember that, even if the true effect of PAS on non-PA suicides was zero, this would not, necessarily mean there is no suicide contagion. One of the arguments for PAS has been that some people who would otherwise have committed suicide now take advantage of PAS. To the extent that this is true, then non-PAS should decrease. If non-PAS does not decrease, then it is reasonable to infer that suicide contagion has taken place and balanced out any switching from non-PAS to PAS. Even in the model with state-trends, we find no decrease in non-PAS. So, as long as there were some people who did switch from non-PAS to PAS, then the model with state trends is still consistent with there being suicide contagion.

On your other question, we did experiment with allowing the effect of PAS to vary over time, but opted for the static model as there are so few PAS states in the sample and only Oregon with enough data points to do anything sensible with divergence over time. We thought it was just asking too much of the data.

We are currently in the middle of updating the research using the two extra years of data that are now available (2014 & 2015). The analysis is not yet complete but early indications are that the results in the SMJ paper hold up well and, if anything, are strengthened.

I hope this is helpful but please let me know if anything needs clarifying further.

Yours sincerely,

David

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From: Thomas Henry Jones [mailto:trieste@prodigy.net]
Sent: 28 February 2017 12:30
To: director@bioethics.org.uk; Paton David <lizdp@exmail.nottingham.ac.uk>
Cc: Laura Jones <tomhj@prodigy.net>
Subject: Physician Assisted Suicide - Need Your Help!

Dr Jones/Dr Paton

My wife and I are currently leading a grass roots campaign to defeat passage of a physician assisted suicide (PAS) bill in the state of Maryland in the United States. In addition to our concern about how this bill could impact the old and vulnerable in our society, we are both very concerned about the impact of physician assisted suicide on suicide contagion, as on of our children struggled for years with suicidal tendencies. We are preparing for a Senate Hearing next Tuesday and I was hoping I could get some insight on a paper you published on the subject in time for next week.

The supporters of the bill are citing your paper published in the Southern Medical Journal to bolster their arguments that PAS does not lead to suicide contagion. My reading of your paper shows lead me to believe that you were attempting to disprove an assertion that PAS lead to lower suicide rates. You modeled and removed a large number of contributors to increased suicide rates, my belief is this was done to make sure people could not dispute your analysis showing there is no decrease in suicides where PAS is legal. My concern is that the state trend variable that was not identified with a specific cause has the potential of over fitting the data and removing the impact of suicide contagion. I think your analysis method is great to disprove decreases in suicides caused by PAS but when using the state trend variable (which the bill's supporters do) I

don't think it is accurate to claim there is not a correlation between PAS and non-assited suicide rates. Could you comment on whether my observation is valid?

Another question, the 6.3% increase in non-assisted suicide rates you found before removing state trends, is a static value. Data from Oregon tends to show a divergence from national suicide rates (i.e. the difference grows with time. Was there a reason you modeled suicide rates as a constant over the time period?

Thanks much for any help or insight you can provide.

Tom Jones
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"How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving and tolerant of the weak and the strong. Because someday in your life you will have been all of these." - George Washington Carver