Support - SB 845- MAID- Rev. Alexa Fraser UULM-MD

Uploaded by: Alexandra Fraser
Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of HB 933-
End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Rev. Dr. Alexa Fraser, Unitarian Universalist Legislative Ministry of Maryland Medical Aid in Dying Lead Advocate
DATE: March 7, 2023

Senators, thank you for letting me speak today.

I am Rev. Alexa Fraser.

I first spoke to you in 2015 to tell you about my father ending his life with a gun as he refused the pain, suffering, and loss of autonomy his advancing Parkinson's was causing.

I would not have chosen this end of life for him, but he spoke through his actions.

Then in 2016, I testified again because I had been diagnosed with cancer.

I'm delighted to say that my cancer is in remission, but I still support this option for those who want it.

Most recently, I testified here in 2019 after I had become a Unitarian Universalist minister.

I follow the dictates of my faith, which treasures bodily autonomy and personal agency.

But some people don't want to let me or others speak for themselves.

That’s why I was shocked what I read in a *Baltimore Sun* article about a pro-life rally here in Annapolis eight days ago.

Anti-abortion speaker and podcaster Gloria Purvis was quoted as saying in part:

> ”We have to speak for those who cannot. That includes…the person at the end of their life … We are their voices.”

No, Ms. Purvis, people at the end of life are speaking for themselves, but you are choosing not to listen to them.

In fact, a January poll by Gonzales Research & Media Services shows seven out of 10 Maryland voters (70%) age 60 and older support medical aid in dying, and more than six out of 10 of them (62%) personally want the option for themselves.

Ms. Purvis, you don’t even speak for the plurality of pro-life voters because the Gonzales poll shows 49 percent of them support medical aid in dying while only 44 percent oppose it.

I have worked in hospitals as a chaplain; I have been with people when they were on their deathbeds.

All of them know how to speak for themselves and will be able to do so with the passage of this bill.

Thank you.

Rev. Alexandra (Alexa) Fraser
503 Mannakee St.
Rockville, MD 20850-1915
Personal email: alexa@iobst.com
Mobile phone: (301) 938-2955-Mobile

SB845 Support.pdf

Uploaded by: Arnold Clem

Position: FAV

SB845/HB933 SUPPORT
Arnold Clem
1201 W Mt Royal Ave
Baltimore, MD 21217

SB845/HB933 SUPPORT
End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
Tuesday, March 7, 2023 – 1:00 PM

Dear Chair Smith, Vice Chair Waldsteicher, and members of the Judicial Proceedings Committee:

My name is Arnold Clem. I live in Baltimore City. This is an important opportunity for elected officials to grant individuals control over the healthcare options available when suffering from a terminal illness. I am very concerned about the state impeding deeply personal, medical decisions that should exist between patients and their physicians. I strongly urge you to support SB845/HB933: End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

Medical aid in dying will serve to alleviate the suffering of competent adults who make the decision to end their suffering at a time. No one should be forced to suffer through a terminal illness. By affording individuals suffering from a terminal illness the option to end their suffering through the processes outlined in the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act), you would grant them the dignity and comfort of knowing that they control their own decisions related to their suffering. This act is important to ensure that all individuals suffering from a terminal illness have the ability to decide what is best for them to maintain their dignity and end their suffering. Please do the right thing and allow individuals suffering from a terminal illness the opportunity to make their own medical decisions with their physicians.

I urge you to support your constituents suffering from terminal illnesses by allowing them the option to maintain their dignity and make their own end-of-life decisions with their physicians. I urge you to support SB845/HB933, the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

_Support - SB 845- MAID- Ashley, UULM-MD.pdf

Uploaded by: Ashley Egan
Position: FAV

Testimony in Support of SB 845- End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Ashley Egan, Unitarian Universalist Legislative Ministry of Maryland Coordinator
DATE: March 7, 2023

I am the Coordinator of the Unitarian Universalist Legislative Ministry of Maryland. I live in Prince George's County Maryland. I am asking you to support **SB 845 - End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act),** so that others don't have to spend their twilight years terrified of living.

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

My grandmother was my best friend, biggest fan and a force of nature. She buried her husband in 1995, beat cancer in 1996 and still played tennis on Tuesdays. However, in 2005, she watched the battle over Terry Schiavo, and became terrified of suffering a similar fate. It started with jokes requesting us to put her on an ice floe. She then started to stash her percocet, just in case. Her tidy home had multiple copies of her "Do Not Resuscitate" order, as per her research. Even though she was nowhere near dying, her intent was clear.

In her 80's she suffered multiple strokes. After living to see her 90's, she was in terrible pain, her memories were fleeting at best and she was ready to die. We knew her wishes, but were powerless to point her in a legal and appropriate direction. She did not live in a state that allowed her to end her life.

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

Ashley Egan
District 26

Support - SB 845- MAID- Stephen Buckingham, UULM-M

Uploaded by: Ashley Egan

Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of HB 933/SB 845-
End-Of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Stephen C. Buckingham, Lay Community Minister and Advocacy Lead, Unitarian Universalist Legislative Ministry of Maryland
DATE: March 7th, 2023

Unitarian Universalists (UUs) have a long and powerful history of belief and action promoting Death with Dignity legislation. Back in 1988, way ahead of its time, UU General Assembly voted a resolution stating in part:

> Guided by our belief as Unitarian Universalists that human life has inherent dignity, which may be compromised when life is extended beyond the will or ability of a person to sustain that dignity; and believing that it is every person's inviolable right to determine in advance the course of action to be taken in the event that there is no reasonable expectation of recovery from extreme physical or mental disability... Unitarian Universalists [should] advocate the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths, . . . advocate safeguards against abuses by those who would hasten death contrary to an individual's desires; and . . . inform and petition legislators to support legislation that will create legal protection for the right to die with dignity, in accordance with one's own choice.

Each of Unitarian Universalism’s Seven Principles offer support for providing end of life options, allowing for individual choice. People make choices within the options available to them – that is how they craft their dignity and worth. Dignity is not a matter of surviving as long as possible, receiving supportive care (e.g., being fed or toileted when you are no longer able to do these things for yourself), or refusing supportive care (refusing to be fed when you can no longer feed yourself), being able bodied or dying “with your boots on.” Dignity is achieved by doing what you can, what you choose, with the choices available to you.

Compassion leads us to offer the full range of options for end of life care and choices around dying. The full range of options includes state-of-the-art medical support provided to all (universal health care), superb hospice and palliative care, and must also include aid in dying. Compassion for others is the reason that we should make as many options as possible available at the end of life so that they, not we, should make those important, personal choices.

We are not accepting one another if someone can determine how someone else will die. Limiting options at the end of life, and most assuredly imposing choices of any kind is the opposite of accepting one another. Spiritual growth can come out of the deep reflection needed to decide how you want to die. Thus limiting end of life options can limit this aspect of spiritual growth. Some might conclude that they personally believe that the use of fewer resources at the end of life is a responsible choice given the interdependent web.

We urge your Committees to adopt a favorable report for this measure and move it to the full House for approval.

In faith,
Stephen C. Buckingham
Lay Community Minister and Chief Advocacy Lead,
Unitarian Universalist Legislative Ministry of Maryland

Support SB 845 - End of Life Options- Dina Miller,

Uploaded by: Ashley Egan
Position: FAV

Testimony in Support of SB 845 - End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Dina Miller, Member, Unitarian Universalist Legislative Ministry of Maryland
DATE: March 7, 2023

I am an 86 year old female with multiple cancers and severe breathing problems. I was very fortunate and made it through COVID, however many of my friends did not. I am at a point now where I need to start thinking about how I'm going to die.

I want to do it with dignity. I do not want to ever want to go to a hospital again. I do not drive anymore. I cannot shop for myself. I have difficulty if I bend over because of the breathing problems. Right now I am still living by myself, however I have no idea how much longer I can do that. When I am ready to give up my apartment I do not want to live with any of my children because I do not want to be a burden.

All of my children and grandchildren are in accord with my wishes, which are to die with dignity. This means in a way where I won't be in pain and I can peacefully leave the earth. I don't have to go to the hospital. I don't have to be resuscitated. I don't have to do all the things that they do to keep people alive for no good reason at my age.

I would truly ask you to pass the **SB 845 - End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act** as it would affect me and any friends that I have left - which out of my whole group is only two.

Thank you,
Dina Miller
Member,
Unitarian Universalist Legislative Ministry of Maryland

Support SB 845 - End of Life Options- Rev. Diane T

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 845 - End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Reverend Diane Teichert,
DATE: March 7, 2023

With a 104 year old family member in mind and heart, I write in support of this bill.

A resident of Maryland, he has long desired to die in peace, without pain, and at a time and in a manner of his choosing. The pills he somehow acquired and stashed away for that purpose decades ago have no doubt expired and are not likely to meet his objectives if he took them. It should not be illegal for a licensed medical doctor, who happens to be a member of his family, to advise him about these matters. There should be no fear of risk for his primary care physician to discuss his wishes with him, prescribe appropriately, coach him on tapering his life-prolonging meds when he feels the time has come and recommend him for hospice care in a timely manner.

Maryland is known as The Free State. Passing this bill is about ensuring bodily autonomy for him and other beloved elders at the end of their lives.

Sincerely,
Rev. Diane Teichert
4321 Van Buren Street
University Park, MD 20782

Support- SB 845 - MAID- Rebecca Forte, UULM-MD (1

Uploaded by: Ashley Egan
Position: FAV

Testimony in Support of SB 845 -
End-Of-Life Option Act
(The Honorable Elijah E. Cummings and
the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair and members of the Judicial Proceedings Committee
FROM: Rebecca Forte, Unitarian Universalist Legislative Ministry of Maryland
DATE: March 7, 2023

This bill is important to me personally as a granddaughter, and as a human being. It seeks to protect my autonomous rights over my body as well as those of my grandmother over hers. I mention my grandmother because she is someone who is grappling with these personal decisions now. The last time this bill was introduced was THREE years ago. Honestly, in her lifespan as a Holocaust refugee, I fear that she may not have three years to wait.

As someone who has researched this topic, I can tell you that the nearest place to have passed the End of Life Option Act is Washington, DC. However, Washington, DC-–and most states with this provision—will only provide end of life options for residents of their state. This means that for current Marylanders the nearest place where they would have to travel to for end of life autonomy is Oregon.

At the Estate Planning law firm where I work, we regularly discuss with people their personal choices for end of life options. Unfortunately, that also means that we regularly have to discuss with people how in Maryland their preferred end of life choices have no legal weight or bearing. This bill aims to rectify that situation and provide legislative backing for them when they make these personal decisions.

Please support SB 845, the End of Life Option Act for Maryland.

Thank you,
Rebecca Forte
District 33
Unitarian Universalist Legislative Ministry of Maryland

SB 845 testimony.pdf

Uploaded by: Barbara Harrison

Position: FAV

Favorable Testimony for SB 845

I am Barbara Harrison, a resident of Bethesda, MD for over 60 years. I submit this testimony in favor of SB 845 in memory of a very dear friend who died five years ago of metastatic lung cancer. In her final months my friend lived with terrible anxiety, and she desperately wished for the option to end her life without suffering. Sadly, despite the best efforts of a caring oncologist, her children, and hospice care, she experienced uncontrollable nausea and vomiting that made the last weeks of her life a misery.

I dearly hope that passage of SB 845 will provide the option for medical aid in dying to help others in our state suffering in their last days from incurable illnesses. I know such an option would comfort me, even if I never chose to use it. Seventy-one percent of Marylanders agree with my views. Please pass SB 845!

Brenda Arredondo. Testimony. In Favor of the End–o

Uploaded by: Brenda Arredondo

Position: FAV

Testimony of Brenda Arredondo

In Favor of the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Most of us have had the misfortune of seeing a loved one suffer from a terminal illness or have at least heard about these situations from friends. It is heartbreaking to watch someone you love suffer until the end or think of the possibility of this happening to oneself.

I have primary lateral sclerosis — the less deadly cousin to ALS. Even though my disease is not usually fatal, there are several side effects that could lead to my death. And I have no interest in suffocating to death through no fault of my own. I am at the mercy of my own body. However, as diseases like mine progress, I believe I should have the choice to make the decision best for myself.

As such, I stand in favor of SB 845/HB 933, the End–of–Life Option Act — The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act.

As an advocate for medical aid in dying, I firmly believe no one should make the choice to end my life for me. However, neither should anyone be able to take that decision from me or from anyone else who may find themselves in a position where they're considering the option.

And others believe the same. 82% of pro-choice voters in Maryland support medical aid in dying, as do 49% of pro-life voters. Three-quarters of Americans (74%) support the option of medical aid in dying, according to a 2020 Gallup Poll.

As a member of the disability community who supports legalizing medical aid in dying for a terminally ill patient likely to die within six months, I can feel alone in my support. Disabled opponents of these types of laws are not shy, many times rising as the loudest voices in the room leading the community to believe there’s overwhelming opposition to medical aid in dying legislation.

This could not be further from the truth. A new poll shows seventy-nine percent of those who self-identify as having a disability agree with the statement that medical aid in dying (MAID) should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully.

Additionally, the poll also found that 73 percent of individuals who identified as living in a household with an individual that identifies as living with a disability support patient-administered MAID for terminally ill, mentally capable adults. Of those who self-identified as being affiliated with a political party, 65 percent of Republicans, 79 percent of Democrats, and 83 percent of Independents supported MAID for terminally ill, mentally capable adults. Additionally, the poll found that 82 percent of African Americans, 81 percent of Latinos, and 75 percent of whites were in support of MAID for terminally ill, mentally capable adults.

The poll was sponsored by Us for Autonomy, a new organization spearheaded by advocates with disabilities — including me — whose aim is to affirm the autonomy of people with disabilities to have access to high-quality health care and choose end-of-life care that meets an individual's needs, values, and priorities. Us for Autonomy supports expanding healthcare options for people with disabilities who are nearing the end of their lives. An equitable healthcare system in this stage of life includes high-quality and affordable medical care; home care; hospice; palliative care; and medical aid in dying. The organization advocates for medical aid-in-dying laws that include strong safeguards to protect individuals from coercion and exploitation.

Prior to providing a prescription for medication to end one's life, two doctors must confirm the status of that person. They will have a terminal illness with a life expectancy of 6 months or less. This individual must be fully informed about additional end-of-life options, including palliative care, hospice and pain control. A person with disabilities is only eligible for medical aid in dying if they are an adult; terminally ill; have six months or less to live; able to make informed healthcare decisions; and able to take the medication themselves.

Coercing someone to use medical aid in dying is a felony punishable under state criminal laws. Medical aid in dying is a practice proven by decades of experience in authorized jurisdictions. There is not a single substantiated case of abuse or coercion nor any civil or criminal charges filed related to the practice. — not one. Currently, medical aid in dying is authorized in 11 jurisdictions. We must let the evidence and facts guide us.

The medical aid-in-dying and disability rights movements share important core values: autonomy, independence and self-determination.

The Maryland Legislature has the opportunity to help end the suffering of terminally ill residents. Give us the option of medical aid in dying to peacefully end our suffering if it becomes unbearable.

I implore you to vote in favor of SB 845/HB 933, the End–of–Life Option Act — The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act.

MD SB 845 American Atheists - Senate Judicial Proc

Uploaded by: Brittany Williams

Position: FAV

AMERICAN ATHEISTS

March 6, 2023

The Honorable Sen. William C. Smith, Jr.
Chairperson
Senate Judicial Proceedings Committee
Miller Senate Office Building, 2 East
Annapolis, Maryland 21401

Re: SUPPORT for HB 933/SB 845, Testimony from American Atheists in support of a bill providing end of life options and care

Dear Chairperson Smith and Members of the Senate Judicial Proceedings Committee:

As a Maryland resident and regional director for American Atheists, which has nearly 1,000 constituents in Maryland, I thank you for considering HB 933/SB 845, a vital measure that will ensure that terminally ill adults have access to compassionate end-of-life care options and medical aid-in-dying. This legislation will reduce government interference in the personal lives of citizens by allowing people who are terminally ill to make fundamentally personal decisions about their health care and lives. We urge you to swiftly pass this important bill.

American Atheists is a national civil rights organization that works to achieve religious equality for all Americans by protecting what Thomas Jefferson called the “wall of separation” between government and religion created by the First Amendment. We strive to create an environment where atheism and atheists are accepted as members of our nation’s communities and where casual bigotry against our community is seen as abhorrent and unacceptable. We promote understanding of atheists through education, outreach, and community-building and work to end the stigma associated with being an atheist in America. As advocates for the health, safety, and well-being of all Americans, American Atheists objects to efforts to subordinate medical care to the religious beliefs of providers and institutions.

HB 933/SB 845 would establish a path for terminally ill patients in Maryland to receive medical aid-in-dying, setting up a process in partnership between the individual and their health care provider. States that have chosen to enact medical aid in dying legislation have been successful in providing comfortable and dignified end of life care for terminally ill individuals.

For example, the state of Oregon passed a medical aid-in-dying law in 1997, and since that time, the process established by law has functioned as intended. There has been no evidence of abuse by providers, nor of loss of control by terminally ill patients.[1] Studies of the Oregon Death with Dignity Act found that, "persons dying in Oregon are less likely to be hospitalized and more likely to use hospice services at home." Furthermore, in 2013 nearly two-thirds of Oregonians died within in their own home, including 97% of individuals that used medical aid-in-dying processes established by the Death with Dignity Act. Nationally, however, although approximately 80% of Americans desire to pass in the comfort of their own home, less than 20% actually do so.[2] Instead, 60% of Americans die in acute care hospitals, often after receiving unwanted medical care.

Research shows that 73% of Americans support medical aid in dying for terminally ill patients, and yet only 8 states have passed laws establishing medical aid-in-dying processes.[3] Maryland should join them by passing this legislation to allow for better end-of-life options for its residents.

This legislation would create a patient-driven system that honors an individual's values and beliefs. We urge you to swiftly pass this important legislation to allow terminally ill people in Maryland to choose to die with peace and dignity. Thank you for the opportunity to testify in favor of this important bill. If you should have any questions regarding American Atheists' support for HB 933/SB 845, please contact Brittany Williams, American Atheists' State Policy Counsel by email at bwilliams@atheists.org.

Sincerely,

Samantha McGuire
Mid-Atlantic Regional Director
American Atheists

cc: All Members of the Senate Judicial Proceedings Committee

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[1] Tolle SW & Teno JM. (2017). Lessons from Oregon in Embracing Complexity in End-of-Life Care. *New England Journal of Medicine*. No. 376, Mar. 2017, pp. 1078-1082.

[2] Bailey A & Periyakoil VJ. (2018). Home Hospice: Home Care of the Dying Patient. Stanford School of Medicine. Available at https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/.

[3] Wood J & McCarthy J. (2017). Majority of Americans Remain Supportive of Euthanasia. Gallup, May 3-7, 2017. Available at https://news.gallup.com/poll/211928/majority-americans-remain-supportive-euthanasia.aspx.

Support SB 0845 Larner-Beckett Testimony.pdf

Uploaded by: Cathy Larner-Beckett

Position: FAV

Good afternoon,

My name is Cathy Larner-Beckett and I live in Annapolis. I am a retired special education principal, a cancer survivor, and a Catholic.

I am here to ask you to support the End of Life Options Act because it allows people with a terminal diagnosis to have control and dignity, and the option for a peaceful death, at the end of their lives.

I've watched both my parents, Catholics from birth, die. Despite hospice's administration of morphine, my father was in intolerable pain. We watched helplessly as this combat veteran, Hall of Fame Boxer, scream in pain while his family stood by hoping, and praying desperately for his suffering to end.

My mother, also a devout Catholic supported this end-of-life option prior to her death. When she was going into hospice with a prognosis of 6 months of life, she cried with joy that there was an end in sight to her own suffering.

She did not die in the 6 months the doctors' predicted, but there was no quality of life in that time. They were miserable for her and her family who watched her waste away, literally. This woman, who normally weighed 145 pounds, was a mere 76 pounds at her death. **Her living was not extended but her suffering was.**

The January 2023 Gonzales Poll of Maryland voters revealed that 71% of Marylanders, **your constituents,** support this option. It gives Marylanders the right to bodily autonomy, prochoice rights we protect prior to birth that should extend to the end of our lives.

Over 45 years of combined data from DC and the 10 states that now have this option have shown **not a single case of abuse.** Individuals with a cognitive disability, dementia or mental illness and people who are physically unable to self-administer the medication **are NOT** eligible to use this option**. To persuade or coerce someone to use this option is a felony.**

Lastly, this option is a CHOICE, not a mandate. Please don't deny this choice to all Marylanders. I ask that you vote FOR the End- of- Life- Option Act so that all terminally ill Marylanders have the right to choose a peaceful, dignified death.

Thank You.

Dr. Cathy Larner-Becket,

1025 Sextant Court, Annapolis, MD 21401

SB0845 End–of–Life Option Act FAV.pdf

Uploaded by: Cecilia Plante
Position: FAV

MARYLAND
LEGISLATIVE
COALITION

TESTIMONY FOR SB0845
End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Bill Sponsor: Senator Waldstreicher
Committee: Judicial Proceedings
Organization: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in favor of SB0845, End-Of-Life Option Act on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of individuals and grassroots groups with members in every district in the state. We have over 30,000 members across the state.

Our Coalition members are very supportive of their fellow Marylanders, many of whom have had to witness the death of someone they love from a horrible, terminal disease. All of those stories are painful, and the suffering that they witness is often the thing they remember most.

What drives us to prolong a person's life past the point where all they feel is pain, and they no longer can even interact with loved ones because they are in the fog of morphine? Why do we take choices away from them at the stage of their lives where they need choices the most?

We currently have laws that prevent terminally ill people from making the choice to end their life. Think about that. It should always be an INDIVIDUAL'S choice to determine the course of their own life and how much pain they can endure before not being able to handle it. They should be able to determine how and when they say goodbye to their loved ones. This is not a role the state should have.

This bill is a show of compassion for people who are suffering. We should not be trying to deny them their choice to end their suffering.

The Maryland Legislative Coalition fully supports this bill and recommends a **FAVORABLE** report in Committee.

Dan Diaz support of SB845.pdf

Uploaded by: Dan Diaz

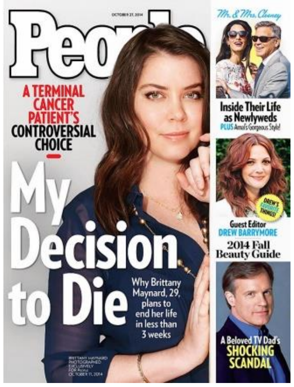
Position: FAV

Dan Diaz
TheBrittanyFund.org

March 5, 2023

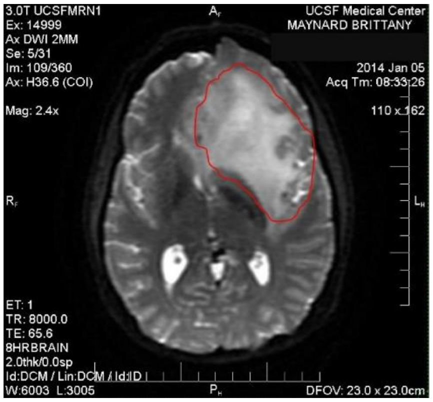
Support: Senate Bill 845 – End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Judicial Proceedings Committee,



My name is Dan Diaz and I am Brittany Maynard's Husband. Brittany died on November 1, 2014 of a brain tumor in Portland Oregon. She was only 29 years old and experienced a gentle dying process <u>only</u> because of the option of medical aid in dying.

But before she died, Brittany very publicly advocated for this legislation because she felt it was a huge injustice that we had to leave our home in California, just to ensure she could experience a gentle death. Had we stayed in California the brain tumor would have tortured her to death.



Brittany was determined to live as long as possible. She endured an 8 hour brain surgery and we researched every treatment option that was available. Unfortunately, the tumor continued growing aggressively.

To be clear, a terminally ill individual that applies for this option is not deciding between living and dying. The option of living is no longer on the table. (The opponents seem to ignore that.) Brittany's only option is between two different methods of dying. One is gentle. The other is terrifying and filled with unrelenting suffering.

The advances of modern medicine are truly remarkable. I want to emphasize the importance of palliative and hospice care at end of life. (Brittany's team played an incredible roll in trying to keep her comfortable.) However modern medicine cannot control an individual's pain and suffering at end of life in 100% of the cases. Period.

Any assertion by any physician or anyone else that they can control suffering in all cases, that is simply not true. Full stop. I can line up physicians, nurses, hospice care workers to refute such arrogant claims. That paternalistic view of a 'doctor telling the patient when you've suffered enough and then hooking up them up to a morphine drip as experience a terrifying death,' Brittany refused to accept that.

After working on this legislation for the past 8 years, it has become increasingly clear that the opponent's campaign is based on fear. They use inflammatory words like 'suicide' and 'euthanasia' in their attempt to scare legislators into continuing with the status quo, instead of acknowledging what a terminally ill individual is going through. And nowhere along the way do they offer an alternative, another remedy, or solution to terminally ill individuals who are in Brittany's predicament.

When Brittany died there were only 4 States with this option. Now there are 11. The people of Maryland deserve better than what she had to endure. No one in Maryland should ever have to leave their home and move to another state in order to have the option of a gentle dying process.

Two final points…
From a religious perspective, as a Catholic I take great pride in the fact that 70% of Catholics nationwide agree with Brittany and support a terminally ill individual's right to have this option. (The church is officially opposed, but the congregants support this option.)

The safeguards in this legislation protects <u>everyone</u> who applies for it, and that includes any terminally ill disabled individual who would apply for it; as well as disabled individuals who don't. The passage of this bill, will for the first time protect disabled individuals from the type of abuse that is currently occurring behind closed doors. (The two letters below from the Executive Director of Disability Rights Oregon refutes the notion of abuse or coercion in the use of their Act over the past **21 years.)**

Sincerely,

Dan Diaz
Brittany Maynard's Husband

DISABILITY RIGHTS OREGON

February 10, 2016

FEB 16 2016

Roland L. Halpern, MNM
Cultivation Manager
Compassion & Choices
4155 E Jewell Avenue
Denver, CO 80222

Dear Roland:

Thank you for your letter of January 22 asking if anything has occurred that would change my former position on the matter.

The answer is no. DRO has still not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act.

Thanks for you inquiry.

Sincerely,

Bob Joondeph
Executive Director

DISABILITY RIGHTS OREGON

February 14, 2019

To Whom It May Concern:

My name is Bob Joondeph. I am the Executive Director of Disability Rights Oregon (DRO). I have held this position since 1991. DRO is the Protection and Advocacy program for Oregon, providing legal based advocacy for individuals with mental and physical disabilities throughout the state.

I have been a licensed attorney in Oregon since 1976. Our staff includes ten other attorneys, paralegal/investigators, intake specialists, benefits planners and support staff. DRO is mandated under federal law to investigate complaints of abuse or neglect of individuals with disabilities including inappropriate actions taken to hasten the death of an individual.

In the years since passage of the Oregon Death with Dignity Act (the Act), DRO has received very few complaints from disabled Oregonians about the Act. All of the complaints we have received have focused on the concern that the Act might discriminate against persons with disabilities who would seek to make use of the Act but have disabilities that would prevent self-administration, thereby denying these persons the ability to use the Act. DRO has never to my knowledge received a complaint that a person with disabilities was coerced or being coerced to make use of the Act.

Yours truly,

Bob Joondeph
Executive Director

SB0845 JCRC testimony 3 7 23.pdf

Uploaded by: David Marker

Position: FAV

JCRC JEWISH COMMUNITY RELATIONS COUNCIL
JEWISH FEDERATION OF HOWARD COUNTY

Hearing Date: March 7, 2023

Testimony on SB0845 – POSITION: FAVORABLE
End–of–Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
To: Chair Smith, Vice-Chair Waldstreicher, and Members, Judicial Proceedings Committee
From: The Jewish Community Relations Council, Howard County, MD
Betsy Singer and Laura Salganik, Co-chairs
Presented by: David Marker, Member JCRC Executive Committee

The Jewish Community Relations Council of Howard County is submitting this testimony in support of SB0845, the Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End-of-Life Options Act. The bill is also supported by most Jewish clergy serving Howard County including:

- Rabbi Gordon Fuller, President of the Jewish Federation of Howard County
- Rabbi Craig Axler
- Rabbi Michael Hess Webber
- Rabbi Daniel Plotkin
- Rabbi Daria Jacobs Veldt
- Hazzan Stephanie Weishaar

The JCRC represents the approximately 25,000 Jews throughout our County, including members of seven congregations and four Chabad centers. We are aware that much of the opposition to this bill have come from people of faith, claiming that their religious tradition causes them to oppose end-of-life options. The JCRC is here to state that while that may be true for some traditions, our Jewish tradition leads us to welcome and strongly support adoption of the Elijah Cummings and Shane Pendergrass End-of-Life Options Act.

Jewish texts have long opposed suicide. But they have also demonstrated an understanding, and even support, for those in desperate situations who need assistance, even with their own death. When the Talmud and Aggadah were written over 1,000 years ago the average life expectancy was 20-40 years, due to pestilence and famine. Those Sages taught that dying after more than seven days was suffering, and only described death taking "ten or twenty days." They did not consider modern medicine and health care making the suffering spread across months or years.

The Talmud has multiple cases where it describes both praying for someone to live and praying for them to die. It also contains multiple stories supporting people who choose to hasten their death (and assist others in doing it), for example when Rabbi Chanina ben Teradyon is martyred by the Romans following the Bar Kochba revolt. As he is being wrapped in the torah and burned to death, he agrees with the executioner to speed it up so he will suffer less. Both are rewarded by God for their actions, including the executioner who assisted in his death.

While Judaism has always been a life centered faith, we understand that the spiritual needs of those suffering incurable conditions must also be considered. We believe our religion recognizes the difference between prolonging life or just postponing death and so we endorse this bill without hesitation or reservation.

SB 845 Support.docx.pdf

Uploaded by: Dawn Luedtke

Position: FAV

MONTGOMERY COUNTY COUNCIL
ROCKVILLE, MARYLAND

DAWN LUEDTKE
COUNCILMEMBER
DISTRICT 7

March 7, 2023

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

SUBJECT: **Support SB 845**

Dear Senator Smith and Members of the Judicial Proceedings Committee,

I write in support of Senate Bill 845, "The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End-of-Life Option Act." This allows adults with terminal illnesses and appropriate capacity for health care decision-making the opportunity to manage their end-of-life treatment options. As presented, Senate Bill 845 contains multiple guardrails and procedural steps that will ensure the individual's decision-making capacity and a system of checks and balances prior to prescribing the required medication. It also ensures that medical facilities and providers who do not want to participate in aid in dying medical care, or wish to preclude it at their facilities, may do so without penalty so long as the patient is referred for care to a provider who can assist.

I watched this bill make it through the House of Delegates in 2019, including some passionate discussion during floor debate. In my prior private practice of law, I spent five years of my career representing individuals who suffered from mesothelioma, a terminal cancer caused by asbestos.

During those five years, I watched as each of my clients suffered in the final weeks of their lives and endured repeated trips to the emergency room to have fluid drained off of their lungs. They had no ability to direct when the suffering had been enough and to do so in a dignified fashion. The decision of whether to avail oneself of the proposed provisions of Senate Bill 845 is a personal choice.

Members of this body, family members of individuals who would use the end-of-life option act's provisions, and members of the general public may disagree or not view it as a viable treatment option for themselves. This Act allows individuals to discern the best course of action for themselves based on their own personal preferences, medical diagnosis and prognosis, and allows them the choice of sharing their decision with their family members or refraining from doing so. Each individual has their own moral and/or religious philosophies that should guide them in making their choices regarding terminal illness. Passing this bill will not interfere with those choices, it simply offers an additional option.

A relative of mine went through this as she battled terminal cancer, but her husband is a vociferous advocate against end-of-life decision making that allows for aid in dying[1]. Again, these are individual choices no different than refusing a surgical procedure that may have little success in a terminal illness, like an extrapleural pneumonectomy for a mesothelioma patient, and complement other existing medical care options such as palliative care and hospice.

For the foregoing reasons, I urge passage of Senate Bill 845.

Very truly yours,

Councilmember Dawn Luedtke
District 7

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[1] https://www.npr.org/sections/health-shots/2014/06/23/323330486/how-a-womans-plan-to-kill-herself-helped-her-family-grieve

Diana Barnard.MD.MD.3.7.23.pdf

Uploaded by: Diana Barnard

Position: FAV

Diana Barnard, MD
Associate Professor of Family Medicine
Lead Physician Palliative Medicine Services
University of Vermont Health Network Porter Medical Center
115 Porter Drive
Middlebury, VT 05753

To Whom It May Concern:

My name is Dr. Diana Barnard. Thank you for the opportunity to share my expertise in Medical Aid in Dying (MAID), and the reasons why I strongly encourage you to support SB 0845/HB 0933. I have been a board-certified Family Medicine Physician for more than 28 years. I am also board-certified in Hospice and Palliative Medicine. The past 14 years of my practice have been spent caring exclusively for patients and families living with serious illness.

I practice medicine in Vermont where Medical Aid in Dying has been legal for nearly 10 years. I regularly prescribe medications under the law and also support and educate other physicians who participate in the process. The most recent legislative report (published in January, 2022) shows that our law is working well and as intended. 116 Vermonters have qualified for the law without a single instance of abuse. Our growing experience in Vermont mirrors that of the 9 other states and the District of Columbia where Medical Aid in Dying is legal.

This practice offers vital comfort and a measure of control for people who are desperate to live, and yet are dying.

Importantly, Medical Aid in Dying laws also protect the right of those physicians and patients who do not believe in its concepts or choose not to participate.

There is a robust and active American Academy of Medical Aid in Dying, as well as MAID Clinical Guidelines and standards of care for the practice which can reliably result in a peaceful death for those utilizing the law.

I cannot emphasize enough the unique and individual challenges people living with terminal illness face. The people I care for want to live as long as possible. When their illness is advancing and treatment options become severely limited, people also want a say in how they will die. Some will have a peaceful death with symptoms that can be managed reasonably well. Some will have difficult deaths with symptoms that are more distressing or even impossible to adequately control. As you consider this law, please keep in mind the deeply personal nature of suffering, the most intimate reality of facing one’s own death, and need for options as we each walk down our own path towards the end of our lives.

I am here to speak for people like Willem Jewett; a 59 year old lawmaker I had worked closely with to pass Vermont's MAID law and who just a few years later was diagnosed with metastatic melanoma. He wanted desperately to live. He had two beautiful daughters and had fallen madly in love with and married his second wife just weeks before his terrible diagnosis. He lived with high disease burden in order to have time with his beloved family. Only when treatment was clearly no longer benefitting him, and when we could no longer alleviate his suffering, did his hopes for a longer life transform into hopes for a decent death. He used MAID and died very peacefully surrounded by his whole extended family in one of the most peaceful deaths I have ever witnessed.

I am here to speak for people like John Roberts; a 90 year old Navy Veteran facing the final stages of advanced metastatic prostate cancer who asked me to share his story. As his Cancer progressed, he became increasingly concerned about what would happen in the final days and weeks of his life. He worried about how and where he would die. As he lost the ability to do more and more of the things that gave his life meaning, he remained steadfast in his wish to remain in his own home and to be able to care for himself. MAID allowed him the peace of mind to be able to die as he had lived; on his own terms. As is often the case with my patients, having access to MAID allowed John to set aside his end-of-life fears and to focus on living fully in the present.

Polls in Maryland show that the vast majority of residents in your state want access to Medical Aid in Dying as an option when they are facing their own terminal illness. I urge you to listen to the residents of your state and to pass SB 0845 and HB 0933 this session.

With gratitude and Peace,

Diana Barnard, MD

Diana Barnard.MD.MD.3.7.23.pdf

Uploaded by: Diana Barnard

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With gratitude and Peace,

Diana Barnard, MD

SB 0845 by Diane Kraus-dying patient and healthcar

Uploaded by: Diane Kraus

Position: FAV

Diane L Kraus
1190 W Northern Parkway, apt 612, Baltimore MD 21210
March 7, 2023

RE: SB 0845 SUPPORT

I support Medical Aid in Dying because I have seen how the end of life can be so painful, even on hospice and medications. I know what the painful comatose person's transition to death is for the dying person as well as for the family and caregivers. If you have ever sat with a dying patient, sat with them for hours, then you know how difficult it can be for the patient and the family.

I have metastatic breast cancer stage 4, and I am dying. Not today, not tomorrow, but that day is soon approaching.

The majority of Maryland voters (71%) support Medical Aid in Dying, across all religions, genders, race, political affiliation, and stance on abortion (pro-life even 49%). Please don't allow some religious beliefs and the minority determine my bodily autonomy. The choice should be mine. Support this bill for people like me, families, and for the right of bodily autonomy.

My story and history of awareness:

I come with a vast knowledge about the dying patient. I took end of day/ night care of my mother who also had metastatic breast cancer. I worked 35 years as an Occupational Therapist, and for 23 years of my career in homecare and in hospice. And now I am the dying patient. I have been caregiver, family, friend, and patient.

I had breast cancer 11 years ago with lumpectomy, intense chemo, radiation, and more chemo. I thought I was in the clear.

Then nearly two years ago, in May of 2021, I developed pain in the bone of my chest, not from my heart. And a lump grew there. They didn't see anything on the Xray. I didn't have insurance in MD, only MA. The lump and pain improved, but was still present, and 6 weeks later when I was finally able to get back to Cape Cod I was checked again. There an ER doctor and CT scan told me I had extensive metastases throughout my chest, liver, and lungs. Brain MRI showed cancer as did my skull.

I moved to MD a week later as planned but couldn't start my new job- I had to start chemo. Tests showed in-numerable tumors in my lungs and liver, all of my lymph nodes, multiple bones, my skull, and my brain. Follow up tests showed growth to 13 tumors in my brain for which I have had whole brain radiation. That was the worst thing I have ever done. I have failed the first 2 types of chemo, but now on chemo 3 have a better potential for being alive in 6 months. I should be dead by now, but the new drug does give me hope to be able to spend time with my son a little longer

And in this last year I have made functional declines. I continue to get weaker every week. I have lost 40 pounds from the cancer and the chemo. I am nauseous, constipated, have severe daily headaches, and bone pain in my back and head. The brain radiation left me with blurred vision in my right eye and very loud ringing with limited hearing in my right ear. That won't improve. The chemo has left me with neuropathy in my fingers and toes. But I continue to fight, for myself, and to spend as much time as I can with my twenty-nine-year-old son.

Having worked and seen up close many people in their transition from life to death, I know what it can look like with multiple different diagnoses. From neurological conditions like ALS, MS, Parkinson's and brain tumors, as well as different types of cancer. I have seen the pain with just moving in bed a few inches can cause. And although hospice is an awesome thing, it can't be there 24/7.

My mother was mentally competent until the last 6 days of her life when she slipped into a coma like state from the cancer. Over the last two months, she had no quality of life and a great deal of pain, and she was on hospice. The pain medicine was helping her but even upped, or changed did not cover the pain she had when we had to roll her side to side or bathe her, moving any limb for any movement.

She would moan. I can still hear that moan. And her breathing was difficult as her lungs were filling with fluid.

Even on hospice, she, like many of my patients, did not have a peaceful or gentle death.

The end of life should be able to be CHOSEN how we want to pass on from this world. Those with the mental capacity should be allowed to avoid the last week or two of suffering. Most of my patients would tell me a week or two before they died that they had had enough and just wanted to pass away then. I don't know if they would have taken the option if it was available to them but it would have been nice to know they could choose it if they were ready.

For me, my biggest concern isn't the physical declines that have started and I know will be coming- those I can adapt for or get help. My realization is that as we get closer to death we are not the person others have known us to be. We become different. I want people to remember me as the fun-loving, playful, yet dedicated, serious, and caring person that I still am. I don't want them to remember me as I remember the declined persons my patients were, or the moaning like my mother, or the end-of-life pain like so many – - and I know I am highly likely to have that intense pain with my bone tumors. National studies show 65 to 85 percent of cancer patients have pain. Of those with metastatic cancer, 90% report pain. In fact, despite the wide availability of hospice, palliative care, and pain management, people experience breakthrough pain that is not controlled by regular doses of pain medicines, and can happen many times a day, especially as the end draws near.

Maryland allows for bodily autonomy in pregnancy. Shouldn't evaluated by doctors, mentally capable adults with medical aid be allowed options for their end of life?

Please pass this medical aid in dying legislation. The majority of Marylanders across all the ages, the ethnicities, and religions agree. NOW IS THE TIME.

Allow me to be the person I am until I get close to the end, and allow me to have the option to have a death that is gentle and peaceful.

Testimony MD Senate Hearing 3:7:23.pdf

Uploaded by: Dixcy Bosley

Position: FAV

March 7, 2023
General Senate Hearing
Bill # SB0845
The Honorable Elijah E Cummings and the Honorable Shane E Pedergrass
End of Life Option Act

Testimony of support

My name is Dixcy Bosley, born in Baltimore, Maryland and after nursing school, I worked in DC on a AIDS research unit from 1985 to 1990.
It was a horrible time in human history when many young people died miserable deaths and as a young nurse, it set me on a path to examine the value of comfort care when curative medical care was limited. I realized early on that caring meant relieving suffering, not prolonging life. After many years of acute care nursing, I served as a hospice nurse, later became a family nurse practitioner and work now as a geriatric nurse care manager advising clients about end of life care planning.

In the last few years, since DC has allowed medical aide in dying for those who qualify, I have volunteered to accompany individuals requesting information to access the DC law. There are many who inquire to expand their options of choice as they battle a terminal illness. Additionally, I lead seminars designed to teach the public about their expanded rights as DC residents and I am intrigued by how many well informed Washingtonians want to understand our human rights law for end of life care. As a nurse who has cared for terminal patients for over 35 years, I feel it is my obligation to provide my clients with full knowledge of care options to promote their bodily autonomy and protect them from relentless suffering.

Since 2018, it has been my privilege to accompany four DC residents while they ingested a solution to end their lives in their private home with family present. It was a decision that was made over months of discernment, collaboration with their medical team and family. I chose to be there as an emotional support and observer of the law. I also wanted learn about how individuals decide to end their suffering, how the process is implemented and how the family caregivers react before and after death. Although most hospice providers in DC claim to be neutral on this issue, I believed my presence would affirm a patient's choice when even excellent hospice care was not enough. Hospice palliation and the option for medical aide in dying are partnerships in providing best practices.

Briefly, I will describe the four courageous people I accompanied as they accessed the DC law.

RT was a 62 year old father and son (I heard him call his 100 year old mother just before he died to thank her for understanding and for loving him) He had suffered from a long history of work related COPD and spent years attached to a oxygen tank. After an unsuccessful attempt to end his life with morphine years earlier, he went from an ICU into hospice and when he learned he could take medical aide, he set his date just after Thanksgiving 2019. His family, close friend and myself were at his side with he mixed and swallowed his life ending beverage. He sang to us and then soon became unresponsive, died 30 minutes later. Across the street, a school playground alive with children laughing was the back drop of this peaceful event.

BF was a 70 yr old film producer who lived with her devoted partner of many years who helped her deal with her physical disability related to advanced Parkinson disease. Her mother had dementia and she fear that her PD would become a disease of her mind as well as her body. Together with her partner's sacrificial support, she decided to request a prescription of medical aide and after months of discernment, she consumed it with full knowledge that she did not want to extend her life with only more predictable debility in the future.

PK was a 95 yr old successful architect having achieved so much in his long life. Even as a POW, bombed out of the sky in WW2, he reported great suffering from years of lung cancer, oxygen dependency and pain from metastatic bone cancer. He hand wrote a beautiful love letter he left at his bedside, found after he ingested his medication. He passed within minutes due to his advanced age and illness but I remember his wife feeling great relief to see him so peaceful after years of suffering. Her own grief was comforted by his unlabored breathlessness..

RL was likely the most profound experience of witnessing the end to of suffering.
At 42 years old, this resident of New Mexico, who had AIDS and lymphoma was escorted by his four siblings in a caravan across the country to come to DC with hopes of accessing the DC law.
RL was under hospice care, with unmanageable nausea, pain, and despair. His siblings were amazing advocates for him to direct his own care and he successfully acquired the medical aide prescription and set a date when his siblings could be with him at time of ingestion. I remember the sister who called to thank me for being with them as they celebrated his life and freedom from years of illness.

As a registered nurse in DC and MD, I hope that all my patients know they are entitled to full access of compassionate care. Most patients who ask about the option for medical aide, do not actually fill the prescription or even take it, But for the few who do, I honor them in my testimony today because I believe all citizens deserve bodily autonomy especially. None of us ever know another person's journey with a harmful and hopeless terminal illness. I air on the side of compassion. Thank you for considering my professional experience in DC to support the legislation for medical aide in dying in Maryland. It is time for expanded human rights in our neighboring state.

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JPR Testimony.pdf
Uploaded by: Donna DeLeno Neuworth
Position: FAV

March 7, 2023

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RE**: SUPPORT SB 845 End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) -SUPPORT**

Dear Chairman William C. Smith and Members of the Judicial Proceedings Committee:

I am writing in support of Senate Bill 845 End-of-Life Option Act –The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act. I am asking for your support as well and requesting you vote to pass this important piece of legislation out of your committee.

I have a keen and in-depth understanding of what terminally and seriously ill persons go through to attempt to maintain some semblance of quality of life as their disease progresses and they move closer to death. I have over 25 years of experience as an aging policy and health care professional working with the elderly, disabled adults and terminally ill persons both in direct care settings and in the Maryland and National policy and legislative arenas, as well as in U.S. Army caring for patients who were in the process of dying at Walter Reed's Army Oncology and Hematology units.

Often times, even in 2023, people are still dying in pain. Pain medication does not work for all, and even when it can assist with the pain levels of some of the more serious types of, for example, Parkinson's disease, it is either not enough or the medication just hastens their death and offers very little quality of life during their precious remaining years.

SB 845 provides an end-of-life option that many older adults and seriously ill adults need. Please support this bill, keeping in mind it is a choice, an option, for those who desire to maintain their bodily autonomy. Marylanders should have the health care right that residents of Washington DC and 13 other states enjoy.

Thank you for your consideration,

Donna DeLeno Neuworth

Donna Smith SB845 3723.pdf
Uploaded by: Donna Smith
Position: FAV

Testimony of Donna Smith, State Director, Compassion & Choices
Regarding SB 845, In Support ofThe End–of–Life Option Act
Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act
Maryland Senate Judicial Proceedings Committee
March 7, 2023

Introduction

Good morning Chair Smith and Vice Chair Waldstreicher,. I am grateful to be back before this committee, hopeful that this year we will realize a more compassionate end of life for residents of Maryland by passing the Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act (SB 845)

My name is Donna Smith. I was a Maryland resident for the last 20 plus years, living in Prince Georges and Anne Arundel County MD.

I am also the advocacy director of Compassion & Choices and the Compassion & Choices Action Network. We are the nation's oldest and largest consumer-based nonprofit organization working to improve care and expand options at life's end. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life.

What is Medical Aid in Dying?

Medical aid in dying refers to a practice in which a mentally capable, terminally ill adult may request from their medical provider a prescription for a medication that they can self-ingest to die peacefully if their suffering becomes unbearable. Ten states, Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, Montana, New Mexico, as well as the District of Columbia, have authorized the compassionate option of medical aid in dying. Seven of these jurisdictions authorized this end-of-life care option within the past seven years (2015-2022). Today, more than one in five people have access to this end-of-life care option.

Most notably, the dying person is in charge of the process from start to finish, and must be able to self-ingest the medication. Two doctors must confirm that the adult is mentally capable, has a medical prognosis of six months or less to live and is not being coerced. There are also more than a dozen additional regulations. All of these regulations are in addition to the education, training and oversight that governs the practice of medicine for any medical procedure.

Medical aid in dying is also entirely optional -- for both the doctor and the patient. Nobody is forced to participate, and the availability of the option brings people comfort during the most difficult time of life.

Public Support for Medical Aid in Dying is Strong

Public opinion polling from a variety of sources, both nationally and at the state level, demonstrates that the American public consistently supports medical aid in dying, with majority support among nearly every demographic group. A 2020 Gallup poll found that 61% of participants support medical aid in dying. Majority support spanned a variety of demographic groups, including 60% of people of color.[1] Research conducted in 2023 of registered voters in Maryland found that 71% support medical aid in dying.[2]

Support for Medical Aid in Dying is Also Strong Within the Medical Community

Physicians nationwide support medical aid in dying. According to the [Life, Death, and Painful Dilemmas: Ethics 2020](#) survey released by Medscape in November 2020, more than a majority of physicians support medical aid in dying, and this support has grown by nine percentage points over the past decade (from 47 to 55%).[3] Notably, physician opposition to medical aid in dying has plunged by 13 percentage points over the same time period (from 41% to 28%).

Most of the medical associations in authorized jurisdictions currently have neutral positions on medical aid in dying, including Oregon[4], California[5], Colorado[6], Vermont,[7] Maine,[8] New Mexico[9], and the District of Columbia[10].

There is growing recognition within the medical profession that patients want, need and deserve this compassionate option at the end of life; and this growing recognition is burgeoning into collaboration. As more jurisdictions authorize medical aid in dying, the

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[1] Susquehanna Polling & Research, Inc. USA Omnibus - Cross Tabulation Report, November 2021 (see pages 18-19). Availavle at: https://compassionandchoices.org/docs/default-source/default-document-library/usa-omnibus-cross-tabulation-report-final-november-2021-2.pdf?sfvrsn=74705b4b_1

[2] Gonzales Maryland Poll – January 2023 Results. Available at: https://compassionandchoices.org/docs/default-source/maryland/compassion-and-choices---gonzales-maryland-poll-january-2023.pdf?sfvrsn=ecbc7e23_1

[3] Leslie Kane. Life, Death, and Painful Dilemmas: Ethics 2020 https://compassionandchoices.org/docs/default-source/fact-sheets/medscape-ethics-report-2020-life-death-and-pain.pdf

[4] Oregon Medical Association. Available from https://oma.informz.net/informzdataservice/onlineversion/ind/bWFpbGluZ2luc3RhbmNlaWQ9NjU0Mzk3MSZzdWJzY3JpYmVyaWQ9ODc4MzYwNjk3.

[5] California Medical Association. Excerpted from: CMA changes stance on physician aid in dying, takes neutral position on End of Life Option Act. June 2, 2015. Available at https://www.cmadocs.org/newsroom/news/view/ArticleId/26466/CMA-changes-stance-on-physician-aid-in-dying-takes-neutral-position-on-End-of-Life-Option-Act.

[6] Colorado Medical Society, Statement by CMS President-elect Katie Lozano, MD, FACR, regarding Ballot Proposition 106. Available from: https://www.cms.org/about/policies#170-ethics

[7] *Vermont Medical Society, Position on Medical Aid in Dying,* (2017). Available from: http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf

[8] MMA Board Withdraws Opposition to Death with Dignity Legislation. May 1, 2017, http://newsmanager.commpartners.com/mainemed/issues/2017-05-01/index.html

[9] *New Mexico Medical Society Council Meeting Minutes 1.5.19* http://bit.ly/2GhwbIO

[10] *Another State Medical Society Stops Fighting Assisted Death* (2017). Lowes, Robert. Medscape. Available from: https://www.medscape.com/viewarticle/889450?reg=1&icd=login_success_gg_match_norm

medical community is coming together, and providers are sharing their experiences and fine-tuning their collaborative efforts to better serve dying patients.

A Solid Body of Evidence

When crafting medical aid-in-dying legislation, lawmakers no longer need to worry about hypothetical scenarios or anecdotal concerns. We now have 25 years of data since Oregon first implemented its law in 1997, and years of experience from the 10 other authorized jurisdictions, including annual statistical reports from nine jurisdictions. The most relevant data — namely, those relating to the traditional and more contemporary concerns that opponents of legalization have expressed — do not support and, in fact, dispel the concerns of opponents."[11] None of the dire predictions that opponents raised have come to fruition. In fact, there has never been a single substantiated case of misuse or abuse of the laws. The evidence confirms that medical aid-in-dying laws protect patients while offering a much-needed compassionate option.

Currently, public health departments in nine authorized jurisdictions have issued reports regarding the utilization of medical aid-in-dying laws: Oregon,[12] Washington,[13] Vermont[14] California,[15] Colorado,[16] Hawaii,[17] the District of Columbia,[18] Maine,[19] New Jersey[20]. The following data from those jurisdictions addresses the most common inaccurate claims about medical aid in dying and sets the record straight. More detailed reports can be provided upon request.

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[11] *A History of the Law of Assisted Dying in the United States.* SMU Law Review, A. Meisel, (2019) Available from: https://scholar.smu.edu/cgi/viewcontent.cgi?article=4837&context=smulr

[12] *Oregon Death with Dignity Act Annual Report* (2021) Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

[13] *Washington Death with Dignity Act Annual Report* (2020) Available from: https://doh.wa.gov/sites/default/files/2022-02/422-109-DeathWithDignityAct2020.pdf?uid=634756e5baf15

[14] *Vermont Patient Choice at the End of Life Data Report* (2020) Available from: https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf

[15] *California End of Life Option Act Annual Report (*2021) Available from: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2021_FINAL.pdf

[16] *Colorado End of Life Options Act Annual Report* (2021) Available from: https://drive.google.com/file/d/1IBp-r-KSjEI9IYdHIx5bLA9dTBB81GlM/view?usp=sharing

[17] *Hawaii Our Care, Our Act Annual Report* (2021) Available from: https://health.hawaii.gov/opppd/files/2022/07/corrected-MAID-2021-Annual-Report.pdf

[18] *District of Columbia Death with Dignity Act Annual Report (*2018) Available from: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DWD%20Report%202018%20Final%20%20%208-2-2019.pdf

[19] *Maine Patient Directed Care at End of Life Annual Report* (2021) Available from: https://legislature.maine.gov/doc/8664

[20] *New Jersey Medical Aid in Dying for the Terminally Ill Act* (2021) Available from: https://nj.gov/health/advancedirective/documents/maid/2021.pdf

- Cumulatively, for the past 20+ years, across all jurisdictions, 10,025 individuals have received aid-in-dying medication, and 6,378 people have taken the prescription to end their suffering.[21]
- Just over a third of people (37%) who go through the process and obtain the prescription never take it. However, they derive peace of mind simply from knowing they would have the option if their suffering became too great. Fewer than 1% of the people who die in each jurisdiction use the law each year.[22]
- Fewer than 1% of the people who die in each state will decide to use the law each year.
- The majority of terminally ill people who use medical aid in dying — more than 87% — received hospice services at the time of their deaths, according to annual reports for which hospice data is available.
- There is nearly equal utilization of medical aid in dying among men and women. There is no data on utilization of medical aid in dying by non-binary people.
- Terminal cancer accounts for the vast majority of qualifying diagnoses, with neurodegenerative diseases such as ALS or Huntington's Disease following as the second leading diagnosis.
- Just over 90% of people who use medical aid in dying are able to die at home. According to various studies, most Americans would prefer to die at home.[23]

Medical Aid in Dying Protects Patients

The evidence is clear: medical aid-in-dying laws protect terminally ill individuals, while giving them a compassionate option to die peacefully and ensuring appropriate support and legal protection for the care providers who practice this patient-driven option. SB 845 contains the same time-tested, evidence-based safeguards that have protected patients in other authorized jurisdictions.

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[21] *Medical Aid-in-Dying Data Across Authorized States, 2023*. Compassion & Choices. Available from: https://compassionandchoices.org/docs/default-source/default-document-library/medical_aid_in_dying_utilization_report_12-13-2022.pdf?sfvrsn=697faeca_2

[22] According to the Center for Disease Control, in 2019 in jurisdictions that authorized medical aid in dying, 427,296 people died in total. In 2019, authorized jurisdictions report 1,027 people died after being provided with a prescription for medical aid in dying–less than 0.002% of all total deaths in 2019. Center for Disease Control, *Deaths: Final Data for 2019*, July 26, 2021. Available from: https://stacks.cdc.gov/view/cdc/106058/cdc_106058_DS1.pdf

[23] Kaiser Family Foundation, Views and Experiences with End-of-Life Medical Care in the U.S., April 27, 2017. Available from: https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings/

There have been no documented or substantiated incidents of abuse or coercion across the authorized jurisdictions since Oregon implemented the first medical aid-in-dying law on Oct. 27, 1997. A 2015 report from the Journal of the American Academy of Psychiatry and Law noted “there appears to be no evidence to support the fear that assisted suicide [medical aid in dying] disproportionately affects vulnerable populations.”[24] Vulnerable groups included the “elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses, including depression, or racial or ethnic minorities, compared with background populations.”[25]

For Some, Comfort Care and Pain Management Is Not Enough

Terminally ill people who request medical aid in dying do not request it because hospice or palliative care has failed to provide the best symptom control available. In fact, the vast majority of individuals who use medical aid in dying are also receiving hospice and palliative care.[26] Good hospice services and palliative care do not eliminate the need for medical aid in dying as an end-of-life care option. Terminally ill people should have a full range of end-of-life care options, whether for illness-specific treatment, palliative care, refusal of life-sustaining treatment or the right to request medication the patient can decide to take to shorten a prolonged and difficult dying process. Only the dying person can know whether their pain and suffering is too great to withstand. The option of medical aid in dying puts the decision-making power where it belongs: with the dying person.

What we hear directly from terminally ill individuals is that people decide to use the law for multiple reasons all at once: pain and other symptoms such as breathlessness and nausea, loss of autonomy, loss of dignity. It is not any one reason, but rather it is the totality of what happens to one’s body at the very end of life. For some people, the side effects of treatments such as chemotherapy or pain medication (sedation, relentless nausea, crushing fatigue, obstructed bowels, to name a few), are just as bad as the agonizing symptoms of the disease. For others, they want the option of medical aid in dying because they want to try that one last, long-shot treatment with the peace of mind

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[24] Gopal, AA. 2015. Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry. Journal of the American Academy of Psychiatry and the Law. Vol 43(2): 183-190. Available from: http://jaapl.org/content/43/2/183

[25] Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal, Bregje D Onwuteaka-Philipsen. Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in “vulnerable” groups. Journal of Medical Ethics, Volume 33, Issue 10, 2007. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652799/

[26] By compiling the data from each authorized jurisdiction’s annual reports and aggregating that over all years, we arrived at these numbers. Medical Aid-in-Dying Utilization Report (2023) Available from: https://compassionandchoices.org/docs/default-source/default-document-library/medical_aid_in_dying_utilization_report_12-13-2022.pdf?sfvrsn=697faeca_2

of knowing that if it results in unbearable suffering, they have an option to peacefully end it.

Only the dying person can determine how much pain and suffering is too much. This law puts the decision in the hands of the dying person, in consultation with their doctor and loved ones, as it should be for such deeply personal healthcare decisions.

Support in Maryland

We are also seeing growing support for passage of this legislation in Maryland. We have increased our supporters to nearly 17,000 and we have increased our bill co-sponsors to 68, more than one-third of the legislature. This bill has been endorsed by United Seniors of Maryland, the ACLU, the Unitarian Universalist Church, Central Atlantic Conference of the United Church of Christ, and the Libertarian Party of Maryland.

Maryland lawmakers have a rare trifecta with this bill:

(1) Widespread public support;
(2) Conclusive data that it will improve end of life care; and
(3) Minimal cost to implement

I urge our Maryland lawmakers to let the evidence, data and strong public support for this end-of-life care option guide your policymaking.

In Conclusion

On behalf of the 73 percent of Maryland residents who support this option, I urge you to pass the End of Life Option Act this year. On behalf of those we have already lost waiting for this bill to be enacted, and on behalf of their families and loved ones who suffer with them, I urge you to pass this bill *now*.

Regardless of whether you would choose the option for yourself, please don’t deprive others of the peace of mind and comfort of medical aid in dying.

Terminally ill Maryland residents don’t have the luxury of endless deliberations; they need the relief that this law affords them right now. Thank you.

Donna Smith
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Dr. Heinrichs SB845 testimony 3723.pdf

Uploaded by: Douglas Heinrichs
Position: FAV

Testimony of Douglas W Heinrichs M.D.
Support for SB 845 and HB 933
In support of the End-of-Life Option Act

I am Dr. Doug Heinrichs, a psychiatrist who has been practicing in Maryland for over 40 years. I am a member of the Maryland Psychiatric Society (MPS) legislative committee, but I am here as a private individual, not representing the MPS. I strongly support this bill and wish to make three points from the perspective of a psychiatrist.

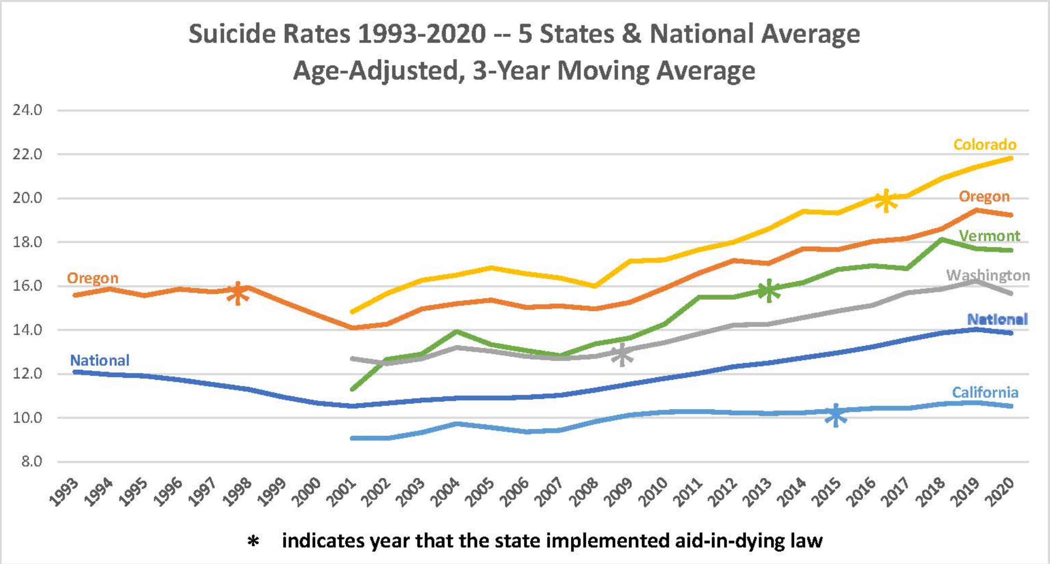
First, a recent poll of the MPS membership showed 57% support medical aid in dying or MAID for the terminally ill, in keeping with polls of psychiatrists nationally and US physicians in general. The official opposition of the MPS is out of step with its membership.

Second, the objection that there should be a mandatory psychiatric evaluation of anyone seeking MAID is unreasonable. The University of California San Francisco chose to require such an evaluation for everyone in its system. A five year review recommended the policy be dropped because "… zero patients in our sample were found to lack capacity due to having a current psychiatric condition that impaired decision-making." (Bell BK, *et al*. 2022) Data from Oregon and Washington State also argue against the need for such a requirement. (Ganzini L, 2014) Furthermore, requiring such a mandatory assessment when mental health resources are so severely stretched is counterproductive, and the inevitable delay would be an extreme burden for those seeking to use this option.

Third, the objection that allowing MAID would lead to increases in copycat suicides is not supported by data from states where it is available. No changes in the pattern of suicide rates are seen that correspond to the introduction of medical aid in dying legislation. (CDC WISQARS Online Database) This should be no surprise. Suicides involve people who want to end their life. People seeking MAID would love to keep living. It is their disease that is determining that they will be dying imminently. They are only seeking control over how they die, to minimize the distress for themselves and their loved ones.

[I am attaching data on longitudinal patterns of suicide before and after the introduction of MAID in 5 states and three recent articles that I have written for the Psychiatric Times that address these and related issues from a psychiatric perspective in more detail. (https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-1; https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-2; https://www.psychiatrictimes.com/view/the-case-for-medical-aid-in-dying-part-3.)]

Aid in Dying Does NOT Increase the Suicide Rate



Suicide Rates 1993-2020 -- 5 States & National Average
Age-Adjusted, 3-Year Moving Average

* indicates year that the state implemented aid-in-dying law

Suicide rates per 100,000 population

Source: Years 1993-1998 CDC WISQARS™ Online Database; Years 1999-2020 CDC WONDER Online Database

The Case for Medical Aid in Dying: Part 1

Aug 23, 2022

Douglas W. Heinrichs, MD

As more states consider legislation permitting medical aid in dying (MAID), the controversy around this practice within our profession continues to swirl. Articles in opposition have appeared frequently in this publication.[1-14] As someone in support of MAID as a reasonable and merciful option for some patients, I have struggled to make sense of the basis for opposition.

In this culture, which highly values individual freedom, we generally hold that persons should be free to choose how they want to live their lives, unless they violate the rights of others. Choosing how to die in the face of a terminal illness is certainly an important life choice—one increasingly supported by the majority of our citizens.[15] Thus, the burden is on opponents to show why this option should be prohibited.

Arguments are of 2 general types: arguments from fundamental principles held categorically by opponents, and arguments that undesirable practical consequences are likely to follow—or have followed—MAID implementation. In this and 2 subsequent articles, I will challenge these arguments as unconvincing. Here I examine arguments from fundamental principles. In subsequent articles, I will consider arguments based on consequentialist concerns.

The Primary Principles of the Opposition

Two primary principles are involved: (P1) It is categorically wrong to take one's own life under any circumstances, and (P2) it is categorically wrong for a physician to help anyone take their own life.[10] Such allegedly self-evident first principles typically derive from religious or other transcendent beliefs, cultural traditions, or appeals to the universal dictates of reason in the spirit of Immanuel Kant. The last is suspect, as rational individuals clearly do not come to the same conclusions about what reason dictates. Transcendent beliefs are only compelling to those who accept that religious or metaphysical system. Even respected traditions may become less relevant or rejected as circumstances and other cultural values change. In short, appealing to principles does not in itself clinch the argument.

For (P1), there is typically an appeal to transcendent beliefs, directly or indirectly religious, hence there is not much room for logical arguments that might persuade someone who operates from different premises. Weekly churchgoers are the only group where the majority do not support MAID.[15] The question is whether one's personal ethical intuitions, religiously derived or not, should be imposed on everyone else. Our cultural tradition and legal system have generally said no to that.

The Hippocratic Oath

The argument that MAID intrinsically does violence to the physician's role (P2) appears to have 2 components. The first is that it violates the Hippocratic Oath and the tradition surrounding it, with its commitment to respect the value of life.[3,5] In its original form, the Hippocratic Oath explicitly forbids the administration of lethal medicine for the purpose of killing the patient. It should also be noted that the original Hippocratic Oath involves swearing in front of Apollo as well as the promise to take care of our teachers and their children as if they were our own.

Traditions are not fixed in time but evolve as the needs and values of society changes. Due to its many anachronisms, the oath has largely been replaced in medical schools around the country by alternative oaths thought to better reflect modern realities and values. It is noteworthy that in a content analysis of medical school oaths administered in 2000, only 6 of the 122 allopathic medical schools surveyed had oaths that contained a stipulation against MAID or euthanasia.[16] We still embrace our commitment as physicians for the valuing of life. But should this reflect the quality or the quantity of life? For many of us, respecting the life of the patient has as much or more to do with supporting their dignity, autonomy, and relief of suffering as it does with simply maximizing the number of days they keep breathing.

One of the developments over time that has changed the balance, certainly from the time of Hippocrates, is that we have largely eliminated bacterial aid in dying (BAID). I think it can be argued that with the discovery and development of antibiotics—overall a tremendously wonderful thing—there has come 1 harmful and unintended consequence: The frequency and duration for which individuals had to face protracted deterioration with extensive suffering and dignity-reducing loss of function before dying was greatly lower in pre-antibiotic times. Patients with such conditions would typically rather quickly contract life-ending infections, such as pneumonia. Having curtailed nature's most common way of alleviating such suffering, I would suggest the least we can do is to provide some merciful alternative.

The Valuable Role of Physicians

A second component of this argument put forward by opponents of MAID is that if an individual wants to die, why involve the physician?[10] This strikes me as a profoundly insensitive attitude. If any of you, like me, has had and loved multiple pets, you have undoubtedly had the difficult experience of being present as one was euthanized by a veterinarian. Beyond the unavoidable sadness of losing a beloved member of the family, I have always found this a peaceful and comforting process made possible by the supportive presence of the veterinarian who cared for my animal over many years, or if that is not possible, by another caring veterinarian. How should I have felt if the veterinarian had said, “As a doctor to animals, I am here to preserve and value their lives, not to end them. Besides, you can do this yourself or ask someone else to help you. If you do not have a gun, a sledgehammer will work”? I would argue that we have a valuable role to play, as physicians, in providing not simply technical assistance but emotional support and understanding to patients if they have reached the difficult decision to end their life.

The example of the veterinarian raises an interesting question. I have never heard anyone say that a veterinarian is violating their professional integrity by euthanizing their patients—rather, it is looked upon as a kind and humane option. It seems to me that the burden is on those who oppose MAID to demonstrate why we should be less kind and humane to our fellow humans than we are to the nonhuman members of our families. It seems to me that once one removes any theological or metaphysical beliefs that humans are categorically different by virtue of our soul or some special plan God has for us, the basic principles of kindness in the face of suffering should apply to humans as well. Besides, humans—unlike our beloved pets—can tell us what they want.

Opponents to MAID argue that it is a whimsical jettisoning of a 2500-year tradition of how physicians should act based on a brief contemporary moment in which autonomy is excessively valued over the other cornerstones of medical ethics—beneficence, non-malfeasance, and justice—as an expression of a consumer-based culture in which physicians have become mere providers.[1,11] Although I agree that long-standing traditions should not be abandoned thoughtlessly, there are times when the tradition needs to be modified in light of changes in conditions or the evolution of other values in society. Slavery is a tradition with a much longer history and more universal acceptance than the Hippocratic tradition, and it is only relatively recently that modern societies have rejected it—yet I doubt any of us would argue that the rejection was unwarranted. Aspects of a tradition need to be judged on their own merits after careful consideration as to whether we should continue, modify, or abandon them.

In the same spirit, opponents of MAID accuse supporters of simply following public opinion based on polls showing that the majority of the public support MAID, as if they engage in less thoughtful ethical reflection than opponents.6 It is true that no one, including physicians, should blindly or reflexively change their position based on the latest poll. However, when our own guild becomes seriously out of step with the values of the larger culture, it may be time for a serious self-examination as to whether we have become ossified and out of touch.

“Noble” Deaths

Opponents of MAID frequently cite in heroic terms cases of individuals bravely facing their gradual deterioration and death, and even fighting it until the end, with courage and dignity.[7,8] And it is certainly fine for individuals to do so, if that is how they choose to end their life. However, there is the implication that this is a nobler way to die than MAID. I see no reason why an individual cannot approach MAID with courage and dignity as well. Just as there is more than one good way to live, there is more than one good way to die.

The flip side of this rhetorical maneuver is to describe the empathic and spiritually edifying experience for the doctor and loved ones of being there and sharing the dying experience with the patient. I suspect that this experience is often more satisfying for the participants other than the suffering patient. Furthermore, it has been a long time since physicians typically spent much time at the deathbed communing with the dying person. That role, if it occurs at all, has long since been abdicated to other health care professionals. But most basically, I see no reason why the same empathy and caring cannot be provided in the context of MAID as well as, if not better than, with a protracted unaided death.

Physician-Assisted Suicide

Opponents of MAID prefer the label of physician-assisted suicide (PAS). Although I think MAID is a less emotionally biasing term, I do not see this as an important argument. What I do think is important is their stress that there should be no fundamental distinction between this practice and any other kind of suicide.[15] Killing oneself is killing oneself. They then go on to argue that MAID should not be allowed because of the devastating effects that suicide has on surviving family, citing either anecdotes or data supporting this.[13] But there is little reason to think that reactions to an unexpected self-inflicted death by a troubled individual would resemble reactions to a planned death in the context of MAID, whether we call that suicide or not. I believe there is quite a difference in these 2 kinds of suicide. If I am taking a family history of a depressed patient and the patient tells me that their parents committed suicide in midlife while depressed, it has very different implications than if the patient tells me that their parents with terminal illnesses chose to end their lives rather than continue to suffer.

Voluntary Stopping of Eating and Drinking

Opponents of MAID insist on making a fundamental distinction where I believe there is none—namely between electing MAID or hastening one's death by other means, such as refusing further treatment or the voluntary stopping of eating and drinking (VSED).[6,7] The latter is viewed as a totally acceptable and even admirable removal of the impediments to death, while the former is ethically wrong. Frankly, this seems like a hairsplitting distinction based on a bit of medieval casuistry. If VSED is acceptable because it is simply refusing essential nutrients rather than actively consuming a lethal substance, I would assume that opponents of MAID have no problem with a person sealing themselves in a small, airtight box and dying of suffocation. After all, they are simply depriving themselves of oxygen rather than actively consuming a lethal substance. I would argue that this is a distinction with no ethical or moral importance—a difference of means, not of ends. If there is no difference between MAID and any other suicide, is there a difference between VSED in the context of a terminal illness and dying from severe anorexia nervosa? Starving to death is starving to death. Whether or not this distinction exists or is significant has important implications for many of the consequentialist arguments that will be addressed in subsequent articles.

Dr Heinrichs *is a psychiatrist in Ellicott City, Maryland.*

The opinions expressed are those of the author and do not necessarily reflect the opinions of Psychiatric Times™.

What are your thoughts on MAID? Share your questions, concerns, and potential solutions via PTEditor@mmhgroup.com.

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The Case for Medical Aid in Dying: Part 2

Aug 30, 2022

Douglas W. Heinrichs, MD

In part 1 of this series,[1] I argued that in our society, in valuing an individual's right to choose how to live their life unless violating the rights of others, the onus is on opponents of medical aid in dying (MAID) to demonstrate why individuals with terminal illness should be deprived of the option of asking a physician to provide a means to end their life.

I considered arguments derived from fundamental principles held by opponents and maintained that they were not compelling. But opponents further argue that MAID should be rejected because of unacceptable consequences that may follow it. We are moving from arguments based on principles and ethical rules (deontological) to ones based on effects (utilitarian). The question is whether undesirable consequences are likely to be of such a magnitude and/or beyond remediation that they outweigh the positive impact of MAID. Such arguments are of 3 types: 1) safeguards to protect the individual from abuse and misuse of MAID will be inadequate, 2) MAID will undermine other important public policy priorities, and 3) permitting MAID puts us on a slippery slope that will inevitably lead to other unacceptable practices. I will consider the first 2 here and the last in the final article of this series.

Safeguards

Some safeguards are certainly important. Individuals choosing MAID should be competent and not subject to excessive external pressure by those who might benefit from their death. They should understand that the prognosis as to how long they have to live is a fallible medical judgment. They should be aware of other available treatments that they have not yet tried that may alter their life expectancy or quality of life. Palliative care options should be discussed. If there is concern that their judgment is impaired by an episode of psychiatric illness, a psychiatric assessment may be indicated. Such safeguards already apply in other situations in which individuals make important decisions about the closing phase of their life—for example, advanced directives and living wills, do not resuscitate orders, naming medical power of attorney, stopping life-sustaining treatments, voluntarily stopping eating and drinking (VSED) to hastens one's death, and making a will. Although at times abuses undoubtedly occur in these situations, we generally feel that our existing safeguards are adequate to minimize such instances.

Opponents of MAID, however, argue that this level of safeguard is woefully inadequate.[2,3] For instance, they cite the relatively small percentage of cases applying for MAID that get psychiatric evaluations.[2] But what portion of patients get psychiatric assessments before we honor their living wills, advanced directives, decisions to end life-sustaining treatment, or to opt for VSED? Opponents argue that there are insufficient protections against other interested parties encouraging an individual to seek MAID. But those same interested parties could also encourage an individual to terminate life-sustaining treatment or to engage in VSED. Opponents point out that individuals often seek MAID not because they are in excruciating pain, but because they want to avoid future suffering and/or deterioration that they feel deprives them of dignity.[4] But the same motives can lie behind the decision to stop treatment or engage in VSED, and we do not generally view them as inappropriate. Opponents have gone so far as to argue that an individual seeking MAID may be subtly influenced by their own inner fantasies and fears about death, and thus cannot exercise true autonomy in making the decision. Such unconscious factors require not a basic competency assessment, but detailed psychiatric exploration.[5] Are opponents arguing for the universal need for psychoanalysis before electing MAID?And besides, unconscious fantasies and fears are as likely to make one fight death to the bitter end as they are to make one opt for MAID.

I believe there is something disingenuous about these arguments. They set up a standard for safeguards that could not ever be achieved in practice, and at the same time, they do not apply this standard to other decisions that hasten death. In my experience, individuals making these arguments also oppose MAID based on their fundamental ethical principles, as discussed in part 1 of this series. Is demanding impossible safeguards just a way to persuade those of us who do not share those fundamental principles?

Opponents argue that MAID is so fundamentally different that different standards for MAID are appropriate. Opponents stress that MAID is simply suicide—preferring the term physician assisted suicide (PAS)—and not fundamentally different from other suicides.[6] Furthermore, suicide is a subset of killing. Hence, it is appropriate to it treat it quite differently than other strategies to hasten death. I argue that whereas there are important practical and ethical differences between MAID and other forms of suicide, there is in fact little ethically relevant difference between MAID and other techniques that hasten death. I see making such a distinction as a bit of medieval casuistry.

Hastening one's death is hastening one's death—the same factors and risk for undue influence come into play in both cases. Should it not be the individual's choice?

This is not to say that every effort should not be made, both in formulating MAID legislation and fine-tuning it once it is enacted, to optimize safeguards that are effective as well as practical. But such safeguards will never be perfect. All laws about anything result in some instances in which the outcome is other than what the law intends. Any law could be attacked on these grounds. Should we never imprison anyone because sometimes an innocent person goes to jail? Should the police not be allowed to carry weapons since they sometimes do egregious things with them? Should no one get disability benefits because some people cheat and get them undeservingly? It seems to me the logical response is not to oppose every law that could be misused, but to work in an ongoing way to fine-tune regulations and controls to minimize the undesirable outcomes.

This is an evolving process over time, as it takes experience with any law to see which regulations work and which need improvement. But it could be argued that in the meantime, some individuals may experience significant harm. That is true, but it must be weighed against the individuals who will be harmed by having to endure protracted pain, suffering, or lack of dignity by not having the option of MAID in place. This weighing of benefit versus harm involves a quantitative judgment that is difficult to make with any precision before significant accumulated experience occurs. Just as in assessing the risks and benefits of a new treatment in medicine, we must be careful not to be unduly swayed by striking anecdotes on either side.

Models designed to project risk and harm can be useful to consider, but they are notoriously unreliable, given that they always involve a host of assumptions that are only approximately true in the real world. As fallible human beings, the best we are likely to do is to make reasonable attempts to provide sensible safeguards and be prepared to fine-tune over time as experience accumulates. This is the equivalent of post-marketing reports of adverse effects with a new therapeutic agent.

Undermining Public Policy Priorities

Opponents have further argued that allowing MAID could adversely impact several important public policy priorities. The concern has been raised that, once available, MAID will encourage a reduction in resources made available for palliative care and improved treatments for terminal illnesses, as well as research dollars in these areas.[3,6] It is unclear to me why this would be the case. It is unlikely that more than a small percentage of individuals with terminal illnesses will opt for MAID, and the need for better palliative care as well as definitive treatments of life-threatening illnesses will remain. There is always a battle between worthy medical projects for the limited funding available, but in comparative terms, MAID requires very little of the health care dollar and is unlikely to meaningfully reduce what is available for other purposes.

Another version of this argument is that if society made optimal palliative care available and affordable to all, there would be no need for MAID.[6] There are 2 points to be made here: (1) Even optimal palliative care cannot always prevent levels of suffering and/or loss of dignity that the individual patient may deem unacceptable to them, and (2) it is insensitive to the individual's unique predicament to say that because society should make better, affordable palliative care available but does not, the individual should be deprived of the option of MAID.

Consider the case of "Mr Smith," a man diagnosed with a terminal illness who is told that without treatment X, he is likely to die after considerable suffering in 3 to 6 months. With treatment X, he may live 1 to 2 years before succumbing to his illness. Treatment X is not covered by Mr Smith's insurance and will deplete the bulk of his modest savings on which he and his healthy spouse were counting for their retirement years. No one in his family is pressuring him on this issue, but he is not willing to leave his wife in such a financially precarious condition. I agree with those who feel it is a travesty that Mr Smith is faced with this dilemma in a society as affluent as ours, and I support the fight for more equitable and affordable health care for our citizens. But given his current reality, should Mr Smith be deprived of choosing to make this sacrifice to provide for the person he loves?

Another aspect of public policy is the concern that MAID legislation could put physicians in situations where they were compelled to play some role in it despite their ethical objections. It is important to note that no current or proposed MAID legislation requires physicians to participate in any capacity. Could they be pressured to do so by a public or private employer? It seems relatively straightforward to safeguard against this possibility, as is done in current legislation. Concerns have been also raised about indirect collaboration with MAID being required of a physician who objects on ethical grounds. For instance, hypothetically, if a psychiatrist is treating a patient who requests MAID, the psychiatrist may be asked to do a competency assessment of the patient. It seems clear that the psychiatrist could refuse to participate. In that case, however, another psychiatrist may be asked to do the evaluation, and that psychiatrist could, with the patient's permission, request treatment records from the first psychiatrist to aid his evaluation. There is a legal obligation to supply the records in such a case. Is the first psychiatrist being compelled to participate in a process they find morally objectionable?[4] I think this is a pseudo-dilemma. By law, medical records are the property of the patient held in our possession. They have a right to those records for whatever purpose they choose. It is not our place, as physicians, to judge the ethical acceptability of their purposes, and supplying records is not an endorsement of those purposes.

Concluding Thoughts

Could future MAID legislation, or court decisions interpreting such legislation, in some way compel physicians to participate in a practice they find ethically unacceptable? I think that is extraordinarily unlikely, but should that occur, that would be something worth fighting against. But because it cannot be guaranteed that such a thing could not happen in the future, is that a basis for rejecting MAID as currently construed? To argue that it is constitutes an instance of one of the most pervasive species of argument employed by opponents of MAID: the slippery slope. Because this sort of argument is so important in this debate, it requires a careful consideration, which will be the focus of the final article in this series.

Dr Heinrichs *is a psychiatrist in Ellicott City, Maryland.*

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The Case for Medical Aid in Dying: Part 3

Sep 6, 2022

Douglas W. Heinrichs, MD

In parts 1 and 2 of this series,[1,2] I examined arguments by opponents of MAID based on beliefs that the practice is categorically wrong, followed by arguments asserting unacceptably harmful consequences that might follow MAID. In both cases, I maintained that these arguments are unpersuasive. In this final article, I will examine a type of argument that has played a prominent role in this debate: the slippery slope.[3-5]

The Slippery Slope

The basic form of the argument is that even if A is not so bad, if allowed, it will inexorably lead to B, which is even worse, then to C, which is worse still, and on to some catastrophic state of affairs. How should we look at these kinds of arguments? Bernard Williams, widely regarded as one of the most astute and nuanced ethicists and philosophers of the late 20th century, wrote an insightful article entitled “Which slopes are slippery?”[6] In it, he points out that there are 2 assumptions behind a slippery slope argument. The first is that what is at the bottom of the slope is something we all see as horrible, even if the first step may seem acceptable and even positive to at least some of us. He points out that frequently, the advocates of this sort of argument actually think the first step is wrong as well, but are not sure they can persuade others. If I think A is wrong but you do not, I may get you to agree to oppose A if I can convince you that it inevitably leads to B, then C, and so forth, until we reach some point that we all agree is wrong.

The second assumption is that the slide down the slope, once begun, is unstoppable. This sometimes involves the notion that the advocates for A will then advocate for B, then for C, and so on. But if we believe A and B are desirable, but C and D are not, is it not logical to support A and B but oppose C and D? The usual response here is that each step is so incremental and essentially indistinguishable from the immediately prior step that drawing a line at any point on the continuum is simply arbitrary and hence hard to defend. One could argue, for instance, that wherever one draws the line of eligibility for MAID procedures, those just outside that line can understandably argue that it is unfair that they are being excluded. Why those with a prognosis limited to 6 months? Why not 7 months or 8 months? In cases of protracted suffering, why not extend MAID to those whose deaths are not imminent? If it is acceptable for age 18, why not 17, 16, and children? If MAID is legal, why not permit euthanasia for those who cannot self-administer a lethal drug? Surely the incompetent suffer as much as the competent, so why not allow a competent person to leave instructions to authorize euthanasia once they reach some future condition that they feel is unacceptable to them at a time they are no longer judged competent? And on and on.

Williams makes the point that this is not a valid type of argument, noting that “indistinguishable from is not a transitive relationship: from the fact that A is indistinguishable from B, and that B is indistinguishable from C, it does not follow that A is indistinguishable from C.” Around most matters, even if it is difficult to draw a precise line between acceptable and unacceptable, it is likely that agreement can be had as to a large portion of the behaviors at issue that some are not acceptable and others are.

In matters of public policy, we nonetheless need to draw some explicit line in the sand between acceptable and unacceptable at a practical level. Williams argues that in such cases, it is a long-established societal practice to draw an arbitrary line as a reasonable and practical approximation to our sense of what is the conceptual breakpoint between acceptable and unacceptable. We draw arbitrary lines all the time, and these can be pragmatic solutions that work quite well even if we cannot logically defend why the line is drawn precisely where it is as opposed to somewhere else. Speed limits on roads are an example. If the speed limit is 55, we cannot logically defend that 54 is categorically safer than driving at 56. The age for consent to marriage, the age at which one may buy alcohol, the blood-alcohol level that defines intoxication, and the age at which we are deemed mature enough to vote are other examples. As a society, we are free to draw arbitrary demarcations in the continuum of behaviors when they have practical utility. We are not doomed to keep sliding down the slope.

Pushing the Agenda

But what about the concern that advocates of MAID do not want to stop at A? Their agenda is to push for more and more permissive laws expanding the pool of individuals who are eligible as well as easing access to the process. Opponents cite changes that have in fact occurred in other states and countries that have permitted MAID. It is indeed true that some advocates believe in much broader applications than imminent terminal illnesses and/or support euthanasia as well. But just because there is a push in this direction does not automatically make it a bad thing. We must judge the merits of each step and decide whether we find it acceptable.

Frankly, I personally find a lot of the subsequent developments cited as if they are obviously horrific to be positive. I think it is totally reasonable to allow MAID for intractable suffering even in the absence of imminently terminal illness. It seems to me quite reasonable to allow a competent individual to state in advance that they wish to be euthanized once they reach a defined level of physical or mental deterioration, even if they are not judged competent at that later point. To me, one of the greatest tragedies of not allowing euthanasia in such circumstances is that an individual who has an illness that is likely to reach a point at which they are no longer physically and/or mentally capable of ending their own life must make and implement the decision to terminate their life while they are still able, when by their own standards some period of satisfying life remains. I am not suggesting that everyone should agree with me around each of these issues. I am only saying that the pressure to move to a next step is not automatically a bad thing. The case needs to be made for each new change as to whether it is desirable or undesirable. The fact that there is pressure to move in and of itself is morally neutral.

The metaphor gets in the way here. If we are on a slippery descending incline and we do not want to end up at the bottom, then any movement we feel is ominous. If it is slippery enough, the only safe thing to do is not get on the slope at all. I think a much more apt analogy in these kinds of situations is a hill rather than a slope. This is in keeping with the Aristotelian notion of the golden mean—namely that the desirable position, the point of virtue, is somewhere between 2 extremes, both of which are morally bad.[7] When an advocate of a position wants to continue moving in a particular direction, the question we need to answer is whether the advocate is pushing us uphill and closer to the optimal position, or downhill toward one of the extremes.

Consider the following slippery-slope argument: “It was a mistake to give women the right to vote. After all, once they had it, they were not satisfied. Advocates then were pushing for equal employment opportunities, equal pay, protection from on-the-job sexual harassment, and increasing numbers of women in management. Where will it end? Before you know it, they will want women’s salaries to be double that of men and all supervisors to be women. This is a slippery slope indeed, and it all started with giving them the right to vote.” I suspect very few of us would find this argument compelling, because most of us see women’s rights as still on the ascending slope of the hill and further pressure to advance them as justified. Furthermore, I suspect we all feel that the movement could and would be stopped long before it reached the projected end of a woman-dominated society. Yet the logical structure of this argument is exactly the same as the ones made regarding MAID and its alleged slippery consequences. The mere fact that there has been pressure to move the line of what is permissible is not in and of itself ominous. We need to assess each proposed step on its own merits, and then decide whether to support it or argue to draw the line there.

The Disability Community

There is one instance of the slippery-slope argument that, because of its importance, merits specific comment. Spokespersons for the disability community have raised concerns that if MAID were extended to individuals based on pain, suffering, or dignity-depriving dysfunction, it could lead to a judgment that individuals with disabilities have lives not worth living and result in pressure for those individuals to request MAID.[6] This would seem a highly unlikely consequence of MAID legislation as currently conceived, even where it has been broadened to individuals without imminently terminal illnesses. Safeguards against undue influence on the individual choosing MAID by persons who stand to benefit from hastening the individual's death have been accepted as important for everyone, not just those with disabilities. Any future attempt to unduly pressure individuals with disabilities should be vigorously opposed by us all. But it is not a reason to reject MAID as currently construed.

Spokespersons for the disability community sometimes go further to argue that even if an individual with significant functional limitations freely opts for MAID, this is an afront to all disabled individuals because it is an assertion that living with significant functional impairments is not a life worth living. I think this is an unfair conclusion. When an individual chooses MAID, they are not making a judgment as to the worth of the lives of a group of people who happen to share their medical condition or limitations. They are not even saying that their particular life is in some abstract sense not worth living. Rather, they are saying that after considering and weighing all the unique components of their situation, they are deciding that they would prefer not to go on living.

Every significant decision we make should consider all the unique circumstances of our lives in light of our own values and preferences. Such a decision should not be seen as a judgment on the lives of others who happened to share some features with our lives, or on the decisions they choose to make in light of their unique circumstances. This is true of all our important life decisions, such as whether to marry, whether to have children, whether to divorce, what career you choose, and where to live. We should not be condemned to having every one of our choices be viewed as a judgment we are passing on others.

Concluding Thoughts

In this series of articles, I have argued that the burden is on opponents of MAID to demonstrate why we should be deprived of this particular exercise of our freedom and autonomy. I have considered in turn what I view as the primary categories of these arguments. I believe they fail to make the case. These discussions have focused on MAID for terminal illnesses, and although I personally support broader applications in cases of intractable suffering or loss of dignity, that merits fuller discussion at another time.

Dr Heinrichs *is a psychiatrist in Ellicott City, Maryland.*

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Dr. Jeff Gardere Testimony in Support of SB0845:HB

Uploaded by: Dr Jeffrey Gardere

Position: FAV

Dr. Jeff Gardere Testimony in Support of SB0845/HB0933

Good day Chairman Will Smith, Sponsor Jeff Waldstreicher and all members of this committee. My name is Dr. Jeff Gardere.

I am a board certified clinical psychologist, an ordained minister, and a professor at a New York medical school, where I teach students about the sanctity and quality of their patients' lives and mental health.

While some who oppose the End of Life Options Act (The Honorable Elijah Cummings and The Honorable Shane Pendergrass Act) and believe that people will be pressured to end their lives, this belief is not supported by the data. We know from more than 20 years of experience in Oregon, where the nation's first medical aid-in-dying law was implemented, and the experience of other authorized jurisdictions, including neighboring Washington, D.C., there has not been *one single instance* of abuse or coercion. And the legislation proposed here in Maryland contains more than a dozen safeguards.

Though I understand the concerns of the opposition, scientifically and factually it is incorrect to equate terminally ill adults who want the end-of-life care option of medical aid in dying with people who unfortunately take their life prematurely.

And according to the American Psychological Association, they are fundamentally different. As well, The American Association of Suicidology also argues, medically and legally, Physcian Aid in Dying and suicide are conceptually different phenomena. In suicide, a life that could have continued indefinitley is cut short, in Medical Aid in Dying, death is foreseeable and in some cases immiment. Most people who take their life prematurely have the choice to live but under the influence of psychological illness choose not to. Terminal patients who may use medical aid in dying do not have the option to live, the illness has taken that decision away from them. The question then becomes *how* they die...not *if* they will die.

I have talked to and counseled countless people and none of them want to die, but they know that one day this will be their fate, and for the terminally ill, it will come sooner rather than later. Many, who have lived life with courage and spirit, are less afraid of the end arriving and more concerned with what the end of their lives will look and feel like. They seek a respectable quality of life, peace, comfort and most importantly, dignity.

Medical aid in dying provides that — by ensuring patient autonomy, a key component of adulthood. Medical aid in dying is not the right end-of-life care option for everyone who would qualify, however, it should be an option, a legal right available to independent, well-informed Marylanders facing this terminal phase of life.

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

SB0845 - EMorrison - Favorable.pdf

Uploaded by: Dr. Elizabeth Morrison
Position: FAV

Testimony of Elizabeth Morrison, M.D.
Support for SB 845 and HB 933
The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

I am Elizabeth Morrison, a psychiatrist for 40 years, first in the U.S. Army and then in private practice in Maryland. I have been active in local and national medical organizations, including leadership positions with the Washington Psychiatric Society — which includes Montgomery and Prince George's counties -- and with the American Psychiatric Association (APA). I speak for myself and I support the End-of-Life Option Act.

I have 3 points:

1. **From a psychiatric perspective, aid-in-dying patients and suicidal patients should be viewed as fundamentally different.**

Suicide in the context of some mental illnesses occurs because of intolerable suffering, distorted and irrational thinking, and impaired judgment. In contrast, individuals eligible for aid-in-dying have terminal, treatment-refractive illnesses. These are people who, if not for their terminal illnesses, want to live.

2. **Most patients with psychiatric conditions do maintain capacity and can continue to make medical and other end-of-life decisions.**

Patients nearing death may be sad and grieving, but <u>still have capacity</u>. They should be allowed to participate in medical aid in dying. Those who have significant depressive or other concerning symptoms should be referred for evaluation by a mental health professional.

3. **The American Medical Association (AMA) has modified its position to accommodate aid-in-dying:**

In 2019 the AMA remained opposed to medical aid in-dying <u>but</u> simultaneously concluded that physicians who participate in it are not violating The Code of Medical Ethics, and that morally admirable physicians can hold divergent views on this issue. Here is the exact language that appears in the Code**.**

Thus, any attempt to say that the AMA opposes medical aid-in-dying is telling only half the story.

Libertarian Party of MD-Statement of Support-SB845

Uploaded by: Eric Blitz

Position: FAV

LIBERTARIAN PARTY of Maryland

Statement of Support: Senate Bill 845

End-of-Life Option Act

To: Senate Judicial Proceedings Committee
From: Eric Blitz, Chair of the Libertarian Party of Maryland

March 6, 2023

Chair Smith, Vice-Chair Waldstreicher, Members of the Committee:

The Libertarian Party of Maryland supports passage of SB 845. Competent individuals should have the power to control their own bodies and lives, including the medical care they undertake in support of both. For terminally ill patients with a prognosis of less than six months to live, this right of self-determination includes the choice to take medicine to end their life in a dignified manner and thus determine for themselves how best to manage the process of dying. We ask that you respect the individual's autonomy and right of self-determination by removing the legal prohibition against medical professionals and facilities assisting a patient to make a choice that empowers them to tailor their care to their particular circumstances. The individual patient is best situated to make their own moral and intellectual choices concerning their death and to choose medical care that protects their personal dignity. We also commend the law's protection of the doctors and medical facilities' choice to participate or not, which respects their autonomy to make their own ethical and professional choices.

Not everyone will make the same choices in medical care at the end of our lives. Some have moral objections to the choice this bill would protect and they should always be free to act in accordance with their moral conclusions. However, the law should not adopt one group's moral conclusions by prohibiting the choice of those who reach different conclusions. Opponents characterize the choice as suicide rather than a medical response to an existing terminal illness, ignoring the substantive differences in causation and intent.

Maryland and federal law have a long history of being most protective of individual control and choice in the area of our medical care, in light of the inherently personal and individual nature of the decisions we make about our mind and bodies. The law protects our right to control such decisions, including the right to refuse medical treatment. This includes the already recognized legal right to withhold food and water with the informed knowledge and consent that it will lead to the patient's death. The law protects the privacy of our medical information and treatment, in order to protect our autonomy and power of choice. The law protects our right of informed consent in our relationship with doctors, to protect our autonomy and power of choice. Our death is the single most personal event of our lives. While our death may impact our friends and loved ones, it remains our death and unlike our birth, we are capable of understanding its gravity and consequences. For this reason, the law should be most protective of individual choice over the circumstances of our death. This includes the medical care we receive as we approach that death.

This bill strikes a careful balance by removing the legal prohibition limiting patient choice in their medical care while also creating a process to protect the patient's choice to ensure it is informed, truly consensual and not the result of coercion, undue influence or duress. It protects the choices of doctors and medical facilities to offer such medical services. It respects life by confirming that it is we, as individuals, who are in control of our lives and our personal evaluation of the quality of that life when facing imminent death from a terminal illness.

On behalf of the Libertarian Party of Maryland, I ask for a favorable report from the committee on SB 845.

Sincerely,

/s

Eric Blitz, Chair
Libertarian Party of Maryland

SB 845- LWVMD- FAV- End-of-Life Option Act.pdf

Uploaded by: Ericka McDonald

Position: FAV

LWV LEAGUE OF WOMEN VOTERS®
OF MARYLAND

TESTIMONY TO THE SENATE JUDICIAL PROCEEDINGS COMMITTEE

SB0845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

POSITION: Support

BY: Nancy Soreng, President

DATE: March 7, 2023

The League of Women Voters Maryland supports **Senate Bill 845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).** The League believes state laws should grant the option for a terminally ill person to request medical assistance from a relevant, licensed physician to end one's life. It also believes that such legislation should include safeguards against abuse for the dying and/or medical personnel.

Per the New England Journal of Medicine:[1] "In **patient-centered care**, an individual's specific health needs and desired health outcomes are the driving force behind all healthcare decisions…Patients are partners with their healthcare providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, [and] spiritual [one]."

Patient-centered care is a true collaboration between patient and medical provider. Patient goals are respected, and care is designed and delivered according to their needs and priorities. When seen through a patient-centered-care lens, relief of suffering- whether physical, mental, or emotional- can be seen as a crucial treatment goal.

When approaching death, when death is inevitable, some patients view the loss of autonomy as more frightening than the prospect of worsening physical pain. The loss of control over their bodies, their mental faculties, and of the ability to make decisions on how to spend their last days, can become a horror. Compassionate care, designed to meet their needs, can suddenly seem out of reach.

Senate Bill 845 is designed to enable patients and providers, if they choose, to help extend compassionate care to a patient's final days. With numerous important safeguards built in to the process, it would provide an option for a terminally ill, capable, competent adult with a prognosis of six months or less to live, to request, legally receive from a physician, and voluntarily self-administer a prescription medication to hasten their death in a peaceful manner.

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[1] https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

This option of maintaining some self-determination and control over one's final days, of preserving one's dignity, is a great comfort, even if the patient winds up not taking the medication.

At present, **ten states** (Oregon, Washington, Montana, Vermont, California, Colorado, Hawaii, New Jersey, Maine, New Mexico) **and the District of Columbia have passed legislation legalizing medical aid in dying.** Oregon's Death with Dignity Act was enacted in 1997.

Marylanders support aid-in-dying legislation. Per the January 2022 Gonzales Maryland Poll: [2] "Among Maryland voters, 69% believe that a mentally sound adult with an incurable, terminal illness, who has only six months or less to live, should have the legal option of medical aid in dying…"

This will likely increase, as the aging population is growing quickly. The Department of Aging estimates that by 2040 there will be 1.79 million Marylanders over the age of 60.

Maryland has a long history of considering, but not passing, death-with-dignity legislation. Attempts were made in **1995** (HB 933), **1996** (HB 474), **2015** (HB 1021 and SB 676), **2016** (HB 404 and SB 418), and **2017** (HB 370). In **2019** (HB 399) the "End-of-Life Option Act" passed in the House, but (SB 311) failed to pass in the Senate. The **2020** re-introduced bills (HB 643 and SB 701) also failed to advance.

After multiple attempts over 28 years, and with broad popular support, it is now time to pass this important legislation. The League of Women Voters Maryland and its 1,500+ members urge the committee to give a favorable report to Senate Bill 0845.

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[2] https://compassionandchoices.org/docs/default-source/maryland/compassion-and-choices-maryland-poll-january-2022.pdf?sfvrsn=c94a1d03_1

SB845.LOS.pdf

Uploaded by: Heather Forsyth

Position: FAV

ANTHONY G. BROWN
Attorney General

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Chief of Staff

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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

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March 6, 2023

To: The Honorable William C. Smith, Jr., Chair
Senate Judicial Proceedings Committee

From: The Office of the Attorney General

Re: SB845 – End of Life Option Act: **<u>Letter of Support</u>**

The Office of the Attorney General writes in strong support of SB845. This legislation has been carefully drafted to allow terminally ill patients considering all their end-of-life options the autonomous right to choose the timing and circumstances of their death while providing safeguards to protect vulnerable Marylanders.

Maryland courts have acknowledged the common law right of a competent adult to refuse medical care under the doctrine of informed consent but have stopped short of allowing a patient to end their life at the time and in the manner that preserves their dignity and prevents undue suffering.[1] This bill – through amendments to the Health General, Insurance, and Criminal Articles - would allow an individual to make an end-of-life decision and self-administer medication to bring about their own death at the time of their choosing. The bill specifically prohibits any person to end the life of another by lethal injection, mercy killing, or euthanasia.

Decisions around end of life are deeply personal for patients and their families. While the vast majority choose palliative or hospice care, only the person confronting their own mortality can decide if their condition is truly unbearable. This bill provides a thoughtful and deliberate multiple-step approach that ensures these decisions are made in appropriate context, with due gravity, and with the patient in control of this intensely private decision.

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[1] *Stouffer v. Reid*, 413 Md. 491 (2010).

The debate around this issue can be passionate. This bill or a similar version has been before the General Assembly many times before. But experience from other states and around the world demonstrates this option can be implemented in a safe and effective manner, without abuse or coercion.[2] This bill in no way permits anyone to end the life of another for any reason; rather, it recognizes that Marylanders suffering from end-of-life conditions want and deserve the bodily autonomy to choose and direct their own care.

We encourage this Committee to advance the End-of-Life Options Act. For people with end-of-life conditions that are reduced to permanent pain without hope of relief or improvement, the lack of such a law is cruel and unjust.

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[2] End-of-Life Options or "Death with Dignity" legislation has passed in 11 U.S. jurisdictions: California, Colorado, District of Columbia, Hawaii, Montana, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington. It is also a right made available in 10 foreign countries: Switzerland, the Netherlands, Belgium, Luxembourg, Colombia, Canada, Austria, New Zealand, Spain and Australia.

S 845 End of Life Option Act Julie Reiley Testiomo

Uploaded by: Julie Reiley
Position: FAV

Julie Reiley
4407 Tournay Rd.
Bethesda, MD 20816
301-320-5573
reiley@aya.yale.edu

FAV: Testimony in Support of S845

I am submitting this testimony in support of Senate Bill 845, the End-of-Life Option Act. I support this bill because I have always believed in what it stands for, and because I may need it.

In July of 2021, at the age of 57, I was diagnosed with cancer. Treatment was not easy. First, over the course of several months, I was infused with three different chemotherapy drugs, with each infusion itself causing extremely painful headaches, followed by post infusion side-effects. That said, one of the chemo drugs I tolerated relatively well (for chemo), but the other two were rougher – increased pain, GI issues, exhaustion, hair loss, and eventually a heart issue. One of these infusions in particular was simply unbearable. I was sent to the ER, and then I was hospitalized with an *extremely* compromised immune system, an infection that needed IV antibiotics, and terrible pain. Because of my immune system's dangerously adverse reaction, my oncologist had to reconfigure my treatment plan, including eliminating two drugs' final infusion and reducing the amount of medicine in what ended up being my last infusion.

After chemotherapy, I had surgery in two sites, followed by twenty rounds of radiation. Finally, I made two multi-week attempts to take standard post-treatment medication to prevent my cancer from reoccurring. Both attempts failed because of intolerable side-effects.

My overall prognosis is good, but it is not great. There is a 20% chance my cancer will return, and if it does, I anticipate a terminal situation. If that happens, I want, and I am entitled to as an independent adult, the option to end my own life and avoid months of needless suffering.

Perhaps just as important to me is that the bill would protect family members who follow the law in good faith from civil or criminal liability, including assisted suicide. That is extremely important to me, because if I need to end my own life to due to cancer, I want to die with my husband holding my hand -- and not be terrified he would be held liable or punished.

I have given this significant thought. In the event my cancer returns and is terminal, I should have the option, the right, to end my own life to avoid needless suffering.

If I am six months from death by cancer, I - and my family - will have suffered enough. Thus, I respectfully request a favorable report for the End-of-Life Option Act.

Julie Reiley

Julie Reiley

SB 0845 - Cummings - Favorable (KP).pdf

Uploaded by: Kenneth Phelps, Jr.

Position: FAV

Testimony in Support of
SB 845 End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

FAVORABLE

To: Senator William C. Smith, Jr., Chair, Senator Jeff Waldstreicher, Vice-Chair, and members of the Senate Judicial Proceedings Committee

FROM: Rev. Kenneth O. Phelps. Jr.

As an Episcopal priest, I regret that I cannot offer this testimony on behalf of the Episcopal Diocese of Maryland.

In 1991, the Episcopal Church passed a resolution against assisted suicide and other forms of active euthanasia, stating that it is "morally wrong and unacceptable to take a human life in order to relieve the suffering caused by incurable illness." This resolution was based on the church's broader view at that time "that one should never take a life, even your own."

But, our church has also come to teach that it is justified to stop medical treatment, including artificial nutrition and hydration, when that treatment brings significantly more burdens than benefits to a person. Such decisions also should be informed by the moral norm against taking life, with the dividing being the difference between the intent to take life and the withdrawing of treatment."

And, as we have continued to wrestle with this question in the ensuing years, there is a sense within the church now that hard-and-fast rules on end-of-life issues may not fit every circumstance. To quote Timothy Sedgwick, a professor of Christian ethics at Virginia Theological Seminary, "Although we have a clear moral norm against the taking of human life, there may be cases that stand beyond that judgment."

As we continue to re-examine our stance on the right of an individual to end one's life under certain circumstances, other Christian bodies have moved to voice their support and I agree with their theological reasoning.

The United Church of Christ supports the right of terminally ill patients to make their own decisions about when to die – including whether to hasten death. This position is in keeping with their broader church teachings that stress the importance of respecting individual conscience and choice, To quote the Rev. Timothy Tutt, a senior minister at Westmoreland Congregational United Church of Christ in Bethesda, Md.

"We believe that each of us approaches God on our own terms, and this includes at the end of our lives," he says. According to Tutt, the church also supports the right of families to discontinue treatment for incapacitated loved ones who are near death or in a vegetative state. "Once again, this is a decision of conscience," he says, adding that families should base their decisions on what their minds and hearts tell them is best for their loved ones. Says Tutt: "We encourage people to ask: Am I being a wise or unwise steward of my parent's life by keeping her alive to the very end?"

In 1988, the Unitarian Universalist Association of Congregations (UUA) passed a resolution advocating "the right to self-determination in dying." As a result, the church supports laws such as those in Oregon and Vermont that enable terminally ill patients, under carefully defined circumstances, to seek physician assistance in hastening their own death. Unitarian Universalists also support the right of a legally designated proxy to make life-and-death decisions for a patient, including withdrawal of life support, in cases in which the patient is unable to make such choices.

From my own life experiences, dealing with a significant number of individuals and families who have wrestled with end of life issues, I can say that I have known cases where the individual in question was in such suffering – and with no hope of recovery or improvement – that they pleaded for their own death as a means of relieving their own anguish and that of their families. This bill would provide a means – not for all patients and not in every circumstance – for someone to end their personal suffering with dignity and humanity, at a time of their choosing.

Ultimately, our faith is one that honors the sanctity and integrity of the individual conscience.

I note with interest that last week the Senate Finance Committee held a hearing on SB 798 – the Declaration of Rights - Right to Reproductive Freedom, which would establish that "every person, as a central component of an individual's rights to liberty and equality, has the fundamental right to reproductive freedom; and prohibiting the State from, directly or indirectly, denying, burdening, or abridging the right unless justified by a compelling State interest achieved by the least restrictive means."

I agree that a woman has a right to determine what is best for her own body and her own health. And, if that is the case, how can we say it is not the right of another individual to determine what is best for their body and not only their health, but the emotional and psychological health of their family and loved ones.

These ultimate questions of life and death belong with the person most intimately affected, not with the church, a legislative committee or a bureaucratic panel.

Besides, this is also – ultimately – a question of love and mercy. And, if there are indeed, "cases that stand beyond that judgment," as my own Church is beginning to see, how can we deny an individual this right, or this dying request.

I ask for a favorable report.

SB 0845 - Cummings - Favorable (LB).pdf

Uploaded by: Kenneth Phelps, Jr.
Position: FAV

FAVORABLE

SB 845 End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

To: Senator William C. Smith, Jr., Chair, Senator Jeff Waldstreicher, Vice-Chair, and members of the Senate Judicial Proceedings Committee

FROM: Rev. Linda Boyd

My support for SB 845 derives from my faith and my life experience. First, as a follower of Jesus Christ, I believe that each of us is made in God's image and each of us deserves dignity and respect. My reason for believing that God is in favor of the possibility of assisted dying is based in God being both loving and perfect. I cannot believe that God would demand that we suffer unnecessarily. It is incompatible with my conception of God that a patient be effectively tortured by being kept alive with no hope of anything but pain and deterioration. My sense of God is that God would not want that to happen to me much less any child of God.

Having been created in God's image, my faith tells me that, based on my understanding of the life and works of Christ, I will have to account for the choices that I make. The teaching of Christ is all about refusing to accept conventional religious wisdom, which would be easy but thoughtless, and instead steadfastly making one's own moral choices. Jesus chose to die rather than compromise this point. The gift that God has given to me is not life, but choices: to use my God-given gift to make my own moral decisions and be responsible for them. No one else can decide the value of my life for me, when it has no further use, if I choose to end it – with or without assistance. I will expect to have to explain myself to God.

My other basis for supporting this bill is my life experience---watching my beloved, elderly father be tortured by bone cancer until he died. Never would I have wished such suffering on anyone, much less my father. He was a man of intense faith—not the kind that you wear on your sleeve, but rather, he lived it daily. He never missed an opportunity to show love to his fellow human beings, regardless of their social and economic status. Because he did not have access to the choice that this law would provide, he was tortured for months. Morphine did not work after a while. He screamed out in pain over and over again.. No child of God should have to endure that.

The presence of this law would allow a dignified end to those wanting to have one, without requiring others to die against their wishes.

I ask you to support this bill. I ask for a favorable report.

SB 845 Support Cummings_Pendergrass Act Mont Co Co

Uploaded by: Leslie Frey

Position: FAV

COMMISSION ON AGING

February 28, 2023

SB 845 SUPPORT

Senator William C. Smith, Jr., Chair, Judicial Proceedings Committee

Dear Senator Smith:

I am writing on behalf of the Montgomery County Commission on Aging (CoA) in support of SB 845 (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) that would authorize an individual, under very specific circumstances, to request aid in dying.

The CoA is authorized by the Older Americans Act, P.L. 116131, and was established by Montgomery County in 1974 to advise County government on the needs, interests, and issues of concern to its older residents, and to advocate on their behalf at the local, state and national levels.

We are aware, that for some individuals and groups the provisions of this bill may be antithetical to their personal convictions and beliefs. The CoA did not come to its decision to support SB 845 lightly. We held open meetings on this issue at the committee and full Commission levels. We carefully reviewed the proposed legislation, as well as the hearing transcripts and testimony from the previous years' legislation to better understand the arguments, both pro and con. After extensive deliberations, we have agreed that SB 845 allows people who are nearing the end of life to die in peace if they meet specific requirements spelled out in the legislation and, importantly, if it is their desire to do so.

The proposed legislation has numerous safeguards to ensure that this is an entirely voluntary process on the part of the individual and that there is no duress or coercion from any source. Further, there are provisions to ensure that the individual has the capacity to make this decision and that the individual may also change his/her mind at any time. The proposed legislation offers an option to a gravely ill, but mentally competent, person while leaving in place other options that are already available. This is an issue of bodily autonomy and people at the end of life deserve this option. Furthermore, it also is an issue of compassion. Sometimes, palliative care or hospice simply do not end an individual's suffering or improve their quality of life.

In conclusion, the Montgomery County Commission on Aging strongly supports SB 845. When hospice and palliative care are no longer effective for a person who has 6 months or fewer to live, that person should have the option to obtain prescription medication so they can die peacefully on their own terms. The State of Maryland should join the ten other states and the District of Columbia to allow this option so individuals may choose not to live the end of their life in intolerable pain and suffering.

Thank you for your attention to our views. We hope you will give them favorable consideration.

Sincerely,

David Engel

David Engel, Chair

Sen testimony for EOLOA.pdf

Uploaded by: Linda M Lampkin

Position: FAV

Statement by Linda Lampkin in support of

SB 845, The End of Life Option Act

My late husband Ron Dickey would have liked to have been here today to present his position on SB 845 – as he said in his October 2022 op ed published by the Baltimore Sun:

> **"For someone who is already dying, <u>I want to say when I'm ready to go</u>, not when the cancer is ready to take me."**

Unfortunately, he passed away on November 7.

In Maryland, we have affirmed that we should protect privacy over one's own body. Maryland legislators have made it a priority to ensure that health care needs are protected and private. But that <u>principle of bodily autonomy needs to be extended to the end of life, not just the beginning.</u>

Ron didn't have a choice – a choice to avoid more suffering when he was out of options. A choice that he would have had if we lived in one of the 10 states plus DC that allow an End of Life Option. One in 5 Americans lives in a jurisdiction where there is a choice. But Maryland is not one of them.

And this is a <u>choice</u> – safeguards are built in and there is a long history of no problems. If you personally don't think this choice is for you, then don't use it. However, do think of others who want this option to end their suffering and pain. And that is clearly what my husband wanted.

Please let Ron's frustrating experience energize your efforts to enact this bill to give terminally ill Marylanders a say in the peaceful ending of their lives. It's only for those who qualify and those who want to use it. Marylanders have said they want this – 71% of them, according to a January poll.

When Ron was diagnosed with prostate cancer 4 years ago and there was only palliative care left for him, he said:

> **"I urge Maryland lawmakers to pass this bill, whether or not I'm still around. There will be someone right behind me that can benefit. I still want lawmakers to enact this bill for those that follow."**

Ron is not here today, but let's get this done for the ones right behind him. The time is now!

TESTIMONY FOR SB0845.docx.pdf

Uploaded by: Lower Shore Progressive Caucus

Position: FAV

TESTIMONY FOR SB0845

SB0845

Title: End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Bill Sponsored by: Senators Waldstreicher, Kagan, King, West, Lam, Hettleman, Elfreth, Zucker, Smith, Lewis Young, Kramer, Feldman, and Guzzone

Committee: Judicial Proceedings
Organization Submitting: Lower Shore Progressive Caucus
Person Submitting: Marie Velong
Position: FAVORABLE

Honorable Committee Members:

I am submitting this testimony in favor of **End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)** on behalf of the Lower Shore Progressive Caucus. The Caucus is a political and activist organization on the Eastern Shore, unaffiliated with any political party, committed to empowering working people by building a Progressive Movement.

I am writing today in support of the *End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)* to authorize medical aid in dying in our state. I would strongly encourage the committee to vote for this compassionate option that would allow a terminally ill, mentally capable adult with six months or less to live, the choice to receive a prescription for self-ingested medication enabling a peaceful, pain-free death.

I would like to tell you why I feel so strongly about this issue. My husband died of cancer in 1974. He left us at the age of 25. I was 26 and we had two children ages 4 and 5. It was without a doubt the most devastating experience of our lives. He was sick for only ten months and would not have been eligible for this compassionate choice. It was just the beginning of chemotherapy and by the time they even figured out he had cancer he was too weak for a biopsy. They guessed at the type of cancer and treatment he needed. They had told us to prepare for his imminent demise. One thing I do remember was at one point during this time, they cut back on his pain medication because they were afraid he would become addicted. I was perplexed by this as it seemed irrelevant if they were expecting him to die. I tell you this because that is how I feel about the objections to this bill.

The method and time period is spelled out for a person who is diagnosed by two doctors to have six months, at best, to live. All of the objections to this bill are irrelevant, when that is taken into consideration. If two doctors are wrong, then we have more problems for you to be concerned about than a person who is in pain and has no future. You need to start looking at the medical profession. This bill is giving this person the *option* to end their life in a purposeful way with some semblance of dignity and grace. Whether they use that *option* is their decision, and should be no one else's.

My children and I were exposed to death at a young age. His death, of course, was only the beginning of our experience with death and dying. In my 75 years of life, I have helped many of my pets to achieve a pain-free death because of the distress they were currently in. When I had to watch my husband, mother and other people I cared about die in so much pain, I could not understand why we can show so much compassion to our animals and not to the people we love. Even convicts on death row get more consideration during their execution. We should at least have the *option or choice* for a better death. People can choose when and how they will give birth, why can't they choose when and how they themselves can leave this earth?

By supporting the *Maryland End of Life Option Act*, I hope my home state is the next to join ten states and the District of Columbia in authorizing medical aid in dying. Thank you for representing me, The Lower Shore Progressive Caucus and others in this state. I truly hope you will vote **Favorable** on this bill that is so vitally important to me and our organization.

Cave Testimony--MAID .pdf

Uploaded by: Lynn Cave
Position: FAV

Lynn Cave
3116 Gracefield Rd, Apt 214
Silver Spring, MD 20904
Support SB0845
End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Hello. I’m Lynn Cave. When I first heard of Medical Aid in Dying as an option years ago, when I was a healthy 20 something–I thought why should people who were facing imminent death have to suffer for any prolonged time. I was all for it. It made perfect sense.

Now I’m a 60-something in poor health. And having the option of Medical Aid in Dying could play a pivotal role as I face my own death.

Here’s my story. I worked at the National Institutes of Health for 38 years, mainly in public affairs where I wrote press releases and pamphlets and ran public education campaigns. I also spent a few years in the part of the Cancer Institute that ran cancer clinical trials.

Ironically, I’m now in a clinical trial to try to stabilize my metastatic eye cancer. My cancer has spread to my liver, it will never be cured, and I probably only have about two years to live. Once my cancer has destroyed my liver, most likely I will have about 2 weeks before my whole body shuts down, and I pass away. Would you want to wait two weeks knowing you’re going to die? I don’t want to perpetuate my own suffering for two long weeks, nor do I want my family to endure the agony caused by a prolonged period of watching me die.

Believe me, I’m doing everything I can to live. I make the two and a quarter hour trip to and from Philadelphia for my treatment, because a world renowned team there works to tame this cancer. And, If this clinical trial stops working, I know of at least two others that I can attempt. But, once I’ve been through everything my doctors know to try, I don’t want to extend my life if it gets to the point that I will suffer and die, no matter what my doctors do. I hope you can make Medical Aid in Dying an option for me.

So I plead with you to follow the will of the Governor and the people of Maryland, over 65% of whom support medical Aid in Dying, to make this choice a reality for Marylanders now. So they–so YOU–so I–don't have to suffer needlessly when a prolonged death is what we face. Thank you.

SB0845 Bill Testimony .docx.pdf

Uploaded by: Maryland Legislative Latino Caucus
Position: FAV

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JESSE T. PIPPY, SECRETARY
MADELIN MARTINEZ, EXECUTIVE DIRECTOR

TO: Senator William C. Smith Jr., Chair
Senator Jeff Waldstreicher, Vice Chair
Judiciary Committee Members
FROM: Maryland Legislative Latino Caucus
DATE: March 6th, 2023
RE: SB0845 End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

The MLLC supports SB0845 End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

The MLLC is a bipartisan group of Senators and Delegates committed to supporting legislation that improves the lives of Latinos throughout our state. The MLLC is a crucial voice in the development of public policy that uplifts the Latino community and benefits the state of Maryland. Thank you for allowing us the opportunity to express our support of SB0845.

According to the American Cancer Society, 1 in 3 male and female Latinos have a probability of developing invasive cancer in their lifetime, compared to 1 in 2 non-Hispanic white males and 1 in 3 non-Hispanic white females.[1] For many of these individuals, palliative care and pain management is what they want and need. However, some individuals might want to explore medical aid in dying. According to a 2016 Lifeway Research poll, 69% of Latinos support medical aid in dying for terminally ill adults. The Latino Commission on AIDS and the Hispanic Health Network has supported similar legislation in New York.[2] Vulnerable Marylanders deserve the right to bodily autonomy. The End of Life Options Act provides them the option to obtain prescription medication that they could choose to take if their suffering becomes intolerable, so they can die peacefully and on their terms.

This bill enables Marylanders to choose the option to obtain prescription medication that they could choose to take if their suffering becomes intolerable, so they can make decisions about their quality of life and choose to die in relative comfort. This Act includes the safeguards needed to ensure terminally ill Marylanders are protected from coercion and abuse.

For these reasons, the Maryland Legislative Latino Caucus respectfully requests a favorable report on SB0845.

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[1] Cancer Facts & Figures for Hispanic/Latino People 2021-2023. (2021). *American Cancer Society*.

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SB 845_mgoldstein_fav 2023.pdf

Uploaded by: Mathew Goldstein
Position: FAV

SECULAR Maryland

Secular Maryland secularmaryland@tutanota.com

March 07, 2023

SB 845 - SUPPORT

End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Chair Smith, Vice-Chair Waldstreicher, and Members of the Judicial Proceedings Committee,

Under the proposed, carefully crafted, law, which Secular Maryland supports, terminally ill patients who are diagnosed to have six months to live and who are mentally competent to make their own medical care decisions may request a prescription of medication to hasten their deaths. These patients must also be able to self-administer the medication. The primary physician's diagnosis must also be certified by a consulting physician to guard against misdiagnosis.

Absent such a law, the practice is forced underground, exposing dying patients to possible abuse or coercion and doctors to possible prosecution and imprisonment. Limiting one's end-of-life options to suffering terrible physical and emotional agony and the loss of personal dignity or to starvation is not humane. Starvation typically takes several weeks to kill and can be unpleasant.

The proposed law protects the rights of patients and physicians by requiring the adult patient who is a resident of Maryland to verbally request the deadly overdose prescription from the physician twice; each request is separated by 15 days, to make a written request to the attending physician; the request is witnessed by two individuals who are not primary caregivers or both family members. It provides an option for the patient to rescind the verbal and written requests at any time. The attending physician must inform the patient of alternatives, including palliative care, hospice and pain management options Use of this law cannot affect the status of a patient's health or life insurance policies. Similar laws on other states have produced good results.

Mathew Goldstein
3838 Early Glow Ln
Bowie, MD

SB845- End-of-Life Options 3.7.23.pdf

Uploaded by: Michael Davis

Position: FAV

To: Members of Senate Judicial Proceedings Committee

From: Michael and Joanne Davis

Date: March 7, 2023

Subject: SB-845: End-of-Life Options Act (The Honorable Elijah E. Cummings and Honorable Shane E. Pendergrass Act).

Position: **Strong Support**

We are writing to express our **STRONG SUPPORT** for Senate Bill 845: End-of-Life Options Act (The Honorable Elijah E. Cummings and Honorable Shane E. Pendergrass Act).

Over the next few weeks, you will be hearing many arguments both in favor of and opposing the basic tenants of the End-of-Life Options Act. As you listen to and review these arguments, please keep in mind that this bill bolsters the liberty, dignity and freedom of Maryland citizens. Indeed, the right to make life and death decisions about one's own body has been and is now considered a fundamental civil right by most Marylanders.

The citizens of each of the following states and DC have what we in Maryland do not have - the right to get some assistance to escape a painful end-of-life while maintaining their dignity.

STATE	YEAR PASSED	POPULATION (2023)
California	2015	40,200,000
Colorado	2016	6,000,000
District of Columbia	2017	700,000
Hawaii	2018	1,500,000
Maine	2019	1,400,000
Montana	2009	1,100,000
New Jersey	2019	9,500,000
New Mexico	2021	2,100,000
Oregon	1997	4,400,000
Vermont	2013	650,000
Washington	2008	8,000,000
Total	11	77,650,000

The processes and procedures for implementing an End-of-Life Option have been tried and tested in the U.S. for over 25 years. The predictions of the naysayers have not been realized. Instead, 77,650,000 of their citizens were given something we don't have in Maryland - peace of mind.

Citizen support for the End-of-Life Options Act can be seen in the poll that Compassion & Choices recently completed.[1] In that poll, 71% of all Maryland voters support enactment of the End-of-Life Options Act. This poll further found, among other things, that 75% of Democrats, 66% of Republicans, 67%, of Independents and 58% of Catholics supported the End-of-Life Options Act.

Please, vote in favor of the End-of-Life Options Act and pass it out of Committee so that this bill can finally be considered by the entire Senate.

Thank you so much for your consideration.

Michael and Joanne Davis
5 Park Place, Unit 601
Annapolis, MD 21401
(443) 472-2965
jtdmwd@mac.com

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[1] See, https://compassionandchoices.org/news/new-md-poll-shows-pro-choice-pro-life-voters-support-medical-in-dying-record-support-statewide. See, also, the poll done in 2019 by Goucher College reflecting 62% support for the End-of-Options Act. https://www.goucher.edu/hughes-center/documents/Goucher-Poll-Feb19-part1.pdf This increase in support, from 62% to 71%, is significant.

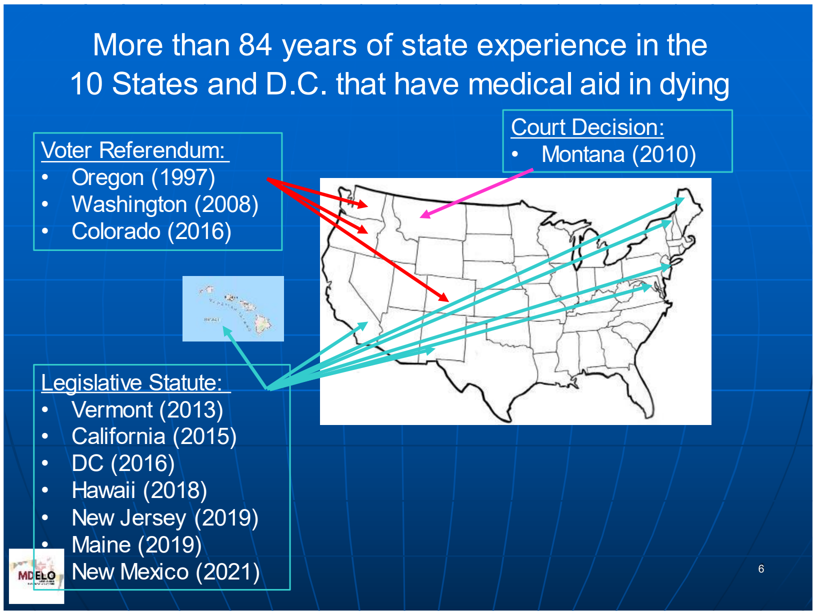
SB0845 - MStrauss - Favorable.pdf

Uploaded by: Michael Strauss
Position: FAV

Testimony of Michael Strauss, MD, MPH
Regarding SB0845/HB0933 -- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
March 7, 2023

I am Dr. Michael Strauss, a board-certified internist, and I strongly support this bill.

You already heard compelling reasons why you should support this bill. Now I want to caution you about the likely misstatements or unrealistic hypothetical issues that the bill's opponents will describe. Because we now have **<u>84 years of experience in the 10 states and District of Columbia</u>** that have medical aid in dying, you need to understand what has and what has not happened in these states.



More than 84 years of state experience in the 10 States and D.C. that have medical aid in dying

Voter Referendum:
- Oregon (1997)
- Washington (2008)
- Colorado (2016)

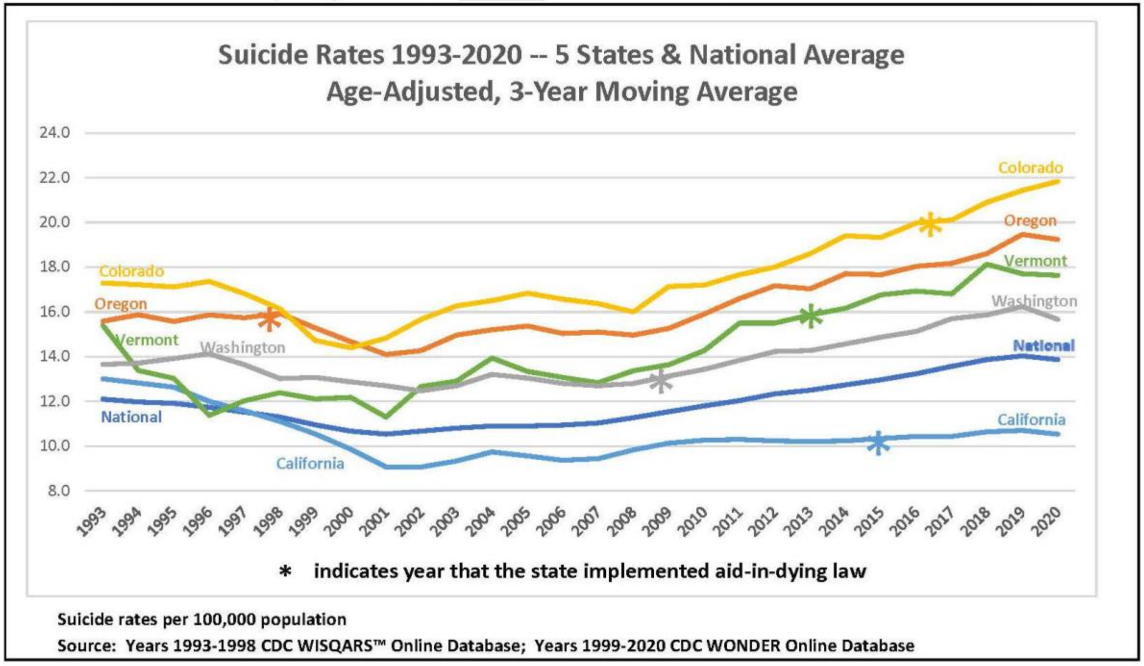
Court Decision:
- Montana (2010)

Legislative Statute:
- Vermont (2013)
- California (2015)
- DC (2016)
- Hawaii (2018)
- New Jersey (2019)
- Maine (2019)
- New Mexico (2021)

	Years with Aid in Dying
Oregon	**25**
Washington	**14**
Colorado	**7**
New Mexico	**2**
California	**8**
Vermont	**10**
New Jersey	**4**
Maine	**4**
DC	**6**
Hawaii	**4**
Total	**84**

- No cases of unused drugs from aid in dying being diverted or abused, in part because most patients do not fill their prescriptions until they are about to take them, and in part because the new powdered forms combining drugs cannot be abused.
- No documented cases of patients being coerced into using aid in dying. Not one.
- No cases of a slippery slope in which one of these states amended its law to be more like Canada or European countries with expanded indications.

Aid in Dying Does NOT Increase the Suicide Rate



Suicide rates per 100,000 population

Source: Years 1993-1998 CDC WISQARS™ Online Database; Years 1999-2020 CDC WONDER Online Database

- No increases in a state suicide rate beyond increases that have happened across all states. Aid in dying does not lead to a contagion of suicide.
- No credible cases of an insurance company denying medical coverage of a treatment because the patient has access to an aid-in-dying program.
- No problem of a failure to notify family because 95% of patients choose to notify family and every one of these patients has mental capacity and gets to choose whom to notify or not.
- No problem of a failure to require the end of life in a specific location. In Oregon, 95% of deaths happen in the home and 4% in nursing homes. It is similar in other states.
- It is misleading to state that physicians oppose aid in dying. MedChi, the state medical society, is neutral. Polls nationwide and in Maryland, including polls by MedChi and the Maryland Psychiatric Society, show that a majority of physicians support aid in dying. See the attached list of some of the many Maryland physicians who support the bill.

So please, as you hear hypothetical and misleading claims later today, ask whether the identified concern has ever occurred in the 84 years of state experience with medical aid in dying laws.

October 21, 2022

Maryland General Assembly
90 State Circle
Annapolis, MD 21401

Re: **Maryland Physicians Support the Maryland End-of-Life Option Act**

To the Maryland General Assembly:

Modeled after Oregon’s Death with Dignity Act, the Maryland End-of-Life Option Act authorizes medical aid in dying in which mentally capable, terminally ill adults may choose to self-administer a medication to bring about a peaceful death. It is patient-directed and completely optional. To qualify, individuals must be fully capable of making their own healthcare decisions and must be able to self-ingest the medication. No one, including physicians and other healthcare professionals, is required to participate.

Medical aid in dying is a well-established medical practice, currently authorized in 10 states (OR, WA, MT, VT, CA, CO, HI, NJ, ME, NM) and the District of Columbia, with clinical criteria published in the peer-reviewed *Journal of Palliative Medicine.*[1]

In a 2016 physician survey, MedChi, the Maryland State Medical Society, found that a majority of its members (58%) and nonmembers (54%) support medical aid in dying as an end-of-life option for the terminally ill. This is consistent with a 2020 Medscape poll that found 55% of U.S. physicians support medical aid in dying.[2] As a result, MedChi adopted and has maintained a neutral stance toward legislation to authorize medical aid in dying, understanding that individual physicians can disagree and allowing room for all views to be expressed.

Medical aid in dying will bring comfort and peace of mind to terminally ill patients by putting them, not the disease, in control.

We urge you to support the Maryland End-of-Life Option Act.

Respectfully submitted,

Michael Strauss, M.D.	David Katz, M.D.	Molly Strauss, M.D.
Rockville, MD	Potomac, MD	Rockville, MD

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[1] J Palliat Med. 2016 Mar;19(3):259-62. doi: 10.1089/jpm.2015.0092. Epub 2015 Nov 5. Clinical Criteria for Physician Aid in Dying David Orentlicher 1, Thaddeus Mason Pope 2, Ben A Rich 3 Affiliations expand PMID: 26539979 PMCID: PMC4779271 DOI: 10.1089/jpm.2015.0092. Available from https://pubmed.ncbi.nlm.nih.gov/26539979/

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SB 845 End–of–Life Option Act (The Honorable Elija

Uploaded by: Nancy Soreng

Position: FAV

Testimony to the Senate Judicial Proceedings Committee

In Support of SB 845 End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

March 7, 2023

Submitted by Nancy Soreng

Some of you know me as an advocate who spends a fair amount of time in Annapolis testifying on behalf of a non-profit organization. I want to make clear that this testimony is submitted as an individual as it is about my personal experience with the Death with Dignity option in Oregon that was used by my closest friend in 2014, and by my mother in October of 2018. These experiences were very different. However, in both cases, having this end of life option didn't make the loss any easier for me. But, for my friend and for my mother, it was a true blessing. I considered testifying in person, but the experiences were so personal that they are still difficult to talk about so once again I am submitting this in writing.

I met my friend Betty in 1974 in Corvallis, Oregon. Like me, she loved politics, public policy and working for non-profit organizations. Her husband, like my husband, was a research biologist. And the four of us shared an enthusiasm for outdoor adventures. Even though my husband and I moved away from Oregon in 1978, over the 40 years we knew each other, the four of us took dozens of trips together in the US and abroad. We went white water rafting, canoeing, biking, cross-country skiing, hiking and camping. When she was diagnosed in December of 2013 with pancreatic cancer, I couldn't believe that this energetic, full-of-passion-for-life friend was struck by such a deadly disease.

She threw herself into beating the cancer. She endured multiple surgeries, chemo and radiation therapy and tried both traditional and non-traditional treatments. By the time I was able to visit, I was shocked by how the disease had ravaged her body. By late October, she was in extreme pain and the heaviest opioids were not providing relief. She called me in November to tell me that she had applied for the Death with Dignity Program. I talked to her a few more times after that, and she told me she didn't think she could wait much longer to take the medication. Just before Thanksgiving, with her husband, her son and her daughter-in-law by her side she ended her life the way she had lived it – on her own terms. I was saddened, but thankful she was no longer suffering. She had just turned 70.

The experience with my mother was more difficult. But then, what is easy about losing a parent? In mid-May, just before her 89th birthday, my mom was diagnosed with an aggressive form of cancer that was in her breast and lymph nodes. They also found a mass in her colon, that they had not confirmed, but suspected, was another form of cancer. She did not want to undergo a colonoscopy. They had said that without treatment, she would have 6 months to a year to live. She was firm in her decision that she did not want to spend the rest of her time on earth going through painful, and likely unfruitful, treatments. I understood and respected that decision. I flew to Portland where she lived in a retirement community with Henry, whom she had met there and married 6 years prior at the age of 83, for a week or more every month after the diagnosis. I was surprised, when I visited her in July, that she was already receiving hospice care.

Each time I saw her, her stamina was waning and her body seemed to be melting away. Most frustrating to her, she couldn't do much to take care of herself or their apartment and she sometimes had difficulty tracking conversations and the events around her. Yet, she could answer Jeopardy questions better than the rest of us and could still win at Scrabble. In August, she told me that she had applied for the Death with Dignity program, but about 40% of the people who qualify, don't end up taking the medication. I was there in September when her primary care physician came to do the first interview. I was impressed by how thoughtful his questions were. He asked her if any one had suggested that she apply for the program. He asked if she understood what she was asking for and asked her to explain it to him. He asked if she felt pressure from her family or anyone else to apply. He also asked questions about her health, how she was sleeping and eating and generally how she felt. She was clear that this was her decision and firm in expressing that she did not want to wait until she could no longer have the capacity to express herself with clarity or function physically. The next step in the process was to wait 3 weeks and be interviewed again by a different physician. She called me and told me that the second physician had indicated he would recommend her for the program.

It was quite a shock when she called me about a week later, on a Saturday and said that she had qualified, and a pharmacy had delivered the medications, and could I come on Monday as I had said I wanted to be with her at the end. I told her that if she could hang on, I needed some time to process this and that I would be there as soon as I could. She understood and said that, actually, she needed some time to make arrangements.

I arrived in Portland on October 21st. On October 24th, my brother, my husband and I, along with her minister and two volunteers from Death with Dignity, were with her as that was the day she had arranged to take to the medication. The volunteers were wonderful. They asked her to explain what was going to happen that day, including what would happen when she took the medication. Then they left the room and let the family have time together. They came back and gave her an anti-nausea medication so she would be able to keep the lethal medication down. They gave us time alone again as they waited for the first medication to get into her bloodstream. Then they came back and asked her again what they were there for and if she still wanted to do this. When she answered that they were there because she was ready to die, they left the room to mix the powdered medication with liquid. They came back with the medication in a cup and a straw. Before they handed it to her, they asked her a third time if she knew what she was doing and if she still wanted to do it. When she answered affirmatively, she took the cup, and drank the contents in less than a minute. They had told her she could have a glass of wine, something she hadn't had since she became ill and really missed. So, she reached for her wine, had a few sips, and was gone.

It was incredibly hard having her leave us when much of who she was, at least in spirit, was still there. But she hated to be dependent on others and had begun taking pain medications that dulled her sharp mind which bothered her tremendously. I'm glad we had those last few days together and could be with her at the end. She spent a lot of time telling us what a wonderful life she had had, and how lucky she felt she was to have a loving family and to have had two caring husbands. Selfishly, I wish she would have waited a bit longer, but once she made up her mind about something, it wasn't like her to waiver.

Because both of these strong women found great relief in having the option not to continue to suffer in the face of terminal illness, I urge you to pass SB 845.

2023 MD Peg Sandeen Written Testimony SB 845.pdf

Uploaded by: Peg Sandeen

Position: FAV

Testimony of Peg Sandeen, PhD, MSW

Bill: SB 845, End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Name: Peg Sandeen, PhD, MSW
Organization: CEO, Death with Dignity National Center
Position: SUPPORT

My name is Dr. Peg Sandeen. I am the CEO of Death with Dignity and a social worker with a PhD in Social Work and Social Research.

I am testifying in support of the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) | SB 845.

I am from Oregon, the place where the first Death with Dignity law was passed in 1994 and affirmed in 1997. I have more than 20 years of experience working directly with people who are terminally ill, including individuals who have opted to hasten their death using medication prescribed under Death with Dignity legislation.

I come to you today to tell you that in Oregon, and in the nine other jurisdictions where medical aid in dying is codified, the procedures and processes we put in place have worked precisely as designed. And I will, with clear research and data, dispel the myths and fears our opponents have tried to spread for years as simply not grounded in reality or fact.

In every state, the very first people who come forward to support this law are those who are facing a terminal diagnosis and simply want to make their own decisions about their end-of-life care.

Like Marcy Rubin from Montgomery County, who was diagnosed with stage IV metastatic breast cancer just five months after her husband, Jon, experienced a painful death from lung cancer. Marcy spent precious time advocating for Death with Dignity in Maryland – fighting for the freedom to choose aid in dying once her suffering became unbearable. Marcy wanted control over her death. She wanted to peacefully die at home surrounded by loved ones. But, instead, she died in a manner that was against her wishes because Maryland did not pass this law in time for her.

The second group of people who come forward are family members of those who died difficult, painful deaths and vowed that they would never watch others suffer as they were forced to watch their loved ones.

Passage of this law will work to increase access to health care for all citizens of Maryland, something I know this Committee cares about deeply.

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

SB 845 is, at its core, a medical standard of care designed to provide physicians and pharmacists with best practice guidelines for situations in which a terminally ill and competent patient requests the right to control the timing and manner of their death. SB 845 is modeled on legislation that has been enacted in ten jurisdictions.

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

The multiple safeguards in Senate Bill 845 include:

- A diagnosis of a terminal illness with a prognosis of six months or less to live, verified by a second physician's opinion.
- A mandatory counseling referral if either the attending or consulting physician believes the patient may not have capacity to make their own health care decisions.
- The individual must be a resident of Maryland.
- Oral and written requests are required. The written request must be witnessed by at least two people, one of whom must be someone who is not a relative or an heir set to receive an inheritance from the individual. The physicians involved cannot be witnesses. The two required oral requests must be at least 15 days apart.
- Information must be provided to the patient on all forms of palliative care, hospice care, and other end-of-life options.
- The patient may opt out at any time and for any reason.
- The patient must self-administer the medication.
- Any health care professional or healthcare institution may choose not to participate.
- Coercion, fraud, euthanasia, lethal injection, and mercy killing are all specifically prohibited in this legislation, as it is in every state where the law is in effect.

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

And no person may receive the prescription unless they are deemed to be within six months of death, acting voluntarily, capable of making their own health care decisions and able to self-administer the medication.

The policy you are considering has been subject to independent research protocols by individuals from a myriad of academic disciplines. These researchers have examined the safeguards and demonstrated there have not been any instances of abuse or coercion of patients in the more than 25 years since all of these laws took effect. These findings continue to refute the claims of our opponents who have never once produced a single shred of verifiable evidence of their claims.

As I said, I am an Oregonian, and I'm very proud of the fact that Oregon has successfully implemented a Death with Dignity law for over 25 years. I want to share with you some facts about the Oregon experience offering Death with Dignity under the very same safeguards you are considering.

The law is rarely used. Statistics collected by the Oregon Health Authority [1] demonstrate that since the law was implemented in Oregon, only 2,159 individuals have ended their lives using the Death with Dignity law in 25 years.

Every year, about one third of the individuals who go through the process to become qualified patients do not ingest the medication, but rather, go on to die from their underlying condition.

Death with Dignity for them is all about peace of mind.

- The median age of participants is 74;
- Over 90 percent are enrolled in hospice;
- Over 87 percent of them die at home;
- Over 99 percent of them have insurance, either private or government sponsored.
- Overwhelmingly, these patients have cancer.

Oregon's law has worked exactly as intended: to give dying and suffering patients more options at the end of life.

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

The data from independent researchers proves that these arguments are based entirely on myths and falsehoods.

In 2007, Battin et al. [2] explored data out of Oregon to determine if there was a disproportionate impact of ten groups of potentially vulnerable patients. The data led the researchers to conclude

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

To reiterate, there is no factual support for the slippery slope argument that vulnerable individuals are at risk for being coerced into using the law. It has simply never happened because of the safeguards in place.

Death with Dignity does not replace, but complements hospice and palliative care services.

In a comprehensive study conducted with family members of 86 Oregonians who were participating in Death with Dignity, researchers [3] concluded:

> "…another concern regarding the legalization of PAD [physician aid in dying] is that PAD would become a substitute for quality end of life care…Insofar as family rating of the quality of a loved one's death is an indicator of end of life care, this study adds to the evidence that the choice to pursue PAD does not appear to be due to, or a reflection of, poorer end of life care."

It is no coincidence that the very first state to pass Death with Dignity—Oregon—was identified in an article published in the *New England Journal of Medicine* [4] as a state with significant and positive differences in how people die, as compared with other states in the country.

We in Oregon do better than the rest of the country in such benchmarks as:

- the percentage of people who die at home (as opposed to the hospital),
- the percentage of people using hospice, and
- the percentage of people who received intensive care services at the end of life.

The passage of our law and subsequent end-of-life policy changes sent a signal nationwide, and in Oregon, that dying patients must be accorded more and better care. Death with Dignity is part of that equation.

National research published in the *New England Journal of Medicine* indicates that physicians in every state, including Maryland [5], help patients die using prescription medication. By enacting this law, the Maryland Senate will send a strong message that a compassionate response to suffering is available in the state through medical aid in dying, but patients, families and physicians must follow the carefully regulated safeguards you are considering today.

As legislators in this great state, if you want to improve the quality of life for dying individuals in your jurisdiction, there is nothing better that you can do than enact a Death with Dignity statute. That's what the data tell us.

It will be rarely used, but a great source of comfort. Its safeguards will protect vulnerable individuals from coercion. Medical aid in dying will likely improve the quality of end-of-life care for the whole population, not just for people who contemplate it or use it.

Many individuals with a terminal illness who have shared their stories, like Marcy Rubin and others you will hear from, have no control over the trajectory of their disease. But they should have control over the time and manner of their death: the right to die on their own terms, with autonomy and peace of mind.

Thank you.

Peg Sandeen, PhD, MSW
Chief Executive Officer
Death with Dignity

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

About Dr. Peg Sandeen and Death with Dignity

Dr. Peg Sandeen (she/they) is a longtime social worker, patient care advocate, and professor who currently serves as the CEO of Death with Dignity. Death with Dignity was at the forefront of the passage of the first Death with Dignity law in the country: Oregon’s in 1994. Since then, Death with Dignity has continued highlighting the importance of ensuring everyone has the right to options in the face of terminal, painful death sentences, including cancer. Currently, Death with Dignity is legal in 10 states, including California, New Jersey, and the District of Columbia.

SB0845 - RBrookland - Favorable.pdf

Uploaded by: Robert Brookland
Position: FAV

Testimony of Robert Brookland, MD
Support for SB845/HB933 The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
March 2023

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

I have two comments.

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

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

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

I cringe when opponents state this process violates the Hippocratic Oath, because in my mind they do not understand the entirety of the Oath. You should think about two different Hippocratic Oaths – the original from 2400 years ago and oaths administered today. There clearly are parts of the original oath relevant to today's practice of medicine that focus on not harming patients, following moral principles, and protecting confidentiality. My problem with opposing witnesses is that they "cherry-pick" one small part of the Oath when there are many parts that today are irrelevant or inappropriate. That original oath has one swear to the God Apollo, acknowledge only male physicians, and agree not to perform surgery, particularly mentioning removing stones. The Oath precludes abortions, but under Maryland law physicians perform safe abortions upon proper informed consent and under accepted guidelines.

Now you should consider modern oaths. Fully 116 of 122 U.S. medical schools now administer oaths that accommodate medical aid in dying, including the updated oath for the Johns Hopkins Med School.

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

Sean Crowley oral-written testimony before MD Sen

Uploaded by: Sean Crowley
Position: FAV

Oral & Written Testimony by Sean Crowley in Support of
In Support of the Maryland End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act,
Judicial Proceedings and Regulations Committee SB 845/HB 933)
March 7, 2023

Chairman Smith, Vice Chairman Waldstreicher, and other committee members, thank you for allowing me to testify today.

My name is Sean Crowley.

I have been the media relations director for Compassion & Choices Action Network's campaign to pass the Maryland End-of-Life Option Act since the bill's original introduction eight years ago in 2015.

But today I want to describe the recent agonizing death of my 92-year-old mother…Carol Crowley.

She lived in Connecticut, another state without a medical aid-in-dying law.

Last Christmas, she got the flu.

Feeling increasingly weak three days later, she fell down trying to walk.

She was hospitalized for 12 days, during which she developed a-fib and internal bleeding.

Then she spent five days in home hospice care--24/7--until she died with needless suffering.

After her first night in-home hospice care, she begged me:
"Sean…Please help me die."

Tearfully, I told her: "Mom, I am sorry, but I can't help you die because it's illegal."

In the end, she could not drink, eat, swallow medication, or speak.

I don't want anyone's loved ones to die with needless suffering.

As a former legislative press secretary, I understand why lawmakers worry about inflaming voters if they make a politically risky vote.

But this issue is not politically risky.

A record-high ratio of more than seven out of 10 Maryland voters (71%) support medical aid in dying, according to a January poll by Gonzales Research & Media Services.[1]

This record-high support spans the geographic[2], faith, race, and party affiliation spectrums.

It includes:

- four out of five self-described pro-choice voters (82%)
- three out of four Democrats (75%)
- seven out of 10 African American voters (70%)
- two out of three independents (67%) and Republicans (66%)
- 65% voter support or higher in every area of the state
- six out of 10 Catholic voters (58%), and
- a plurality of self-described pro-life voters (49% vs. 44%).

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[1] Gonzales Maryland Poll, January 2023. Accessed at: https://compassionandchoices.org/docs/default-source/maryland/compassion-and-choices---gonzales-maryland-poll-january-2023.pdf?sfvrsn=ecbc7e23_1

[2] Gonzales Maryland Poll - January 2023. Washington suburbs. Accessed at: https://compassionandchoices.org/docs/default-source/maryland/washington-suburbs-results.pdf?sfvrsn=1e9c7b80_1

In addition, while the Gonzales poll didn't measure support among voters with disabilities, a new national poll released today shows four out of five voters with disabilities (79%) support medical aid in dying.[3]

Finally, a 2021 poll shows Maryland and other northeastern state voters are five times more likely than less likely to support a legislative candidate who supports medical aid-in-dying legislation.[4]

Clearly, the time is now to pass this long-overdue law in Maryland.

Thank you.

Sean Crowley
Senior National Media Relations Director
Compassion & Choices/Compassion & Choices Action Network
(Compassion & Choices is comprised of two organizations that improve care and expand options at life's end: Compassion & Choices (501(c)(3)) educates, empowers, defends, and advocates; the Compassion & Choices Action Network (501(c)(4)) focuses exclusively on legislation, ballot campaigns, and limited electoral work.)
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202-495-8520-mobile
scrowley@compassionandchoices.org
www.compassionandchoices.org/Maryland

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[3] USA/National Public Opinion Survey - Cross Tabulation Report, February 2023, Susquehanna Polling & Research, Inc., Page 4. Accessed at: https://static1.squarespace.com/static/60dcd3979f161646a5a9f459/t/6406276ce7433d26650714c5/1678124908756/Raben_Crosstabulation_Report_2023.FINAL+%281%29.pdf

[4] USA Omnibus - Cross Tabulation Report, November 2021, Susquehanna Polling & Research, Inc., Page 26. Accessed at: https://compassionandchoices.org/docs/default-source/polling-documents/usa-omnibus---cross-tabulation-report-november-2021-revised-feb2022.pdf?sfvrsn=b96116db_1

SB0845 - SMorgan - favorable.pdf

Uploaded by: Seth Morgan
Position: FAV

Testimony of Seth A. Morgan, MD, FAAN

Regarding SB0845/HB0933

The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End-of-Life Option Act

March 7th, 2023

My name is Seth Morgan. I am a physician, a person with disabilities due to multiple sclerosis and cancer, and an advocate for people with disabilities. I strongly support this End-of-Life Option Act.

Like most Americans with or without disabilities, I value my right to make independent choices. I find it both condescending and offensive when organizations attempt to speak on behalf of all of us with disabilities. Some individuals with disabilities might consider aid in dying as an option if the situation arose; others might not. The data indicate that a large majority of all Americans with disabilities capable of independent decision-making support aid in dying. Surveys performed in Massachusetts, Connecticut and New Jersey found that 62 to 75 % with self-identified disabilities support aid in dying. Regardless, each of us should be allowed to make our own choices.

Also, in the more than eighty years of combined experience of states authorizing Medical Aid In Dying, there has been no evidence of abuse or coercion of individuals to elect MAID, no expansion of the medical conditions for which it is allowed, and no lowering of the age requirement. Experience has proven that there simply is no “slippery slope” caused by this law. A paradoxical phenomenon is that patients who have access to life-ending medication do not always use it but are willing to fight on longer because they have the comfort of knowing they can use the medication if their suffering became intolerable.

Lastly, two current Maryland laws permitting actions hastening death through either palliative sedation or Voluntarily Stopping Eating and Drinking provide none of the protections built into the End-of-Life Option Act and use of palliative sedation may be initiated without the permission of the affected individual. Requirements of the proposed legislation, including evaluation by a second physician and a 15-day “cooling-off” period, are unique to this legislation. The Act provides more protections and a better process in which a person can die comfortably at home surrounded by loved ones.

Anne Arundel County_FAV_SB845 (1).pdf

Uploaded by: Steuart Pittman

Position: FAV

ANNE
ARUNDEL
COUNTY
MARYLAND
County Executive Steuart Pittman

March 7, 2023

Senate Bill 845

End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee

Anne Arundel County **SUPPORTS** Senate Bill 845 – End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act). This Bill establishes a process by which a qualified individual may request and receive aid in dying from the individual's attending physician and exempts licensed physicians from civil or criminal liability who, in compliance with specified safeguards, dispense or prescribe a lethal dose of medication following a request made by a qualified individual.

People who are suffering with a terminal illness and are of sound mind deserve the option to choose a peaceful death, in consultation with their physician. The right of a person to end their suffering at a time of their choosing, surrounded by loved ones, is fundamental to personal autonomy and dignity. Medical aid in dying is already allowed in 10 states and the District of Columbia, and a growing majority of Marylanders support such an option.[1] Allowing Marylanders to make their own end of life choices is a principle that is shared by a significant majority across the state, regardless of geography, race, or political affiliation.[2]

For all of these reasons, Anne Arundel County respectfully requests a **FAVORABLE** report on Senate Bill 845.

Steuart Pittman
County Executive

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[1] *Compare* Sarah T. Hughes Field Politics Center, Goucher College Poll, Feb. 18, 2018, *available at:* https://www.goucher.edu/hughes-center/documents/Goucher-Poll-Feb19-part1.pdf (finding 62 percent of Marylanders supported the aid-in-dying bill in the 2018 session) *with* Public Policy Polling, Maryland Survey Results, Feb. 6-7 2019, *available at*: https://mdelo.org/wp-content/uploads/dlm_uploads/2019/02/Cross-Tab- Survey-Results-Feb-2019.pdf (finding 66 percent of Marylanders supported aid-in-dying legislation.).

[2] Compassion and Choices, *Support for Medical Aid in Dying is Consistent Across Maryland*, 2023. https://compassionandchoices.org/in-your-state/maryland (Mar. 6, 2023).

Peter Baron, Chief Strategy Officer Phone: 443.685.5198 Email: Peter.Baron@aacounty.org

PRO - FINAL-SB0845 Testimony S Lyon Medical Aid in

Uploaded by: Susan Lyon

Position: FAV

PRO
End of Life Options Act Testimony SB 0845
Elijah Cummings and Shane Pendergrass Act
March 7, 2023

I'm Susan Lyon and I live in Rockville.
I'm here because I've witnessed first-hand what's possible for us in Maryland once we pass the *End-of-Life Options Act.*

I was with my friend, Leah Ray, in Washington DC, when she raised her hand and sipped the legal medicines that ended her suffering.

Leah was brilliant and kind. She embraced all of life. She was joyously married to her husband Daniel. She had been a reporter in Japan. She created art, tutored Latin, rode horses, loved silent films and binge-watched TV westerns.

Then, for six years, cancer ravaged Leah's body. She participated in so many traditional and experimental protocols. But each eventually failed.

In her last three months, her body sat in a chair from which she could not move. For the last three weeks, she could not eat.

But, on November 15, 2019, Leah could act. She could choose. She wrested power away from the cancer that had interrupted and ruled her life.

That day, *she* determined the where and the when. Not the cancer. Not anyone else.

Leah died quickly and peacefully. Not among machines or lost in the din of a sterile hospital. but at home, with those she treasured, and who cherished her. She left how she lived, with agency, dignity, and resolve.

No one is forced to avail themselves of medical aid in dying, but for those who need it—and for those who love them—it is a godsend.
Please, pass this bill—and pass it now. Thank you.

PRO - LYON -Photo of Leah Ray, WDC patient who ben

Uploaded by: Susan Lyon

Position: FAV

Photo of Leah Ray, Washington, DC, resident who benefited from
Medical Aid in Dying in 2019. The End of Life Options act of 2023 would enable Maryland
residents to have a similar choice.
--Testimony of Susan Lyon, March 7, 2023

PRO - Lyon Testimony SB0845 Medical Aid in Dying d

Uploaded by: Susan Lyon

Position: FAV

PRO
End of Life Options Act Testimony SB 0845
Elijah Cummings and Shane Pendergrass Act

March 7, 2023

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Please, pass this bill—and pass it now. Thank you.

Testimony SB 0845.pdf

Uploaded by: Teri Jacobson

Position: FAV

My name is Teri Jacobson and I am an Advanced Illness and End of Life Doula.

Case #1: Client was end stage metastasized cancer.

Endured five years of approved treatment as well as clinical trials in different phases all over the country.

This Pt clearly had a desire to live, even with harsh side effects the trials produced.

The clinical trials left Pt with additional medical and physical challenges beyond the cancer, including being transfusion dependent. After being told what the end-of-life process most likely would look like (heart attack or bleed out), Pt pursued MAID via the State of Oregon and began assimilating a plan to get there. This is not an easy travel plan to put together. The logistics of medical air transport, the financial hardship, the emotional hardship of leaving a safe place called home (where most Americans say they want to die), a family hardship of not having support because they are now in a strange city, the complicated real concern of the what ifs during the in-between traveling and how to go from hospice in his home state to hospice in Oregon so there would be some continuity of care to help with symptoms and pain while waiting the two weeks.

The planning took too long, and Pt became too weak to go to Oregon. Hospice was unable to manage the pain and symptoms due to the complexity of conditions.

The suffering was compounded with distress as pt witnessed the helplessness and fear of loved ones and care partners while they waited for the "fatal event". Frustration and anger regarding how pt did not have a voice, or a choice amplified the suffering. All the pt wanted was to be at peace in the dying. To have moments with loved ones who were not wretched with fear and helplessness. Dignity, compassion, care. CHOICE.

So, I submit these questions for you to consider:

What would it feel like to be bed bound and waiting for cardiac arrest? What would it be like to sit and wait for your loved one to bleed-out? What does it look like to have uncontrollable pain, vomiting, air hunger, knowing there is even a more challenging event to endure in order for you to die.

Helpless? Hopeless? What choice was there? Every one suffered more because there was no choice.

2022-03-06 TDB SB0845 Testimony.pdf

Uploaded by: Todd Becker

Position: FAV

Todd Becker, LMSW
Regarding the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
March 6, 2023

To Whom It May Concern:

My name is Todd Becker. I am a doctoral candidate in the University of Maryland School of Social Work where I study end-of-life care and am currently completing my dissertation on medical aid in dying. I write this testimony to express my full support of the End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).[1] My support stems from three distinct, yet interrelated, domains: my professional experience as a hospital social worker, my scholarly experience as a medical aid in dying researcher, and my personal experience as a fellow Marylander who wants not just to live—but also to die—in accordance with my values. Through my support, I join the 66% of Marylanders found to be in favor of medical aid in dying by Public Policy Polling in 2019.

Medical aid in dying offers an applied way through which law can make health care more equitable and socially just. Notwithstanding, much of what conditions the ultimate legality of the practice rests on interpretations of morals and ethics. Where this reliance can go wrong is when assumptions about medical aid in dying are conflated with other mechanisms of self-actualized death, most notably suicide. Leading medical, psychological, public health, and suicidological organizations have issued statements affirming that medical aid in dying is categorically different from suicide. The distinction is that, unlike those who die by suicide, for those pursuing medical aid in dying, death is both assured and imminent. That these individuals are likely to die within 6 months, regardless of the cause, is not questionable. In this way, when one's terminal illness has filled in the blanks for them pertaining to "who," "what," "where," "when," and "why" they will die, their ability to craft for themselves the "how" becomes all the more intimate and meaningful.

Such was the experience of Brittany Maynard, who publicly chronicled her process with medical aid in dying. In so doing, she recounted the dissonance of not recognizing the reflection staring back at her in the mirror due to the changes in her physical appearance prompted by her illness. She spoke of the trepidation of potentially forgetting to tell others that she loved them each day for fear that she would not get another opportunity. Most strikingly, she described that the "worst thing that could happen" would involve her terminal illness robbing her of her autonomy to live and die on her own terms through medical aid in dying. Throughout this process, she made clear that she loved her life and had no desire whatsoever to die but that her illness rendered death an inevitable and impending reality. Complicating this already-fraught situation was the fact that she, her husband, and her parents had to move from their native California to Oregon in order to access legal medical aid in dying. Moving an extended family across state lines is challenging in the best of circumstances and is not realistic for people of varying backgrounds. This recognition led to California's legalization in the year following Maynard's death. Even alongside legalization in nearby New Jersey and the District of Columbia, local disparities in equity and health care access can be counteracted by advancing legislation here in Maryland.

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[1] The views expressed in this testimony are my personal views and do not reflect the views of either the University of Maryland or the University of Maryland School of Social Work.

Longitudinal report data from U.S. environments where the practice is legal show that responsible implementation of medical aid in dying is feasible. Indeed, empirical studies have found a lack of widespread abuse of medical aid in dying, thereby combatting the commonly invoked boogeymen of slippery-slope and other arguments. These same reports show a growing divide between (a) the number of prescriptions written and (b) the number of deaths attributable to medical aid in dying. What we should deduce from this trend is that the relief that legalization offers to patients and families is not tied exclusively to death. Instead, awareness of the mere availability of a medical aid in dying option has been recognized for offering a psychological benefit to patients through restoring one's sense of control relinquished to their terminal illness. This recognition has led others to contend that the availability of medical aid in dying itself is palliative in nature, irrespective of whether or not it is ultimately used.

This same recognition is precisely why medical aid in dying—beyond its professional and scholarly importance—is personal to me. In full disclosure, I doubt that I myself would use medical aid in dying even if I qualified for it. Still, actively choosing not to use medical aid in dying is radically different from never having that choice in the first place. Getting to determine my own course of action in this regard would make a world of difference in improving my dying experience by reinvigorating my sense of agency, dignity, and personhood. These three factors are virtues that everyone should have at the end of life and that exist at the core of this policy.

Opponents have long asserted that providing quality hospice care would stem the impetus underlying medical-aid-in-dying requests by palliating symptoms and increasing comfort. Yet, these arguments fall flat when considering that the aforementioned longitudinal report data show that over 75% of those who use medical aid in dying are also enrolled in hospice care. Although most assuredly not a criticism of hospice care, this high proportion of overlap suggests that medical aid in dying may offer avenues of interest available outside of traditional hospice care.

Medical aid in dying's illegality does not nullify the desire to hasten one's death in the context of terminal illness. Research (my own included) shows that health care workers receive requests for medical aid in dying even in states where the practice remains illegal. The lack of availability traps patients in a cruel bind that discourages open and safe dialogue with their families and their health care teams—those who ostensibly warrant the clearest lines of communication—and, thus, perpetuates suffering. In certain cases, this restriction has led to some patients and families compassionately facilitating death independently. That this action occurs outside of a medical purview drastically threatens its safety and the psychosocial well-being of family, friends, and health care workers. This harrowing miscarriage of justice can be ameliorated by your action.

At 66%, Marylanders support medical aid in dying even more than the general American population, recently estimated by Pew Research Center to be 61%. Both of these proportions are expected to continue climbing. I, therefore, passionately call on Senate members to advance this policy pursuant to the stated interest of their constituents. Advancing this policy is the ethical and humane thing to do. Thank you in advance for your consideration of my testimony.

Sincerely,

Todd Becker, LMSW

SB0845-VThuronyi-Favorable.pdf

Uploaded by: Victor Thuronyi

Position: FAV

Testimony of Victor Thuronyi
Support for HB933 and SB845
The End-of-Life Option Act
March 7, 2023

My body – My Choice

My name is Victor Thuronyi. I have an incurable and fatal blood cancer (myeloma), and I strongly support passage of the End-of-Life Option Act.

In the not too distant future my treatment options will likely run out. At a point when I might just have a few days to live, I would like to have as many options as possible.

Myeloma used to have a life expectancy of three years. I have now lived over ten years, and I hope to continue living as long as possible. I am not atypical. Most cancer patients want to live longer, not die.

While I would likely ask for aid-in-dying once I qualify, I would wait to decide whether to use the prescription until my doctor advises that (1) further therapy for the cancer is futile, and (2) I am likely to die soon. Who knows whether I get there. Many myeloma patients die of an infection like pneumonia, or from another side effect of therapy.

The debate about this bill often involves the motivation of patients: to avoid pain, to achieve control over the manner of death, or what? Relatedly, some ask why patients need this if pain relief can be obtained through hospice care. These questions seem to me misguided. Medical care often does not go as planned. My motivation for wanting the end of life option is simple: if things don't go well with Plan A, I want a Plan B.

It may be an issue of pain. I experienced level 9 pain when first diagnosed (pain just below what causes you to black out), as well as during bone marrow biopsies. I'd want to avoid that.

Specifically why I might want to end my life using this legislation is something I can't predict at the moment, and might not know until shortly before. I do know that I do not wish to die while comatose or drugged.

Supplement to Testimony of Victor Thuronyi

I do not wish to die while comatose or drugged

I know someone who died from myeloma while comatose on a respirator, after his family pulled the plug. (He was blogging until near the end; his last post was about 3 days before he died.) Another patient I know was in a similar situation. Dying while comatose does not seem ideal. Neither would I want to die having been administered high levels of pain killing drugs (which would also imply being comatose or nearly so). Both these methods of dying are legal and not uncommon. Patients (or their designated agent) can refuse treatment (including requests to disconnect their respirators) and high levels of pain relieving drugs can be administered as long as the intention is to relieve suffering.

This is a matter of planning the time and manner of death, not suicide

Opponents sometimes label the process authorized by the end-of-life option act “physician-assisted suicide.” In this context, the term “suicide” is inappropriate. Patients using this legislation will in any event die shortly from the underlying illness. “End-of-life option” better reflects the reality. Dying in this manner might be called planning or speeding along the death process. It is a death that will occur shortly anyway. For a patient, the legislation offers a way to best arrange the manner and timing of death so as to be able to say good-bye to loved ones and die while still alert and mentally functioning. I would rather be remembered as someone with the courage to end my own life at a time of mental clarity, rather than being delirious, unable to communicate, or the like.

Under this law, the patient takes the action to end life, not the physician or family members

Family members or designated health care agents often face what can be an agonizing choice about discontinuing life support or authorizing the injection of high-dose pain-killing drugs. This places a burden on family members. Often, family conflicts linger for years about whether the decision was right or if other family members should have been involved or consulted. By contrast, when a patient takes responsibility to plan their own death under the end-of-life option act, the patient can take responsibility and lift the burden of making this decision off others. This is a gift that I would like to give my family members – I would rather take responsibility myself rather than having them make a decision to end my life when I am comatose or delirious.

When a physician prescribes life-ending medication under this legislation, death is not a necessary consequence of the physician’s action. This is because many patients (roughly one-third) never use the medication. If the physician intends to provide an option to the patient, rather than to cause the patient’s death, then the physician is even less involved in causing death than in the case where the physician terminates life support or administers pain relieving drugs at a dosage that will likely lead to death. Providing this option benefits the patient by providing peace of mind. The patient knows that if the dying process becomes undesirable for whatever reason, the patient has this option for the manner of death. If the doctor’s intention is to provide peace of mind to the patient and to comply with the patient’s wishes to have life-ending medication available to use should the patient decide to do so, then the physician is not causing the patient’s death. The physician is empowering the patient, and providing the patient with a tool that the patient can decide whether or not to use.

Legislators should base decision on facts, not hypothetical abuse

Opponents of this bill tend to emphasize hypothetical abuses that could occur. The proper approach is to ask whether there is any evidence of actual, as opposed to hypothetical, abuse. In the several states that have had an end-of-life option act for years, there is no evidence of any abuse of this law. On the contrary, the law is being used by a patient population that is clearly qualified and informed. Roughly one-third of patients end up not using the prescribed drugs. This suggests that patients are by and large not rushing into it. The prescription provides peace of mind to the patients, who know this is an option that they can use when they need to and when the time comes.

In the absence of evidence of substantial abuse, legislators should heavily discount complaints about the bill that are made on the basis of imaginary situations Under current law there are hundreds of people dying in Maryland every year who might like to use the end-of-life option act but cannot, and some of the deaths are not good ones. This is a fact, and a consequence of legislative inaction. These actual bad deaths should be balanced by legislators against the hypothetical abuses that the opponents describe.

The legend of the greedy relative

The legend of the greedy relative is an example of hypothetical abuse adduced by opponents. This story features a greedy relative of the dying patient. The relative stands to inherit money on the patient's death, and can't wait for the patient to die. The relative browbeats the patient into asking for end-of-life medication and then either coerces the patient to take the drug or administers it to the patient by stealth. The first thing about this story is that it is entirely hypothetical; such a thing has never been observed in the history of thousands of patients who have benefited from the end of life option act in different states. If this sort of thing were at all common, we would expect to see patients dying soon after getting the prescribed drug, but the opposite is the case: unless they are late in asking for aid in dying, patients tend to wait for quite some time before taking the drug and many never take it. Second, it is entirely implausible. It would be quite rare for someone's spouse or child to be so malignant. Aid in dying does not advance the time of death by much, so in most cases the financial benefit to the relative from a slightly earlier death would be minimal. Moreover, the relative would have to fool the doctor as well as hospice care providers. Remember that virtually all patients taking advantage of aid in dying are getting hospice or palliative care.

Finally, compare the regulated situation under the aid in dying legislation to the virtually unregulated alternatives. Under Maryland law, there is no interview with a doctor when a patient signs an advance directive designating a relative as a health care agent. Isn't the greedy relative scenario much more likely in a context where the relative is the designated agent and either authorizes the administration of high-dose pain killers (leading to the patient's death), the cessation of life support, or the cessation of treatment such as antibiotics? On the order of half a million patients die in the U.S. each year in an intensive care unit,[1] a high portion of which die after life support is withdrawn. There are no safeguards in the system against abuses by "greedy relatives" who authorize withdrawal of life support in the ICU context. Part of the reason is that in most cases the problem is not family members who want the patient to die earlier; typically,

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[1] Angus DC, Barnato AE, Linde-Zwirble WT, Weissfeld LA, Watson RS, Rickert T, Rubenfeld GD; Robert Wood Johnson Foundation ICU End-Of-Life Peer Group. Use of intensive care at the end of life in the United States: an epidemiologic study. Crit Care Med. 2004 Mar;32(3):638-43. doi: 10.1097/01.ccm.0000114816.62331.08. PMID: 15090940.

family members are arguing with physicians to prolong care, even if the physician considers this futile.

Under Maryland law, there is no rule that a designated health care agent cannot be one who will receive a benefit from the estate. In fact, probably most designated agents are spouses or others who will inherit from the patient. The only restriction is that one of the two witnesses to the signature on the advance directive is someone who will not receive money from the estate.

Gun suicides

Suicide by gun in the United States is unfortunately not hypothetical. There were over 24,000 suicides by gun in the U.S. in 2020.[2] Motivation for suicide varies, but certainly some suicides are committed by people who are diagnosed with a serious illness. Guns are a pretty effective way to commit suicide, but the consequences for the family are usually grim and often devastating. A patient with a terminal illness who has a gun and who might be tempted to commit suicide, could be deterred from doing so if there is a system in place for achieving a death that is much less fraught than suicide by gun. Offering patients this alternative, which is bolstered by safeguards, empowers patients to act in a way that is more considerate of family members and is likely to be preferred by the patient.

Encouraging good patient conversations and use of hospice care

Many patients with terminal conditions are reluctant to face reality. Medicare criteria allow admission to hospice if the patient has a prognosis of living six months or less. But the average stay in hospice is much shorter. According to a study published in the Journal of Palliative Medicine, roughly half of patients who enrolled in hospice died within three weeks, while roughly one-third died within one week. Even physicians might have a tendency to continue prescribing drugs where the chances of success are close to zero. As a patient, I have heard pushback in discussion groups where a patient reports that their doctor said there was nothing more they could do. Typical reactions are: “Get another doctor!” “Keep on fighting!” The current tendency is for both patients and physicians to be unrealistically optimistic. By contrast, the end-of-life option act encourages patients to have honest conversations with their doctors about end of life. The existence of the law can encourage patients to have a conversation with their doctor that includes all available options. Use of the end-of-life option act goes hand in hand with hospice. In California, about 92% of patients who ingested the prescribed aid-in-dying drugs, were receiving hospice or palliative care (see California Department of Public Health report on 2021).

Patients should be free to act on their own religious views

Theologians differ on the morality of choices at the end of life. Most would not mandate taking extraordinary measures to continue life, leaving this to the decision of the patient. While some argue that the decision to give life or end life belongs to God, not to humans, others hold that “the all-merciful God, who has given men and women freedom and responsibility for their lives, has also left to dying people the responsibility for making a conscientious decision about the manner and time of their deaths….If God makes the whole of life a human responsibility, then this responsibility also applies to the last phase of our lives.”[3] Religious views about end of life

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[2] https://www.pewresearch.org/fact-tank/2022/02/03/what-the-data-says-about-gun-deaths-in-the-u-s/.

[3] Hans Kung, Dying with Dignity (1998).

choices differ. Patients should be free to act on their own views of what morality calls for at the end of life. It is not legitimate for some to impose their religious views on others.

Relevance of six-month diagnosis

Some opponents of the legislation have fixated on the fact that a prognosis that a patient has six months to live can be wrong. The six-month rule included in the bill is the same as that used for hospice. It is true that some patients entering hospice end up living longer than six months (about 15 percent outlive the original six-month prediction). The question is what is the relevance of this? The purpose of the six-month rule is to limit participation in the aid-in-dying program to those patients who truly are terminally ill. The fact that a doctor has made a determination that a patient qualifies does not mean that the patient is certain to die within six months. Any careful doctor will tell their patient that the six-month prognosis is just an average, that there is a chance that the patient will live longer, and that it is impossible to predict so far in advance how long a patient will live. As a patient, if I were told that I qualified for aid in dying, I would not assume that it meant I had only six months to live, only that it seemed that I was getting into the terminal stage of my illness. The six-months rule gives the patient time to make the various requests needed, get the second opinion, and so forth in order to qualify for the prescription. Suppose this takes a few weeks. At that point, the six-month prognosis become irrelevant.

As a patient, I would normally want to live as long as possible. At the same time as getting a prescription for aid in dying, I might also be participating in a clinical trial, or taking other therapy for my cancer, as long as my doctor tells me that it might be effective. At some point after getting the prescription, I would expect my consultations with my doctor to give me a better idea of life expectancy. Normally, a patient would not want to take the life-ending medicine until a doctor advised that death was imminent, perhaps a few days away at most, assuming that the patient was still capable at that point and not in great pain. In other words, the patient does not rely on the six-month prognosis as an indication of when to take the medication. That decision comes much later when the doctor advises the patient that no further treatment is warranted and that death is imminent. So the fact that some patients live longer than six months after getting that opinion from a doctor simply is irrelevant. In fact, I would turn this around and say that the fact that some patients live much longer than six months after getting a prescription for life-ending medication is great. I would like to be in that group.

Possibility that drug will not work as hoped

Opponents of aid-in-dying have made much of the fact that there is a possibility of things going wrong and the drug not working as intended. As a cancer patient, I have gotten used to taking drugs with side effects, asking doctors about side effects, and dealing with side effects. No cancer patient is under the illusion that drugs work perfectly without any side effects. This is not a good reason to disapprove aid-in-dying. A key point is that the legislation does not mandate any particular drug or drugs. That is up to the patient and doctor to decide. As with medicine generally, doctors are working to anticipate side effects and manage them where possible. The possibility that the drugs prescribed to end life will not work as planned is something that patients and doctors can be expected to take in stride and deal with, as they deal with other aspects of medical care. It is simply not a reason to disapprove aid in dying. The possibility of side effects may of course influence whether a particular patient decides to go through taking the drugs and how they do this. This is a decision that should be up to the patient, as the patient also makes other decisions about medical care in consultation with their doctor.

Insurers not paying for a drug but paying for aid in dying prescription

I am fortunate to have good health care coverage. If I told you how much the drug I am currently taking costs, you would blanch. I am concerned about the cost of drugs, and something should be done about it, but that is really a separate issue. Opponents of this legislation have raised the issue that insurers might pay for the end-of-life prescription but not for a treatment drug. But there has never been a credible case of an insurer denying treatment coverage because the patient qualifies for an aid-in-dying drug. It would be desirable for people to have insurance that covers all the necessary drugs for treatment, and to keep the costs of those drugs down, but this is not really relevant to aid in dying. The number of people who use aid in dying is quite small, so the availability of this option is not going to be significant for insurers in determining which drugs to cover.

Conclusion

The End-of-Life Option Act should be approved as a modest expansion of the existing legal framework allowing physicians to comply with a request of their patients about having an option as to how and when to die.

7a- Elijah Cummings Letter.pdf

Uploaded by: Wendy E Minor
Position: FAV

HOUSE OF REPRESENTATIVES
WASHINGTON, D. C. 20515

ELIJAH E. CUMMINGS
SEVENTH DISTRICT
MARYLAND

February 12, 2019

Delegate Luke Clippinger, Chair, Judiciary Committee
Email: luke.clippinger@house.state.md.us
Delegate Shane Pendergrass, Chair, Health and Government Operations Committee
Email: shane.pendergrass@house.state.md.us
Senator Bobby Zirkin, Chair, Judicial Proceedings Committee
Email: bobby.zirkin@senate.state.md.us

Compassion at the End of our Lives
The End of Life Option Act: HB 399 / SB 311

Dear Colleagues & Friends – I have been informed that you would welcome my thoughts regarding the ***End of Life Option Act***, proposed for enactment by the 2019 Maryland General Assembly. Despite my general reluctance to interject my personal views into decisions that, under our federal system, are properly within your discretion, I have decided to respond.

I do so, in part, because, like many of you, I have reached a time in my own life when I have experienced the loss of far too many people whom I admired and loved – some who suffered for months knowing that they were about to die. As I recall these losses for you, I must acknowledge that my prayer for those dying loved ones, deprived of any reasonable hope for a prolonged life, was for a respectful and compassionate end to their suffering – and a swift journey to that better place that is promised to all people of faith.

I say this to you in full knowledge that there are those among us whose conscience can never accept that any person should have the right to choose the manner and time of their passing, even when facing death in the very near term. My reading of the proposed legislation is that it would respect and extensively protect those determinations of conscience, both for the terminally ill person and for all others who may become involved.

It seems to me, however, that the critical issue addressed by ***The End of Life Option Act*** is different, both morally and constitutionally. It is the question of who has the right to choose.

The Act would recognize that the constitutional right to privacy in Maryland includes the right of a terminally ill human being – legally competent, fully informed and protected from coercion – to choose the manner and time of their passing. It would recognize and declare that, at the end of life, an individual's right to self-determination about one of the most personal decisions that anyone could make supersedes the moral sensibilities of others.

As a just and compassionate society, we cannot value life in the abstract and deny to those who are about to die the self-determination that they deserve. For these reasons, I commend and support those who would enact this reform in our laws, and at your discretion, I would welcome the inclusion of these comments in the record of your proceedings.

Respectfully submitted,

Elijah Cummings

Diane Rehm testimony 3723.pdf

Uploaded by: Wendy E Minor

Position: FAV

Testimony by Diane Rehm
In Support of the Maryland End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act, SB 845/HB 933)
Joint Committee on Health and Government Operations
March 7, 2023

Good afternoon.

I am grateful to have this opportunity to speak with you in support of the Maryland End-Life Option Act.

Most people I know hope they will die in their sleep, peacefully and without pain.

Unfortunately, when my husband of 54 years, John Rehm, died, that was not his experience.

In June 2014, when John was 83, he was placed under hospice care in a Maryland nursing home.

His doctor had concluded that he had six months or less to live.

That's when John told his physician that — because Parkinson's disease had so affected him that he could no longer use his hands, arms, or legs, because he could no longer stand, walk, eat, bathe, or in any way care for himself on his own — he was now ready to end what was becoming a prolonged dying process.

He knew how Parkinson’s would take away the dignity of his life, and he knew the physical and mental suffering that was to come.

He declared to me, his children, and his physician that he was "ready to die."

But when his physician explained that he was unable to carry out John's wishes in the state of Maryland, John became very angry.

He said, "I feel betrayed."

Then his doctor explained that the only alternative John had if he wished to end his suffering, was to stop eating, drinking fluids, and taking medications.

He asked his physician how long the dying process would last and was told it could be 10 days to two weeks.

The very next day, my husband began his journey to the end.

He ceased drinking fluids, taking medications, or eating any food whatsoever.

I sat by my husband's side as he slowly died.

The legislation you are considering may have permitted John Rehm and so many others to have the measure of autonomy that he wanted over his own death.

His own death.

I absolutely believe that laws permitting medical aid in dying affirm every individual's precious right to autonomy at the end of life.

And so, again I thank you for hearing from me today.

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Word count: 350 (approximately 3 minutes)

Endorsement of SB 845 and HB 933 (2).pdf

Uploaded by: Wendy E Minor

Position: FAV

ATTN: Maryland Senate Judicial Proceedings Committee
Maryland House Health and Government Operations Committee

Ref: SB 845 and HB 933

On behalf of For the Common Good Indivisible of Rockville, I write in support of passage of the pending End-of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) (SB 845 & HB 933). These bills strike a reasonable balance between the State's interest in protecting vulnerable individuals and the right of individuals to make informed decisions concerning their bodily autonomy. Especially with our State's aging population choosing to stay in the State, residents of the State of Maryland must have the right to die with dignity and make informed end-of-life decisions with assistance from medical care providers.

Thank you.

Respectfully Submitted by,

Raj K. Gupta, Esq.
On behalf of
For the Common Good Indivisible of Rockville
5 Cumbernauld Court
Rockville, MD 20850
301-424-0163
Rajkgupta13@hotmail.com

Indivisible Montgomery in support of SB B45.pdf

Uploaded by: Wendy E Minor

Position: FAV

ATTN: Maryland Senate Judicial Proceedings Committee
Maryland House Health and Government Operations Committee

Ref: SB 845 and HB 933

On behalf of For the Common Good Indivisible of Rockville, I write in support of passage of the pending End-of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) (SB 845 & HB 933). These bills strike a reasonable balance between the State's interest in protecting vulnerable individuals and the right of individuals to make informed decisions concerning their bodily autonomy. Especially with our State's aging population choosing to stay in the State, residents of the State of Maryland must have the right to die with dignity and make informed end-of-life decisions with assistance from medical care providers.

Thank you.

Respectfully Submitted by,

Raj K. Gupta, Esq.
On behalf of
For the Common Good Indivisible of Rockville
5 Cumbernauld Court
Rockville, MD 20850
301-424-0163
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JCRC Endorsement Letter (1) (2).pdf

Uploaded by: Wendy E Minor

Position: FAV

JCRC JEWISH COMMUNITY
RELATIONS COUNCIL
JEWISH FEDERATION OF HOWARD COUNTY

Donna Smith
Maryland State Director
Compassion & Choices

We, the Jewish Federation of Howard County and its Jewish Community Relations Committee are thrilled to see the introduction of "The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End-of-Life Options Act", SB0845/HB0933. While Judaism has always been a life centered faith, we understand that the spiritual needs of those suffering incurable condition must also be considered. We believe our religion recognizes the difference between prolonging life or just postponing death and so we endorse this bill without hesitation or reservation.

Sincerely,

Rabbi Gordon Fuller,

President

Jewish Federation of Howard County

Maya R. Cummings writttten testimony only SB845.pdf

Uploaded by: Wendy E Minor

Position: FAV

February 23, 2023

Senator Will Smith, Chair, Judicial Proceedings Committee
Delegate Joselyn Peña-Melnyk, Chair, Health and Government Operations Committee
Delegate Luke Clippinger, Chair, Judiciary Committee
Maryland General Assembly
Annapolis, MD 21401

Re: Elijah Cummings' Unwavering Support for the End-of-Life Options Act

One of the hardest things my late husband Elijah Eugene Cummings ever said to me was, "I am ready to die." Suffering from medical complications related to kidney disease, thymic cancer, and a heart valve transplant, Elijah and I had had a number of extended hospital stays over the previous two and a half years prior to his death. But this time was different. After the doctor informed us that they had run out of treatment options for him, Elijah asked me to find a hospice where he could spend his last days on earth.

A deeply religious man, the son of two preachers, who practiced the Christian faith his entire life, Elijah took the path of accepting a natural end to his life no matter how painful and dispiriting it was. But as a University of Maryland trained lawyer and a long-serving legislator, Elijah was nothing if not practical. He understood that the personal faith beliefs guiding his end-of-life choice may not be right for others who might make different choices, perhaps because they follow other faith traditions or none at all.

Elijah believed it was his duty to ensure that the law provided people of different backgrounds and beliefs with end-of-life options. Indeed, he felt the protection of the law was critical regarding this matter given the complex and delicate nature of the factors shaping end-of-life decisions.

For this reason, Elijah firmly supported the End-of-Life Option Act, which gives terminally ill persons in Maryland the right to determine when and how they end their lives. The Act offers a clear process for applying for medical aid in dying and for defining terminal illness, has appropriate guidelines for assessing the mental capacity of the patient, and conscientious procedures for ensuring that there is no coercion or abuse involved in the patient's decision-making process. Licensed medical professionals are involved every step of the way. Finally, people who do not want to die in this way are not compelled to apply for this program. It is completely optional.

End-of-life decisions are deeply personal. Marylanders who are suffering from terminal illnesses deserve the right to choose when and how they end their lives. The Maryland legislature must respect their dignity and right to self-determination by passing the End-of-Life Option Act.

Thank you for your time and careful consideration.

Sincerely,

Maya R. Cummings

Maya Rockeymoore Cummings, Ph.D.

SB 845- LWVMD- FAV- End-of-Life Option Act.pdf

Uploaded by: Wendy E Minor
Position: FAV

LWV LEAGUE OF WOMEN VOTERS®
OF MARYLAND

TESTIMONY TO THE SENATE JUDICIAL PROCEEDINGS COMMITTEE

SB0845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

POSITION: Support

BY: Nancy Soreng, President

DATE: March 7, 2023

The League of Women Voters Maryland supports **Senate Bill 845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).** The League believes state laws should grant the option for a terminally ill person to request medical assistance from a relevant, licensed physician to end one's life. It also believes that such legislation should include safeguards against abuse for the dying and/or medical personnel.

Per the New England Journal of Medicine:[1] "In **patient-centered care**, an individual's specific health needs and desired health outcomes are the driving force behind all healthcare decisions…Patients are partners with their healthcare providers, and providers treat patients not only from a clinical perspective, but also from an emotional, mental, [and] spiritual [one]."

Patient-centered care is a true collaboration between patient and medical provider. Patient goals are respected, and care is designed and delivered according to their needs and priorities. When seen through a patient-centered-care lens, relief of suffering- whether physical, mental, or emotional- can be seen as a crucial treatment goal.

When approaching death, when death is inevitable, some patients view the loss of autonomy as more frightening than the prospect of worsening physical pain. The loss of control over their bodies, their mental faculties, and of the ability to make decisions on how to spend their last days, can become a horror. Compassionate care, designed to meet their needs, can suddenly seem out of reach.

Senate Bill 845 is designed to enable patients and providers, if they choose, to help extend compassionate care to a patient's final days. With numerous important safeguards built in to the process, it would provide an option for a terminally ill, capable, competent adult with a prognosis of six months or less to live, to request, legally receive from a physician, and voluntarily self-administer a prescription medication to hasten their death in a peaceful manner.

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[1] https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0559

This option of maintaining some self-determination and control over one's final days, of preserving one's dignity, is a great comfort, even if the patient winds up not taking the medication.

At present, **ten states** (Oregon, Washington, Montana, Vermont, California, Colorado, Hawaii, New Jersey, Maine, New Mexico) **and the District of Columbia have passed legislation legalizing medical aid in dying.** Oregon's Death with Dignity Act was enacted in 1997.

Marylanders support aid-in-dying legislation. Per the January 2022 Gonzales Maryland Poll: [2] "Among Maryland voters, 69% believe that a mentally sound adult with an incurable, terminal illness, who has only six months or less to live, should have the legal option of medical aid in dying…"

This will likely increase, as the aging population is growing quickly. The Department of Aging estimates that by 2040 there will be 1.79 million Marylanders over the age of 60.

Maryland has a long history of considering, but not passing, death-with-dignity legislation. Attempts were made in **1995** (HB 933), **1996** (HB 474), **2015** (HB 1021 and SB 676), **2016** (HB 404 and SB 418), and **2017** (HB 370). In **2019** (HB 399) the "End-of-Life Option Act" passed in the House, but (SB 311) failed to pass in the Senate. The **2020** re-introduced bills (HB 643 and SB 701) also failed to advance.

After multiple attempts over 28 years, and with broad popular support, it is now time to pass this important legislation. The League of Women Voters Maryland and its 1,500+ members urge the committee to give a favorable report to Senate Bill 0845.

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[2] https://compassionandchoices.org/docs/default-source/maryland/compassion-and-choices-maryland-poll-january-2022.pdf?sfvrsn=c94a1d03_1

Terry Lierman 3723.pdf

Uploaded by: Wendy E Minor

Position: FAV

TERRY LIERMAN TESTIMONY IN SUPPORT OF THE MARYLAND END-OF-LIFE OPTION ACT (SB 845)

(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act, SB 845/HB 933)
Joint Committee on Health and Government Operations
March 7, 2023, 1pm

Passing this medical aid-in-dying law is good public policy.

Polls indicate that most Marylanders are in support, Gov. Wes Moore, Lt. Gov. Aruna Miller and Comptroller Brooke Lierman are supportive.

Since the first medical aid-in-dying law took effect in Oregon in 1997, there have been no reports of misuse of this end-of-life care option.

We have been debating this bill in Maryland for eight long years.

The time is now to pass the End-of-Life Option Act.

My advocacy began when my beloved wife Caroline suffered unnecessarily from cancer at the end of her life.

I married Caroline, the love of my life, on May 17, 2019 and I lost her on Nov. 23, 2019, to five different cancers: liver, lung, bone, spine and colon.

We were told of her diagnosis only 3 weeks before we married.

I spent the majority of our marriage watching my wife Caroline suffer in pain and begging me to let her die.

TERRY LIERMAN TESTIMONY IN SUPPORT OF THE MARYLAND END-OF-LIFE OPTION ACT (SB 845)

(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act, SB 845/HB 933)
Joint Committee on Health and Government Operations
March 7, 2023, 1pm

We spent the last 3 months of her life in the hospital and hospice.

Her pain level was high even though she received copious amounts of painkillers.

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

The doctors told us she would die in a matter of months, but because this law was not passed so there was nothing they could do to stop her suffering.

She went into hospice and they treated her with palliative sedation which helped her pain some.

But, it took her two weeks to die and she chose voluntary stopping of eating and drinking, which basically amounted to her starving to death.

No one should have to endure what she endured, what we endured with her.

If we have the means to end unnecessary suffering why shouldn’t we do it?

TERRY LIERMAN TESTIMONY IN SUPPORT OF THE MARYLAND END-OF-LIFE OPTION ACT (SB 845)

(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act, SB 845/HB 933)

Joint Committee on Health and Government Operations

March 7, 2023, 1pm

I promised Caroline before she died that I would do what I could to make sure no one else suffered at the end of life like she did.

An individual has every right to follow their own conscience and religious beliefs but they don't have the right to impose their beliefs on others.

I want to thank all the legislators who voted to pass this bill in the past and encourage others to do the right thing and support this bill.

It means everything to the people and their families who are suffering as we speak.

The time is NOW to pass this bill!

Thank you.

(Word count: 405)

The-Young-Democrats-of-Maryland.pdf

Uploaded by: Wendy E Minor

Position: FAV

YOUNG DEMOCRATS OF MARYLAND

STATEMENT OF SUPPORT

February 18. 2020

Senate Judicial Proceedings Committee
Maryland Senate
Annapolis, MD

Dear Chairman Smith,

The Young Democrats of Maryland are pleased to write today in support of SB701.

The Executive Board of the Young Democrats of Maryland (YDM) has elected to take the following position on the End of Life Choices Act (SB701/HB643):

1. YDM believes state laws should grant equal access to the option for a terminally ill person who is able to make medical decisions for themselves to request medical assistance from a licensed physician to end one's life.
2. YDM believes that providing well regulated access to a full range of end of life options is ideal for the residents of Maryland and that the absence of such regulations puts Marylanders at risk of exposure to dangerous and unnecessarily painful alternatives; YDM further maintains that certain prohibition on certain end of life options do not produce health care services which are of higher quality or more equitable--they only serve to sweep the use of certain end of life options under the rug and stifle the development and delivery of high quality end of life healthcare to all Marylanders.
3. After review of a combined legislative history of more than 30 years in 9 states, YDM has found no confirmed evidence of family coercion of the developmentally disabled or elderly--rather, this and other bills like it, contain safeguards which go above and beyond in protecting the vulnerable members of our communities.
4. Like right to choose abortion, or the right to refuse care, YDM also holds true that the right to access a full range of end of life options is fundamentally a personal right.

Maryland's terminally ill persons should have the right to request medical assistance from a license physician to end one's life because it is a human rights issue. YDM believes in personal freedom and the decision of ending one's life is a very personal decision that one makes with themselves and a physician, which they could revoke at any time. We must allow people to have this option, it is important that we give them a choice.

Moving Maryland forward takes the work of all Marylanders and we implore you to favorably report this piece of legislation out of your committee.

Sincerely;

Demetrius Briscoe
Legislative Director

Joseph Lynn Kitchen

Joseph Lynn Kitchen Jr.
President

USM SUPPORTS SB 845 & HB 933 End-Of-Life 2023.pdf

Uploaded by: Wendy E Minor
Position: FAV

UNITED
SENIORS
OF
MARYLAND

USM SUPPORTS SB 845 & HB 933

End-of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

KEY POINT: **United Seniors of Maryland**, through its coalition member groups & individuals, **represents 2.5 million seniors in our state**. We are a non-partisan, non-profit over 48 years of senior advocacy. We are the **fastest growing population in our state**, from rural Allegheny County & the Shores to the urban areas of Montgomery and Prince Georges counties. USM is the voice of seniors in Maryland.

KEY POINT: **United Seniors of Maryland endorses the End-of-Life Options Act.**

1. It is good legislation.
2. It has many checks and balances.
3. It provides access to an end-of-life care option that many of our members want.
4. It facilitates open and transparent dialogue between patient and doctor.
5. It provides the right to access care, when requested.
6. Marylanders should have the health care right that residents of Washington DC and 13 other states enjoy.

KEY POINT: USM is **UNANIMOUS** in supporting the bill.

1. **USM FULLY AGREES Maryland needs an End-of-Life Option that is regulated and provides access to our care options.**
2. USM believes this is a right to care bill.

KEY POINT: Our USM Legislative Committee has carefully reviewed the bill.

1. We have endorsed the bill since 2015;
2. Eight years later- **We still want the right to access our care options.**

<u>Conclusion:</u>

As the President of United Seniors of Maryland, I am here on the behalf of 2.5 million seniors and the behalf of myself as a CEO of a Health Care Provider for Community Based Home Care Services that cares for end-of-life clients for over 66 years, all over the State of Maryland.
I too am a Maryland resident, and my career has been serving our state's aging and disabilities population as one of the first State Disabilities Commissioners under Governor Ehrlich. It is always my goal to make sure they have access to the best possible care, and are **empowered to make healthcare decisions that match their own values and priorities.** Thank you for your favorable support of SB 845 & HB 933..

Campbell Testimony.pdf

Uploaded by: Andrea Campbell

Position: UNF

SB0485 -written testimony 3/7/2023
Andrea Campbell
Position- Unfavorable
Arnold, MD

In a perfect world, someone asking for a physician to assist in their death would have a clear mind with no pressure to cloud their decision. We don't live in a perfect world.
Not everyone asking to die will be surrounded by compassionate family members.
It will not always be the bedside scene with hands being held lovingly.

It is common sense and and simple understanding of human nature to know there will bef real life ' end-of -life ' situations that will not have compassion or dignity. A very 'real life' scenario may have one or several of the following possibilities. An elderly person who does not have support is diagnosed. They don't have the assistance of others to have a second opinion. People can be diagnosed wrongly or live years past the doctors estimate.

They feel that they are a burden to their family anyway. The family may hint at this. They may be in some stage of dementia. Individually, without their families, they make a decision that is not " truly informed."

We hope that all medical professionals are ethical and not swayed by costs or revenue, however, there is human nature. Recently, zoom calls have been used to make decisions with diffusing the personal doctor-patient relationship. Doctors are limited in their time to access patients. A network may develop of doctors who can enable the outcome easily. The right wording can sway a patient.

You will have the ability to go to the pharmacy by yourself, go home alone and take the many many pills alone. Anti- nausea pills are needed because the prescription is poisonous to your body. Perhaps you don't die quickly, but have the impact of the poison. With no required medical assistance or doctor, will you die in fear and terror? Where is the dignity of dying alone ?

You may believe you should not inform your family. However, they may love you dearly and do not believe you are a burden. They may find you and are absolutely devastated. This is the kind of devastation that can tear up families for the next generation and cause imaginable sorrow.

The best of intended safeguards will go only so far. They open the possibility of others comparing their own situation and sharpening the focus their own pain. " My Mom and Dad helped my grandmother die, so why can't I try it ? " says the confused, overwhelmed teenager. One 'compassionate' death situation impacts not just one family, but many families, a community and state. Once legislated, who will honestly tell the story of the the confused lonely person given a prognosis of terminal illness who has dementia and killed themselves alone?

The website of Compassion and Choices states " Many people regard being confused all the time as a fate worse than death." On January 29, 2023, the respected Alzheimer's Association terminated their partnership with Compassion and Choices, an advocate of this legislation. In a statement they said " We deeply regret our mistake and have started the termination of the relationship, and apologize to all families we support who were hurt or disappointed."
The values of Compassion and Choices impact this legislation. The word compassion means to " Suffer Together or Suffer With" - not just give you the means to kill yourself alone.

Written Testimony_SB845_ Angela Guarda M.D._Senate

Uploaded by: Angela Guarda
Position: UNF

Angela S. Guarda M.D.
Professor of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine
Director, Johns Hopkins Eating Disorders Program, Johns Hopkins Hospital
Meyer 101, 600 N. Wolfe Street, Baltimore, MD 22187

Monday, March 6, 2023

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

Dear Chairpersons and Honorable Members of the Senate Judicial Proceedings Committee

RE: UNFAVORABLE – SB 845 "End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

I write in opposition to SB 845 or the Maryland assisted suicide bill. This bill cannot be safely implemented and will lead to unnecessary premature deaths. I am a Professor of Psychiatry at the Johns Hopkins School of Medicine and have directed the Johns Hopkins Eating Disorders Program for over 25 years. I treat patients with severe and extreme anorexia nervosa, a population at high risk under the proposed law. Despite a high mortality rate, anorexia nervosa is not a terminal illness. Nearly every case can improve with expert psychiatric care and nutrition, and a majority achieves full recovery at 20-year follow up, including many who were severely ill. Importantly, **seasoned clinicians who treat anorexia nervosa cannot predict who will recover or when, and who will remain chronic, or succumb to their illness**.

Patients with anorexia nervosa are often in the care of general practitioners and general psychiatrists. **Most doctors — psychiatrists included, can diagnose anorexia but have no training to treat it**. Faced with a patient in intensive care who weighs 50 pounds, is in kidney failure with unstable vital signs, all resulting from their starved state, the attending physician, the community provider or even the palliative care specialist may judge the patient terminal because they are unaware of, and don't know how to get her, the treatment she needs — especially when she refuses it. The starved patient could be influenced to view "aid-in-dying" as the best way out of an intolerable situation or believe her family would be better off without her emotionally and financially as the care of anorexia nervosa is extremely costly.

Anorexia nervosa is challenging to treat because persons with this disorder are ambivalent about accepting the treatment they need: nutrition. Additionally, capacity to make treatment decisions is often impaired -- in one specific realm – in the ability to appreciate the seriousness of one's condition, to freely choose treatment, and to imagine the possibility of life without the disorder.

Patients with anorexia appear rational in all ways but one: they often **lack the capacity to accept the curative treatment they need. How then can they have the capacity to accept physician assisted suicide?**

When a patient's life is at risk, involuntary treatment provided by an expert behavioral inpatient specialty program, can be lifesaving, and when effective is often met with gratitude by patients. When such treatment is inaccessible, or when involuntary treatment has failed, other approaches, including harm reduction and palliative care, focus on improvements in quality of life, yet still foster hope in eventual recovery and motivation to reverse malnutrition. There should be no room however for prescribed suicide as a "treatment" for this condition.

In Colorado, where a similar bill is law, and despite reported safeguards against misuse, physician assisted suicide is taking place for patients with treatable anorexia nervosa. Dr Jennifer Gaudiani, the attending physician (a specialist in internal medicine) involved in these cases, recently published an article advocating for a diagnosis of "terminal anorexia" eligible for physician assisted suicide (referenced below) and described her participation in prescribing lethal medication for two patients in their 30s with anorexia nervosa, neither of whom based on the information provided, had failed adequate treatment. The arguments presented in this paper, easily accessible electronically to the public, risk fueling demand for physician assisted suicide amongst demoralized patients and their families grappling with this serious yet treatable condition. These deaths, the first instances of physician assisted suicide for a primary psychiatric diagnosis in the U.S., should be a wakeup call as they illustrate why safe application of this law is not possible.

Following news media attention to these cases, Compassionate & Choices issued a statement that "This law does not and was never intended to apply to a person whose only diagnosis is anorexia nervosa". Dr Gaudiani however retains an active license not only in Colorado, but in multiple U.S. states including Maryland, where she can assess and treat patients remotely by telemedicine.

I published a response to Gaudiani et al.'s article (see reference below) noting the dangers of a diagnosis called "terminal anorexia" and of physician assisted suicide in this population. In return I received several emails from patients thanking me and noting that they believed they would likely be dead today had physician assisted suicide been an option when in the depths of their illness.

I was also contacted by an ex-patient of Dr Gaudiani's who reported "I was told that, although I wasn't yet 30 years old at the time, she would "make an exception" for me and "allow" me to die, if that was my choice. It didn't feel like my choice – I felt coerced.... I'm not sure how to describe it, but something inside me wouldn't let me take the MAID. I ate just enough to "not die" right away… I weaned off of the morphine, and all the other hospice drugs that kept me in such a fog…In those 18 months since, I moved…I have a job …that I love, a new puppy, and a great group of friends. I'm able to fuel my body to hike and do the things I love. I'm repairing my relationship with my family, and I have a great therapist who is helping me process all of this…I want to thank you for being a voice for those of us who have been told we are beyond hope".

These words detail how easily a patient with extreme anorexia could feel seduced or coerced into accepting “aid-in-dying” as a solution to their suffering. I urge you to oppose the Maryland aid-in-dying or assisted suicide bill because there’s too much room for error. It risks endangering the most vulnerable, not only the 0.5-1% with anorexia nervosa but by extension the one in five Americans who suffer from a treatable mental condition that affects their ability to visualize a better day. Our job as psychiatrists is to help patients cope, improve their quality of life and heal, not to facilitate their death.

Yours sincerely,

Angela A Guarda

Angela Guarda M.D.
Director, Eating Disorders Program, Johns Hopkins Hospital
Stephen and Jean Robinson Professor of Eating Disorders
Professor of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine

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Testimony Against SB 845.pdf

Uploaded by: Anita Cameron

Position: UNF

Testimony Against SB 845

Good afternoon. I'm Anita Cameron, Director of Minority Outreach for Not Dead Yet, a national disability rights organization opposed to medical discrimination, healthcare rationing, euthanasia and assisted suicide.

I am writing in opposition to SB 845: End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

This bill is dangerous because though this law is supposed to be for people with six months or less to live, doctors are sometimes wrong about a terminal diagnosis.

My mother, while living in Washington state, was determined to be at the end stage of chronic obstructive pulmonary disease. I was told her death was imminent, that if I wanted to see her alive, I should get there in two days. She rallied, but was still quite ill, so she was placed in hospice. Her doctor said that her body had begun the process of dying.

Though she survived 6 months of hospice, her doctor convinced her that her body was still in the process of dying, and she moved home to Colorado to die.

My mum didn't die. She became active in her community and lived almost 12 years!

SB 845 will put sick people, seniors and disabled people, especially, at risk due to the view of doctors that disabled people have a lower quality of life, therefore leading them to devalue our lives. Now add race and racial disparities in healthcare to this. Blacks, in particular, receive inferior health care compared to whites in the areas of cardiac care, diabetes, cancer and pain management.

As a Black Latina, I didn't see assisted suicide as part of my culture. This is borne out in a 2013 Pew study that shows Blacks and Latinos are 65% opposed to assisted suicide and in states where it's legal, rarely use the program. Assisted suicide proponents tend to be white professional and managerial class folks.

What's especially dangerous is that in states where it's legal, if you lose access to healthcare, turning your chronic condition into a terminal one, you can request assisted suicide. It'll be cheaper to kill you than to care for you.

Proponents speak of pain as their number one reason why they want assisted suicide, yet according to the data, pain or the fear of pain was not among the top five reasons people seek assisted suicide. That can be addressed by effective pain control, palliative care, hospice services and palliative sedation.

The 5 top reasons people ask for assisted suicide according to the Oregon data are:

Loss of autonomy
Loss of dignity
Loss of the ability to do things they once loved
Loss of bodily control, such as incontinence and vomiting
Feelings of being a physical, emotional or financial burden on family, friends and caregivers

All these are disability related issues that can be addressed with home based care, services and supports.

Assisted suicide laws are deadly public policy. As long as disability discrimination and racial disparities in healthcare exists, assisted suicide has no place in Maryland. Please vote no on SB 845.

SB845_Dowling_Opposed.pdf

Uploaded by: Ann Dowling

Position: UNF

Statement to the Senate Judicial Proceedings Committee
Re: SB845End of Life Options Act
Tuesday, March 7, 2023
Oppose

In 2013 I had the opportunity to attend a full series of workshops on dementia and caregiving sponsored by the Anne Arundel County Department of Aging. While these sessions contained a wealth of extremely helpful information, there are two points that were discussed during the course of those classes that are particularly relevant for these hearings: 1) That people living with dementia can often appear to those not part of their inner circle to be very coherent, quite charming, and perfectly capable of making their own decisions regarding health care and their living situations; and 2) That when an elderly parent is no longer capable of living alone, in a large percentage of cases, even when there are multiple children, the caregiving often falls either by choice or default to one adult child.

My own experience confirms these assertions. My parents lived with my family for 4 ½ years, during which time I was their primary caregiver. Even though I have five siblings, I was the only one who actively participated in the caregiving of my parents. My mother, having had a series of mini-strokes, suffered from vascular dementia as well as a brain tumor. After the death of my dad, I managed all my mother's medical care, attending every doctor's appointment, every surgery, every emergency room visit. Time and time again, I watched my mom transform into a different person at her doctors' appointments. Indeed, the wit and sarcastic humor she displayed for her primary care physician convinced him that even though she had dementia, she could manage quite well. Somehow, in his ten-minute visits with her a few times a year, he was able to determine that she was certainly capable of making her own healthcare decisions. What he didn't see in those visits is what I routinely saw because I lived with my mom 24/7—that she had to ask me what a toothbrush was for, that she couldn't remember that she had three sons, and that she had just had a wonderful visit with her mother who, incidentally, had been dead for 25 years. It is no surprise, then, that I have no confidence when this bill assures us that a person requesting 'aid in dying' must possess the 'capacity to make medical decisions' and not be 'suffering from impaired judgment.' What if that person, like my mother, quite convincingly appears mentally fit to the very professional making that determination?

Additionally, although proponents of this bill insist that there is no risk of coercion regarding vulnerable populations, I would again offer my own personal experience. I can tell you that at every doctor's appointment whenever any decision had to be made regarding my mom's care, she always turned to me and said, "Whatever you think, Annie. You decide." In other words, *my* decisions *became* my mother's decisions. She was perfectly content, and insistent even, that all decision-making be left to me because she trusted me implicitly. And why wouldn't she? I was, after all, of all her children, the one who had faithfully cared for her for years. Never once was any decision I made ever questioned by my brothers and sisters because I had willingly assumed full responsibility for our mother's care. The potential danger here should be obvious. Let us not be so naïve to believe that undue influence over another's actions must be overt and forceful. It can be as subtle and unintended as the exhausted face of a caregiver. Anyone who has ever cared long-term for an ill family member knows that their loved one often feels acutely guilty for “being a burden.” I can vividly recall my own mother routinely apologizing to me for needing my care and assistance. With a rapidly increasing aging population, my caregiving experience is bound to become more and more common. What a grave injustice to place any vulnerable person in the position of having to consider that it might just be better for all concerned if they simply chose to die. Legalizing physician-assisted suicide has to potential to do just that.

Furthermore, what if the coercion to make a drastic end-of-life decision comes from the physician himself? Ten years ago, I sat in a doctor’s office with my mother to complete the Maryland MOLST form. The MOLST (Medical Orders for Life Sustaining Treatment) form details one’s preferences regarding life-sustaining treatment, and this form was required to be filled out before my mother was admitted to an assisted living facility. As my mother’s physician went through the list of questions with us that day, I noticed he was filling in her preferences for treatment **before** we even responded to his questions. When he got to one question in particular regarding the time frame that my mother would want to be on an artificial ventilator, I stopped him and told him that I was not at all comfortable with the response he had written. I will never forget his reaction. He pointed his pen at my face and said to me, “I didn’t ask you. You’re not my patient; your mother is.” However, this doctor knew my mother couldn’t tell him her address or even what year it was, and he was aware that I had medical power of attorney. When I pressed him on the issue, telling him I thought the number of days he had picked was arbitrary, he sarcastically asked me, "Well, what number would make you happy?” He then proceeded to angrily scribble out his original response, initial it, and then select a different response. Though my mother died in November 2015, I still have a copy of that MOLST form in my possession because it serves as a very powerful lesson for us all. Had I not been there that day acting as my mother’s advocate, it would have been her doctor’s, not her preferences, that were represented on that form. I realize that this was just one instance with one doctor. But if a doctor can so clearly violate the protocol and guidelines that establish our wishes for life-sustaining treatment, how can we have confidence that he will follow the requirements that allegedly establish our preferences regarding death?

Ann Dowling
2795 Spring Lakes Drive, Davidsonville, MD 21035
410-956-3621

SB 845 testimony.pdf

Uploaded by: Anne Fox

Position: UNF

The End of Life Options act is for the perceived benefit of those who are privileged and empowered. At the same time, it would greatly hurt those who are not – the poor, the elderly, the disabled, immigrants, and minorities - by subjecting them to pressure from health care providers and from family to end their lives.

In California and Oregon, where physician-assisted suicide is legal, insurance companies have denied chemotherapy drugs to cancer patients, while offering to pay for the drugs for physician assisted suicide, which are much less expensive.

I know from caring for my mother, who died recently, that pain and depression can be well controlled, that time with family and friends, and spiritual guidance can be very important, and that the dying need our presence, not drugs to end their lives.

Please vote no on this bill.

Thank you,
Anne Fox
2711 Clayton Road
Joppa, MD 21085

SB 845 - Oppose - MPS WPS.pdf

Uploaded by: Anne Hanson
Position: UNF

MARYLAND PSYCHIATRIC SOCIETY
Washington Psychiatric Society

March 3, 2023

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

RE: Oppose - Senate Bill 845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Chairman Smith and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

The MPS & WPS recognize that proponents of this bill have reasonable concerns about the wish to end suffering and may ethically favor legislation supporting personal autonomy and the privacy of the doctor-patient relationship. Our members have been encouraged to contact their elected officials to contribute their thoughts, and we welcome consideration of both sides of this serious policy.

The MPS & WPS oppose Senate Bill 845 (SB 845): End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

While we recognize that the law has statutory requirements, there is no mechanism to ensure adherence as written. Thus, the Health Department should adopt regulations to conduct random audits of the prescribing physician's records to ensure adherence with the law.

No standardized procedures exist for assessing both capacity and coercion in these specific circumstances in the primary care setting. While a standardized mental health assessment is not routinely required before most medical procedures, the provision of fatal care is unlike any existing treatment. Given the severe consequences of an erroneous outcome, the decision-making capacity for fatal care should require a more rigorous assessment.

Many serious medical conditions are known to cause a variety of capacity-impairing mental disorders, such as clinical depression, cognitive impairment, and delirium. Indeed, as many as 25% of patients diagnosed with terminal illnesses may suffer from clinical depression. Infection with the human immunodeficiency virus is often associated with increased rates of treatable mood disorders and dementia. Neurodegenerative diseases like Parkinson's disease and ALS (Lou Gehrig's disease) can also cause cognitive impairment and depression. A recent study showed that more than half of patients in hospice care exhibit unrecognized cognitive impairment, and these deficits are directly related to impaired decision-making capacity. Furthermore, a psychological screening tool that physicians could use is insufficient to detect all conditions that could cause impairment, nor does any existing screening tool have the ability to detect a patient who deliberately conceals his/her symptoms.

A full mental capacity evaluation is a complex and multifaceted process. A clinician who performs a capacity assessment must consider information from collateral sources such as family members or friends and must also review psychiatric treatment records if they exist. Yet, under this law, no provision exists for a clinician to access this information if the patient refuses to consent. This is a serious shortcoming given that a clinician would need to speak with a treating psychiatrist as part of any ordered assessment. Similarly, a treating psychiatrist could be barred from communicating potentially relevant information to the prescribing physician if the patient declines to consent to that communication.

This bill has implications for Maryland's involuntary treatment laws as well. The bill is unclear regarding whether a qualified patient who possesses a lethal prescription would be required to permanently surrender that medication already received if he meets civil commitment criteria because of mental illness. Maryland's civil commitment law is based upon dangerousness to self or others rather than decisional capacity. A civil commitment should require a re-evaluation of eligibility to receive a new prescription.

SB 845 also has implications for institutionalized patients in Maryland's prison and state hospital systems. Institutionalized patients are a protected class under the federal Civil Rights of Institutionalized Persons Act (CRIPA). Failure to intervene and protect these patients from suicide is commonly accepted as a civil rights violation under CRIPA as well as by established federal case law. A patient committed to a psychiatric facility retains the legal right to make medical decisions. This includes long-term patients residing in Maryland's public institutions with potentially terminal medical conditions. In fact, the Maryland Division of Corrections maintains a palliative care unit for terminally ill prisoners. Under the End-of-Life Options Act, the attending physician would be the individual who prescribes the fatal medication. For institutionalized psychiatric patients, this would require that the treating physician certify the diagnosis and prognosis of a terminal medical condition. In light of *Estelle v Gamble*, 42 U.S. 97 (1976), an institutional physician would be placed in a professional quandary between federal and state laws.

Finally, for the safety of the patient and the welfare of others present, lethal medication should be consumed in a controlled or monitored setting. Through regulation, we encourage the Maryland Department of Health to develop standards to provide the necessary protections.

To conclude, MPS and WPS recognize that this is an ethically complex issue affecting patients and colleagues struggling with desperate, painful situations. We know that reasonable people have strong convictions on both sides. Nevertheless, more must be done to ensure adequate protections are in place so we cannot support the bill as written.

For those reasons, MPS/WPS asks this committee for an unfavorable report on SB 845. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Joint Legislative Action Committee
of the Maryland Psychiatric Society and the Washington Psychiatric Society

SB845 End of Life Option.pdf

Uploaded by: Barbara Cantilena

Position: UNF

I am opposed to SB845 End of Life Option.

Although assisted suicide is fundamentally wrong for Christians, it is also wrong for those of other faiths and for non-believers. Assisted suicide produces a strong economic incentive for governments and family members to eliminate those who are a burden because of infirmity, handicap, or just age. This is not hypothetical because it is happening today in Canada. A veteran requested funding to assist with having a wheel-chair ramp installed to improve access to her house and instead received a letter urging suicide.

The so-called safeguards attached to the bill to attempt to minimize abuse just don't work in reality. Once the right to die is enacted, any impediment will be eliminated by legal action. This is an historical fact with other legislation.

Summarizing the specific problems with this bill:

- Legalizing Assisted Suicide enables health insurance and medical providers to deny life sustaining care to patients and evade liability for the death of patients.

- There are no standard requirements that each patient receives mental health screening and counseling. A screening from a doctor untrained in mental health is not sufficient to assess a patient's true needs.

- No family notification is required.

- One in three patients who fill the lethal prescription-typically 100 pills, decide against taking it. There are no safeguards to ensure the unused drugs stay out of the hands of children and prescription drug dealers. This is particularly irresponsible, as we are experiencing an opioid crisis nationwide.

- No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.

- Assisted Suicide laws make suicide socially acceptable. States which have legalized Assisted Suicide have experienced increased suicide rates.

- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.

- The poor as well as those with disabilities would be faced with choosing suicide as an option so as not to become a burden on their loved ones. To the most vulnerable, a right to die may become a responsibility to die.

Sincerely,

Barbara Cantilena
10326 Watkins Mill Drive
Gaithersburg, MD 20886

Testimony SB845 .pdf

Uploaded by: Becky Ford

Position: UNF

Testimony Opposing SB845

Viktor Frankl once wrote, “When we are no longer able to change our situation- we are challenged to change ourselves”. I strongly oppose Senate Bill 845. In 2019, after writing letters to the House, using the example of my best friend who had Stage IV Pancreatic Cancer, I then only wrote a letter to one person in the Senate- former Senate President Mike Miller. I forwarded him what the members of the House Committee received, and I told him he knew this was wrong. I worked for Senator Miller while attending Anne Arundel Community College, for his political fundraiser. I knew he had the ability to work with both parties. He kindly mailed me back a letter that I will treasure forever and said that as long as he was there, this bill would never pass. If you want to leave a legacy, just look at the work of Senator Miller. And he’s a pivotal role model for this bill, he fought his cancer, he stepped down as Senate President, but still served as a Senator until he no longer could. He passed away with terminal cancer, surrounded by his family.

I was diagnosed with fibromyalgia in early 2022, a condition that bores doctors, but one that means chronic pain. But things have only gotten worse. I’ve had 3 MRIs to find nerve endings are sticking out of my spine. My next MRI is for my brain, my left side can go limp at any moment causing me to fall and my once stellar memory has turned me into one who now easily gets lost in places I’ve been most of my life. At a neurologist appointment last week, I was asked one question and immediately because of how long it took me to answer, he knew I had problems immediately. No, it’s not fair. I can’t do everything that everyone else can, I’m in pain every day, but I know as hard as it is, I, like so many others with any chronic, or terminal disease, am a pioneer. Maybe life is harder for certain people, but it’s those people that help the advances in healthcare. It's those who take on that suffering, whose strength is relentless that will help save lives, or make things better of those who get the same diagnosis in the future.

But I, too, know what it's like to want to give up. Physician Assisted Suicide is not the answer. It's a permanent choice that can't be changed. I know this because I also have chronic major depression, anxiety, and PTSD. I am a multiple suicide survivor. In April 2011, police were called to my home by my psychiatrist. I thought they were there to see my Dad, a Natural Resource Police Officer, so I figured I'd give them iced tea just as he always did. But that's not what they wanted. I had taken pills and drank…a lot. My psychiatrist told them to look at the texts on my phone I had sent him, which apparently the last one I had sent him was, "I'm dead, so very dead". My father was called by headquarters, and he rushed home to find officers he taught in the police academy, and I never felt ashamed for doing such a thing to embarrass him. It's called a Section 29, when your forced to go to the hospital, and that's how I ended up at Dorchester General Hospital. My medication dosage was increased, things got better.

I moved to the North Shore of Massachusetts in July of 2012. But in May of 2013, I was Sectioned 29'd, again. Taken to a hospital in Massachusetts, Memorial Day weekend. So, the 72-hour hold, under Massachusetts state law didn't count on weekends, or holidays, meaning a much longer stay. Again, medications were changed. I left.

There have been more recent times I have been suicidal, or had suicidal ideation. I moved with my parents to Southern Maryland after my best friend passed away from pancreatic cancer because no one felt it was a good idea me to live by myself at that time. It happened again in June 2021, and it has happened as recently as this past fall due to chronic pain and feeling like a burden. But someone talked me out of it and was always checking in on me. I may have memory issues, but it doesn't mean I'm stupid. The danger of physician assisted suicide for someone like me, someone with chronic depression, who doesn't know on any given day when they'll wake up in that black hole. That's not the solution I want, or one for insurance to ever push on me. Because the ripple effect is one that is too far reaching. Too many people can get hurt. No one is a burden, those of us with various diagnoses, we're the strong ones. But most mood disorders are often an invisible illness, one many people think if you just eat certain things, take vitamins, go for a walk, that's the cure. And often, you put on a fake smile, and no one knows what's really going on.

Suicide is not the way out. It leaves people behind wondering why. We're each given a purpose in life, sometimes it's very hard to figure out what that is. If I had succeeded, I'd have missed out on so much. I'd have left a family behind and a boatload of things on my bucket list. For those who think this is death with dignity, no, it's death that's fast and permanent, and there is regret. I absolutely regret the choices I made, giving up. I'm worth something, even when I don't always feel that way. And I am thankful that I am still here to advocate and pester on the issues that matter most.

We are allowed to feel messed up and inside out. But it doesn't mean we're defective - it just means we're human.

Each of you were elected into office to serve your districts. The best way to do that is to ensure that everyone has access to the best treatments, they have access to get their prescriptions, that mental health services are available to everyone, and to know that every constituent and person you encounter has worth. The very first inalienable right in the Constitution is life! Please do not pass this bill.

Thank you.

Brandie Dawson Oppose Assisted Suicide SB845-HB933

Uploaded by: Brandie Dawson
Position: UNF

BILL: Senate Bill 845/House Bill 933
TITLE: End-of-Life Option - Assisted Suicide
COMMITTEE: Senate Judicial Proceedings Committee
DATE: March 6, 2023
WHO: Brandie Dawson, MBA, BSN
POSITION: **OPPOSE**

RE: Senate Bill 845/House Bill 933 End-of-Life Option - Assisted Suicide discriminates against physicians, hospitals and other healthcare providers who object to ending a person's life, and pressures them to participate in murder, in violation of their rights of conscience and free exercise of religion.

Committee Chair, the Honorable Senator William C. Smith, Jr., Vice Chair, Senator Jeff Waldstreicher and Senate Judicial Proceedings Committee Members:

I was a practicing Registered Nurse for twenty-six years, and obtained my RN to BSN degree and Business of Nursing Graduate Certificate from Johns Hopkins University School of Nursing, followed by a Master of Business Administration from Drexel University LeBow College of Business. I respectfully submit my testimony to you, as an example of the impact that ending a life had on me as a practicing nurse, and now as a disabled person, and the detrimental effect the End-of-Life Option - Assisted Suicide Bill could be expected to have on healthcare workers in Maryland.

First, a few evidence-based facts for the Committee to consider:

- Healthcare workers have been trained to save lives, not end them. In fact, death anxiety among nurses and health care professionals is a well-established fact on an international level.[1] (A personal example can also be found in my testimony below).
- It is well-established that physicians and health-care workers are at higher risk for suicide.[2]
- Post-Traumatic Stress Disorder (PTSD) and Burnout Syndrome (BOS) have a dramatic and cyclic effect on nurses "in response to interpersonal and emotional stressors that are experienced in the workplace and are characterized by emotional exhaustion, depersonalization, and lack of personal accomplishment."[3]
- 62% of surveyed Maryland Board of Nursing licensees and certificate holders thought about leaving nursing recently.[4]
- Healthcare workers should not be mandated to perform procedures that violate their conscience or religious convictions. "The majority of well-conducted studies found that higher levels of religious involvement are positively associated with indicators of psychological well-being (life satisfaction, happiness, positive affect, and higher morale) and with less depression, suicidal

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[1] Nia HS, Lehto RH, Ebadi A, Peyrovi H. Death Anxiety among Nurses and Health Care Professionals: A Review Article. Int J Community Based Nurs Midwifery. 2016 Jan;4(1):2-10. PMID: 26793726; PMCID: PMC4709813. As found on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4709813/

[2] Dutheil F, et al. Suicide among physicians and health-care workers: A systematic review and meta-analysis. PLoS One. 2019 Dec 12;14(12):e0226361. doi: 10.1371/journal.pone.0226361. PMID: 31830138; PMCID: PMC6907772. As found on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6907772/

[3] Mealer M, Burnham EL, Goode CJ, Rothbaum B, Moss M. The prevalence and impact of post traumatic stress disorder and burnout syndrome in nurses. Depress Anxiety. 2009;26(12):1118-26. doi: 10.1002/da.20631. PMID: 19918928; PMCID: PMC2919801. As found on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2919801/

[4] Task Force on Maryland's Future Health Workforce. (August 2022). 2022 State Of Maryland's Health Care Workforce Report. Maryland Hospital Association. As found on https://www.mhaonline.org/docs/default-source/default-document-library/2022-state-of-maryland-s-health-care-workforce-report.pdf

thoughts and behavior, drug/alcohol use/abuse… Usually the positive impact of religious involvement on mental health is more robust among people under stressful circumstances[5]...”

- “The complicated grief experienced by suicide loss survivors leads to feelings of abandonment, rejection, intense self-blame, and depression. Stigma surrounding suicide further burdens survivors who can experience rejection by their community and social networks.”[6]

While abortion is not assisted suicide, the concepts are similar and Committee members will nonetheless be able to get a glimpse into healthcare provider stress, distress, job dissatisfaction and moral dilemmas by reading my testimony.

At the age of twenty-four, I moved to Maryland and began looking for a job. While sitting in a hospital human resource department filling out an application for the operating room, HR requested that I interview for an open Labor & Delivery position and immediately escorted me to the nurse manager. I did not have a background in L&D, but the manager liked that I had medical-surgical experience as the L&D unit cared for high-risk pregnancies with co-morbidities. I asked the nurse manager if abortions were performed on the unit and told her that I was a Christian and would not participate in performing an abortion. I was advised that, “The doctors are not supposed to do them here, but sometimes they slip them in,” and “that I could request someone to switch with me, just the problem would be if no one would”. Naïvely, I accepted the position, excited to help deliver babies and care for expectant mothers.

One day during my orientation, my preceptor informed me that there was a saline abortion taking place and that she wanted me to assist in the procedure. I immediately told her that I would not assist with an abortion and that this had been discussed with the nurse manager prior to hiring me. My preceptor replied, “Well, I at least want you to look at it”, and later showed me a second trimester baby in a wash basin, bright red with burns from the saline abortion. My first instinct was repulsion and to quit, but I did not resign that day.

On our unit, the nurses were able to select our patient assignments, as long as we were taking our turn scrubbing and circulating in our operating rooms, and recovering and triaging obstetric patients to keep up with competencies. I stayed away from any assignment that appeared to be a “slipped in” or obvious abortion, but I noticed that the physician charting for the dilation and curettage (D&C)/ dilation and evacuation (D&E) vacuum procedures was vague. I did not know that Maryland did not require providers to report abortion statistics, and in fact, I did not know until just prior to preparing this testimony. Now most of the D&C/D&E patients that I encountered were mostly tearful and appeared in some form of emotional anguish. It was meaningful to me to be able to comfort and reassure my patients that about 25% of pregnancies resulted in miscarriages, and that we would sometimes see patients who had lost their babies come back the following year or so experiencing a healthy pregnancy.

One day, I had a D&C patient that seemed a little odd to me. She denied any symptoms like bleeding or cramping and seemed quite pleasant and almost giddy with a slight smile. Since we had a slow OR schedule that day, I was her nurse for pre-op, the procedure and recovery. Everything went as usual, until in Recovery, she sat up in bed and declared to me, “Thank God I am not pregnant anymore!” to my horror and shame. I realized that I had likely just helped perform an elective abortion. Sometime later, I was talking with another young nurse on our unit about my feelings on the abortion situation in our department and she began to cry, sharing that at a previous hospital, she assisted with a late-term abortion and that she “didn’t know that she was allowed to say no”.

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[5] Moreira-Almedida, A. et al. (2006). Religiousness and Mental Health: A Review. Rev Bras Psiquiatr. 2006:28(3):242-50. As found on https://www.researchgate.net/publication/6864541_Religiousness_and_Mental_Health_A_Review

[6] Goulah-Pabst DM. Suicide Loss Survivors: Navigating Social Stigma and Threats to Social Bonds. Omega (Westport). 2021 Jul 4:302228211026513. doi: 10.1177/00302228211026513. Epub ahead of print. PMID: 34218692. As found on https://pubmed.ncbi.nlm.nih.gov/34218692/

There was one other occasion, when I was assigned to assist with an abortion, and I needed someone to switch with me. The nurse I approached was often in charge, and we went back and forth a bit discussing how I believed abortion was wrong and murder, and how she didn't and if she truly believed that, why she had a problem with switching patients. Because of her pro-choice stance, she did switch assignments with me but she was very unhappy about it, and so was I. Then and now, I have felt bad and guilty for having a hand in someone else ending a life.

Sometime later, I was approached by my nurse manager requesting that I begin acting in the charge nurse role. I really enjoyed many aspects of Labor & Delivery, and I considered this an honor, until one night as I was performing charge nurse duties, I realized that I would be responsible for assigning other nurses to abortions, which is purposely ending the life of a baby. After just under two years in L&D, I put in a transfer to a different department, but my nurse manager would not allow me to transfer out of the unit. As a result, I resigned from that hospital and I left L&D forever. During my exit interview, I told management that one of the reasons I was leaving was the abortion issue, and I was told that others before me had left for the same reason. The long-term emotional impact for me has always been one of sadness, regret and shame at my youthful gullibility in having a hand in ending the life of a baby/babies, whose life was created by God for God[7].

There is one other L&D days that I want to share with you, and it also pertains to my testimony about how terminated pregnancies/untimely death can traumatically impact healthcare workers. A young patient of mine had Pitocin running for retained products of conception. She quickly became uncomfortable and in a matter of seconds, in the midst of her frantic screams, the greenish, dead 2nd trimester baby was quickly and forcefully expelled across the bed in the midst of green fluid; the experience of which was all very distressing to everyone in the room. The delivery happened so quickly that there was no physician present and I immediately called our resident to the bedside. The doctor was a resident that I did not know well, and when she arrived, she began screaming at me in front of the patient, "How dare (I) call her to see this when she was 12-14 weeks pregnant herself?" and stomped out of the room. I cried long and hard that day at work, and all that plays in my mind of that day are those traumatic moments. This is a very clear example of the potential distress that a miscarriage, abortion and death can have on a doctor, nurse, patient and loved ones.

I share these experiences to underscore the likelihood of physical, emotional and mental trauma for all parties involved in the death of a patient. How much more traumatic when a healthcare worker violates their spiritual and religious conscience? For the Christian, it is not a matter of karma or a cosmic scale of good deeds versus bad. According to the Bible, the taking of an innocent life is murder[8] and it is sin against a Holy Creator God.[9] Christians understand from the Bible that everyone is accountable to God[10] and that Hell is real and a future reality for those who disobey God and reject the saving sacrifice of Jesus Christ.[11] The Bible tells us that God created us in His image,[12] that He ordains our life and that it exists by

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[7] Colossians 1:16-18 For in Him all things were created, things in heaven and on earth, visible and invisible, whether thrones or dominions or rulers or authorities. All things were created through Him and for Him. 17 He is before all things, and in Him all things hold together.

[8] Exodus 20:13 You shall not murder.

[9] Ephesians 1:4 Even as he chose us in him before the foundation of the world, that we should be holy and blameless before him in love. And 1 Peter 1:15-16 But as he who called you is holy, you also be holy in all your conduct, since it is written, "You shall be holy, for I am holy."

[10] Romans 14:11-12 t is written: "As surely as I live, says the Lord, every knee will bow before Me; every tongue will confess to God." 12So then, each of us will give an account of himself to God.

[11] Revelation 20:11-15 Then I saw a great white throne and him who was seated on it. From his presence earth and sky fled away, and no place was found for them. 12 And I saw the dead, great and small, standing before the throne, and books were opened. Then another book was opened, which is the book of life. And the dead were judged by what was written in the books, according to what they had done. 13 And the sea gave up the dead who were in it, Death and Hades gave up the dead who were in them, and they were judged, each one of them, according to what they had done. 14 Then Death and Hades were thrown into the lake of fire. This is the second death, the lake of fire. 15 And if anyone's name was not found written in the book of life, he was thrown into the lake of fire.

His will for His purposes.[13] In the book of Psalms we learn that God is present at our conception, when our inward parts are being formed and that all of our days are written in God's book before any of them came to be.[14] Throughout the Bible, we can see that children are a blessing, a reward, a heritage and a source of strength in the family;[15] a crown[16] and a source of joy[17] and honor;[18] and we retain that same value and dignity as an adult.[19]

The memories that I shared with you are some of the strongest of my nursing experience, despite that they occurred more than 20 years ago. Today, my youngest daughter wants to be a Labor & Delivery nurse. It is her dream and a noble desire that she may not ever be able to fulfill as a Christian in the state of Maryland; and that is unfortunate because according to the Maryland Hospital Association, the nursing shortage is dire[20] and has reached a crisis level.[21] Forcing healthcare providers to violate their consciences or religious convictions, or deterring young people from entering the healthcare field because of conscience conflicts is not ethical, constitutional, helpful or wise, and will only further negatively impact healthcare in the state of Maryland.

Lastly, I am now currently disabled as a result of a progressive medical condition that has no cure. Despite many days of misery, I know that I am made by and loved by God. My value lies in being made in His image and His plan for my life has been the blessing of motherhood, being a wife, a nurse, and for a season, illness. I don't relish thoughts of potentially being in a wheelchair, becoming bedbound or having respiratory weakness to the point of respiratory distress; but I know that this life is not the end, and because of my faith in the saving work of Jesus the Christ, I will live again with Him where there is no more death or mourning or crying or pain.[22] For those who die outside of a relationship with Christ, assisted-suicide ushers them into eternal damnation.[23] Please oppose Senate Bill 845/House Bill 933 End-of-Life Option - Assisted Suicide.

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[12] Genesis 1:27-28 So God created man in His own image; in the image of God He created him; male and female He created them. 28God blessed them and said to them, "Be fruitful and multiply, and fill the earth and subdue it;

[13] Colossians 1:16-18 For in Him all things were created, things in heaven and on earth, visible and invisible, whether thrones or dominions or rulers or authorities. All things were created through Him and for Him. 17 He is before all things, and in Him all things hold together.

[14] Psalm 136:13-16 For You formed my inmost being; You knit me together in my mother's womb. 14I praise You, for I am fearfully and wonderfully made. Marvelous are Your works, and I know this very well. 15My frame was not hidden from You when I was made in secret, when I was woven together in the depths of the earth. 16Your eyes saw my unformed body; all my days were written in Your book and ordained for me before one of them came to be.

[15] Psalm 127:3-5 Behold, children are a heritage from the Lord, the fruit of the womb a reward. Like arrows in the hand of a warrior are the children of one's youth. Blessed is the man who fills his quiver with them! He shall not be put to shame when he speaks with his enemies in the gate.

[16] Proverbs 17:6 Grandchildren are the crown of the aged, and the glory of children is their fathers.

[17] John 16:21 When a woman is giving birth, she has sorrow because her hour has come, but when she has delivered the baby, she no longer remembers the anguish, for joy that a human being has been born into the world.

[18] Exodus 20:12 Honor your father and your mother, that your days may be long in the land that the Lord your God is giving you.

[19] Jeremiah 29:11-13 11 For I know the plans I have for you, declares the Lord, plans for welfare and not for evil, to give you a future and a hope. 12 Then you will call upon me and come and pray to me, and I will hear you. 13 You will seek me and find me, when you seek me with all your heart.

[20] Task Force on Maryland's Future Health Workforce. (August 2022). 2022 State Of Maryland's Health Care Workforce Report. Maryland Hospital Association. As found on https://www.mhaonline.org/docs/default-source/default-document-library/2022-state-of-maryland-s-health-care-workforce-report.pdf

[21] Mensik, H. Healthcare labor trends in 2023: increased burnout, executive stress. A rise in union activity also may persist as the sector continues recovering from the COVID-19 pandemic. Healthcare Dive. Published online Jan. 30, 2023. As found on https://www.healthcaredive.com/news/healthcare-labor-trends-2023/641352/

[22] Revelation 21:4 And God shall wipe away all tears from their eyes, and there shall be no more death, neither sorrow, nor crying, neither shall there be any more pain; for the former things are passed away.

[23] Revelation 20:15 And if anyone's name was not found written in the book of life, he was thrown into the lake of fire.

Maryland Catholic Conference_UNFAV_SB845.pdf

Uploaded by: Brian Barnwell

Position: UNF

MARYLAND
CATHOLIC
CONFERENCE

March 7, 2023

Senate Bill 845

End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Senate Judicial Proceedings Committee

Position: Unfavorable

The Maryland Catholic Conference is the public policy representative of the three (arch)dioceses serving Maryland, which together encompass over one million Marylanders. Statewide, their parishes, schools, hospitals, and numerous charities combine to form our state's second largest social service provider network, behind only our state government.

Senate Bill 845 would allow license physicians to legally prescribe medication at the request of a patient who has been deemed "capable of making a medical decision" and has a terminal illness. The bill defines a terminal illness as a medical condition that, within a reasonable medical judgment, involves a prognosis for an individual that likely will result in the individual's death within 6 months. The individual must have the ability to self-administer the medication. The Maryland Catholic Conference joins many in the faith community who oppose this legislation, not only because it violates the most basic tenet of our belief in the sacredness of life, but also because of the many dangers this legislation poses to vulnerable populations.

At the heart of the Catholic Church's ministry to the sick, the disabled, the elderly, and those without access to adequate medical care is the recognition of the Gospel's call to embrace the lives of those most in need of our love, care, and compassion. There is no life that we consider not worth living, and no person who does not deserve to be valued. While some may view this legislation as a response to the understandable fears about pain and loss of "dignity" that someone diagnosed with a terminal illness might face, we insist firmly that the answer to those fears should be a demand for medical treatment that provides adequate pain management and excellent palliative or hospice care. A terminally ill patient requesting a prescription to commit suicide deserves to be surrounded by compassion, not handed lethal drugs to take their own life.

In addition, we have many concerns about the bill which are shared by numerous other groups, including countless physicians, mental health providers, hospice nurses, pharmacists, disability rights groups, advocates for senior citizens, and others. From the perspective of the Catholic Church, however, we wish to convey our deep dismay about the message this legislation sends to those who might feel that their illness and the care they require is nothing more than a burden to their families and the rest of society. Passage of this bill will undermine societal support for communities that are currently prone to higher suicide attempt rates – young adults, adolescents, and the military community. It is also important to note that in jurisdictions where similar legislation has been introduced, once enacted, the effort immediately begins to expand who can qualify for assisted suicide.

For these reasons, the Maryland Catholic Conference asks for an unfavorable report on **SB 845**

Thank you for your consideration.

SB845 - HB933 End of Life Option 2023 .pdf

Uploaded by: Brigitta MULLICAN

Position: UNF

Brigitta Mullican March 6, 2023
1947 Lewis Ave.
Rockville, MD 20851 LD-17 (Montgomery County)

OPPOSE SB845/HB933 End–of–Life Option Act

Please oppose this end-of-life bill. As a Catholic, my faith calls me to respect all life, from birth to natural death. I request that you not approve these Bills. How can helping someone die by drugs be considered “died by natural causes?” It is inhuman to help someone die. We should have compassion and help each individual to be out of pain but not to kill.

I am very concerned about the push to legalize the dangerous practice of physician-assisted suicide in our state. Maryland has rejected similar bills multiple times. I am asking the committee to oppose MD SB 845 / HB 933 End-of-Life Option Act.

Assisted suicide is a danger to Maryland. Allowing doctors to prescribe large and lethal doses of drugs with no protection to make sure those drugs don't end up in the wrong hands or on our streets puts us all at risk.

I'm also concerned about the elderly, our veterans, people with disabilities, and those diagnosed with a terminal illnesses who may be pressured to end their lives early if this becomes a so-called "option" in Maryland. At any given moment, we may find ourselves in a situation where we need others to care for us if we become sick, disabled, or elderly. Our state should focus on making it easier to get quality treatment and care, not to end our lives.

My experience is that elderly people go through a period when they don’t want to live. I experienced this with my mother. I believe elderly people fear death and are lonely. They sometimes feel they have nothing to live for. There are no reasons to assist someone to die. They need nurturing and love. Death should be natural.

Opponents are correct when they state the measure is dangerous and could enable vulnerable people to kill themselves, even if they are not terminally ill. There is a constitutional right to life.

Just because Goucher College released a survey that 62% support a proposal that would allow patients to take a fatal dose of drugs, does not mean there aren’t more people who oppose this method. Survey results tend to reflect the views of those people who are biased toward the position the survey is seeking. The survey doesn’t reach those who disagree.

Please protect all Marylanders from this extreme legislation and OPPOSE SB845/HB933, End of Life Option. Be compassionate and respect life.

MD SB 845 PAS Testimony.pdf

Uploaded by: Catherine Foster
Position: UNF

Americans
United
for Life

Written Testimony of Catherine Glenn Foster, M.A., J.D.
President and CEO, Americans United for Life
In Opposition to Senate Bill No. 845
Submitted to the Judicial Proceedings Committee
March 7, 2023

Dear Chair Smith, Vice-Chair Waldstreicher, and Members of the Committee:

My Name is Catherine Glenn Foster, and I serve as President and CEO at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides on end-of-life issues,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states.[3] Courts have cited AUL briefs, including the Supreme Court decision in *Washington v. Glucksberg*,[4] which ruled the federal Due Process Clause does not recognize suicide assistance as a fundamental right, and the Massachusetts Supreme Judicial Court's recent decision in *Kligler v. Attorney General*, which ruled there is no fundamental right to assisted suicide under the state constitution.[5] I have litigated end-of-life cases and published scholarship on assisted suicide.[6] Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

Thank you for the opportunity to testify against Senate Bill No. 845 ("bill"). It is in my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and coercion, the bill's "safeguard" provisions fail to adequately protect

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE (last visited Feb. 13, 2023), https://aul.org/law-and-policy/.

[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE (last visited Feb. 13, 2023), https://aul.org/law-and-policy/state-legislation-tracker/.

[3] *See, e.g.*, *Revoking Your Rights: The Ongoing Crisis in Abortion Care Access Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life); *What's Next: The Threat to Individual Freedoms in a Post-Roe World Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life).

[4] 521 U.S. 702, 774 n.13 (1997) (citing Brief for Members of the New York and Washington State Legislatures as *Amicus Curiae*).

[5] 491 Mass. 38, 40 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical and Dental Associations).

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

vulnerable end-of-life patients, and the bill erodes the integrity and ethics of the medical profession.

I. *Suicide by Physician Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion*

Individuals living in poverty, the elderly, and those living with disabilities are already exposed to greater risks of abuse, neglect, and coercion. Maryland should be protecting these vulnerable citizens rather than subjecting them to further abuse under S.B. 845.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management. State reports show that patients seek assisted suicide because of the challenges they face living with severe illnesses or disabilities. In 2021, only 26.9% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control, or concern about it" as a reason for choosing suicide by physician.[7] "[T]he main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . ."[8] Physicians should be helping their patients cope with these feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, physicians are instead encouraging their patients to take their own lives, which opens the door to real abuse.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states with approved suicide by physician, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.[9] In Oregon and Washington, individuals have died by assisted suicide even though they were not terminal ill and did not have the capacity to consent.[10] Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.[11] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms such as written and witnessed requests from patients, attending and consulting physician

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[7] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13 (Feb. 28, 2022); WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).

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

[9] José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see also* WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).

[10] *See* Disability Rights Education & Defense Fund, *Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DREDF, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_edn1 (last visited Mar. 2, 2023).

[11] *See Id.*

compliance forms, pharmacy dispensing forms, after-death reporting forms, and death certificates.[12]

There have been similar instances of abuse and coercion in Maryland even though assisted suicide is illegal in the state. In 2014, it was reported that a Maryland doctor had participated in assisted suicide deaths of *non-terminally ill* Maryland residents, three of which had clinical depression.[13] The state never charged or prosecuted the doctor even though he was involved in 15 assisted suicides in Maryland.[14] These examples from Oregon, Washington, and Maryland, evidence the wide-spread abuse physicians subject their vulnerable end-of-life patients to when assisting in their deaths.

Notably, the Alzheimer's Association recently terminated its relationship with a prominent assisted-suicide advocacy group, Compassion and Choices.[15] Accordingly, the Alzheimer's Association issued a press release stating, that Compassion & Choices' "values are inconsistent with those of the Association. We deeply regret our mistake and have begun the termination of the relationship . . . ."[16] The Alzheimer's Association clarified that it "stands behind people living with Alzheimer's, their care partners and their health care providers as they navigate treatment and care choices throughout the continuum of the disease. *Research supports a palliative care approach as the highest quality of end-of-life care for individuals with advanced dementia*."[17]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected the practice of assisted suicide, advocacy groups continue to promote the legalization of physician-assisted suicide. This has led to a "suicide contagion," or the Werther Effect.[18] Empirical evidence shows that media

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[12] Richard Doerflinger, *Lethal Non-Compliance with Washington's "Death with Dignity Act"*, CHARLOTTE LOZIER INST. (Dec. 20, 2022), https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/.

[13] *See* Scott Dance, *Maryland Strips Doctor of License for Assisting in Six Suicides*, BALTIMORE SUN (Dec. 30, 2014), https://www.baltimoresun.com/health/bs-hs-suicide-doctor-20141230-story.html; *See also* End-of-Life Option Act (Richard E. Israel and Roger "Pip Moyer Act): Hearing on S.B. 701 Before the S. Comm. on Judicial Proceedings, 2020 Leg., 442nd Sess. (Md. 2020) (written statement of the Legislative Action Committee for the Maryland Psychiatric Society).

[14] *Id.*

[15] Wesley J. Smith, *Alzheimer's Association Terminates Partnership with Assisted-Suicide Advocacy Group*, NAT'L REV. (Jan. 30, 2023), https://www.nationalreview.com/corner/alzheimers-association-terminates-partnership-with-assisted-suicide-advocacy-group/.

[16] *Id.*

[17] *Id.* (emphasis added).

[18] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOVERNMENT (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.*, Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/.

coverage of suicide inspires others to commit suicide as well.[19] Studies have also demonstrated that legalizing suicide by physician in certain states has led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[20] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[21] Unfortunately, these effects are even greater for individuals older than 65, which has seen a 14.5% increase in overall suicide rates for that demographic.[22] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[23]

Legalizing suicide by physician is neither "compassionate" nor an appropriate solution for those who may suffer from depression or loss of hope at the end of their lives. S.B. 845 targets these vulnerable individuals and communicates the message that their lives are not worth living. However, individuals living in poverty, the elderly, and those living with disabilities, are indeed worthy of life and are entitled to equal protection under the law, which is why this Committee should reject this bill.

II. *The Bill's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although this bill includes so-called "safeguard" provisions, in effect, these protections cannot adequately protect vulnerable end-of-life patients. For example, the bill only requires a physician to refer a patient to a mental health professional for an assessment "if, in the medical opinion of the attending physician or the consulting physician, an individual may be suffering from a condition that is causing impaired judgment or otherwise does not have the capacity to make medical decisions . . . ." Yet, even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.[24] In Oregon in 2021, for example, assisted suicide physicians prescribed lethal drugs to 383 patients yet only referred two of these patients for counseling—*approximately 0.5% of patients*.[25] Further, as of 2021,

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[19] *See id.*; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RES. 137 (2004).

[20] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015), https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CENTRE (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf.

[21] *Id.*

[22] *Id.*

[23] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, Jan-Feb 2015, available at https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").

[24] Glenn Foster, *supra* note 6, at 54.

[25] OR. PUB. HEALTH DIV., *supra* note 7, at 8.

Oregon data shows that the median duration of an assisted suicide patient-physician relationship was only five weeks.[26] Therefore, if this bill is passed, the likelihood of a Maryland physician referring an end-of life patient to a mental health professional is extremely low, especially when they may have only known the patient for less than five weeks.

The bill also fails to define "impaired judgment," which means that even if the patient is suffering from depression, that in and of itself does not preclude the patient from being prescribed and utilizing life-ending medication. This is concerning given that scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[27] "[A]round 25–50% of patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed."[28] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[29] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[30]

Moreover, on the off chance that a Maryland physician refers a patient for a mental health assessment, the bill has no requirement that the patient and mental health professional meet more than once. One study has shown, "[o]nly 6% of psychiatrists were very confident that *in a single evaluation* they could assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[31] Nevertheless, under this bill, an individual suffering from depression can be deemed competent to take their own life after only one consultation with a psychologist or psychiatrist. For these reasons, it is difficult to argue that these "safeguards" will allow physicians and mental health professionals to accurately assess an individual's mental health.

Lastly, the bill assumes that physicians can make the correct diagnosis that a patient has a terminal illness that "will produce a patient's death within six months." This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating a patient's terminal illness life expectancy. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months.

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[26] *Id.* at 13.
[27] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).
[28] *Id.* at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").
[29] *Id.*
[30] *Id.*
[31] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996). (emphasis added).

It is common for medical prognoses of a short life expectancy to be wrong."[32] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[33]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[34] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[35] which resulted in the individual's death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their diagnosis.[36] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[37] In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness, or had a longer life expectancy than six-months.

In sum, the bill's purported "safeguards" fail to protect vulnerable end-of-life patients, leaving them susceptible to coercion and abuse at the hands of physicians and mental health professionals. H.B. 845 does not give end-of-life patients "control over their deaths," as some proponents of the bill may argue. Instead, the bill gives physicians the ability to prematurely end their patients' lives, which directly violates physicians' Hippocratic Oath "to do no harm."

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession and Allows for Physicians to Experiment with Lethal Drugs on End-of-Life Patients*

Prohibitions on suicide by physician protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[38] Despite these ethical obligations, physicians are using experimental lethal drugs when assisting in suicide. There is no standardized drug nor required dosage for assisted suicide. "Of course, there is no federally approved drug for which the primary indication is the cessation of the

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[32] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).

[33] *Id*. at 22.

[34] Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VERYWELL HEALTH (Aug. 2, 2018), https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481.

[35] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, THE LOCAL (Apr. 24, 2014), https://www.thelocal.ch/20140424/swiss-doctor-acquitted-for-aiding-seniors-suicide (reporting the doctor was not held accountable for his negligence).

[36] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

[37] *See id.*

[38] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

mental or physical suffering by the termination of life."[39] The Food and Drug Act regulates pharmaceuticals at the federal level and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[40] Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[41] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[42] As the U.S. Food and Drug Administration ("FDA") notes on its website, "[c]ompounded drugs are not FDA-approved. *This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients*."[43] This means physicians have experimented their lethal drug compounds on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients." [44] Notably, the bill is silent as to what drugs doctors must use and there are no safeguards preventing doctors from using experimental lethal drug compounds directly on patients.

Ultimately, S.B. 845 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. Thus, the bill opens the door for physicians to be forced to violate their conscience rights[45] and medical ethics, such as the Hippocratic Oath, and increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits.

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[39] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POLL. & CIV. RTS. L. REV. 323, 339 (2006).
[40] *Id.* at 340.
[41] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).
[42] *See* Robert Wood et al., *Attending Physicians Packet*, END OF LIFE WASH. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors' experiments with different lethal drug compounds).
[43] *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies (emphasis added).
[44] Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, THE ATL. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.
[45] *Cf. Christian Med. & Dental Ass'ns v. Bonta*, No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022) (issuing a preliminary injunction against California's requirement that doctors medically document a patient's lethal drug request, which counts towards the two required drug requests, despite doctors' conscientious objections to assisting a suicide); *Lacy v. Balderas*, No. 1:22-cv-953 (D.N.M. filed Dec. 14, 2022) (alleging New Mexico provisions that require doctors to tell patients of the availability of suicide assistance and refer for the practice infringe upon conscience rights).

Even the U.S. Supreme Court has acknowledged that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[46] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, he pointed out: "Virtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[47] This bill directly contradicts with Maryland's legitimate interest to protect the integrity and ethics of the medical profession and instead allows physicians to freely violate their ethical obligations, causing lethal harm to their patients with experimental drugs.

IV. *Conclusion*

The majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Since Oregon first legalized the practice in 1996 "about 200 assisted-suicide bills have failed in more than half the states."[48] Likewise, this Committee should reject S.B. 845 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession.

Sincerely,

Catherine Glenn Foster
President and CEO
AMERICANS UNITED FOR LIFE

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[46] Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

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

[48] Foster, *supra* note 6, at 53.

230306-SB845 - asstd-suicide.pdf

Uploaded by: Christine Hunt

Position: UNF

Christine Hunt and Jay Crouthers
1014 Dockser Drive
Crownsville, MD 21032

March 6, 2023

Maryland General Assembly
Members of the Judicial Proceedings
Annapolis, MD

RE: SB 845 – End-of-Life Option act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Senators,

We oppose SB 845 and respectfully request that you vote against it.

We cannot condone suicide in any form, assisted or otherwise. End-of-Life is just another word for suicide and we cannot support this bill in any way.

This is also a very slippery slope that can be abused. In some states, terminally ill patients are denied chemo therapy and prescribed drugs to end their life. Canada gives end of life drugs to the people who are too poor.

Death is a natural process and happens at a certain time for a certain reason. This is just another example of “man” playing God. It is unjust and immoral.

Sincerely,

Christine Hunt and Jay Crouthers

Testimony_Written_SB845_2023.pdf

Uploaded by: Christine Sybert

Position: UNF

Statement to the Senate Judicial Proceedings Committee
Re: Senate Bill 845 – "End-of-Life Option Act"
Tuesday, March 7, 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.

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.

Drug diversion potential

Drug-involved overdose deaths in the U.S. are rising (up 16% in 2021 over 2020).[1] 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

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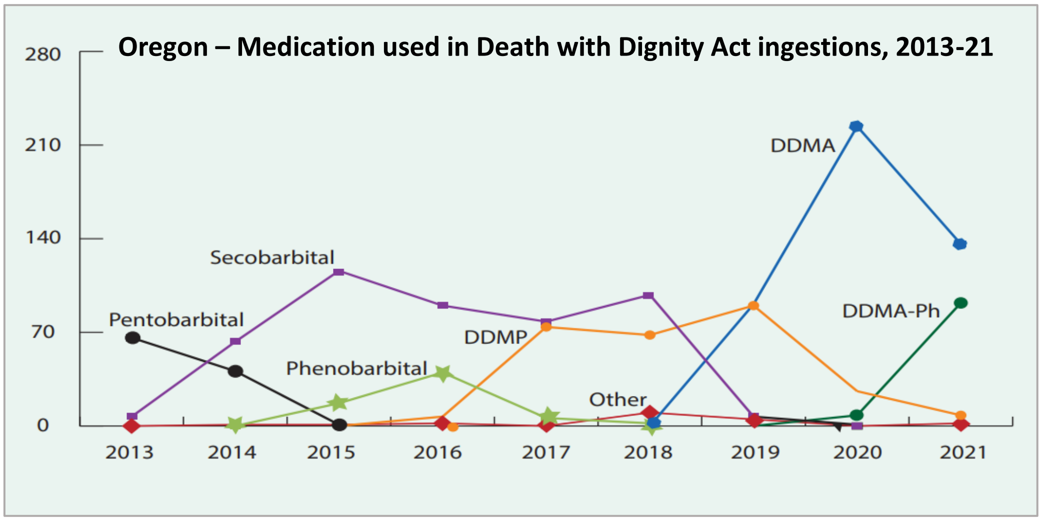
[1] https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

No accountability is required once these prescriptions are written or filled. No ID is required for picking up 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.[2]
- Washington 2021 – 27% were not used or had an unknown status.[3]

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.



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[2] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

[3] 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."[4] 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.[5] 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.

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.[6] 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

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[4] Humphry, Derek and Mary Clement. *Freedom to Die*, St. Matin's Press (New York), 1998, p. 313.

[5] 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/

[6] 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

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.[7] 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).[8] 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?

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

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

[8] 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/

- Washington (2009) – took 14 years for first attempt to change: 2023 - seeking to allow NPs and PAs to be prescribers and <u>mailing</u> 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 <u>*saving*</u> 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 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 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.

HB 0845 Suicide Murder.pdf

Uploaded by: Dana Schulze

Position: UNF

SB 0845

I am a combat veteran, hold a BS, and MA in counseling. I oppose SB 0845.

My dear mother passed into heaven March 4, 1996 twenty-seven years ago almost to this day.
She fought a difficult battle against cancer including end of life care in hospice care. She never gave up and her family loved her to the very end.
I understand families desire to decrease and end suffering for their loved ones.
Marylanders want to celebrate life and the value of each life at every single second of that life.

Murder, is not the answer.

This pervasive culture of death unfortunately spreads and reaches into steal life from unsuspecting medically fragile members of society and their families.
As reported by the Robert Powell Center for Medical ethics.

Safeguards do not work.
WhySafeguardsDontWork.pdf (nrlc.org)
FACT: A large number of non-terminally ill persons are given lethal prescriptions where assisting suicide is legal.
FACT: Insurers have and continue to deny life-saving medical treatment and cover cheap lethal drugs where assisting suicide is legal.
FACT: There is no requirement for a witness at the time of death.
FACT: There is nothing in the law to protect those with mental illness.
FACT: There are numerous complications that can and will occur.
FACT: Dying in pain is unacceptable, and everyone agrees patients in pain need better options. Startlingly, the assisted suicide law is rarely invoked for pain.
FACT: There is no requirement that the doctor has any knowledge of or relationship with the patient.
FACT: It is nearly impossible to penalize doctors under the law.

Learn from Oregon.
"Those promoting assisted suicide promised Oregon voters that it would be used only for extreme pain and suffering. Yet there has been no documented case of assisted suicide being used for untreatable pain. Instead, patients are being given lethal overdoses because of psychological and social concerns, especially fears that they may no longer be valued as people or may be a burden to their families." —Dr. Greg Hamilton, Portland psychiatrist.

Following is a brief summary of points worth making in rebutting arguments for legalizing active euthanasia:	**For more detailed info go to: http://www.nrlc.org/medethics**
1. A request for assisted Suicide is typically a cry for help.	It is in reality a call for counseling, assistance, and positive alternatives as solutions for very real problems.

2. Suicidal Intent is typically transient	Of those who attempt suicide but are stopped, less than 4 percent go on to kill themselves in the next five years; less than 11 percent will commit suicide over the next 35 years.
3. Terminally Ill patients who desire death are depressed and depression is treatable In those with terminal illness.	In one study, of the 24 percent of terminally ill patients who desired death, all had clinical depression.
4. Pain is controllable.	Modern medicine has the ability to control pain. A person who seeks to kill him or herself to avoid pain does not need legalized assisted suicide but a doctor better trained in alleviating pain.
5. In the U.S. legalizing "voluntary active euthanasia [assisting suicide] means legalizing*non*voluntary euthanasia.	State courts have ruled time and again that if competent people have a right, the Equal Protection Clause of the United States Constitution's Fourteenth Amendment requires that *incompetent* people be "given" the same "right."
6. In the Netherlands, legalizing voluntary assisted suicide for those with terminal illness has spread to include *nonvoluntary* euthanasia for many who have no terminal illnesses.	Half the killings in the Netherlands are now nonvoluntary, and the problems for which death in now the legal "solution" include such things as mental illness, permanent disability, and even simple old age.
7. You don't solve problems by getting rid of the people to whom the problems happen.	The more difficult but humane solution to human suffering is to address the problems.

WhySafeguardsDontWork.pdf (nrlc.org)

In the wake of the 2005, Terri Schiavo case, many authorities urged Americans to complete advance directives. Every state authorizes these legal documents, which allow a person to specify whether and under what circumstances she or he wants life-preserving medical treatment, food or fluids when no longer able to make health care decisions.

However, the laws of ***all but twelve states*** may allow doctors and hospitals to disregard advance directives when they call for treatment, food, or fluids.

Increasingly, health care providers who consider a patient's "quality of life" too low are denying life-preserving measures against the will of patients and families – and the laws of most states provide no effective protection against this involuntary denial.

The result: in most states, if you want life-saving treatment – or even food and fluids – there is no guarantee your wishes will be honored, even if you make them clear in a valid advance directive."

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SB 0845

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Learn from Oregon.
“Those promoting assisted suicide promised Oregon voters that it would be used only for extreme pain and suffering. Yet there has been no documented case of assisted suicide being used for untreatable pain. Instead, patients are being given lethal overdoses because of psychological and social concerns, especially fears that they may no longer be valued as people or may be a burden to their families.” —Dr. Greg Hamilton, Portland psychiatrist.

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1. A request for assisted Suicide is typically a cry for help.	It is in reality a call for counseling, assistance, and positive alternatives as solutions for very real problems.

2. Suicidal Intent is typically transient	Of those who attempt suicide but are stopped, less than 4 percent go on to kill themselves in the next five years; less than 11 percent will commit suicide over the next 35 years.
3. Terminally Ill patients who desire death are depressed and depression is treatable In those with terminal illness.	In one study, of the 24 percent of terminally ill patients who desired death, all had clinical depression.
4. Pain is controllable.	Modern medicine has the ability to control pain. A person who seeks to kill him or herself to avoid pain does not need legalized assisted suicide but a doctor better trained in alleviating pain.
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WhySafeguardsDontWork.pdf (nrlc.org)

In the wake of the 2005, Terri Schiavo case, many authorities urged Americans to complete advance directives. Every state authorizes these legal documents, which allow a person to specify whether and under what circumstances she or he wants life-preserving medical treatment, food or fluids when no longer able to make health care decisions.

However, the laws of ***all but twelve states*** may allow doctors and hospitals to disregard advance directives when they call for treatment, food, or fluids.

Increasingly, health care providers who consider a patient's "quality of life" too low are denying life-preserving measures against the will of patients and families – and the laws of most states provide no effective protection against this involuntary denial.

The result: in most states, if you want life-saving treatment – or even food and fluids – there is no guarantee your wishes will be honored, even if you make them clear in a valid advance directive."

HB 0845 Suicide Murder.pdf

Uploaded by: Dana Schulze

Position: UNF

SB 0845

I am a combat veteran, hold a BS, and MA in counseling. I oppose SB 0845.

My dear mother passed into heaven March 4, 1996 twenty-seven years ago almost to this day.
She fought a difficult battle against cancer including end of life care in hospice care. She never gave up and her family loved her to the very end.
I understand families desire to decrease and end suffering for their loved ones.
Marylanders want to celebrate life and the value of each life at every single second of that life.

Murder, is not the answer.

This pervasive culture of death unfortunately spreads and reaches into steal life from unsuspecting medically fragile members of society and their families.
As reported by the Robert Powell Center for Medical ethics.

Safeguards do not work.
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PAS testimony.pdf
Uploaded by: Debbie Ryan
Position: UNF

As a child in the 80's, my parents brought us to the hospital to visit our Grandfather who was suffering from cancer. I remember watching the nurses caring for my grandfather: keeping him comfortable with positioning and pain medication and attending to his needs in a loving and compassionate manner until he passed away peacefully. It was then that I knew that I wanted to be a nurse.

Compassion, defined as "suffering with" is the foundation from which the nurse builds his or her practice. However, Compassion and Choices has hijacked this word, using it to make the public feel as though offering this lethal prescription is the compassionate choice. It is not. It is the antithesis of compassion, the antithesis of what it means to be a nurse.

I find it ironic that you would introduce this SB845 following the 3 years of the Covid Pandemic. We nurses worked so hard taking care of critically ill Covid patients, saving their lives every day when they were dying by the hour. We know that the worst cases were those with other preexisting health conditions, so-called "high risk." Those were the patients we meticulously cared for, wore masks in public for, were early adopters of the vaccine for. Those patients will now be offered this lethal concoction in order to *hasten* their death.

A second irony and hijacking of the compassion of nurses is listed in Compassion and Choices' pamphlet. It's called MEDICALAID IN DYING: A Guide for Patients and Their Supporters.

- page 54, they state that, "if one cannot swallow the lethal prescription, then a clinician, usually a nurse, inserts a catheter so that the patient can self-administer." The nurse is now complicit in this early death.
- page 64: "There is nothing in any aid-in-dying law that prohibits hospice staff from mixing these medications or handing the mixture to you." Complicit.
- page 67: "those around the patient should become something of a cheering squad to achieve the 2 minute goal of swallowing the prescription." I ask, how is a "cheering squad" not complicit; how is this not coercion?

SB845 does not specifically mention nurses, a conspicuous omission. You have neither given us immunity nor have you given us conscience protections. Nurses could be accused of abandoning their patients if we do not comply and/or be forced to be complicit in a practice for which we do not agree.

Last, we know from Sloan Kettering Hospital Pain and Palliative Care Service that 95% of individuals that initiate the process of Assisted Suicide will change their minds once their Depression is treated. And yet, there is no requirement for a mental health evaluation prior to these lethal prescriptions.

In summary, Assisted Suicide is not necessary; it is not Nursing Care; it is not Compassionate care. You are asking nurses to turn our back on the very thing that drives most of us to do our work: Compassion.

2023 SB845 AS Opposition Statement (personal) (1).

Uploaded by: Deborah Brocato

Position: UNF

OPPOSITION STATEMENT SB845

End of Life Option Act

Deborah Brocato

3206 Glouchester Dr, Fallston MD 21047

Words cannot express how strongly I oppose **SB845**.

My father suffered emotionally, psychologically, and physically at the hands of his father. In spite of the trauma of his childhood, he pursued his talents and opened a business. He met my mother and started a family. Underlying this outward success, my father battled depression and alcoholism. For a time, we experienced the loving father and husband my dad was meant to be. However, by middle school, alcoholism and depression controlled his life. He lost his business and was increasingly violent. My mother worked one job, then two, then three. My siblings and I began working when we were of age and contributed. Due to my father's violence, the police were called to our home many times over the years. He sought treatment several times with no success. The trouble with treatment back then is that it did not address the psychological underpinnings of the alcoholism and depression.

Finally, in October of 1986, my father took an industrial strength electrical cord and hung himself. My memories from that day are still vivid.

Some might say we were lucky to no longer have to deal with the chaos of a violent, alcoholic father. They'd be wrong. We wanted our father to get effective treatment. That suicide opened a pandora's box of emotional trauma. **Suicide is not a solution**.

Alcoholism is treatable. Depression is treatable.

Suicide is not a cure for depression. Suicide is not a cure for alcoholism. Suicide is not a cure for pain. Suicide is not a cure for anything.

Another point about my father's suicide is that suicide already happens every day without a law prescribing how to do it. According to the CDC (Centers for Disease Control), in 2021, there were over 48,000 suicides which breaks down to **132 suicides per day**. (See Suicide Fact Sheet)

Do not normalize suicide by passing this bill. Do not turn suicide into some kind of healthcare choice. Killing yourself is a result of despair, not a decision of a healthy mind.

There are millions of people in healthcare dedicated to helping those who are suffering whether it is emotional, psychological or physical pain**. Do not turn these professionals into executioners.**

OPPOSITION STATEMENT SB845, page 2 of 2

End of Life Option Act

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In contrast, I cared for my mother during her battle with cancer. She was bedridden for the last 3 months of her life. The cancer had spread to most of her body and she required total care. Although I had 2 toddlers and was pregnant with our third child, it is something I am grateful I was able to do. Her pain was well managed. The last weeks of her life she was prescribed morphine drops because she had difficulty swallowing. Although she was in pain, my mother started refusing the morphine. She stated, “I don’t want to sleep my life away. I would rather have pain and spend time awake with my family.” Her desire to live remained strong even though she knew she was dying.

The American Clinicians Academy on Medical Aid in Dying has put out a manual on Assisted Suicide, *Medical Aid in Dying, A Guide for Patients and Their Supporters* (https://www.acamaid.org). While it is supposed to be a positive guide for assisted suicide, it reveals the unpleasant reality of this prescribed death. Between the barbiturates, the anti-emetics and the analgesics, the prescription can be as much as 100 pills. The length of time it takes to die varies from one person to another. **Death can take hours or even days**. No one can say for sure if death is pleasant because the person is dead. Once the person is dead, they cannot report on their death or whether or not they voluntarily took the medication.

Many proponents of Assisted Suicide express fear of pain or fear of suffering. Fear is not a good reason for suicide. There is no good reason to encourage suicide. That’s cruelty.

This bill is not compassionate. It is the opposite. When our fellow human beings are suffering, they need appropriate treatment for what ails them along with emotional support and reassurance.

I urge you to promote compassion and appropriate treatment for those who suffer and turn away from this inhumane bill for assisted suicide. I ask you for an unfavorable report on **SB845**.

U.S.A. SUICIDE: 2021 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths
Nation	48,183	132.0	14.5	1.4
Males	38,358	105.1	23.3	2.1
Females	9,825	26.9	5.9	0.6
Whites	41,426	113.5	16.5	1.4
Blacks/African American	3,807	10.4	8.4	0.8
American Indian/Alaska Native	733	2.0	16.8	2.5
Older Adults (65+ yrs.)	9,652	26.4	17.3	0.4
Young (15-24 yrs.)	6,528	17.9	15.2	17.0
Middle Aged (45-64 yrs.)	14,668	40.2	17.6	2.1

Group (Number of Suicides)	Rate
White Male (33,139)	26.4
White Female (8,287)	6.6
Black/African American Male (3,058)	14.1
Black/African American Female (749)	3.2
Asian (1,409)	6.9
Native Hawaiian/Other Pacific Islander (92)	10.7
More than One Race (716)	7.3
Hispanic/Latino (4,907)	7.8
Non-Hispanic/Latino (43,157)	16.0

Fatal Outcomes (Suicides): ***a 3.6% rate increase was seen from 2020 to 2021 (a 3.4% decrease was observed from 2019 to 2020)***

- Average of 1 person every 10.9 minutes killed themselves—1 male every 13.7 minutes, 1 female every 53.5 minutes
- Average of 1 older adult every 54.5 minutes killed themselves; Average of 1 middle aged adult every 35.8 minutes
- Average of 1 young person every 1 hour and 20.5 minutes killed themselves. (If the 607 suicides below age 15 are included, 1 young person every 1 hour and 13.7 minutes)
- 11th ranking cause of death in U.S.— 3rd for **young** -->>
- 3.9 male deaths by suicide for each female death by suicide
- Suicide ranks 11th as a cause of death; Homicide ranks 16th

Leading Causes of Death 15-24 yrs

Cause	Number	Rate
All Causes	38,307	88.9
1-Accidents	15,792	36.7
2-Homicide	6,635	15.4
3-Suicide	6,528	15.2
10-14 yrs	598	2.8
15-19 yrs	2,343	10.9
20-24 yrs	4,185	19.4

Nonfatal Outcomes (Attempt Survivors§) (figures are estimates):

- 1,204,575 annual attempts in U.S. (using 25:1 ratio) or one attempt every 26.2 seconds
- 2021 SAMHSA study: 1.7 million adults (age 18 and up) and 892,000 adolescents (12-17 years old)
- Translates to 1 every 18.6 seconds for adults and 1 every 35.4 seconds for adolescents
- 25 attempts for every death by suicide for nation (one estimate); 100-200:1 for young; 4:1 for older adults
- 3 female attempts for each male attempt

Postvention (Exposure and Survivors of Suicide Loss)

Exposed ("Affected") – those who "know" someone personally who has died by suicide † (figures are estimates)

°Recent (Cerel et al,, 2019) research-based estimate suggests that for each suicide death →135 people are *exposed* (for 2021, 6.5 million annually) – among the exposed there are subgroups with a variety of effect levels (see Cerel et al., 2014) – as many as 40-50% of the population have been exposed to suicide in their lifetime based on a 2016 representative sample's results (Feigelman et al., 2017)

Suicide Loss Survivors (those bereaved of suicide - definition below): *† (figures are estimates) [Subgroup of "Exposed" above]*

°Survivors of Suicide Loss = experience high levels of distress for a considerable length of time after exposure (Jordan & McIntosh, 2011)

°Among those exposed to a death by suicide, *more than* 6 experience a major life disruption (loss survivors; a low, non-research based estimate see Cerel et al. 2020)

- *If each suicide has devastating effects and intimately affects > 6 other people, there are* ***over 289,000 loss survivors a year***
- Based on the 948,090 suicides from 1997 through 2021, therefore, the number of *survivors of suicide loss* in the U.S. is *more than* 5.69 million (1 of every 58 Americans in 2021); number grew by more than 289,098 in 2021
- If there is a suicide every 10.9 minutes, then there are *more than* 6 new loss survivors every 10.9 minutes as well

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides (1st)	26,328	7.9	54.6%	All but Firearms	21,855	6.6	45.4%
Suffocation/Hanging (2nd)	12,431	3.8	25.8%	Fall (4th)	1,184	0.4	2.5%
Poisoning (3rd)	5,568	1.7	11.6%	Cut/pierce (5th)	965	0.3	2.0%

U.S.A. Suicide Rates 2011-2021

(Rates per 100,000 population)

Group/ Age	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Group/ Age
5-14	0.7	0.8	1.0	1.0	1.0	1.1	1.3	1.5	1.3	1.5	1.5	5-14
15-24	11.0	11.1	11.1	11.6	12.5	13.2	14.5	14.5	13.9	14.2	15.2	15-24
25-34	14.6	14.7	14.8	15.1	15.7	16.5	17.5	17.6	17.5	18.4	19.5	25-34
35-44	16.2	16.7	16.2	16.6	17.1	17.4	17.9	18.2	18.1	17.4	18.1	35-44
45-54	19.8	20.0	19.7	20.2	20.3	19.7	20.2	20.0	19.6	18.0	18.2	45-54
55-64	17.1	18.0	18.1	18.8	18.9	18.7	19.0	20.2	19.4	16.9	17.0	55-64
65-74	14.1	14.0	15.0	15.6	15.2	15.4	15.6	16.3	15.5	14.5	15.3	65-74
75-84	16.5	16.8	17.1	17.5	17.9	18.2	18.0	18.7	18.6	18.4	19.6	75-84
85+	16.9	17.8	18.6	19.3	19.4	19.0	20.1	19.1	20.1	20.9	22.4	85+
65+	15.3	15.4	16.1	16.7	16.6	16.7	16.8	17.4	17.0	16.4	17.3	65+
Total	12.7	12.9	13.0	13.4	13.7	13.9	14.5	14.8	14.5	14.0	14.5	Total
Men	20.2	20.6	20.6	21.1	21.5	21.8	22.9	23.4	23.0	22.5	23.3	Men
Women	5.4	5.5	5.7	6.0	6.2	6.2	6.3	6.4	6.2	5.6	5.9	Women
White	14.5	14.7	14.9	15.5	15.8	15.9	16.5	16.8	16.4	15.7	16.5	White
Nonwh	5.8	6.1	6.0	6.0	6.3	6.8	7.2	7.5	7.6	7.8	8.4	NonWh
Black	5.3	5.5	5.4	5.5	5.6	6.1	6.7	7.0	7.1	7.5	8.4	Black
45-64	18.6	19.1	19.0	19.5	19.6	19.2	19.6	20.1	19.5	17.4	17.6	45-64

15 Leading Causes of Death in the U.S.A., 2021

(total of 3,464,231 deaths; 1,043.8 rate)

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	209.6	695,547
2 Malignant neoplasms (cancer)	182.4	605,213
3 COVID-19	125.6	416,893
4 Accidents (unintentional injuries)	67.8	224,935
5 Cerebrovascular diseases (stroke)	49.1	162,890
6 Chronic lower respiratory diseases	42.9	142,342
7 Alzheimer disease	36.0	119,399
8 Diabetes mellitus (diabetes)	31.1	103,294
9 Chronic liver disease and cirrhosis	17.0	56,585
10 Nephritis, nephrosis (kidney disease)	16.4	54,358
11 Suicide [Intentional Self-Harm]	**14.5**	**48,183**
12 Essential hypertension and renal disease	12.9	42,816
13 Influenza & pneumonia	12.6	41,917
14 Septicemia	12.4	41,281
15 Parkinson's disease	11.6	38,536
- All other causes (Residual; > 15)	201.9	670,042
16 Homicide (Assault)	7.8	26.031

• Older adults made up 16.8% of 2021 population, but 20.0% of suicides • Young made up 13.0% of 2021 population and 13.5% of suicides •
• Middle Aged made up 25.2% of the 2021 population, but were 30.4% of suicides •
1,414,041* Years of Potential Life Lost Before Age 75 (43,671 of 48,183 suicides are below age 75)
* alternate YPLL figure: 1,409,143 using individual years in calculations rather than 10-year age groups as above.

Many figures appearing here are derived or calculated from data in the following *official data sources:* downloaded 11 January 2023 from CDC's WONDER website: https://wonder.cdc.gov. • Other references cited on this page are listed on the State Data Page. •

suicide rate = (number of suicides by group / population of group) X 100,000

Suicide Data Page: 2021

Prepared and © by Christopher W. Drapeau, Ph.D. & John L. McIntosh, Ph.D.

12 January 2023

§ Alternate terms = **Survivors of Suicide Attempts** or those with **Lived Experience** (of suicide attempt)

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2021*

Rank	State [Division / Region]	Deaths	Rate
1	Wyoming [M / West]	190	32.8
2	Montana [M / West]	350	31.7
3	Alaska [P / West]	220	30.0
4	New Mexico [M / West]	533	25.2
5	Colorado [M / West]	1,384	23.8
6	South Dakota [WNC / Midwest]	203	22.7
7	Nevada [M / West]	691	22.0
7	Oklahoma [WSC / South]	877	22.0
7	Vermont [NE / Northeast]	142	22.0
10	West Virginia [SA / South]	375	21.0
11	Oregon [P / West]	889	20.9
12	Arkansas [WSC / South]	618	20.4
12	Idaho [M / West]	387	20.4
14	Arizona [M / West]	1,475	20.3
15	Maine [NE / Northeast]	277	20.2
16	North Dakota [WNC / Midwest]	156	20.1
17	Utah [M / West]	643	19.3
18	Kansas [WNC / Midwest]	560	19.1
18	Missouri [WNC / Midwest]	1,177	19.1
20	Kentucky [ESC / South]	816	18.1
21	Tennessee [ESC / South]	1,222	17.5
22	Iowa [WNC / Midwest]	549	17.2
23	Indiana [ENC / Midwest]	1,129	16.6
24	Alabama [ESC / South]	827	16.4
25	Mississippi [ESC / South]	480	16.3
26	New Hampshire [NE / Northeast]	223	16.1
27	Washington [P / West]	1,229	15.9
28	Georgia [SA / South]	1,676	15.5
28	South Carolina [SA / South]	802	15.5
30	Florida [SA / South]	3,351	15.4
31	Wisconsin [ENC / Midwest]	905	15.3
32	Ohio [ENC / Midwest]	1,766	15.0
33	Louisiana [WSC / South]	689	14.9
34	Michigan [ENC / Midwest]	1,485	14.8
35	Nebraska [WNC / Midwest]	288	14.7
36	Pennsylvania [MA / Northeast]	1,885	14.5
	Nation	**48,183**	**14.5**
37	Minnesota [WNC / Midwest]	808	14.2
37	Texas [WSC / South]	4,193	14.2
39	Hawaii [P / West]	202	14.0
40	Delaware [SA / South]	137	13.7
40	North Carolina [SA / South]	1,448	13.7
40	Virginia [SA / South]	1,188	13.7
43	Illinois [ENC / Midwest]	1,454	11.5
44	Connecticut [NE / Northeast]	401	11.1
45	Rhode Island [NE / Northeast]	117	10.7
46	California [P / West]	4,148	10.6
47	Maryland [SA / South]	620	10.1
48	Massachusetts [NE / Northeast]	604	8.6
49	New York [MA / Northeast]	1,660	8.4
50	New Jersey [MA / Northeast]	688	7.4
51	District of Columbia [SA / South]	46	6.9

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Suggested citation: Drapeau, C. W., & McIntosh, J. L. (2023). *U.S.A. suicide: 2021 Official final data.* Minneapolis, MN: Suicide Awareness Voices of Education (SAVE), dated January 12, 2023, downloaded from https://save.org/about-suicide/suicide-statistics.

Division [Abbreviation]	Rate	Number
Mountain [M]	22.4	5,653
West North Central [WNC]	17.3	3,741
East South Central [ESC]	17.2	3,345
West South Central [WSC]	15.5	6,377
South Atlantic [SA]	14.5	9,643
Nation	**14.5**	**48,183**
East North Central [ENC]	14.3	6,739
Pacific [P]	12.5	6,688
New England [NE]	11.7	1,764
Middle Atlantic [MA]	10.1	4,233

Region [Subdivision Abbreviations]	Rate	Number
West (M, P)	15.7	12,341
South (ESC, WSC, SA)	15.2	19,365
Midwest (WNC, ENC)	15.2	10,480
Nation	**14.5**	**48,183**
Northeast (NE, MA)	10.5	5,997

Source: Obtained 11 January 2023 from CDC/NCHS's *WONDER* (to appear in *Deaths: Final Data for 2021*, forthcoming) http://www.cdc.gov/nchs/products/nvsr.htm

[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

Suicide State Data Page: 2021
12 January 2023

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SAVE
SUICIDE AWARENESS
VOICES OF EDUCATION

These sheets posted online at:
https://save.org/about-suicide/suicide-statistics &

Other suicide data, and an archive of state data, appear at the website:
https://jmcintos.pages.iu.edu/SuicideDataCompiled.htm

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TESTIMONY AGAINST SB845.pdf

Uploaded by: Deborah Yatsuk

Position: UNF

TESTIMONY AGAINST SB845 – END OF LIFE OPTION ACT
MARCH 7, 2023
SENATE JUDICIAL PROCEEDINGS COMMITTEE

DEBORAH YATSUK
ANNAPOLIS, MD

Dear Committee Members,

I am reaching out to you, as leaders, to not accept the culture of killing that we have allowed to permeate society. It is scary. Yet we wonder why killers don't value life.

Our middle-age and young people have grown up with easy access and use of abortion which casually kills a beating heartbeat and growing human. Now with this bill, encouraging killing by allowing someone to take their own life, kills a human that may want out.

Humans by nature want to be in control. But we are only human and make a mess of things as we do not hold the wisdom necessary to make judgements on who should live and who should die. But nature knows. A supreme being knows.

There are other ways than this bill to die. Hospice and Palliative Care have trained staff to provide medications and other support, covered by insurance, to keep a patient and their family comfortable and supported.

We are not asked to be born, and we should not ask to die. Let us love one another and care for each other whatever our circle of life encompasses.

Thank you for your consideration, and I urge an UNF on SB845.

life is sacred.pdf

Uploaded by: Denise Blair-Nellies

Position: UNF

Denise Blair-Nellies

2101 Hammond Ave.

Marriottsville, MD 21104

SB845 – Opposed

Life is Sacred at Every Age and Stage

I urge you to oppose Senate Bill 845 which would legalize Physician Assisted Suicide. For more than 20 years our family has had the blessing of visiting nursing homes, assisted living facilities, and senior housing apartments to sing and converse with senior citizens. Many of these residents would be at risk of death by physician assisted suicide if Senate Bill 845 is passed. People who suffer can have an amazing impact on others. Our family members have experienced firsthand the joys of spending time with these senior citizens, many of whom are faced with serious health challenges. These senior citizens have inspired us by the strength they have shown in the way they cope with their suffering.

One time our daughter, Catherine, who was six years old at the time, told me she colored a picture for the “woman who loves me.” When I asked her whom it was for, she told me Ms. Shavon from the nursing home. When we took it to the nursing home to give it to Ms. Shavon, we told her Catherine said she made it for “the woman who loves me.” Ms. Shavon pointed to herself and said, “That’s me.” Months later we learned Ms. Shavon had died. Catherine told my husband and me that she wished Ms. Shavon did not have to go so soon. Catherine told us: “I feel like my life is a puzzle. I feel like a piece of the puzzle is missing.” The love that Ms. Shavon shared with Catherine during our monthly visits touched our daughter’s life to the point that our daughter felt like part of her world had gone when Ms. Shavon died. Our daughter made Ms. Shavon feel loved during her visits. Ms. Shavon shared love with our daughter. Although Ms. Shavon faced various hardships, her life had an amazing impact on our daughter and our family.

Our children learn important life lessons from the senior citizens they encounter during our regular visits. Our children distribute cards to the residents at the facilities. One time we went into one of the rooms, and the senior citizen had hung many cards we had given her over the past several months. The resident told us that when she gets out of the nursing home, she is going to put these cards in a binder and come back to the nursing home one day to give these cards to residents who are still living at the facility. From this resident, our children learned how important it is to be generous.

One of the residents of the nursing home was blind. Despite the challenges she faced due to her inability to see, this resident lit up the room with her smile. She enjoyed hearing the children sing, and the children learned from her that although she must cope with the difficulty of not being able to see, she can light up a room with her smile and her positive outlook on life.

Each month children made personalized birthday cards for residents, and we sang happy birthday to each resident who had a birthday that month. During one of our visits, we had the blessing of singing happy birthday to a senior citizen who turned 100 years old. Celebrating the birthdays of the senior citizens helps teach our children that life is sacred at every stage.

Instead of planning ways to end the lives of individuals who are faced with suffering, we need to stand beside people who are suffering and remind them that they are loved. We must always respect the dignity of others. Life is sacred at every age and stage.

SB845-HB933 -A.S.S^.pdf

Uploaded by: Dr. James Kelly

Position: UNF

AAPS
Association
of American
Physicians
and Surgeons

Testimony respectfully submitted on behalf of **The Association of American Physicians and Surgeons** – by Dr. James Kelly to The Maryland Senate – March 6, 2023.
The A.A.P.S. recognizes that so called “assisted suicide “is actually killing **vulnerable** people and encourages the Maryland General Assembly to vote **AGAINST SB 845/HB 933.**

As a psychiatrist, every day I have patients who feel **suicidal and hopeless**; and every day my staff and I help them overcome their suicidal ideas and want to live again. We do this by treating their underlying medical and emotional illnesses and by affirming their value as persons and their personal dignity in the midst of their suffering. Most people suffering from chronic pain and terminal illnesses want to live - until they are told and get convinced that they are a **burden** and are **worthless**, unloved, unwanted, and become depressed, and give up hope.

The major reason people give up on life is **NOT** from their **terminal illness** or physical pain it is because they are suffering from **depression, hopelessness** and emotional pain. We should be **helping people** who are suffering **not killing** them or helping them kill themselves. Proper treatment, even for those in great pain and those who have given up all hope, is effective, improves their quality of life and saves lives. Legalizing “assisted suicide” is actually licensing people to legally murder **innocent vulnerable**, depressed and distressed persons.

One of the worst things that can happen to a family is for someone in their family to die from suicide. Suicide tends to be “**contagious**”. Once there is a suicide in a family, the suicide rate in that family skyrockets. This phenomenon is known as **“Suicide Contagion.”** Suicide contagion will be even worse in a family that helped in killing their family member. Legalizing suicide will only increase the suicide rate in Maryland. Suicide is already a major crisis in Maryland. Last year **MD Senate Bill 94** was passed in order to address the suicide crisis and help reduce the suicide rate. We should not pass legislation that will increase the already high suicide rate.
SB 845/HB 933 will **definitely increase the suicide rate** in Maryland.

One of the great historic accomplishments for Maryland has been our historical medical breakthroughs and our worldwide reputation for excellent “Maryland Medicine”. There may be good but misguided intentions by the proponents of SB 845/HB 933 - but legalizing “assisted suicide” will totally change healthcare from a profession only devoted to saving and improving lives - to a **new industry** that will **PROFIT** by **DENYING HEALTHCARE**, encouraging **death** over treatment and create a new industry that profits by killing vulnerable people to increase profits. Suicide for any reason is still suicide. **Killing for any reason is still killing.** Legalizing “assisted suicide” will forever change Maryland’s reputation from “great **Maryland Medicine** to **Maryland Murders”.**

Please vote NO on SB 845/HB 933

End of Life Option Act 2023.pdf

Uploaded by: Dr. Marie-Alberte Boursiquot
Position: UNF

Marie-Alberte Boursiquot, MD, FACP
Testimony to the Senate Judicial Proceeding Committee
March 7, 2023
RE: Senate Bill 845 (House Bill 933)-**"End of Life Option Act"**
Oppose

Dear Honored Senate Committee Members

My name is Marie-Alberte Boursiquot. I am a Board certified Internist and have been licensed to practice Medicine in the state of Maryland for over twenty five years. In that time I have managed thousands of adult patients. I am also a Fellow of the American College of Physicians (ACP). The ACP[1] and the American Medical Association (AMA)[2] remain opposed to the legalization of assisted suicide under any title.

Today I wish to express my personal opposition to the "End of Life Option Act". Medicine is a noble profession. Physicians are trained to be healers and not the agent of harm to patients. Suicide is not medical care. It has now become a public health crisis and is the tenth leading cause of death in this country. And its' rates are rising.[3] Suicide is unacceptable in a civilized society.

It is natural that a patient and their families may experience fear and anxiety at the end of life. Even in this circumstance a physician must first fulfill his or her obligation to always act in the best interest of the patient as healer, comforter and trusted advisor.

There are a number of flaws in this bill including, but not limited to,:

1. Placing our most vulnerable populations (i.e. the poor, those with disabilities, those who suffer from mental illness, members of minority groups, etc.) at risk.
2. Bills such as this one create an incentive for insurance companies and other medical plans to deny life saving care to our patients.
3. Bills such as this one can potentially make suffering patients feel that they are a burden and coerce them to consider suicide.

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[1]
[2]
[3]

Under this bill a suffering patient essentially asks an “attending physician” to assist them in committing suicide. Following a mental evaluation with a “consulting physician”, the “attending physician” writes a prescription for a cocktail of drugs with the intention that the patient commits suicide by self administering/ingestion of the cocktail. Drugs are developed for their therapeutic value and not to harm patients.

In the event that the patient succeeds at committing suicide, the “attending physician” is then selectively protected by law to falsify the death certificate by listing some other underlying medical condition as a cause of death instead of the true cause—Physician Assisted Suicide.

This is absolutely appalling especially in a day and age when transparency is expected of our political leaders, physicians, and anyone in the position of authority. This act is a corruption of the integrity of the medical profession.

There are already “end of life” options available to suffering patients. Palliative Care[4] for instance is designed to prevent and alleviate the suffering associated with a serious medical condition. It can be introduced as early as possible in one’s care. It is life affirming and addresses the physical, psychosocial, and spiritual needs of a patient and their family. It properly regards dying as a normal and natural process.

Psychosocial/emotional conditions such as Depression and Anxiety can already be effectively managed. Physicians are already trained to recognize, in some instances manage, and refer to subspecialists those who experience these conditions.

Even when all modalities of management have been exhausted or management has become futile, Hospice Care[5] is available and provides humane and compassionate care for those in the last phase of their serious ailment. It facilitates having the patient live as comfortably and as fully as possible.

It should be the desire of all physicians that all patients know that they will be well cared for throughout their lives including the end of life. The “End of Life

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[4]

[5]

Option Act" ultimately undermines the patient-physician relationship. A relationship based on trust.

In closing I wish to quote as is so eloquently expressed in the AMA Code of Ethics[6]: "Physician Assisted Suicide is fundamentally incompatible with a Physicians role as healer".

Thank you for hearing my testimony.

Marie-Alberte Boursiquot, MD, FACP
Columbia, MD 21046
Mariealberte1115@gmail.com

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[6]

testimony sb845 pdf.pdf

Uploaded by: duffy kane

Position: UNF

Please oppose SB845/HB933 Assisted Suicide.

Assisted Suicide legislation puts Maryland's most vulnerable populations at risk-including individuals with disabilities, minorities, those experiencing poverty, individuals being treated for or have a history of mental illness, our veterans, and those suffering from prescription or other drug addictions.

Lawmakers nationwide reject Assisted Suicide. The Maryland General Assembly has rejected some form of this bill at least five times. Your peers made their legislative intent very clear that Assisted Suicide is a criminal act and should remain so.

- Maryland's leading disability rights groups recognize the many dangers the bill poses to those with intellectual and developmental disabilities.
- There is no standard requirement that each patient receives mental health screening and counseling.
- No family notification is required.
- One in three patients who fill the lethal prescription-typically 100 pills, decide against taking it. There are no safeguards to ensure the unused drugs stay out of the hands of children and prescription drug dealers. This is particularly irresponsible, as we are experiencing an opioid crisis nationwide.
- No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.
- Assisted Suicide laws make suicide socially acceptable. States which have legalized Assisted Suicide have experienced increased suicide rates.
- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.

For these reasons, I respectfully ask that you protect Maryland's most vulnerable citizens. Please oppose legislation to legalize SB845/HB933 Assisted Suicide.

SB0845 End of Life Options Act-final.pdf

Uploaded by: Ella Ennis

Position: UNF

MFRW Est. 1921
Maryland Federation of Republican Women

Ella Ennis, Legislative Chairman
Maryland Federation of Republican Women
PO Box 6040, Annapolis MD 21401
Email: eee437@comcast.net

The Honorable William Smith, Chairman
And Members of the Judicial Proceedings Committee
Senate of Maryland
Annapolis, Maryland

RE: **SB 0845** End of Life Options Act – **UNFAVORABLE**

Dear Chairmen Smith and Members,

For the following reasons, the Maryland Federation of Republican Women strongly opposes SB 0845 – End of Life Options Act -- that would legalize assisted suicide in Maryland:

- Physicians often cannot definitively forecast how long a patient will live.
- Most pain can be relieved or eliminated with medicine or other treatments.
- It is immoral to encourage a person to take their own life.
- Once assisted suicide is legalized, patients may be pressured to end their lives.
- Assisted suicide could be expanded in the future to include teens and children.
- Parents could choose to eliminate infants if they have a disability.
- Patients who do not accept assisted suicide could be kept unconscious and denied nourishment to hasten death.
- Lethal drugs prescribed for an individual may end up killing someone else by error or purpose.
- People could be denied economic and home health assistance.

Voluntary “assisted suicide” can quickly become pressured and even an involuntary remedy to illness and disability. In the State of Oregon in 2008, there were reported cases where the state-run health system refused to provide physician-prescribed treatment for advanced-stage cancer patients, saying it was “inappropriate” for their situation, but offered to pay for prescriptions for them to end their lives.

Vulnerable, elderly, disabled or ill patients could be pressured to commit suicide by being made to feel they are a burden on their family and on society. “Right to Die” can morph into “Duty to Die”.

In 2020, Roger Foley, a 45 -year-old Canadian, testified via Zoom from his hospital bed to the Canadian Parliament Justice Committee that he had an incurable neurological disorder and had been told he would have to pay $1,800/day in hospital costs or face a forced discharge, even though he couldn’t get the necessary support to live at home. “Assisted dying is easier to access than safe and appropriate disability supports to live”, he said.

MFRW Est. 1921
Maryland Federation of Republican Women

Ella Ennis, Legislative Chairman
Maryland Federation of Republican Women
PO Box 6040, Annapolis MD 21401
Email: eee437@comcast.net

In the Netherlands, Assisted Suicide has advanced to a point where patients are euthanized without their knowledge. A January 2019 Article in NATIONAL REVIEW[1] reported:

> "Also in 2017, some 1,900 Dutch people killed themselves, while the number of people who died under palliative sedation – in theory, succumbing to their illness while cocooned from physical discomfort, but in practice *often dying of dehydration while unconscious* [that is, terminal sedation] – hit an astonishing 32,000. Altogether, *well over a quarter of all deaths in 2017 in the Netherlands were induced*."

In looking at the statistics from the State of Washington for 2016[2], about 1/3 of the prescriptions were not used. Some of the individuals died of other causes; and some individuals died from ingesting the death prescriptions authorized in a previous year. This undermined the accuracy of "likely to die within six months" criteria. The Oregon Death with Dignity Act 2021 Data Summary[3] reported that 383 people received prescriptions for death drugs but only 238 people died from ingesting the drugs, leaving the disposition of 145 prescriptions (40%) unknown. The question is what happens to these unused prescriptions? They could easily be used to kill someone else, knowingly or unknowingly.

Oregon Death with Dignity Act of 2021 Data Summary stated, "As in previous years, the three most frequently reported end-of-life concerns were loss of autonomy (93%), decreasing ability to participate in activities that made life enjoyable (92%), and loss of dignity (68%). Uncontrolled pain was not one of the top three reasons for requesting aid in dying.

Instead of encouraging people to end their lives, our focus should be on providing those services needed to help them live their lives.

For these reasons, please give **SB 0845** an **UNFAVORABLE** report. Do not make Maryland a "Death State."

Sincerely,
Ella Ennis
Legislative Chairman
Maryland Federation of Republican Women

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[1] https://www.nationalreview.com/corner/doctors-induce-twenty-five-percent-of-dutch-deaths/

[2] https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/422-109-DeathWithDignityAct2016.PDF

[3] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf

2023.SB0845.Arlinghaus.pdf
Uploaded by: Francis Arlinghaus
Position: UNF

SB0845

Dr. Frank Arlinghaus

Opposed

I ask the committee to oppose Senate Bill SB0845, The End of Life Option Act. I believe there are many such reasons for opposition. Additionally, I find a number of reasons for those who support the ideas in the bill to oppose this particular bill on the basis of its flaws. I outline a few of these below.

1. **Vulnerable populations are at risk from this bill**

-There will be an economic incentive that leaves the poor more vulnerable. The "right to die" will become a "duty to die".

Medical care options vary by socioeconomic status, and insurance companies and the healthcare industry are driven by profit. Over time, options offered to people may be limited, particularly for expensive end-of-life care. There are no protections from insurance companies who will offer to pay for ending one's life, but not for the treatment to prolong that life. Such arguments are already being made in Canada, utilitarian arguments that recognize the expense of end-of life health care (note that savings is provided by hospice options which promote positive experiences for patients and families). One envisions a not-to-distant future where some will experience a pressure not to hang on to life; long before that, it is not difficult to predict that insurance will have at least a bias toward end-of-life solutions over those which prolong life, and that the limiting of options will fall more heavily on the poor. In fact, these arguments are being made already in Canada, which legalized assisted suicide less than a decade ago.

-Those with some form of medical limitation (physical or mental challenges, for example) will be at greater risk.

I make this claim based on our history of mistreatment and misunderstanding of those who are born less than perfect and those who have some progressive medical condition that puts them in a higher risk category. I defer to the examples that the disability rights community provide, and only wish to reinforce that they constitute a group at much higher risk than many others. Similarly, many of us are familiar with the increased vulnerability of our parents and other elderly persons as they become more susceptible to such risk

2. **Mental Health protections are inadequate**.

The bill fails to adequately protect patients who may be depressed--note that only 5 of over 200 patients in Oregon (cf. Oregon 2017 report) were referred for counseling; that doctors are only required to refer if they believe the depression rises to the level of impairing the patient’s judgement; and that doctors may have no training in detecting or fully understanding depression. Significantly, almost three times the number of patients cite being a burden than cite pain as a reason for terminating their life. A proper mental health evaluation should be done for each patient before a prescription can be issued.

3. **The bill sends an ambiguous message on suicide to our youth and to the rest of society at a time when suicide is increasing across the United States.**

Whether we call aid in dying “suicide” or not, we are allowing a segment of society to self-terminate life with the cooperation of medical professionals. The United States is seeing a continued increase in suicide, mental health issues are increasing, and our teenagers are considering suicide at an alarming rate. Suicide increases have been even higher in states that have legalized assisted suicide. The message this bill sends is that suicide under certain circumstances is acceptable, and it’s not surprising for people to extend those parameters under which suicide is acceptable. If such laws become more prevalent across the United States, one of the next debates we will be having will cover the various circumstances under which we’ll permit this, as we’ve seen other jurisdictions expand suicide laws to wider populations.

4. **Safeguards still leave patients vulnerable.**

In previous hearings, caregivers, family, and medical professionals presented specific scenarios of vulnerable patients that should raise serious concern. Each of these cases is an existential threat under the law proposed in this bill. Beyond that, the law leaves patients vulnerable due to potential financial interest of heirs (as an heir of my father, I need only have a friend serve as the other witness, so we could conspire to influence my father toward PAS; he has a number of underlying conditions that without treatment, would qualify under current Oregon law). Other scenarios mentioned above include the vulnerability of the economically disadvantaged, especially the poor, the immigrant, the disabled, experiencing a form of health care rationing where insurance companies or providers steer them toward PAS and away from life-extending treatment.

Within this committee, during a previous year's hearing, we watched Senator Smith (the year he was the primary sponsor) questioned on the legal and medical standards of care within the bill by Senator Cassilly; unusually he had many items where the language of the bill was not justified, particularly with respect to these standards. While I may have disagreed with the Senator on issues, I have rarely seen him at a loss to justify his position. This is indicative of how flawed the bill is when examined carefully, and the extensive analysis presented in that hearing provides guidance as to the areas of greatest concern, including multiple areas where the professional standards protect doctors more than the proposed patients, whether standards of care or level of scrutiny by those who watch over and protect those patients.

5. **Bill fails to provide "Death with Dignity" and moves physicians from healer to agent of death.**

With no doctor or other medical personnel present to attend to any difficulties while taking a megadose of pills, likely in a slurry of some sort, the likely scenario for consuming the lethal medication is anything but dignified. This bill has further complications from moving doctors from their traditional role as healers, and instead having them prescribe death.

Much time will be spent discussing the Hippocratic oath and how it might fit into the modern context. Instead I look to the Marbella statement made in 1992 at the 44th World Medical Assembly well after the international right to die movement had pushed for assisted suicide and aid in dying. It said "Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession." In the years since, most medical groups continued their opposition to such legislation, while the right to die lobbying efforts have tried to get them to stay neutral. Doctors remain uncomfortable at prescribing lethal medications, and are even more uncomfortable at being present (thus we have a law in which the "attending physician" rarely attends the patient during the lethal act). These acts are in fundamental conflict with the view of doctor as healer.

6. **The term " Medical Aid In Dying" gets confused with hospice care.**

Supporters of the bill object to the term "Assisted Suicide" because the language weakens their support. To be accurate, we have a patient who seeks to end their life, who administers the means of ending that life by their own hand, and who is enabled in self-termination by a physician prescribing a lethal dose of medication. If the same patient were to commit this same act by collecting the same dose on their own, administering it the same way the law prescribes, but without a physician's involvement, we would call it suicide. However, "Assisted Suicide" conjures up images of Dr. Jack Kevorkian who set back the Aid in Dying movement at least a decade.

In the meantime, the term “medical aid in dying” makes one think of hospice care, which has an entirely different approach, providing palliative care and comfort, and which the state should instead make an increased investment in.

7. Holes in **safeguards for lethal medications leave dangerous medication unaccounted for.**.

I will refer repeatedly to the 2017 Oregon report listed elsewhere in the report. Once a prescription is obtained and filled, there is no effective tracking of the medication. A significant portion of the lethal medication is prescribed and never used. Proponents claim that the prescription is rarely filled in that case, but there’s no evidence of that. Given the types of medication used, the state should have an obligation to track it more carefully. In the case where the prescription is filled and is not used, there is a real potential for abuse of several types, including use on an unwilling victim as well as abuse of the drug in other ways. Once the prescription is filled, a patient who changes their mind is at risk for coercion or unwittingly consuming the medication. Record-keeping rules inhibit investigations of such scenarios, making it difficult to expose and investigate problems. One need only look to the opioid death epidemic and a recent case in Ohio to some potential abuses in other contexts.In the past five years, movement toward use of morphine sulfate means that these drugs can also contribute to the opiod epidemic.

8. **Canadian and European examples show that further risks to patients are likely to rise in the future**

There is a steady progression over time where such laws “evolve”. Sometimes we refer to the potential for a “slippery slope” while others may refer to it as the method for “boiling a frog”. Proponents point to court cases that fundamentally changed what is permitted, and yet dismiss the possibility of it happening again. The Candians have had PAS legal for less than a decade, and yet many of the concerns expressed are becoming a reality there. Some of the examples we’re concerned about may not be happening in this country yet, but are some of the next logical steps in such a progression, and in fact, supporters of this bill in other states have proposed amendments relaxing protections, extending the scope of the bill, or even using the courts to argue for doing the same. Thirty years ago, I argued against denying patients nutrition and hydration when the law changed to allow them to decline medical treatment. Refusing medical treatment didn’t guarantee death as long as patients were given food and water. In order to guarantee they would die, rules had to “evolve” to treat nutrition and hydration as a medical treatment that could be refused. This would allow one to guarantee death. Now denying nutrition and hydration is cited as an inhumane way to die, justifying more humane methods.

Perhaps the proper response is not to permit the inhumane way rather than to find other ways one may choose to die. We have seen a similar progression in European countries regarding assisted suicide and even euthanasia. The medical establishment and the courts may decide that medical treatments aren't worth the cost, that patients should die against their wishes (in Belgium, where a patient was physically restrained by their own family) or the wishes of their parents (in England even to the point of not allowing a child to be treated out of country at someone else's expense). In such cases, we are not all treated as equally valuable with an equal right to life-extending treatment, and unfortunately, the first to be devalued are the disabled and the elderly. Furthermore, those in poorer communities have less opportunity for life-affirming treatments, less access to mental health care, and are at greater risk.

9. **Conscience protections should be extended further.**

Given the definitions within the bill, it's not clear that a healthcare facility could prohibit assisted suicide deaths on its site. Additionally, if a facility permits assisted suicide deaths on its site, additional protections are needed to prevent that facility from requiring participation (or other forms of facilitation) by pharmacists, nurses, and other health care workers. Additional protections should be put into the bill to protect them more fully.

10. **Statistics that deceive: what's missing leads to serious questions on use of medication among other points.**

Proponents of the bill will cite over 50 years of legality to dismiss problems. We have not had 40 years of legality, we have had over 50 state-years (one state-year is one year of legality in one state). Only in Oregon do we have as many as 20 years of legality, and we will note some of the gaps and some of the trends, drawing directly from the 2017 Oregon report (successive years pre-COVID are consistent with the data at https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year20.pdf). Note that the number of deaths has increased in all but two of the years, and that there is a steady trend upward with greater increases over the last five years of the data. Elsewhere the report lacks a number of items of interest. The data not collected often would answer opponents' objections which are at this hearing dismissed by proponents, including the tracking of medication and ingestion of said medication (prescription versus fulfillment of said prescription versus death of the patient by ingestion). Note that the times between ingestion and death are mostly unknown, but even given that, the time to unconsciousness and death can be much longer than expected. Further buried in the report is the detail that in 2017, morphine sulfate became one of the two prominent medications used, of further concern because of the better known abuse potential of morphine.

11. **The bill is based on a false compassion: doctors who specialize in care for the elderly are less likely to support the bill, and pain is not one of the core underlying reasons PAS is pursued..**

People on both sides have genuine concerns, but the premise of compassion (in ending suffering) is contraindicated in two ways. First is that pain is cited less than 25% of the time in the most recent Oregon report. Also previous medical surveys have shown that the doctors more involved with patients favor bills like this at a much lower rate, and the lowest rate of approval comes from specialists in palliative care and care of the elderly. Those who attend the elderly and those in hospice see the greatest suffering in their patients. Seeing patients near the end of their lives, they should approve of this in the name of compassion. A survey by the Glasgow University Institute of Law and Ethics in Medicine showed pharmacists supported physician-assisted suicide at rates twice as high as medical general practitioners. A survey of over 3700 physicians by the National Council for Palliative Care showed that over 90% of doctors who specialized in palliative care or in the care of the elderly did not support making changes in the law to allow physician-assisted suicide.

12. **"Doctor Shopping" will and does exist.**

In the 2017 Oregon report, 92 doctors wrote 218 prescriptions, but at least one doctor wrote 29 of those. In a 2015 article in the Oregonian ("Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die," *Oregonian*, February 4, 2015. Available at: http://www.oregonlive.com/health/index.ssf/2015/02/physician-assisted_suicide_a_f.html), a case of doctor shopping was described, one which raises additional questions on the testimony of the proponents of this legislation. A woman died of assisted suicide under Oregon's "Death with Dignity Act," even though she was suffering from early dementia (a condition which appears to disqualify her from being able to make the decision). Her own physician declined to provide a lethal prescription for her. When counseling to determine her capacity was sought, a psychiatrist determined that she was not eligible for assisted suicide since she was not explicitly pushing for it and her daughter seemed to be coaching her to do so (another disqualifying condition). She was then taken to a psychologist who determined that she was competent but possibly under the influence of her daughter who was "somewhat coercive." Finally, she was assessed by a managed care ethicist who determined that she qualified for assisted suicide, and the lethal dose was prescribed. Beyond this, one could imagine a doctor who would be receptive to helping patients he felt were in need--we had one where I grew up in Michigan whose name became infamous--and this case from 2015 shows the potential for redefining who qualifies for help.

14. **The state has an obligation to err on the side of protecting life**

From a purely secular governmental view, this state has an obligation first to protect its citizens. Ask yourself what level of “collateral damage” you are willing to accept given that such damage involves ending someone’s life. Those susceptible to abuse are among the most vulnerable and in greatest need of protection.
These are only some of the reasons for opposing this flawed bill. You may also stand with the religious opponents of the bill, ministers and leaders of many faiths who find the bill objectionable on moral grounds. You may stand with the many doctors, nurses, and other health professionals who find the bill objectionable on professional and ethical grounds. You may find yourself favoring personal autonomy in principle, but see that in practice this bill is too flawed to provide sufficient protection to people at risk. In any of these cases, I ask that you stand against this bill.

15. **This is a continued public relations campaign of the international right-to-die movement, the positions of the Hemlock Society dressed up in the guise of compassion and of choices.**

The ideas in the bill are very similar to those debated in the 1980’s and 1990’s when Derek Humphry’s Hemlock Society was pushing for medically assisted and medically enabled death, and were strongly opposed by the medical establishment. In the past 20 years, there has been a calculated public relations campaign to dress up the same ideas to be more palatable to the public and to legislators. At this hearing, you will hear objections to language that might weaken public opinion, and statistics presented using language designed to elicit your support. Anything that I claim you are welcome to question, and I will be happy to provide appropriate references (contact me at farlinghaus@yahoo.com). I also ask that you test this by offering amendments to the bill to provide reasonable protections mentioned.

I respectfully ask that you oppose this bill. Even if you are a supporter of this conceptually, the bill is fundamentally flawed and must be amended to provide additional prtoections for so many of the things mentioned here.

SB0845_testimony-20230306.pdf

Uploaded by: Franklin Welch
Position: UNF

SB0845: UNFAVORABLE

The Right-to-Life is the most important right in Christianity. The medical community's general behavior over the past 3 years and beyond have left it zero credibility in handling such a serious topic.

gayno_sb845.pdf
Uploaded by: George Gayno
Position: UNF

Senate Bill 845 - End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
March 7, 2023

George A. Gayno
Edgewater, MD

OPPOSE

I am writing to express my strong opposition to SB 845. I have a family member who suffers from mental health issues. She has battled periods of depression, but with help she is able to live a relatively normal life. If SB 845 becomes law, I am concerned that my family member and others like her will be placed at a greater risk of suicide. Here are my specific concerns:

Data from other states and countries show that this law will quickly expand once enacted - SB 845 causes suicide to become a legally-recognized medical treatment. As a result, it will quickly expand from patients who are deemed terminally ill to those with chronic illnesses, uncomfortable lifestyles and mental health challenges. You can't give a "right" to only a certain class of people. Depression and other mental health problems are treatable - suicide is not a solution.

There are no safeguards for the poison - My family member has lived with roommates. Suppose her roommate brings home a prescription for suicide pills. If she becomes depressed, she could find the poison in the medicine cabinet and ingest it. These drugs will pose a danger to anyone in the household.

Insurance companies will push suicide to save money - My family member will likely need psychological help for the rest of her life. These treatments cost money. As our society ages and our health care systems become more strained, people who struggle with mental illness may be pushed to commit suicide. Advocates for physician-assisted suicide readily admit this.[1] And people with mental illness are already discriminated against by our healthcare system.[2]

There are no safeguards against coercion - The bill requires witnesses when someone requests suicide, but no witnesses are required at the time of the suicide. Because of her illness, my family member can be easily influenced by people who don't have her best interests in mind. What is to stop someone from coercing her into taking her own life?

I respectively ask that you oppose this bill. The state of Maryland should work to alleviate suffering - not to eliminate the sufferer. I urge an unfavorable report.

Respectively submitted,
George A. Gayno
219 Tilden Way
Edgewater, MD 21037

1. Derek Humphry and Mary Clement, Freedom to Die, St. Martin's Press (New York, 1998).
2. Stigma and discrimination against people with schizophrenia related to medical services. *Int J Soc Psychiatry*, 2014.

LULAC MA Letter copy.pdf

Uploaded by: Grace Garcia

Position: UNF

Massachusetts League of United Latin American Citizens

Senator/Representative
Maryland Statehouse
Baltimore, MD

March 2023

Re: Massachusetts Chapter of Nation's Largest and Oldest Latino Civil Rights Organization (LULAC) Strongly Opposes Physician Assisted Suicide

Dear Honorable Senator/Representative:

The League of United Latin American Citizens (LULAC) State of Massachusetts, the Massachusetts chapter of our nation’s largest and oldest civil rights volunteer-based organization, wishes to encourage your opposition to the twin assisted suicide bills – SB0845/HB0933. We are asking that you join with us in the fight for equal human dignity and healthcare access, because assisted suicide puts everyone, including the most vulnerable, at risk of deadly harm. LULAC State of Massachusetts empowers Hispanic Americans and builds strong Latino communities; and has historically been at the forefront in opposing Assisted Suicide (AS) laws, and therefore, we strongly urge you to oppose this legislation.

Throughout the years, in response to efforts by Assisted Suicide (AS) promoters, LULAC has democratically adopted at its annual national conventions powerful resolutions urging physicians, hospitals, legislators, and all stakeholders to oppose adoption of policies and/or legalization of Assisted Suicide. Please find attached the current National LULAC Resolution Championing Health Care and Opposing Physician Assisted Suicide.

However, LULAC urges the MD legislature to reject these bills, because every single supposed "safeguard" is unenforceable. Further, it is a gross distortion to claim Assisted Suicide laws add to autonomy when no universal right to care is established in our nation. Latinos face a myriad of health challenges and inequities, and now, amidst the COVID-19 pandemic, are experiencing greater disadvantages due to lack of access to healthcare.

Our greatest concerns with Assisted Suicide include that no mental health assessment is required at any point in the Assisted Suicide request process despite major depression being a common experience with terminal illness. No declaration by any witness (especially a financially non-interested party) to the patient's ingestion of prescribed poison is required. Protections against elder abuse and foul play are eliminated without any opportunity for investigation. No meaningful protections exist for culturally and linguistically diverse populations, particularly as Latinos or Spanish-Speaking remain grossly underrepresented in medical professions.

What's worse is that none of the aforementioned even takes into account bias, discrimination, or racism, whether latent or blatant, in our nation's health and other systems, which only further exacerbates these stark concerns

As an independent federal agency that advises the President, Congress, and state and federal policymakers, the National Council on Disability, states in their recent report on Assisted Suicide, “Legalizing assisted suicide means that some people who say they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status, leading to a two-tiered system that results in death to the socially devalued group.” Inequities and disparities in healthcare for people with disabilities and people of color remain a persistent problem.

In 2012, the Latino community of Massachusetts opposed legalization of Assisted Suicide by ballot referendum. Ultimately, the people of Massachusetts rejected legalization during that effort. Our Latino communities desperately need a right to medical care and equal access to it, and we strongly believe AS laws foreclose rather than advance either.

LULAC State of Massachusetts’s programs, services and advocacy address the most important issues for Latinos, meeting critical needs of today and the future, and so we thank you for your consideration to stand with us in opposing AS, as a dangerous and inherently discriminatory public policy. If you have any questions, please don’t hesitate to contact me.

Respectfully,

Grace Garcia
Massachusetts LULAC State Director
Member, LULAC National Board of Directors

SB 845 2023 End of Life Option Act GMurray.pdf

Uploaded by: Gwenn Murray

Position: UNF

SB0845 – End-of-Life Option Act - AGAINST

Submitted by:

Gwenn Murray

706 Cypress Road

Severna Park, MD 21146

410.440.8005 gwenn.murray@hotmail.com

Why Oppose Senate Bill 845 and House Bill 933

End-of-Life Option Act?

There is no way to legislate adequate safeguards against the following major shortcomings:

- No mental health screening is required. There is nothing in the legislation to protect people with mental illness or depression.

- Individuals can become a victim of elder abuse under this legislation as one of the witnesses can be a family member. A family member who stands to gain after death could see this legislation as a means to an end and apply undue pressure. An heir can actually serve as a witness for the request for the lethal prescription.

- Individuals may not want to be viewed as a burden to family members and feel pressured to choose death.

- There are no safeguards for the disabled. This legislation poses serious danger to those with disabilities as these individuals often feel that they are a burden throughout their entire life and are frequently coerced into making decisions that are not in their best interest because they are lead to believe it will relieve a health care provider or family member.

- There is no way to predict accurately a 6 month lifespan. Terminal illness is often difficult to predict and patients frequently outlive them. Further there is evidence that many non-terminally ill patients receive the lethal prescription in states that have similar legislation.

- There is no one required to be present at the time of death and so there is no witness to ensure that an individual will not be pressured to take the pills or that the person that is going to take the pills is able to self-administer the lethal dosage willingly.

- This type of legislation is often presented as a solution to intense pain however in states that have this legislation pain is not given as the reason selected to terminate one's life. Palliative care and hospice services can and do alleviate the pain and suffering of patients. I have personally witnessed family members on palliative care and hospice care that have relatively unlimited access to pain killers including morphine as needed.

- Overdosing on barbiturates does not necessarily lead to a peaceful death. Overdosing on barbiturates has caused documented cases of persons vomiting while becoming unconscious and then aspirating the vomit. People have begun gasping for breath or begun to spasm. Overdosing on these drugs can cause feelings of panic, terror, and confusion. There have also been cases of the drugs taking days to kill the patient. There is no requirement for nurse or doctor to be present at time of death.

- It is nearly impossible to punish physicians for abuses under this legislation because the legal threshold is lowered from that of regular malpractice to good faith.

- Death certificates are falsified under this legislation, listing only the underlying illness as the cause of death, making the real number of suicides unknowable.

- People in poverty can be coerced into ending their lives when health insurance providers including Medicaid refuse to providing treatment and are able to recommend lethal prescriptions. Insurers continue to deny life-saving medical treatment and cover cheap lethal drugs where this type of legislation is legal.

- Pharmacists are not required to counsel patients on proper ingestion methods or on the safe disposal of the lethal barbiturates. There is no drug take-back plan for unused lethal pills. Highly addictive barbiturates go unaccounted for in a state already fighting against drug addiction.

- There is no family notification required.
- Overall suicide rates increase where states have this type of legislation.
- The state can't truly punish violations. Doctors are held to a 'good faith standard' which is far lower than the malpractice standard applied to other health providers.

This seems to be an issue which affects the elderly or sick, however this type of legislation will affect everyone in Maryland. Anyone can become sick or injured. Even if the illness or injury isn't terminal, assisted suicide has shown to threaten those seeking wanted treatment. This type of legislation empowers public and private insurance providers to reject potentially expensive wanted healthcare. Sadly, ending the life of a patient can be less paperwork and cost than treating the patient, forever damaging access to wanted healthcare and generating suspicion between patients and their doctors. There are better ways to help Marylanders improve their end-of-life care than this dangerous legislation.

Please vote against SB845.

SB845 Oppose.pdf

Uploaded by: Hindley Williams

Position: UNF

Maryland
Independent Living
Network

SB845— End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Oppose

Testimony of Maryland Centers for Independent Living

Senate Judicial Proceedings, March 7, 2023

The seven Centers for Independent Living (CIL) were established by federal law and work to ensure the civil rights and quality services of people with disabilities in Maryland. Centers for Independent Living are nonprofit disability resource and advocacy organizations located throughout Maryland operated by and for people with disabilities. CIL staff and Boards are at least 51% people with disabilities. We are part of a nationwide network which provides Information and Referral, Advocacy, Peer Support, Independent Living Skills training, and Transition Services.

The Maryland Centers for Independent Living know that all lives are worth living. If legalized, this bill would endanger all vulnerable populations, such as the elderly and people with intellectual and developmental disabilities, opening the door for abuse and coercion. It would allow Maryland doctors to prescribe a lethal drug overdose to patients deemed to be terminally ill with less than six months to live. The range on negative possible outcomes makes this bill dangerous rather than compassionate, and it destroys dignity rather than preserving it. It has the potential for exploiting the disparities within our healthcare system in the most heinous way imaginable. Vulnerable, ill people would have the option to choose death because of feeling like a burden on family, friends, and support rather than basing that choice on their dignity and value. Doctors' terminal diagnoses are hypotheses at best, and they are not accurately able to predict timelines, thus opening the possibility for ending life prematurely. There are no safeguards that can truly protect against the coercion and abuse of vulnerable populations that would surely occur if this bill is passed. The Maryland Centers for Independent Living do not support this bill because it fails to consider the impact it would have on vulnerable populations and those living with various illnesses.

Contact Information:
Sarah Basehart
Independence Now
240-898-2183
sbasehart@innow.org

Hindley Williams
The IMAGE Center
410-305-9199
hwilliams@imagemd.org

2023 Opposition to Physician Assisted Suicide SB84

Uploaded by: Holly Dahlman

Position: UNF

Holly Ryerson Dahlman, MD, FACP
Green Spring Internal Medicine, LLC
2360 W Joppa Road – Suite 210
Lutherville, MD 21093

March 4, 2023

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

Dear Honorable Senate Judicial Proceedings Committee Member:

My name is Holly Ryerson Dahlman, MD, FACP. I am a graduate of the Johns Hopkins University School of Medicine and trained in internal medicine at the Johns Hopkins Hospital. I am CEO, owner, and lead physician of Green Spring Internal Medicine, a small independent primary care practice in Lutherville. I am writing in opposition to SB 845.

Health insurance companies have profited handsomely by not spending money on healthcare. Significant obstacles to patient care already exist in the form of prior-authorizations and denials. Here in Maryland, the Total Cost of Care Model began in 2019, a model which incentivizes hospitals to lower healthcare costs. Accountable Care Organization (ACO) models throughout Maryland are also incentivizing physician practice groups to achieve shared savings in healthcare. In other words, practices like mine are given a yearly bonus when we have reduced costs across a population of patients.

Life-saving care is often expensive. This is not the time for the low-cost death option! To permit medically-prescribed death would be to open the way to an entirely unmanageable set of financial conflicts of interest for insurance companies, hospitals, and medical practices. What will be the priority in healthcare: profitability or people?

To cast this issue as “compassion and choices” is deceptive. What is being debated is a prescription for death. The medical profession is full of compassionate doctors who offer choices to our patients every day. In primary care, we help our patients throughout their lives, even to the end. “MAID” (or “Medical Aid in Dying”) deceives the public as a term since help is already available for terminally ill patients, including home-based and inpatient hospice care.

Personal autonomy must be weighed against other medical ethics such as beneficence, non-malevolence, and social justice. Autonomy of an individual should not come at the expense of another person or group of people. The following individuals would be at greatest risk of harm if physician-assisted suicide were to be legalized in Maryland: people unable to afford healthcare or medication, elders believing they are a burden, those wanting to avoid health costs in order to leave an inheritance, the lonely, the chronically ill, patients with weary caregivers, and people living with disability.

The “Right to Die” is tied to this legislation. It is false to imply that this form of autonomy depends upon legalizing physician-assisted suicide (PAS). Autonomy already exists in the rights of patients to decline medical treatment or to discontinue it. For physicians and healthcare teams to stand out of the way of the natural dying process is fundamentally and unalterably ethically different than to act with the intent to prescribe death. Most physicians in states where PAS has been legalized have refused to participate.

Professional physician organizations oppose PAS. I am a member of the American College of Physicians (ACP), the largest organization of internal medicine doctors in the United States, representing over 160,000 physicians. The ACP opposes physician-assisted suicide. I have attached our ethics paper on this topic.

This is no time for Maryland to legalize physician-assisted suicide. It is ironic that there is a push to enable physicians to prescribe death at a time when our great State of Maryland is reeling from opioid overdose death and suicide epidemics, both of which preceded but have worsened during COVID times. The desire to end life is often a symptom of severe mental illness. As my clinical experience has also taught me, the wish to die may be transient.

Terminal illness remains difficult to define precisely. Patients whom I thought would die within months have lived for years. Some conditions such as Parkinson's disease have been used to push the case for physician-assisted suicide. Yet, degenerative conditions have a long disease trajectory. In other countries where PAS was legalized, euthanasia has followed. At which point would terminal illness or even personal consent be cast aside as requirements? One should look to Europe and Canada for modern examples.

What is good, or beneficent, at the end of life is to provide high-quality, patient-centered care. Hospice care should be available for all Marylanders. We need to continue to improve the systems which help terminally ill patients and their families in the settings of their preference. In my practice, we have increasingly supported patients at the end of life with the help of home hospice. Hospice care needs ongoing investment to improve access and quality. This includes the need to study symptom management in terminal illness. Better hospice care should dissolve all demand for physician-assisted suicide by providing assurance to our society that physicians and other healthcare workers will labor to relieve suffering while shaping treatment plans around patient goals.

In summary:

- Because of financial conflicts of interest in healthcare, we must not allow the low-cost death option to be legalized in the State of Maryland.
- Compassionate care centered on patient goals at the end of life already exists, within the limits of what is beneficial and not harmful.
- Personal autonomy has limits where harm to others is involved. Physician-assisted suicide threatens vulnerable populations.
- The "Right to Die" does not depend upon the existence of PAS.
- Amidst an opioid overdose epidemic, this is not the time to release more dangerous drugs into society.
- Amidst a suicide epidemic, this is not the time to signal ending one's own life as a favorable option.
- Standing out of the way of the natural dying process is ethically distinct from actively prescribing or administering death.
- Most physicians in states where PAS has been legalized have refused to participate
- The American College of Physicians opposes physician-assisted suicide.

- Defining terminal illness is inexact.
- Voluntary physician-assisted suicide opens the door to euthanasia, including involuntary euthanasia.
- Hospice care makes physician-assisted suicide unnecessary.

What is just, what is good, what avoids wrong, what is safe, and what is wise must be at the forefront of every consideration in healthcare. Though other states have legalized physician-assisted suicide, this would not be good for Maryland. Please do not vote in favor of this dangerous bill!

Professional regards,

Holly Ryerson Dahlman, MD, FACP
CEO, Owner, Physician
Green Spring Internal Medicine, LLC

ACP Position Paper on Ethics and the Legalization

Annals of Internal Medicine POSITION PAPER

Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper

Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH*; for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians

Calls to legalize physician-assisted suicide have increased and public interest in the subject has grown in recent years despite ethical prohibitions. Many people have concerns about how they will die and the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Some have advocated strongly, on the basis of autonomy, that physician-assisted suicide should be a legal option at the end of life. As a proponent of patient-centered care, the American College of Physicians (ACP) is attentive to all voices, including those who speak of the desire to control when and how life will end. However, the ACP believes that the ethical arguments against legalizing physician-assisted suicide remain the most compelling. On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient–physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities regarding other issues and the physician's duties to provide care based on clinical judgment, evidence, and ethics. Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. The ACP remains committed to improving care for patients throughout and at the end of life.

Ann Intern Med. doi:10.7326/M17-0938 **Annals.org**
For author affiliations, see end of text.
This article was published at Annals.org on 19 September 2017.

How we die, live, and are cared for at the end of life is important, with implications for individuals, their families, and society. The 1997 report *Approaching Death: Improving Care at the End of Life*, by the Institute of Medicine (IOM), documented inadequate end-of-life care in the United States (1). The investigators of SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment; 2000) agreed (2, 3). The emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining—physically, emotionally, and financially—for patients and their families. Many people have concerns about death. At the end of life, some patients receive unwanted care; others do not receive needed care (4–6). Some end-of-life concerns are outside of medicine's scope and should be addressed in other ways. Although medicine now has an unprecedented capacity to treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle with getting it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revisiting these issues in 2014, the IOM's *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* reported that challenges remain in delivering quality end-of-life care to a growing and diverse elderly population, especially with regard to access to care, communication barriers, time pressures, and care coordination (7). Inadequate reimbursement and other disincentives also are barriers to palliative and hospice care.

Hospice and palliative care may ease apprehension about the dying process. Such care requires improving access to, financing of, and training in palliative care; improving hospital, nursing home, and at-home capabilities in delivering care; and encouraging advance care planning and openness to discussions about dying. Of note, 90% of U.S. adults do not know what palliative care is; however, when told the definition, more than 90% say they would want it for themselves or family members if severely ill (4).

Within this context of challenges in providing palliative and hospice care, a few U.S. jurisdictions have legalized physician-assisted suicide. This paper presents the position of the American College of Physicians (ACP) on the topic. The ACP recognizes the range of views on, the depth of feeling about, and the complex-

See also:

Related article 1
Editorial comment 2

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* This paper, authored by Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH, was developed for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Individuals who served on the Ethics, Professionalism and Human Rights Committee at the time of the paper's approval were Carrie A. Horwitch, MD, MPH† (*Chair*); Omar T. Atiq, MD† (*Vice Chair*); John R. Ball, MD, JD†; Nitin S. Damle, MD, MS†; Pooja Jaleel, BA†; Daniel B. Kimball Jr., MD†; Lisa S. Lehmann, MD, PhD†; Ana María López, MD, MPH†; Paul S. Mueller, MD‡; Alexandra Norcott, MD†; Sima Suhas Pendharkar, MD, MPH†; Julie R. Rosenbaum, MD†; Molly B. Southworth, MD, MPH†; and Thomas G. Tape, MD†. Approved by the ACP Board of Regents on 27 March 2017.
† Nonauthor contributor.
‡ Author.

ity of this issue. This executive summary is a synopsis of the ACP's position. See the **Glossary** for definitions and the **Appendix** for the full position paper.

METHODS

This position paper was developed from September 2015 to March 2017 on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper; the paper was then reviewed by members of the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, Council of Subspecialty Societies, Patient Partnership in Healthcare Center and Advisory Board, and other committees and experts. The paper was revised on the basis of comments from the aforementioned groups and individuals, reviewed again by the full leadership, and then revised further. Finally, the ACP Board of Regents reviewed the paper and approved it on 27 March 2017. Financial support for this project is exclusively from the ACP operating budget.

BACKGROUND AND BRIEF RATIONALE

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). This issue also has been considered every few years in the *American College of Physicians Ethics Manual*, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient–physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients on the basis of the ethical principles of beneficence (that is, acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient autonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient judges to be inconsistent with his or her goals and preferences. Death follows naturally, after the refusal, as a result of the underlying disease (9).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering (10). Proponents view physician-assisted suicide as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort, that physicians should not participate in intentionally ending a person's life, and that physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter (12, 13).

Both sides agree that patient autonomy is critical and must be respected, but they also recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient–physician partnership. Only by this balancing of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write an illegal prescription, or breaches confidentiality to protect public health. It also undergirds the physician's duty not to engage in futile care (such as care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering. Both proponents and opponents of physician-assisted suicide wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other principles reflects ethical arguments about the nature of the patient–physician relationship—a relationship that is inherently unequal because of power differentials and the vulnerability of illness—physicians' duties, and the role of the medical profession in society. A fuller consideration of this ethical balance, intent and

Glossary

Suicide: The act of killing oneself intentionally.
Physician-assisted suicide: Physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).
Euthanasia: The act of intentionally ending a life to relieve pain or other suffering (e.g., lethal injection performed by a physician).

causation in acts near the end of life, medicalization versus personalization of death, and the ethics and implications of physician-assisted suicide are presented in the Appendix.

POSITION STATEMENT

The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and management of pain and other symptoms, and support for families. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

CONCLUSION

Society's goal should be to make dying less, not more, medical. Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life. On the basis of substantive ethics, clinical practice, policy, and other concerns, the ACP does not support legalization of physician-assisted suicide. This practice is problematic given the nature of the patient–physician relationship, affects trust in that relationship as well as in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities on other issues and the physician's duty to provide care based on clinical judgment, evidence, and ethics. Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter.

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Appendix and Expanded Rationale: Ethics and the Legalization of Physician-Assisted Suicide—An American College of Physicians Position Paper

Framing the Issues: Care Near the End of Life

We all will die. How we die—and live at the end of life—is important, with implications for individuals, their families, and society. How we are cared for at the end of life matters.

The groundbreaking 1997 report *Approaching Death: Improving Care at the End of Life*, by the IOM, documented inadequate end-of-life care in the United States (1). In 2000, the SUPPORT investigators agreed (2, 3). Although the cultural norm of fighting disease aggressively is the right approach in many cases, the emphasis by medicine, as well as society, on intervention and cure sometimes comes at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining—physically, emotionally, and financially—for patients and their families. Many of us have concerns or apprehensions about how we will die. Indeed, some patients receive unwanted care at the end of life, whereas others do not receive the care they need (4–6). Although medicine now has an unprecedented capacity to treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle to get it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revisiting these issues in 2014, the IOM report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* found that challenges remain in delivering quality end-of-life care to a growing and diverse elderly population, especially regarding access to care, communication barriers, time pressures, and care coordination (7). Inadequate reimbursement and other disincentives also create barriers to palliative and hospice care.

Appendix Table. U.S. Jurisdictions Where Physician-Assisted Suicide Is Legal

Where	When	How
Oregon	1997	Voter-approved ballot initiative
Washington	2008	Voter-approved ballot initiative
Montana	2009	Court decision*
Vermont	2013	Legislation
California	2015	Legislation
Colorado	2016	Voter-approved ballot initiative
District of Columbia	2016	Legislation

* A patient's request for physician-assisted suicide can be an affirmative defense for a physician who participates.

Wide agreement exists that hospice and palliative care may ease apprehension about the dying process. Such care requires improving access to, financing of, and training in palliative care; improving hospital, nursing home, and at-home capabilities in delivering care; and encouraging advance care planning and openness to discussions about dying. Of note, 90% of U.S. adults do not know what palliative care is, but when told the definition, more than 90% say they would want it for themselves or family members if severely ill (4).

Access to state-of-the-art symptom control remains limited for all dying patients. Of particular concern, evidence of ethnic and racial disparities in access, outcomes, and communication is increasing (5, 6). Many patients fear they will not receive appropriate end-of-life care when they need it. Others are concerned about being a financial, physical, or other burden on their family, losing autonomy or control, or being placed in a long-term care facility. Some are alone or lonely; loneliness has a mortality risk similar to that of cigarette smoking, yet its health implications are underappreciated (16). Many persons approaching death are clinically depressed or have other psychiatric comorbid conditions, and some contemplate suicide (17, 18). According to Wilson and colleagues, "the expression of a desire for death by a terminally ill patient should raise a suspicion about mental health problems; by itself, however, it is not definitively diagnostic of one" (17). This desire fluctuates over time (19, 20) and may be related to inadequate symptom management. Medicine can and should ameliorate many of these problems; some, however, are outside the scope or goals of medicine and should be addressed in other ways.

As challenges in providing palliative and hospice care continue, a few jurisdictions have legalized physician-assisted suicide (see the **Glossary** for definitions and the **Appendix Table** for U.S. jurisdictions with physician-assisted suicide laws). The ACP recognizes the range of views, depth of feeling, and complexity of the issue of physician-assisted suicide.

Revisiting Physician-Assisted Suicide

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). The issue also has been considered every few years in the *American College of Physicians Ethics Manual*, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient–physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

The Context

Physician-assisted suicide is medical help with a patient's intentional act to end his or her own life (for example, an individual taking a lethal dose of medication prescribed by a physician for that purpose). It is ethically, legally, and clinically different from patient refusal of life-sustaining treatment through the withdrawal or withholding of treatment. Physician-assisted suicide also differs from euthanasia, an act in which a physician intentionally terminates the life of a patient (such as by lethal injection), the purpose of which is to relieve pain or other suffering (8). Dictionaries define suicide as intentionally ending one's own life. Despite cultural and historical connotations, the term is neither disparaging nor a judgment. Terms for physician-assisted suicide, such as aid in dying, medical aid in dying, physician-assisted death, and hastened death, lump categories of action together, obscuring the ethics of what is at stake and making meaningful debate difficult; therefore, clarity of language is important.

Although suicide and attempted suicide have been decriminalized in the United States, assisting a suicide remains a statutory offense in most states. Euthanasia is illegal everywhere in the United States. In New Mexico, a lower-court decision authorized physician-assisted suicide, but it was struck down; like all appellate courts, the New Mexico Supreme Court ruled that there is no right to physician-assisted suicide. Elsewhere in the world, in 2015, the Parliament of the United Kingdom voted down a physician-assisted suicide bill, 330 to 118, and Canada legalized both physician-assisted suicide and euthanasia. In 2016, the Parliament of South Australia rejected a bill on euthanasia. Physician-assisted suicide and euthanasia are legal in the Netherlands, Belgium, and Luxembourg; euthanasia is legal in Colombia; and Switzerland has decriminalized assisted suicide.

Principles of Medical Ethics and Arguments, Pro and Con

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients based on the ethical principles of beneficence (acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient autonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient considers unduly burdensome and inconsistent with his or her health goals and preferences. Death follows naturally after the refusal, due to the underlying disease (9).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering. The decision to intentionally end one's life is regarded as intensely private and therefore should not be prohibited (10). Seeking physician-assisted suicide is most frequently associated with concerns about loss of autonomy and control, decreasing ability to participate in enjoyable activities, and loss of dignity, rather than pain or other symptoms (21, 22). For persons who seek this type of control, palliative and hospice care are not the issue—they often are already receiving those services. In Oregon, the state with the most experience, 1327 persons have obtained prescriptions for lethal doses of medications under the law since 1997; 859 died after taking the medication. Of 105 deaths during 2014, 68% occurred in persons older than 65 years, 95% were white, 56% were men, 48% were persons with a baccalaureate degree or higher, and 69% had cancer (21). More recent justifications present physician-assisted suicide as a personal choice, avoiding discussion of important medical ethics considerations (11).

Proponents of physician-assisted suicide view it as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). In support of legalization, they also argue that some patients receiving a lethal prescription ultimately do not use it. In addition, some maintain that physician-assisted suicide already occurs where it is illegal (23), so legalization would result in standardization, transparency, and monitoring.

Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort and that physicians should not participate in intentionally ending a person's life (12). Physician-assisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter

(13). Pronouncements against physician-assisted suicide date back to Hippocrates.

Opponents agree that patient autonomy is critical and must be respected but recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient–physician partnership. Only by such a balance of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write illegal prescriptions, or breaches confidentiality to protect public health. It also undergirds the duty that physicians not engage in futile care (for example, care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

Death certificate requirements under physician-assisted suicide laws ask physicians to list the cause of death as the underlying illness, not the new pathology caused by ingestion of a lethal dose of medicine (24), which seems inconsistent with the physician's duty of honesty. Moreover, although individual physicians may decline to participate, conscientious objection to physician-assisted suicide does not address the fundamental ethical objections to it.

The suffering of dying patients may be great; it is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering; attempting to do so ultimately leads to bad medical care (25). Good medicine demands compassion for the dying, but compassion also needs reason (26). Both proponents and opponents wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other ethical principles reflects arguments about the nature of the patient–physician relationship, physicians' duties, and the role of the medical profession in society. In fact, one may argue that making physicians arbiters of assisted suicide is a return to paternalism and not a power physicians should want (27), that "the legalization of physician-assisted suicide does not empower patients; it empowers physicians" (28).

Legalization of physician-assisted suicide also raises social justice issues. Society and the medical profession have duties to safeguard the patient–physician relationship and human dignity. These duties apply especially to the most vulnerable members of society: the sick, the elderly, children, the disabled, the poor, minorities, and others. Some individuals might view themselves as unproductive or burdensome and, on that basis, as candidates for assisted suicide, especially if a physician raises it or validates a request. Physician-assisted suicide laws have been associated with a 6% increase in total suicides (15% in those older than 65 years) in the states where physician-assisted suicide is legal, controlling for state-specific time trends (29, 30). Although a recent study did not find vulnerable groups being pressured to accept physician-assisted suicide, it did raise questions about a lack of data on complications and on how many physicians may have assisted without reporting (31). Vulnerable communities and individuals raise strong concerns that legalization leads to attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living (32, 33). National disability groups are opposed to physician-assisted suicide (32, 34). One article reported various opinions among focus group participants (35). Finally, advocating for physician-assisted suicide where there is no general right to health care and access to hospice and palliative care services is limited, especially in an era of health care cost containment, is ironic (8).

Ethics and the Nature of the Patient–Physician Relationship

The ACP's main concerns in this debate are ethical ones. The patient–physician relationship is inherently unequal. Physicians have specialized medical knowledge, training, experience, and prescribing powers that patients do not. Illness makes patients vulnerable (including physicians who are patients [36, 37]). Patients disrobe, are examined, and disclose intimate information to their physicians. The physician must earn the patient's trust, preserve his or her confidentiality, and act as a fiduciary. Physicians publicly profess that they will act for the benefit of their patients, putting patients' welfare and best interests first and helping them cope with illness, disability, suffering, and death. The physician has a duty to respect the dignity and the cultural and spiritual uniqueness and traditions of every patient (9).

Physician-assisted suicide and euthanasia were common during the time of Hippocrates, leading to their specific prohibition in the Hippocratic Oath (38). Together with the prohibition of sexual relationships between physicians and patients and the duty to maintain patient confidentiality, the Oath provides a context for a therapeutic alliance to prevent the exploitation of patient relationships.

The Hippocratic Oath, of course, is not followed word for word today; however, it has been analyzed and applied over time in light of its fundamental principles. Acting in the best interests of the patient and recognizing the special nature of the patient–physician relationship, principles and prohibitions set ethical boundaries to prevent misunderstandings and misuse of medical authority. These boundaries encourage patients to be open and honest regarding intimate health matters in a safe space, in the context of a trusted relationship.

Physicians can influence patients, even in ways physicians may not appreciate. Patients seeking physician-assisted suicide may seek validation to end their lives. Indeed, studies have shown that socially isolated, vulnerable persons seek social support and contact through visits with their physicians (16). Physicians may influence patients based on their own fears of death and disability (39). Evidence also suggests that many physicians who participate in physician-assisted suicide are adversely affected by the experience (40). Some commentators question whether assisted suicide needs to be physician assisted and whether others might provide assistance instead (41).

The Ethics of Refusal of Treatment and Providing Symptom Control: A Closer Look at Intent and Causation

For decades, the consensus has been that after a careful weighing of patient autonomy, beneficence, nonmaleficence, and societal interests, a patient may forgo life-sustaining treatment. Although Hippocratic writings explicitly proscribe euthanasia and physician-assisted suicide, they deem treatment abatement ethically appropriate in patients who are "overmastered by disease" (42). Although some lower courts have questioned the importance of this distinction (43), the U.S. Supreme Court has distinguished the refusal of treatment from suicide (44, 45). Withdrawal of treatment based on patient wishes respects the patient's bodily integrity and right to be free of unwanted treatment. Physician-assisted suicide and euthanasia are interventions done with the intent to end the patient's life (46, 47). This distinction is ethically and legally important (9).

Some argue that withdrawing treatment on the basis of patient wishes—an omission, such as forgoing a mechanical ventilator in a patient with respiratory failure—and prescribing a lethal dose of medicine for the patient's use—a commission—are equivalent, because they both are acts that lead to the patient's death. However, commission (doing something) versus omission (not doing something) is not alone determinative. Withdrawing ventilator support is an act, but the act merely removes an intervention that prevented a preexisting illness from running its course. The aim of the act is not to terminate the patient's life (47). Intent and causation are critical factors in distinguishing physician-assisted suicide from withdrawal of life-sustaining treatment.

Death may be accelerated if a patient requests withdrawal of a life-sustaining treatment and that request is carried out. However, the patient could have refused the treatment when it was originally offered; therefore, he or she may request its withdrawal after it is started. If not for the intervention to which the patient consented, death would have occurred as a result of the underlying disease. As the International Association for Hospice and Palliative Care, citing the European Association for Palliative Care, stated, "Withholding or withdrawing ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments does not constitute euthanasia or PAS [physician-assisted suicide] because it is not intended to hasten death, but rather indicate the acceptance of death as a natural consequence of the underlying disease progression" (48).

The intent of treatment refusal is freedom from an unwanted intervention. A natural death follows due to the underlying disease (in fact, imposing unwanted treatment is a bodily invasion and is considered unethical and an illegal battery). In contrast, if a person disconnects a ventilator without patient consent and the patient subsequently dies, that person has acted wrongly. In both instances, the patient dies after withdrawal of life-sustaining treatment, but in very different ways under ethics and the law. Death by medication overdose is not a natural death due to an underlying medical condition.

Research advances have introduced new life-sustaining technologies into clinical practice. For example, many patients have life-sustaining devices, such as pacemakers, implantable cardioverter-defibrillators, and ventricular assist devices. Physicians inevitably encounter patients whose underlying disease no longer is being treated effectively by the device or who have a terminal illness the device cannot treat (such as cancer). Desiring a natural death, patients or their surrogates may request withdrawal of therapies delivered by these devices. In these situations, the death that follows is due to the underlying heart disease or other comorbid conditions (49, 50). Physicians should honor these requests. However, without a firm line drawn between withdrawal of life-sustaining treatment and physician-assisted suicide, or because of confusion between the two, some physicians might consider discontinuation of these therapies as intentional killing and refuse to implement such requests. Patients and families often, but not always, see the line.

Intent and causation also are critical factors in providing pain or symptom relief. Competent provision of symptom control is an ethical duty (9). Patients often fear the prospect of unrelieved pain. Some physicians withhold pain medication because of ungrounded concerns that higher doses may accelerate death through respiratory suppression or that the patient may become addicted to the medication. Appropriate pain relief, however, rarely results in either (51, 52), and patients and families need to understand this (52). Under the rule of double effect, strong ethical support exists for increasing pain medication for terminally ill patients if the intent is to relieve pain, even if it might shorten life (9, 53, 54).

The rule of double effect holds that an action undertaken with the intent of achieving a benefit is morally acceptable even if it has a harmful side effect, provided that the harmful side effect is not intended, the side effect is not the cause of the benefit, and the benefit outweighs the harm. Vigorous management of pain and symptoms, such as dyspnea and nausea, at the end of life is ethical, even if the risk for shortening life is foreseeable, if the intent is to relieve those symptoms. The beneficial effects are pain and symptom control; the rare but potential harmful effect is respiratory suppression, but it is not intended. If the intent was to cause death, or to cause death to relieve pain, it would not be permissible. Likewise, it would not be in keeping with the rule of double effect to use pain control to "treat" loneliness, depression, being tired of living, or existential suffering.

Law and Ethics: U.S. Supreme Court Decisions on Assisted Suicide

Although the language of rights is sometimes invoked, there is no right to physician-assisted suicide in the United States. In fact, in landmark decisions, the U.S. Supreme Court overruled 2 lower courts that had found a constitutional right (45, 55). The lower-court rulings differed in important ways. In *Compassion in Dying v. Washington* (56), the U.S. Court of Appeals for the Ninth Circuit had held that persons have a right to choose how and when they die. As applied to the limited circumstance of the competent, terminally ill adult who wants a physician's prescription for a lethal dose of medication, the Washington State criminal statute banning physician-assisted suicide was found unconstitutional as a violation of the Due Process Clause of the 14th Amendment, which says a state may not "deprive any person of life, liberty, or property without due process of law."

In contrast, in *Quill v. Vacco* (43), the U.S. Court of Appeals for the Second Circuit specifically declined to "identify a new fundamental right." It said a New York law was unconstitutional on much narrower grounds, as a violation of the Equal Protection Clause of the 14th Amendment, because competent patients at the end of life were being treated differently: Some patients could refuse life-sustaining treatment and thereby accelerate death, but others were prohibited from seeking prescriptions from physicians to hasten death. The Equal Protection Clause says that no state shall "deny to any person within its jurisdiction the equal protection of the laws."

The U.S. Supreme Court found both lower-court decisions unpersuasive. Instead, it found refusal of treatment and physician-assisted suicide to be very different. Refusal of treatment, the Court concluded, means being free of the bodily invasion of unwanted medical treatment—a right to be left alone, not a right *to* something. This is a "negative right"—a form of right of which Americans have many—and differs from a positive right to secure assistance to kill oneself and control the manner and timing of death. Lending support to the rule of double effect, Justice Sandra Day O'Connor pointed out in her concurring opinion that vigorous pain control for the dying is ethical and available: " . . . a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death." This would include what some refer to as palliative sedation or terminal sedation, although a more accurate term would be double-effect sedation.

The U.S. Supreme Court ruled that there is no constitutional right to assisted suicide and that states may prohibit it. However, the Court also left open the possibility that individual states could legalize it.

Slippery Slopes

Although the ACP's fundamental concerns are based on ethical principles, research suggests that a "slippery slope" exists in jurisdictions where physician-assisted suicide and euthanasia are legal. In the Netherlands, requests are granted for patients whose "medical condition" is categorized as "tired of living." Many patients report "loneliness" and "psychological suffering" as symptoms (57). One study found that persons receiving euthanasia or physician-assisted suicide in the Netherlands for psychiatric disorders were mostly women with complex and chronic psychiatric, medical, and psychosocial histories, and disagreement about patient eligibility among physicians was not unusual (58, 59). In Oregon, referrals for psychiatric evaluations have been infrequent (60); in 2014, only 3 of 105 persons who died under the law were referred for formal psychiatric or psychological evaluation. In a study from Belgium, death by euthanasia increased from 2% in 2007 to 5% in 2013. Similarly, approvals of euthanasia requests increased from 55% in 2007 to 77% in 2013 (61). An editorial said these trends were "worrisome" and "require that [the slippery-slope concern] be taken very seriously" (62).

A recent review found that safeguards and controls in jurisdictions where physician-assisted suicide and euthanasia are legal are not always followed (63), and concerns have been raised about underreporting (31). Subtle long-term changes in attitudes are difficult to detect. For example, although only a small number of persons have requested physician-assisted suicide in Oregon, as noted earlier, questions arise regarding whether that fact lessens these and other concerns.

Limiting physician-assisted suicide to the terminally ill is said to be a safeguard, but prognostication raises practical concerns. Laws such as Oregon's require a consultation from a second physician to confirm the diagnosis and prognosis. However, predicting how long a terminally ill patient will live or to what extent cognitive capacity will be impaired by disease or injury often is difficult. In addition, many patients do not have long-standing relationships with physicians who know them well. Furthermore, current safeguards are likely to be challenged. Restricting physician-assisted suicide to terminally ill adults with decision-making capacity raises legal concerns about arbitrary discrimination (64). Fairness, it may be argued, would require granting access to decisionally incapable and non–terminally ill persons. Also, because some patients cannot take pills, arbitrary discrimination could be asserted, unless the practice is broadened from physician-assisted suicide to euthanasia.

Dying Well: Moving From Medicalization to Personalization of Death

Is a medicalized death a good death? Have we already gone too far down a path in which dying patients receive unwanted technology in the intensive care unit while their family members are regarded as "visitors"? Is the solution medicalization of death through medication overdose? Physician-assisted suicide is not a therapy. It runs counter to the goal of the patient rights movement to empower patients to experience a more natural death.

Medicalizing death does not address the needs of dying patients and their families. What is needed is care that emphasizes *caring* in the last phase of life, facilitating a natural dying process, and humanizing institutions that are used only when those settings are unavoidable. The 3 Wishes Project shows how even simple, nontechnologic approaches in the hospital intensive care unit can improve care, ease dying, enhance dignity, and give voice to patients and families while deepening the sense of vocation among clinicians (65). The 3 Wishes researchers said the project

> . . . aimed to integrate palliative care and spiritual care into critical care practice. Eliciting and honoring wishes fostered a community of caring, promoting patient- and family-centeredness as a core component of palliative care. It encouraged the verbalization and realization of unmet spiritual needs, whether secular or faith-based. Our findings underscore the drive that we all have to search for meaning, memories, and closure in anticipation of death while helping to create preparedness, comfort, and connections during the dying process (65).

In "A Modern Ars Moriendi," a physician recounts the death of her rancher father, noting the challenges they faced trying to refuse hospital treatment. Ultimately, his wishes were met by going home and changing the "focus from life-prolonging technology to life-enriching community" (66). Earlier hospice care, avoiding the intensive care unit in the last month of life, and experiencing death at home are associated with family perceptions of better care for cancer patients (67). Studies have found regional variations in end-of-life care, with "little relationship to patient preference," but some evidence of lower-intensity care when the primary care physician is more involved in care (68). Longitudinal relationships should be valued and supported by health care systems and payers.

Home is where most patients want to die (69), and even the discontinuation of ventilators (70) or implantable cardiac devices (71) can be done compassionately and effectively at home with hospice care. This approach is more patient centered and a better use of resources when hospital care is not truly necessary. This is the control the medical profession can and should give patients and their families. Dying well requires science and an art of caring for the dying.

Medicine's Role in a Societal Decision

The ACP recognizes that some patient cases will be medically and ethically challenging, that autonomy-based arguments in support of legalization of physician-assisted suicide are compelling, and that some might find physician-assisted suicide justifiable in rare circumstances. Patients have the ultimate authority over their lives, but whether physicians should assist them in carrying out suicide is another matter.

Despite changes in the legal and political landscape, the ethical arguments against legalization of physician-assisted suicide remain the most compelling. We are mindful that ethics is not merely a matter for a vote. Majority support of a practice does not make it ethical. Medical history provides several cautionary examples of laws and practices in the United States (such as racial segregation of hospital wards) that were widely endorsed but very problematic.

Furthermore, the ACP does not believe neutrality on this controversial issue is appropriate. The medical profession should not be neutral regarding matters of medical ethics (9). The ACP is not neutral on practices that affect the patient–physician relationship and trust in the profession, such as laws that restrict or mandate discussions with, or certain recommendations for, patients. According to the *American College of Physicians Ethics Manual*, physicians have a duty to come forward, to "clearly articulate the ethical principles that guide their behavior in clinical care, research, and teaching, or as citizens or collectively as members of the profession. It is crucial that a responsible physician perspective be heard as societal decisions are made" (9).

A few patients want to control the timing and manner of death; many more are fearful of what living the last phase of life with serious illness will be like. To the extent that the debate about legalizing physician-assisted suicide is a dilemma because of the failings of medicine to adequately provide comfort and good care to dying patients, medicine should do better. Legalized physician-assisted suicide medicalizes suicide (72). Physician-assisted suicide is not a private act but a social one, with effects on family, community, and society.

Responding to Patient Requests for Assisted Suicide

Etymologically, to be compassionate means to "suffer with" another person; remaining with a dying patient is the essence of nonabandonment (73). When the patient's suffering is interpersonal, existential, or spiritual, care coordination is necessary, and the roles of the physician are to remain present; provide compassionate care; and enlist the support of social workers, psychologists, hospice volunteers, chaplains, and family in addressing sources of suffering that are beyond the scope of medical care.

Regardless of jurisdiction, physicians may encounter patients who request physician-assisted suicide (or express fear of suffering with death). Patient concerns and reasons for the request should be discussed thoroughly. As for all patients nearing the end of life, the physician should:

1. Be present (74), listening to the patient and keeping dialogue open, exploring the reasons for the request, trying to understand its meaning and seeking alternative solutions where possible.
2. Affirm that he or she will care for and not abandon the patient, accompanying and advising the patient through the journey of end-of-life care (studies suggest "the desire to hasten death is future focused and appears to be related to fear of distress and not coping, rather than with current levels of distress or coping ability" [75]).
3. Discuss patient goals of care and the nature of curative and comfort care, explaining a both/and approach to disease-oriented and palliative care as well as an either/or approach and asking, for example, how do you hope I can help you?
4. Facilitate advance care planning and an understanding of surrogate decision making, as desired by the patient.
5. Ensure that the patient is fully informed of the right to refuse treatments and what that entails.
6. Discontinue or do not start medications and interventions that interfere with the patient's values, goals, and preferences.
7. Assess and treat the patient's pain and other distressing physical and psychological symptoms.
8. Assess and optimize patient function through a whole-patient focus.
9. Coordinate, as desired by the patient, the efforts of other members of the health care team, and use community-based resources to address financial, emotional, and spiritual burdens on the patient and family.
10. Prepare the patient and family for what they can expect as illness progresses, addressing uncertainty together and ensuring that the patient and family have informed expectations, including, for example, an understanding that advanced illness often entails a natural loss of appetite and thirst.
11. Regularly assess the patient's status and decision-making capacity.
12. Arrange hospice care at home if that is the patient's preference, being cognizant that palliative and hospice care expertise should be used as early as is indicated. Many patients in the United States receive such care too late or not at all.

Requests for physician-assisted suicide are unlikely to persist when compassionate supportive care is provided (76, 77). However, providing this care may be challenging, especially in today's time-pressured health care environment. It requires us to reflect and act on " . . . the original purpose of physicians' work: to witness others' suffering and provide comfort and care . . . the privilege at the heart of the medical profession" (78).

Physicians should consult with colleagues in caring for the patient and family but also seek support for themselves. According to Kearney and colleagues, "Self-care is an essential part of the therapeutic mandate" (79). Collegial support also reinforces better care of the patient and family. Describing a phone conversation with a colleague about the shared care of a patient, a physician reflects that it was, "A call whose sole but worthy purpose was to say, 'I feel powerless, and I know you do, too, so let's talk this over.'" Yet, it " . . . allowed two physicians to share . . . and reconcile to the inevitable. All too often, we announce our triumphs but camouflage our losses, as if the death of a patient represents a personal failure. In hindsight, acknowledging the impending loss enabled appropriate palliation for the patient and timely pastoral care for her husband . . . " (80).

The need to ensure the central role of families in care; provision of consistent, high-quality care; and education, training, and support of physicians were identified as overarching themes in a series of reports on end-of-life care recently issued by the British Medical Association (81). The British Medical Association and Australian Medical Association both reaffirmed opposition to legalization of physician-assisted suicide and euthanasia in 2016.

Conclusion

The art of medicine is arguably most needed as patients live out the last phase of life. Society's goal should be to make dying less, not more, medical. The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all persons can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and the management of pain and other symptoms, and support for family. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter. Throughout patients' lives, including as they face death, medicine must strive to give patients the care, respect, and comfort they deserve.

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Dr. Janet Conway - SB845 Opposition.pdf

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Position: UNF

SB.845 - Opposition

I cannot believe this bill is being introduced again in Maryland. There are so many patient safety issues at stake. There are no protections for the patient against coercion by others, no protections against neglect in treating and diagnosing depression, and no protection against inaccurate diagnoses of terminal illnesses. The patient is in a weakened and debilitated state and should never be pressured internally or externally to end their life. It is at this point that hospice and palliative care are so important and can provide a loving and comfortable environment for patients to live their remaining days maximizing each moment with family and friends to die naturally and peacefully.

As a physician, it is my job to protect my patient. I was never taught to kill anyone in medical school. Asking a physician to assist in suicide is like asking the bus driver to run over the school children he was entrusted to protect. Life itself is so fragile, and tragically as we know from all the gun violence there are other ways to end a life besides involving a doctor- the one person whose job it is to ensure patient protection and physical well-being. I am adamantly opposed to this bill.

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John Kelly Testimony Maryland SB 845 March 2023.pd

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Position: UNF

SECOND THOUGHTS MASSACHUSETTS
Disability Rights Advocates against Assisted Suicide

March 6, 2023

SB 845

"End of Life Options Act"

Senate Judicial Proceedings

Position: Oppose

I am the New England Regional Director for Not Dead Yet, the national disability rights group that has long opposed euthanasia and assisted suicide, and the director of Massachusetts Second Thoughts: Disability Rights Advocates against Assisted Suicide. Our opposition is based in universal principles of social justice that apply to everyone, whether disabled or not.

We ask that you reject SB 845 because it violates core tenets of public health policy. The bill would, predictably and inevitably, endanger the lives of innocent people. That’s because mistakes and abuse are impossible to prevent, and the harm – wrongful death – impossible to reverse.

SB 845’s definition of “terminal illness”– two doctors making the “reasonable medical judgment” that someone is “likely” to die within six months – is arbitrary and without clinical basis. It was borrowed wholesale from the Medicare hospice benefit established by Congress, which limited the benefit time period out of cost concerns.

The hospice definition of “terminal” established in-home services promoting living well in exchange for eschewing curative treatment. The “mistakes” that result in thousands of people “graduating” from hospice every year may result in continuity of care issues, but these people have their lives.

Assisted suicide advocates took a definition of terminal illness that was essentially a bureaucratic criterion and made it the linchpin of a program of a state-approved death. Mistakes that are innocent in hospice become tragic under assisted suicide. Indeed, every Oregon report shows that people dispensed lethal drugs were not actually terminal. In 2020, Oregon revealed that 4% of patients who have been prescribed lethal medication remain alive after 6 months. NPR reported five years ago that nearly 20% of people who enter hospice will be alive after six months. The difference between the 4% who are surviving now and the percentage of people who would be alive after six months – nearly 20% – the number of people who weren’t actually dying.

TV star Valerie Harper was told incorrectly she had 3 months to live because of brain cancer in early 2013, more than a year before Brittany Maynard’s diagnosis. Yet Harper was nowhere near her “end of life.” If, based on the false information given to her, Valerie had exercised her “right” to aid in dying, she could have died years earlier. Valerie Harper lived a total of six years after her diagnosis.

This committee should be skeptical when bill proponents talk of ideal, loving families, not when our news is full of the deeds of abusive, even murderous families and “friends.”

Under SB 845, abusers and criminals would be offered a no-questions-asked opportunity to engineer someone's death. Especially vulnerable will be the 10% of Maryland elders estimated to be abused every year, almost always by adult children and caregivers.

The Associated Press reported in 2013 that now-imprisoned Oregon realtor

> Tami Sawyer also faces charges of criminal mistreatment and theft as a result of a state charge that she stole more than $50,000 after a man [Thomas Middleton] who suffered from Lou Gehrig's disease moved into her home, named her his estate trustee, deeded his home to a trust, and then died by physician-assisted suicide.

Because no assisted suicide law requires an impartial witness to the death, we have no idea how Thomas Middleton really died. We do know that days later, Sawyer listed Middleton's property and then stole some of the proceeds. Her crimes came to light, not through any program safeguards, but by a federal investigation into suspicious real estate transactions. Only then, did the state draw up charges –later dropped.

Suspicious circumstances like Middleton's are not included in the Oregon reports. Even when there is evidence of abuse, Oregon has taken no action.

Wendy Melcher was killed by massive doses of barbiturate suppositories administered by two nurses, one of whom was having an affair with Wendy's partner. The nurses claimed that Melcher had requested assisted suicide, but there was no doctor's prescription, Wendy did not self-administer, and the nurses never reported her death to the Oregon Department of Health as an assisted suicide.

Yet instead of referring the nurses to authorities for criminal charges, the state nursing board secretly suspended one nurse's license for 30 days and placed the other on two years "probation." The killing only came to light years later when a departing member of the nursing board told the governor. It took a reporter's phone call to inform Melcher's devastated family that she had actually been killed.

It seems that the very existence of the assisted suicide law turned evidence of a serious crime into an excusable mistake. The Portland Tribune editorialized, "If nurses — or anyone else — are willing to go outside the law, then all the protections built into the Death With Dignity Act are for naught."

Coercion can come from every direction. Oregonian Kathryn Judson wrote of bringing her seriously ill husband to the doctor. "I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought)," she wrote. "To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher."

A belief common among people thinking of suicide, whether "conventional" or assisted, is that their deaths will benefit others. SB 845 reclassifies what should be evidence of impaired judgment as a rational response to disabling, serious illness.

But impairing judgment is what depression ***does***.

As Ruthie Poole of Massachusetts MPOWER testified:

> Those of us in MPOWER are very familiar with the insidious nature of depression. As a therapist once told me, depression does not cause black and white thinking; it causes black and blacker thinking. Absolute hopelessness and seeing no way out are common feelings for those of us who have experienced severe depression. Personally, as someone who has been suicidal in the past, I can relate to the desire for "a painless and easy way out." However, depression is treatable and reversible. Suicide is not.

The committee will certainly hear a lot of testimony describing deaths in which pain was not properly treated, but Oregon physicians report giving lethal drugs mainly due to psychosocial distress about disability. First is distress about dependence on other people ("losing autonomy" 93%), second is distress over lost abilities ("less able to engage in activities making life enjoyable" 92%), followed by feelings of shame and perceived/actual loss of social status ("loss of dignity" 68 %), distress about needing help with incontinence ("losing control of bodily functions" 47%), and despair at feeling unwanted ("burden on family and friends/caregivers" 54%)

These reasons suggest a meaning of dignity that depends not on everyone's inherent worth, but on an ability-based meritocracy. This sort of dignity is fragile and easily lost through disability. The people whose suicides are informed by these views, proponents admit, tend to be wealthier, better educated, and people with a strong preference for control. Their desire to hold onto this privilege is understandable, but it cannot justify a pro-suicide public policy that endangers everyone else.

The lives of non-"terminal" disabled people share many traits with people requesting assisted suicide, but we reject as bizarre and dangerous the notion that personal dignity is somehow lost through reliance on others, or because we are not continent every hour of every day. That's why for 50 years the disability rights movement has insisted on funded programs to provide necessary personal care attendant (PCA) services for all disabled people, including people disabled by their serious illness.

SB 845 would set up a two-tier system, under which some people get suicide prevention services while others get suicide assistance. The difference between the two groups would be based on value judgments about so-called "quality of life." Many of us already get told, straight to our face and through medical hostility, that we might be better off dead. Legalized assisted suicide makes that prejudice official policy.

Every leading national disability rights group that has taken a position on assisted suicide has come out against it.

Let's make sure that people have the choice and supports to live pain- and burden-free at home. As you consider SB 845, please think about Maryland residents, elders and disabled people who may be vulnerable and without the sort of support and control assisted suicide proponents take for granted, innocent people who will lose their lives because of this bad social policy.

Invidious quality-of-life judgments have no place in a democracy. Please reject this bill and the discrimination it promotes.

Thank you.

John B. Kelly
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Document 9 (5).pdf

Uploaded by: John Roswell

Position: UNF

I am adamantly opposed to SB845. Doctors cannot accurately tell when a person is going to die. For example, Steven Hawking was told at 21 years of age that he would only live for 2 years, but instead became a well-known scientist who lived 53 years beyond that life assessment. Look at what would have been lost if he had been encouraged to commit suicide instead of the productive life that he led. Only God knows the time of a natural death and giving terminally ill people loving care gives them and their death dignity, whereas giving them poison does not.

When humans decide that they can take lives' duration from Gods' hands they are stepping on a very slippery slope where abuse by insurance companies as well relatives will take place. Life and love are almost synonymous and to destroy life is to destroy love!

Both the US constitution and the Maryland Constitution were by their writers based on Divine Law which does not change and includes the words "Thou shall not kill!" This states Legislators all swear to an oath before this Divine Being to uphold the constitution and laws based on His Devine law.

John Roswell

Testimony opposing SB845.pdf

Uploaded by: Joseph Gillin

Position: UNF

This is my written testimony opposing SB798, the State Constitutional Abortion Amendment. I support the protection of human life at every stage and condition. Science tells us that human life exists during the nine months before birth.

Access to abortion is already part of current Maryland law, so implementing a constitutional amendment would be unnecessary. The "Maryland Freedom of Choice Act" (1991) allows abortion-on-demand, for any reason and up until birth. Maryland is one of only four states that forces taxpayers to pay for other people's abortions. Maryland is one of only three states that shield abortionists from liability by refusing to report abortion data to the CDC. As a result, Maryland is failing to address women's reproductive health and the incidents of abortion-related maternal injury and death or risks of future miscarriage, pre-term birth or loss of fertility.

Maryland currently has one of the highest rates of abortion in the country, while a majority of Marylanders believe there should be at least some reasonable restrictions on abortion. Public funding of abortion-on-demand is not supported by a majority of the public. The open-ended wording of HB705/SB798, if enacted by ballot, could even threaten the ability of pro-life pregnancy centers to serve pregnant women in need and deny medical providers their rights of conscience.

Pushing a constitutional amendment for unlimited abortion will further divide our state. This measure may be labeled by some as "progressive", but it would be antithetical to authentic human progress. Real progress is measured not by pitting mother against child, but by expanding the sphere of protection for both.

Our state needs to support both women and their children, starting at conception. This includes life-affirming healthcare and practical resources to address basic needs such as food, housing, work, and childcare that help them and us embrace the gift of life.

Again, please reject SB798, the State Constitutional Abortion Amendment.

Joseph P. Gillin

21 Castle Cliff Court, Silver Spring, MD 20904

LD14

MD Dr. Marine -Senate JPR Committee Testimony 3.7.

Uploaded by: Joseph Marine
Position: UNF

Joseph Marine, MD
Testimony to Senate Judicial Proceeding Committee
March 7, 2023
Re: Senate Bill 845 - "End of Life Option Act"
OPPOSE

Senator Smith and Honored Committee Members:

Good morning. My name is Joseph Marine. I am a cardiologist practicing with Johns Hopkins Medicine in Baltimore with over 18 years of experience caring for thousands of patients throughout the state of Maryland. As part of my job, I am responsible for overseeing cardiology patient quality and safety efforts for my health system. I am also a member of the American Medical Association, the American College of Physicians, and the Baltimore City Medical Society, all of which oppose the legalization of assisted suicide. The views expressed here are my own.

The End of Life Option Act represents shockingly dangerous and misguided public policy, which violates many basic principles of patient safety, and which does nothing to address the real needs of Maryland patients with advanced illnesses and disabilities.

Assisted suicide is not medical care. It has no basis in medical science, practice, or tradition. In states that have passed assisted suicide laws, very few physicians are willing to participate.[1] The lethal drugs used in assisted suicide have never been scientifically tested, and the US FDA has never approved any drugs for this purpose. The drug recipes for assisted suicide have been invented by the Euthanasia Movement, not the health professions.

Furthermore, we know that doctors practicing assisted suicide in other states have been performing uncontrolled, unregulated, and unethical experiments on human beings using combinations of cheaper drugs. This is because almost any drug, given in a high enough dose can serve as a poison. Tragically, these experiments have caused some patients to scream in pain and to take over 2 days to die.[2] This is not medical care, this is a disgrace. Experimentation such as this violates basic principles of medical ethics, including the Declaration of Helsinki, upon which most protocols for oversight of experimentation on human subjects are based.

We know that in other states with assisted suicide, some patients have taken up to 4 days to die, and that the drugs have failed to kill some patients.[3] We know that every other country with assisted suicide using pills has almost entirely abandoned it in favor of intravenous euthanasia because of complications and failure in up to 20% of patients.[4] The State of Oregon, which has had assisted suicide for 20 years, admits that in the 80% of cases with no witnesses to consumption of drugs, they have no idea if complications occurred.[3] Without witnesses, no one can know whether the drugs were self-administered or whether some patients were assisted to die in some other way.

We know that in states with assisted suicide, patients have lived up to 3 years after receiving a prescription, in violation of the law which requires a 6 months prognosis, with no accountability or consequences for the physician.[3] We also know that 15- 20% of US patients referred for hospice care survive their 6 month prognosis, 6% are found not to be terminally ill, and that doctors are even more inaccurate in prognosis in other settings.[5] All this means that we cannot know how many wrongful deaths are occurring in other states under this law.

We know that patients who qualify for PAS under this law have a 50-75% incidence of clinical depression, and that at least 1 patient, received a prescription in Oregon despite a history of severe depression and suicidality.[6-8] Yet in 2018, less than 2% of Oregon patients received a formal mental health evaluation - virtual proof that the law is being violated.[3]

The law can be routinely violated because it relies entirely on self-reporting, with broad legal immunity given to physicians, protection of records from discovery and subpoena, no witnesses to consumption of drugs, falsification of death certificates, and no routine audits, investigations, or supervision by an independent safety monitoring board.

The End of Life Option Act provides a new license for doctors to violate basic principles of medical ethics and to kill vulnerable patients with broad legal immunity and with no real oversight or accountability. It does not give any patients any new rights at all, and it takes away many basic legal protections.

What Maryland patients with advanced illnesses need is more support and greater access to excellent palliative and hospice care programs. We have some of the best health care in the world right here in Maryland. We should use it and not undermine our health care system with assisted suicide.

Thank you for hearing my testimony.

Joseph E. Marine, MD
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marinejoseph@hotmail.com

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MD Testimony.pdf
Uploaded by: Jules Good
Position: UNF

Legalizing assisted suicide, also referred to as medical aid in dying, will result in the coercion, endangerment and unnecessary death of too many Maryland residents with disabilities. I urge you to vote NO on SB 845.

Disabled people have been warning against the dangers of assisted suicide for decades. Reputable, secular, nonpartisan disability rights organizations such as the Disability Rights Education and Defense Fund, the National Council on Disability, the American Association of People with Disabilities, and many more publicly oppose the legalization of assisted suicide.

In the eyes of the state, everyone must be seen as having equal dignity, which legal assisted suicide undermines by promoting the idea that suicidality among disabled people is rational. Maryland policy should champion fully funded home and community-based services, for a caring society rooted in mutual aid and interdependence. Sick and disabled people need more resources to live, not more resources to die.

Assisted suicide laws lead to the denial of suicide prevention services to seriously ill and disabled people, a violation of the Americans with Disabilities Act's guarantee of equal program access. Assisted suicide laws redefine depression and feeling like a burden as "rational," rather than as evidence of impairment or need for intervention, as they would be for a non-disabled person. This means that sick and disabled people living with depression may be encouraged to consider assisted suicide under the same conditions that a non-disabled person would be offered mental health resources. Additionally, overall rates of suicide have been shown to increase in places where assisted suicide is legal, a phenomenon referred to as "suicide contagion".

In conclusion, legalizing assisted suicide in Maryland will further endanger the lives of an already vulnerable population. No amount of "safeguards" in the bill will protect disabled residents from dying prematurely if assisted suicide becomes legal in our cost-conscious healthcare system. I urge you to do everything in your power to prevent this bill from passing.

Against SB845.pdf

Uploaded by: Kathleen Basil

Position: UNF

Dear Senators,

I ask you to remember that law affects behavior indirectly. Others observe a new legal behavior, perceive its feasibility and absorb it as their own. Suicide accepted as a "compassionate choice" in one cross-section of the population will bleed into others. Over time, the legal rule becomes a behavioral norm influencing all cross-sections, medical and mental conditions, ages, as well as health and life insurance policies, medical practices, acceptable and "non-judgmental" options for care, families, schools, etc. The ripple is a tsunami and will have unattended, unimagined consequences.

I attend church and work on Wilkens Ave in the City of Baltimore. Senator Antonio Hayes is our senator, District 40. We serve a population that is often invisible to the upper echelons of Marylanders, but are people who for whatever reason, are dependent on society. I don't care how many "safeguards" you put in this bill, this population will not be safe from this allegedly compassionate, inexpensive, state sanctioned and probably recommended in many cases, option of care. The wherewithal of the Honorable Cummings and Pendergrass are not the lens to examine this question.

The legal rule becomes a behavioral norm influencing everyone. Please vote against this precedent in Maryland.

Kathleen Basil
Arnold, MD, District 33

FIRST THINGS

SUICIDE CONTAGION

by
Wesley J. Smith
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I have often argued that, as a matter of logic and intuition, the widespread legalization of assisted suicide will increase both the rate of assisted suicides and the rate of unassisted suicides. After all, many people conflate what is "legal" with what is "right." Once a state gives its imprimatur to assisted suicide as a way of alleviating suffering and providing "medical aid in dying," as it is euphemistically called, an ever-increasing number of people will resort to that means of ending their lives. And indeed, some recent studies suggest that in places where assisted suicide is legal, both assisted suicides and unassisted suicides increase.

Advocates of assisted suicide disagree, of course. One argument—which the media often parrots—holds that people with suicidal ideation not caused by terminal illness are unlikely to be influenced by legalization of assisted suicide because "medical aid in dying" is a treatment and not "suicide." This argument has never rung true for me. That is simply not how the human mind works, particularly when we are in extremis. It has always seemed to me that suicidal people are likely to think that society's approval of suicides for the terminally ill also applies to them, even if the cause of their existential crisis and misery falls outside the current parameters of legalization.

Even though overall suicide rates have risen considerably throughout the West in recent years, few studies have been conducted to determine whether the legalization of assisted suicide has had any effect on this concerning trend. That is slowly beginning to change. In 2015, a study published in the *Southern Medical Law Journal* applied CDC suicide data from states where assisted suicide was legal (Oregon, Washington, Vermont, and Montana, where legality remains a matter of dispute). The authors reported that "PAS [physician-assisted suicide] is associated with an 8.9% increase in total suicide rates" (including assisted suicides), and when "state-specific time trends" are included, "the estimated increase is 6.3%." The authors concluded: "The introduction of PAS seemingly induces more self-inflicted deaths than it inhibits."

This report, as is usual in professional discourse, was praised and criticized in a responsive paper published in 2017 in *Journal of Ethics in Mental Health* (JEMH). While the critics recognized some strengths in the earlier study, they noted that suicide rates in Washington and Montana had been increasing before legalization, that the work exhibited "methodological weaknesses" (such as not taking trends in nations such as the Netherlands and Belgium into account), and that "association does not prove causation." Still, even these critics did not contend that legalizing assisted suicide had no effect on overall suicide rates. Rather, they argued that much more research needed to be conducted "before definitive claims about the effects of legalization of medical assistance in dying on non-assisted suicide can be made."

Earlier this year, the original authors responded to this criticism in the JEMH. This time, they compared suicide rates in European countries that had legalized euthanasia with demographically similar countries that had not. Again, the authors found a "concerning pattern" where EAS (euthanasia/assisted suicide) is legal. They found, much to my expectation, that in the four jurisdictions they studied in which euthanasia and assisted suicide (EAS) are legal, "there have been very steep rises in suicide." Moreover, "In none of the four jurisdictions did non-assisted suicide rates decrease after introduction of EAS." In the Netherlands—which has recorded the highest number of deaths by EAS, "the rates of non-assisted suicide" increased since legalization. Even in Belgium, where "non-assisted suicide decreased in absolute terms, they increased relative to its most similar non EAS neighbor: France."

A third study was just released also showing an increase in suicide rates associated with assisted suicide legalization, with a particularly adverse effect on women. Two professors, writing for the Centre for Economics Policy Research (CEPR), tested the hypothesis that legalizing assisted suicide would actually reduce suicide rates, and countered with their own hypothesis that doing so would "not only reduce practical barriers to committing suicide but may also lower societal taboos against suicide," leading to "an increase of suicide rates overall."

After reviewing data taken from U.S. states that legalized assisted suicide as of 2019, and referencing the studies described above, the authors concluded:

> There is very strong evidence that the legalisation of assisted suicide is associated with a significant increase in total suicides. Further, the increase is observed most strongly for the over-64s and for women. To give an idea of the size of the effect, the event study estimates suggest assisted suicide laws increase total suicide rates by about 18% overall. For women, the estimated increase is 40%.

And what about the unassisted suicides in that increase in total suicides?

> There is weaker evidence that assisted suicide is also associated with an increase in unassisted suicides. The effect is smaller (about a 6% increase overall, 13% increase for women). It is still statistically significant in the main estimates but not in all of the robustness checks, meaning we have less confidence in that result. However, we find no evidence that assisted suicide laws are associated with a reduction in either total or unassisted suicide rates.

What are we to make of all of this? There is evidence that suggests suicide begets suicide, and that legal assisted suicide has an effect on suicide rates overall. Obviously, we need to undertake more empirical studies and pointed analyses, but if we care as a society about preventing suicides generally—regardless of our beliefs about assisted suicide for the seriously ill—surely the question of assisted suicide contagion should become a pressing concern in fashioning public policy. Before any more states legalize doctor-assisted death, policymakers and the public should focus much more closely on this little-considered aspect of the debate. Human lives literally are at stake.

Wesley J. Smith is host of the podcast Humanize *and chairman of the Discovery Institute's Center on Human Exceptionalism.*

What does "suicide contagion" mean, and what can be done to prevent it?

Suicide contagion is the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults.

The risk for suicide contagion as a result of media reporting can be minimized by factual and concise media reports of suicide. Reports of suicide should not be repetitive, as prolonged exposure can increase the likelihood of suicide contagion. Suicide is the result of many complex factors; therefore media coverage should not report oversimplified explanations such as recent negative life events or acute stressors. Reports should not divulge detailed descriptions of the method used to avoid possible duplication. Reports should not glorify the victim and should not imply that suicide was effective in achieving a personal goal such as gaining media attention. In addition, information such as hotlines or emergency contacts should be provided for those at risk for suicide.

Following exposure to suicide or suicidal behaviors within one's family or peer group, suicide risk can be minimized by having family members, friends, peers, and colleagues of the victim evaluated by a mental health professional. Persons deemed at risk for suicide should then be referred for additional mental health services.

Learn More:

- Suicide Prevention (http://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml) (National Institutes of Mental Health)
- Warning Signs of Suicide (https://www.mentalhealth.gov/what-to-look-for/suicidal-behavior) (MentalHealth.gov)
- Suicide Prevention Resources for Tribes (http://beta.samhsa.gov/tribal-ttac/resources/suicide-prevention) (SAMHSA)

Posted in: Mental Health and Substance Abuse (/answers/mental-health-and-substance-abuse/index.html)

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ACP and Maryland chapter PAS letter opposing SB845

Uploaded by: Kathy Wynkoop

Position: UNF

ACP American College of Physicians
Leading Internal Medicine, Improving Lives
Maryland Chapter

Colleen Christmas, MD, FACP, Governor
920 Trinity Street
Baltimore, MD 21202

SB 845 and HB 933—Opposed

March 2, 2023

Senator William C. Smith, Jr., Chair
Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Joseline A. Pena-Melnyk, Esq. and Luke H. Clippinger, Esq., Chairs
House Health & Government Operations and Judiciary Committees
6 Bladen Street
Annapolis, MD 21401

Re: Senate Bill 845 and House Bill 933-- "End-of-Life Option Act"- Opposed

Dear Honorable Senator Smith, Representative Pena-Melnyk, and Representative Clippinger,

The American College of Physicians (ACP) writes to you to express our opposition to Senate Bill 845 and House Bill 933 ("End-of-Life Option Act"). ACP is the largest medical specialty organization and the second-largest physician group in the United States with over 160,000 members. Our Maryland Chapter has 2,600 physician members. We oppose these bills because they will harm patients and patient care, undermining patient-physician relationships and trust in medicine. They are discriminatory, putting our most vulnerable patients at risk.

The term "aid-in-dying" is confusing and blurs what is at stake here. When physicians are asked to bring about a patient's death, this is physician-assisted suicide (PAS). This is very different than the patient's right to refuse treatment, which we strongly support. ACP does not support legalization of physician-assisted suicide (see Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper (acpjournals.org), reaffirmed in the current edition of our *Ethics Manual*, our code of ethics). The American Medical Association and the World Medical Association also oppose physician-assisted suicide.

We are deeply sympathetic to the concerns of patients and their families at the end of life. As healers, comforters, and trusted advisors, physicians must fulfill their ethical obligations and always act in the best interests of the patient. Often, lack of awareness of the care that physicians and others can provide to dying patients and very real concern that patients will not have access to this care drive interest in PAS. Research shows many individuals do not know what palliative care is but when it is described, they overwhelmingly respond that they would want it if they or family members were severely ill. Palliative and hospice care have not received the attention PAS has received. We can do better.

We need to ensure that all patients know they will be well cared for at the end of life, not medicalize suicide. The highest priorities for the care of dying patients should include the alleviation of pain and other symptoms, a team approach to care, and strong support for the patient's right to refuse treatment. Patients often fear pain at the end of life, but physicians have an ethical obligation to treat pain with competence and compassion. Vigorous management of pain at the end of life is ethically acceptable even when the risk of hastening death is foreseeable, if the intent is to relieve pain: the *ACP Ethics Manual* states that "…the physician may appropriately increase medication to relieve pain, even if this action inadvertently shortens life" and this has been consistently supported by US courts.

Legalization of PAS in Maryland, given continuing disparities in access to health care, is very troubling. The COVID-19 pandemic has made it clear that much work needs to be done to provide equitable care to all of our patients, especially those in minority communities and those living with disabilities. They, and we, have deep concerns about legalization and the message it sends about the value of their lives and their ability to get the care, including palliative and hospice care, they want and deserve. Vulnerable communities raise extremely valid points that legalization leads to "attitudinal changes, subtle biases about quality of life, and judgments that some lives are not worth living" as we discuss in our paper. The pressures on individuals to not be a "burden" are real. Canada has been rapidly expanding its law, which has moved from PAS to euthanasia. Canada, and now US states that have legalized PAS, are rescinding what were said to be safeguards such as residency requirements, waiting periods, terminal illness restrictions and others, causing much controversy and fear. Canada shows where this leads, with the expansion of eligibility to include patients with mental illness.

Physician-assisted suicide is not medical therapy. We hope you will join ACP in advocating that those who seek suicide with a physician's help instead be provided with the care and compassion that can alleviate suffering and reaffirm our commitment to all patients. The best medical care for patients throughout life, including the last phase of life, requires our full attention. In this way, physicians can fulfill their ethical responsibilities and give dying patients and their families care, compassion, and comfort. We continue to believe no Marylander, or any other American, should have to fear an undignified or pain-filled life or death.

Thank you for the opportunity to comment. Please let us know if you have any questions.

Sincerely,

ACP Maryland Governor

The American College of Physicians is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 160,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Oppose SB845.pdf

Uploaded by: kim chambers

Position: UNF

Written Testimony Of Kim Chambers
Submitted to the Senate Judicial Proceedings Committee
On SB845
End-of-Life-Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
March 6, 2013

Members of the Senate Judicial Proceedings Committee,

Thank you for giving me the opportunity to submit my written testimony to this committee in opposition of SB845, the End-of-Life-Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

This bill is condoning murder, murder in the First Degree and also, is not a socially acceptable behavior.

The Bible states, Thou shalt not kill. Exodus 20:13; Deuteronomy 5:17; Matthew 5:21; Mark 10:19; Romans 13:9 and James 2:11.

Our own laws state murder is illegal and is subject to punishment.

The Maryland General Assembly defines murder as…under "§2–201.

(a) A murder is in the first degree if it is:

(1) a deliberate, premeditated, and willful killing;

(2) committed by lying in wait;

(3) committed by poison;

b) (1) A person who commits a murder in the first degree is guilty of a felony and on conviction shall be sentenced to:

(i) imprisonment for life without the possibility of parole; or

(ii) imprisonment for life.

(2) Unless a sentence of imprisonment for life without the possibility of parole is imposed in compliance with § 2–203 of this subtitle and § 2–304 of this title, the sentence shall be imprisonment for life.

(c) A person who solicits another or conspires with another to commit murder in the first degree is guilty of murder in the first degree if the death of another occurs as a result of the solicitation or conspiracy.

https://mgaleg.maryland.gov/mgawebsite/Laws/StatuteText?article=gcr&section=2-201

So please tell me how this bill differs from murder with malicious intent forethought. If a "loved one" and I use the term loosely, agrees and maybe gets the drugs, shouldn't they be found a conspirator?

Are you treating people no better than an animal, that can be euthanized at the drop of a hat?

Why does this deny life sustaining care? Why are there no standard requirements for mental health screening/counseling? Why are there no safeguards to ensure that drugs stay out of hands of children? Why is there no doctor or nurse required to be present when the person ingests the lethal dose? If the person is alone, who will know? How long will the person be in their surrounding before they are found? Why should taxpayers foot the bill to pay for this? Why are you making it easier for the poor, disabled and uninformed choose suicide?

For the above statements and reasons listed, I strongly encourage the members of this committee to stop this bill.

Thank you for your time,

Kim Chambers

UNFAVORABLE.SB845.MDRTL.L.Bogley.pdf

Uploaded by: Laura Bogley

Position: UNF

Opposition Statement SB845/HB933
Assisted Suicide/ 'End of Life Option Act'
Laura Bogley-Knickman, JD
Executive Director, Maryland Right to Life

Position Statement

On behalf of the Board of Directors of Maryland Right to Life, and medically vulnerable people across our state, we strongly oppose SB845/HB933 and the legalization of 'assisted suicide' also known as 'doctor-prescribed suicide'. By licensing doctors and other medical providers to prescribe lethal drugs to bring about a person's death, the state will be reducing the standard of medical care for all people with potentially disparate impact on the poor and underinsured.

This bill would put Maryland's most vulnerable populations at risk, including individuals with disabilities, those experiencing poverty, individuals in need of treatment for mental illness, our veterans, and those suffering from drug addiction.

The dangers presented to these populations and others far outweigh any perceived benefit being sold by the bill's out-of-state, well-funded proponents.

Good Public Policy Serves the Many

Legalizing assisted suicide will create great inequities in healthcare for Maryland residents. A *right to die* chosen by the wealthy few, will become a *duty to die* for many on public insurance. In Oregon, where this has been legal since 1994, nearly 70% of people who died from Assisted Suicide were Medicare or Medicaid patients, while only 30% had private insurance.

Empirical Evidence of Risk

We have the benefit of looking at two decades of history in Oregon to evaluate the credibility of the safeguards in this legislation. Unfortunately, substantially similar language in Oregon law has only wrought problems rather than protections.

The following illustrate immense problems with this legislation based on the data available to us, including:

- the failure to guarantee competence and mental health
- the lack of a required witness at the time of death
- the lack of a doctor-patient relationship and reality of doctor shopping
- the gravely flawed definition of terminal illness
- the reality of coercion and undue influence
- the reality of denial of wanted lifesaving care
- the indefinite requirement of self-administration
- the lack of specified data collected
- the mandate to falsify death certificates
- the casual standard to which doctors are held
- the failure of the state to be able to reasonably enforce violations of this policy and

- the stories of Michael Freeland, Helen X, Dr. Charles Bentz, Kate Cheney, Kathryn Judson, Mrs. Neill, Randy Stroup, Barbara Wagner, Barbara Houck, Patrick Matheny, and others experiencing firsthand the failures of safeguards in states with legal doctor-prescribed suicide.

In 2019 the proponents of the bill withdrew their support after state senators attached amendments that would have provided critical safeguards for patients. During the 2019 House of Delegates hearing on this bill, when asked about adding patient safeguards, Kim Callinan, CEO of **Compassion and Choices** (formerly the Hemlock Society and the organization advocating for this legislation), refused stating:

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

FALLACY 1: "The Patient Must Be Competent/Have the Capacity to Make Medical Decisions"

The capacity to make medical decisions and the requirement of a patient being a 'qualified individual' to request aid-in-dying, pose numerous problems. Though there is a requirement to posses "the capacity to make medical decisions", substantial research and practical requirements of the legislation can offer no guarantee of competence or mental health.

Depression is a Normal Response to Terminal Diagnosis

Research studying numerous cases of suicide has concluded a well-established psychological fact that nearly every terminally ill patient who desires death is suffering from a treatable mental disorder.[1] It is not uncommon for these patients to express depressive or suicidal thoughts, which may be a normal part of emotionally processing a severe diagnosis. Nonetheless, depression and suicidal ideation can be successfully treated and reversed. The worst response to a patient with suicidal thoughts is to affirm his or her worst fears of insignificance and of being a burden by helping that person end his or her life.

No Requirement of Assessment by Mental Health Professional

Additionally despite language allowing the attending physician or consulting physician to refer a patient for a mental health professional assessment, there is absolutely no requirement that such action ever occurs in this bill. In practice, under the proposed language, if a mental health professional is given the opportunity to determine that a patient does suffer from a mental disorder or depression, if they also determine the person has decision-making ability, the individual can receive the lethal prescription.

Data from Oregon's experience show only 4.9% of patients were referred for an evaluation in over 19 years of the practice.[2] In real numbers, that means 1,213 patients ended their lives through lethal prescriptions without being reviewed by a licensed mental health professional to ensure competency and clear decision making ability. This massive danger has resulted in documented cases reported in *The Oregonian* newspaper of patients suffering from depression and dementia receiving doctor-prescribed suicide.[3] One proponent of this legislation testified in the workgroup that patients with diagnosed depression are not disqualified from using this law in Oregon. Language in this legislation is not sufficient to protect patients.

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[1] Barraclough, Bunch, Nelson, & Salisbury, *A Hundred Cases of Suicide: Clinical Aspect*, 125 BRIT. J. PSYCHIATRY 355, 356 (1976) and E. Robins, THE FINAL MONTHS 12 (1981).

[2] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[3] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

Depression is Treatable

In Oregon, a patient by the name of **Michael Freeland** was diagnosed with lung cancer and received a lethal prescription under Oregon's law. Over a year after receiving his first prescription (clearly calling into doubt the validity of the 6-month lifespan diagnosis) he was admitted to a psychiatric treatment facility with depression and suicidal intent. After being treated and seeing great improvement, his caregivers ensured his 32 guns and all ammunition were removed from his home before Mr. Freeland could return home. However, his guardians knowingly allowed Mr. Freeland to keep the lethal prescription. Mr. Freeland's treating psychiatrist even submitted a letter to the court after his discharge indicating Mr. Freeland was not competent and was in need of a guardian. Fortunately after accidentally dialing a suicide prevention group when attempting to call an assisted suicide advocacy group, he was able to continue quality treatment for his depression and receive help in reconciling with his estranged daughter. He died naturally and in comfort almost two years after receiving a lethal prescription. Mr. Freeland released his medical records for public review.[4]

Unattended Ingestion and Death

Because of the bill's lack of safeguards, there is serious concern as to whether a patient will still be competent at the time she or he actually ingests the lethal prescription. Patients prescribed a lethal prescription under this bill may not ingest it either for a period of time, or ever. 35.18% of patients prescribed a lethal prescription never take it (692 never ingested of 1,967 total prescriptions, 692 figure calculated from presentation of 1,275 patients who were reported having died from 1,967 lethal prescriptions written).[5] If a patient does not take the prescription, a lethal substance remains unmonitored and unregulated, potentially accessible to unintended recipients.

Additionally, the time reported between first request for death and actual ingestion is as little as 14 days to as high as 1,009 days (approaching 3 years).[6] Three years with a severe diagnosis can be one of dramatic changes. Aside from seriously challenging the definition of "terminal", it is unknown what changes to the patient's condition or life occurred in that time. Did the person's mental state deteriorate? Did the person's condition improve to no longer be considered terminal? Did caregivers tire of caring for a sick relative? Simply put, we don't, and will likely never know.

Death Doctor Shopping

There is also no requirement in this legislation that the doctor has any notable relationship with the patient. Oregon's data show that 'doctor shopping' exists. A network of doctor-prescribed suicide proponents ensure that patients will receive lethal prescriptions[7], even when their family doctor knows their desire for death is transient and could be alleviated. Oregon's data show that patients were prescribed fatal prescriptions after a duration of a "patient-physician relationship" of 0 weeks.[8] Clearly, the reality of a person searching for a willing physician after a family physician denying a request for suicide exists because of this bill's permissive allowance of it.

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[4] Patients Rights Council | N. Gregory Hamilton, MD and Catherine A. Hamilton, MA, "Competing Paradigms of Response to Assisted Suicide Requests in Oregon," American Journal of Psychiatry, June 2005, pp. 1060 - 1065.

[5] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[6] Ibid.

[7] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

[8] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

With regard to doctor shopping, **Compassion and Choices** openly admitted that they have worked with between 75% and 95% of all patients ending their lives in Oregon[9], advertised their willingness to connect patients with willing doctors on their Washington chapter's website[10], and promoted their referral program on their Vermont chapter's website[11].

In Oregon, the story of **'Helen X'** clearly shows this. She had a history of breast cancer and was enrolled in hospice. She was using a wheelchair for two weeks and used oxygen when shortness of breath struck her. She reported no pain and was still doing aerobic exercises regularly. Her physician declined her request for a lethal prescription. A second physician she saw did the same due to feeling she was showing signs of depression. Her husband called Compassion and Choices and found a willing physician- Dr. Peter Reagan, a known advocate for doctor-prescribed suicide. Despite reporting surprise at her eagerness to die, Dr. Reagan nonetheless wrote the lethal prescription.[12]

Likewise, **Dr. Charles Bentz** diagnosed a malignant melanoma in an elderly man who had been under his care for 10 years. After the patient underwent radiation therapy, the radiation oncologist informed Dr. Bentz that the patient was depressed due to his diminished physical stamina. At about the same time, the patient completed his chemotherapy and requested a lethal prescription from his medical oncologist. The medical oncologist sought Dr. Bentz to be the required second physician, noting that secobarbital "works very well" and that the oncologist had used it many times. Dr. Bentz refused to agree citing the patient now had documented depression and needed appropriate therapy. The oncologist rather than reevaluating the effort to obtain a lethal prescription, found a willing second physician and did not refer the patient back to Dr. Bentz. Two weeks later, the patient ingested the lethal prescription and died.[13]

FALLACY 2: "The Patient Must Be Terminally Ill"

Terminal illness is often difficult to predict. While physicians do their best to care for patients, there is a plethora of evidence that non-terminal patients have received lethal prescriptions. We are now seeing evidence from other states that lethal drugs may be prescribed for non-lethal and even mental health diagnoses, including depression or anorexia.

The aforementioned data indicating as long as 1009 days between first request for death and actual death indicates an obvious problem with the practicality of restricting this policy to only terminal patients.

Diabetes Can be Basis for Lethal Prescription

Simply put, the definition of terminal in this legislation is overly broad. The definition does not preclude someone from ceasing treatment of an otherwise non-terminal condition in order to qualify. For instance, an insulin reliant diabetic could qualify under this bill. Whereas essentially no one would consider the condition terminal, a person with the condition could qualify if he or she ceases to

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[9] "FAQs." Compassion & Choices Oregon, n.d. Web. 12 Feb. 2016. <https://www.compassionandchoices.org/what-you-can-do/in-your-state/oregon/frequently-asked-questions/>

[10] "Death with Dignity Act - End of Life Washington." End of Life Washington. End of Life Washington, n.d. Web. 12 Feb. 2016, Feb 2019. <http://endoflifewa.org/dwd/>

[11] "Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life." Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life (2014): Compassion & Choices Vermont. Web. <https://www.compassionandchoices.org/userfiles/Talking-to-Your-Doctor-About-Act-39.pdf>

[12] Patients Rights Council | Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective, *Michigan Law Review*, Vol. 106:1613 (June 2008), p. 1616.

[13] Patients Rights Council

administer the required insulin. In Oregon, patients with HIV/AIDS, multiple sclerosis, diabetes, viral hepatitis, and a number of other potentially non-terminal conditions ended their lives via this policy.[14]

FALLACY 3: "The Request Must Be Voluntary"

While the bill states that the patient must request suicide voluntarily, the risk of coercion and undue influence is possible in several ways.

Bill Authorizes Heir to Witness Request

While the bill states that coercion and undue influence are prohibited, it simultaneously allows an heir to serve as a witness for a request for doctor-prescribed suicide. In fact, there is no language in this bill to prevent an heir from serving as a witness- under 'Declaration of Witnesses' in the "Maryland Request for Medication for Aid in Dying" form and explicitly authorized in the bill, language specifically allows an heir to be a witness who knows of his or her benefit from the patient's death, and allows another person to benefit from the patient's death providing that benefit is merely established after the written request. One of the two of these beneficiaries is allowed to be a relative by blood, marriage, or adoption.

Oregon data show that people regularly request doctor prescribed suicide due to the feeling that they are a burden on friends, family, and/or caregivers (43.7% of patients dying under this policy cited this reason since legalization of the policy).[15] It is unknown how many of these patients would have made a different decision with true compassion or with the absence of coercive pressure.

Kate Cheney was a woman diagnosed with terminal cancer and asked for a lethal prescription. Her doctor refused to write a prescription because of questions surrounding her competence due to dementia and referred her to a psychiatrist. The psychiatrist noted Kate Cheney's short term memory loss and that her daughter seemed much more interested in doctor-prescribed suicide than Cheney did, going so far as noting that, "[Kate] does not seem to be explicitly pushing for this," and that the patient lacked the, "very high capacity required to weigh options about assisted suicide." While Kate Cheney seemed to accept the verdict, her daughter did not. A third effort done by Kate's HMO determined she was capable of making the decision and authorized the writing of the prescription. Later, she went into a nursing home so her family could have a respite from caring for her. After returning home she proclaimed a desire to take the pills.[16] Kate Cheney, a patient with dementia, not only had a caregiver advocating for her death, but one willing to doctor shop until finding a willing doctor. Sadly, it was her own insurance coverage which helped authorize ending her life.

Doctors May Pressure Patients

The same pressure has been documented from health care providers as well. **Kathryn Judson's** husband was gravely ill when brought to the doctor. To her shock, she overheard his doctor giving a sales pitch for doctor-prescribed suicide. "Think of what it will spare your wife, we need to think of

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[14] Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[15] Ibid. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

[16] Patients Rights Council | Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian,* October 17, 1999. | Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective, *Michigan Law Review*, Vol. 106: 1613 (June 2008), p. 1624

her," she noted the doctor said. They quickly changed physicians and Mrs. Judson's husband lived another five years. Mrs. Judson was appalled by this treatment and feared leaving him alone with medical professionals again, remarking, "It's not a good thing, wondering who you can trust in a hospital or clinic."[17]

The same horror stories have already occurred in Vermont. **Mrs. Neill** was admitted to the Berlin Health and Rehab Center in Vermont for four months. Her daughter, Beth Neill, reports that her caregivers repeatedly reminded her of her 'right' to use Act 39 (Vermont's doctor-prescribed suicide law), going so far as to say, "it is the law" and the patient could "off" herself at any time. The repeated, ceaseless discussions initiated by caregivers after Mrs. Neill expressed she was not interested, caused unwanted pressure on the patient. Interestingly, Mrs. Neill was in generally good health and had no terminal illness. The privilege of a strong, involved family and personal physician opposed to doctor-prescribed suicide helped her to resist the unwarranted pressure.[18]

Pain Basis for Only ¼ of Lethal Prescriptions

Oregon's data show only about 1 in 4 patients (25.8%) cite inadequate pain control or a concern about it. Despite the image of a patient suffering being the appeal to emotion behind support for this legislation, the evidence does not support it. Only 1 in 4 patients dying from fatal prescriptions cite this, and a notable proportion of these people may merely have been concerned about what may happen in the future, rather than experiencing any improperly controlled pain presently. In fact, this reason is not even in the top five reasons a patient asks for the lethal drugs.

Economic Pressure

Realistically, coercion could arise out of a mere lack of affordable 'feasible alternatives'. Although the bill requires that the patient be informed of "feasible alternatives and health care treatment options, including palliative care and hospice", there is no such requirement that any of these alternatives be covered in insurance plans. This particularly hurts those in poverty and anyone without insurance or without enough insurance.

A striking example of coercion highlights precisely why we are opposed to the policy of doctor prescribed suicide generally. In Oregon, **Randy Stroup** and **Barbara Wagner** were each denied treatment they wanted and needed to survive by the Oregon Health Plan (Medicaid) and were informed in the same letter that they could instead "choose" doctor-prescribed suicide, which would be covered.[19] In a program designed to give true dignity to people in poverty through access to healthcare, the very opposite happens- wanted lifesaving treatment is denied because ending the lives of sick people is easier and cheaper than treating them.

The mere legalization of doctor-prescribed suicide threatens the access to wanted healthcare of everyone in society. There are surely many more people affected who didn't have the courage to come forward. Just as this occurred with a public plan, the same can occur in state healthcare exchanges, and with any private insurance plan operating in the state. After all, private health insurance plans have the same, if not more, motivation for profit; eliminating the extent of coverage for treatment because there is a cheaper "option" can unquestionably occur right here in Maryland.

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[17] Patients Rights Council | Letter to editor, "Assisted Suicide? 'I was afraid to leave my husband alone again with doctors and nurses'" *Hawaii Free Press*, February 15, 2011.

[18] Patients Rights Council | "From the Netherlands to Vermont: Patients Under Pressure to Die - True Dignity." *True Dignity*. True Dignity Vermont, 13 July 2015. Web. 15 Feb. 2016. <http://www.truedignity.org/from-the-netherlands-to-vermont-patients-under-pressure-to-die/>.

[19] Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, Aug. 6, 2008, and Susan Harding and KATU web staff, "Letter noting assisted suicide raises questions," July, 30, 2008.

FALLACY 4: <u>“The Patient Must Self-Administer”</u>

While the bill requires a person to self-administer the fatal drugs, many legal observers argue that this provision is one court challenge away from being overruled. For instance, the Oregon Attorney General’s office has stated that if there is a person with a particular disability which prevents the ability to swallow, the requirement in statute to self-administer is unconstitutionally discriminatory.[20] Realistically, this means lethal injection euthanasia is merely a court challenge away from being legal in Maryland, if this bill would pass.

During the 2019 House of Delegates hearing on this bill, Dr. Michael Strauss, the leading Physician promoting the bill, revealed the bill does permit others to administer the poison testifying:

> *“The capsules- by either the patient or a family member – are pulled apart, the powder goes into about four to six ounces of a liquid and the patient ends up consuming the four to six ounces of liquid.” “A physician could be there or a family member could put the powder in a liquid.”*

There are already numerous stories of inappropriate “assistance” provided to patients’ suicide attempts. **Barbara Houck** was diagnosed with Amytropic Lateral Sclerosis (ALS or colloquially Lou Gehrig’s Disease). She immediately called Dr. Peter Rasmussen (an assisted suicide supporter) for a prescription which was written a few months later when Dr. Rasmussen thought she was closer to a terminal condition. He was present with her on the day of her death where he emptied the 90 capsules in her lethal prescription into a bowl of chocolate pudding and her two sons spoon fed it to her. She died about twelve hours after being fed because of illegal assistance.

Patrick Matheny was only 43 years old when contemplating doctor-prescribed suicide. He, too, had ALS. He set numerous arbitrary deadlines only to see them reached and extended. On March 10, 1999, Matheny tried to swallow the barbiturates mixed into a chocolate nutrition drink, sweetened with a sugar substitute. He reportedly had difficulty swallowing and the only person present — his brother-in-law Joe Hayes — had to “help” him die. Hayes did not disclose how he “helped” his father-in-law die, but he did state, “It doesn’t go smoothly for everyone…For Pat it was a huge problem. It would have not worked without help.”[21]

FALLACY 5: <u>“The State Will Punish Violations”</u>

There are numerous concerns about the ability of the state to adequately monitor and punish violations of this bill, if it would become law.

Low Liability Standard

The bill only holds a physician to a “good faith compliance” standard, rather than the higher “malpractice standard” applied to other health providers and to the same physicians in different medical circumstances. When dealing with a policy literally intending to cause death, physicians should be expected to uphold the highest professional standard. There are no do-overs when it comes to fatal prescriptions intended to cause death.

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[20] Letter from Oregon Deputy Attorney General David Schuman to State Senator Neil Bryant, March 15, 1999, “Oregon controversy: How assisted can suicide be?” *American Medical News*, April 12, 1999.

[21] Patients Rights Council | Erin Hoover Barnett, “Dilemma of assisted suicide: When?”, *Oregonian*, January 17, 1999 | Erin Hover Barnett, “Man with ALS makes up his mind to die,” *Oregonian*, March 11, 2000.

Insufficient Reporting Requirement
While there is a requirement for the Department of Health and Mental Hygiene to promulgate regulations to collect data, the bill is silent on what data must be collected. Data should be collected at least on the points currently collected by Oregon and featured in their annual report. Additionally, there must be means in place to enforce a reporting requirement, one significant reality missing in Oregon.

Falsification and Fraud
Likewise, this bill would mandate, by statute, falsifications of death certificates. The bill mandates that death certificate for an individual using this option would be falsified to state that the individual died of "natural causes". This prevents any ability to investigate a death or to monitor the frequency and circumstances involved in deaths under this policy. Therefore, when combined with a lack of specific points required in reporting, there could be absolutely no way to know the number of real suicides through this policy in Maryland.

In Conclusion
Because of the plethora of concerns with this legislation, Maryland Right to Life asks the committees to put patients before profit and support the concerns of people with disabilities, the underinsured and the medically vulnerable by issuing an unfavorable report on this bill.

There are simply too many grave concerns- each in and of itself significant enough to halt pursuing this policy- to correct with a simple amendment. The very policy is so innately flawed that it cannot be implemented as good public policy in Maryland.

Laura Jones - full testimony - 23.pdf

Uploaded by: Laura Jones
Position: UNF

Oppose HB 933 / SB 845
Laura Jones - The Dignity Mandate - 410-246-5166

In 2016, 2017, 2019, and 2020, my husband and I testified against the End of Life Option Act because assisted suicide would put our loved ones in danger. Our daughter had once planned to end her life by overdosing and we kept all our medications under lock and key. When we testified, we only had time for part of our story but today I want to share with you more.

Dying early, before your time, may be the worst type of death. My father-in-law, Tom, died this way. We share a little of his story in the documentary we created about the Maryland Bill. You can see it on our website – www.TheDignityMandate.org/documentary Tom was given 6 months to live by a doctor who said his cancer had spread to his liver. We sought a second opinion and found his cancer had not spread and he qualified for a Whipple Procedure that was very invasive and was more likely to kill him than save him. He agreed to have the Whipple procedure and, against all odds, he lived another 10 years cancer free. Insurance companies have denied coverage of cutting-edge treatments in favor of inexpensive lethal drugs in Oregon and California. https://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/

How will medical breakthroughs like the Whipple procedure ever be realized and perfected if they are no longer covered by insurance? The lethal pills will always be the most inexpensive form of treatment, and it usually stops the disease dead in it's tracks. I say usually, because the 2021 Oregon Report states one person regained consciousness. (page 13 under complications https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf)

After 10 years, my father–in-law developed a different form of Pancreatic cancer. Again, with only 6 months to live, he lived 1 ½ years before at trip to the emergency room because of shortness of breath brought him face to face with the doctor who set him up to die early.

The doctor offered to put in a pace maker to "help" my father-in-law. After the surgery, we waited for 2 days in intensive care for the doctor to come to the room and answer our questions. As chance would have it, I ran into the doctor leaving the hospital cafeteria.

I said, " Hey, you're the doctor who put a pace maker in my father-in-law and you have not stopped back to see how he is doing. We have some questions for you." He said, "Your father-in-law was a sick man. He was going to die anyway." I asked, "Why did you do the surgery then?" - and he walked away without answering me.

What a sham and a shame for a doctor to treat a cancer hero with such disdain. My father-in-law died the next day. It was the day we were scheduled to take him home to be on hospice. It was the day before his birthday. Our children never got to say good-bye because they were not allowed in the hospital. This callous doctor robbed us of our last family birthday together. This is the day I stopped trusting doctors.

This doctor did not know my father-in-law. He did not care that he had beat pancreatic cancer once and he was a survivor. All he saw was a man on borrowed time. He thought - I should take advantage of the situation. If he dies, it will not matter – "he was going to die anyway".

If you pass this law, you not only allow doctors to act in this way, you actually assume some doctors will want to act this way and give them the means to do it without legal recourse for the family. Why would anyone want to pass a law that would require at least some doctors to work below the expected ethical standards of the profession? Maybe the law would not force any doctor to do it, but it does expect some doctors to fulfill the duties of the law. This will erode the trust and confidence we have in all doctors, because everyone will always wonder if they are dealing with a "death" doctor.

Proponents of this bill think this is a personal choice that does not affect anyone else but that is simply not true. This law will change the way we all face death. We will face new pressures. People like my father-in-law will no longer be seen as heroic, but as selfish and they will be mocked for continuing to live and wasting their grandkid's college fund to keep their old, ragged bodies alive. It will change the professional expectations of people in a broad range of professions, including doctors, hospice care givers, assisted living care givers, coroners, insurance agents, psychiatrists, psychologist, pharmacists and many more.

Do not pass this bill to appease the select few who fear having a difficult death and want to die in a specific way. Do not allow the media and large well-funded national organizations to lure us into believing killing ourselves is dignified and doctors who help hasten death are compassionate. This law would open the door to so much harm. It is not needed and you will not be able to fix the problems it will create.

Please give HB 933/ SB 845 an unfavorable report.

Sincerely,
Laura Jones

Annapolis, MD 410-246-5561 laura.jones@thedignitymandate.org

Testomony against SB845.pdf

Uploaded by: Marco Colombini

Position: UNF

I am opposed to **SB845 End of Life Option.** Although assisted suicide is fundamentally wrong for Christians, it is also wrong for those of other faiths and for non-believers. Assisted suicide produces a strong economic incentive for governments and family members to eliminate those who are a burden because of infirmity, handicap, or just age. This is not hypothetical because it is happening today in Canada. A veteran requested funding to assist with having a wheel-chair ramp installed to improve access to her house and instead received a letter urging suicide. The so-called safeguards attached to the bill to attempt to minimize abuse just don’t work in reality. Once the right to die is enacted, any impediment will be eliminated by legal action. This is an historical fact with other legislation.

Summarizing the specific problems with this bill:

- Legalizing Assisted Suicide enables health insurance and medical providers to deny life sustaining care to patients and evade liability for the death of patients.
- There are no standard requirements that each patient receives mental health screening and counseling. A screening from a doctor untrained in mental health is not sufficient to assess a patient's true needs.
- No family notification is required.
- One in three patients who fill the lethal prescription-typically 100 pills, decide against taking it. There are no safeguards to ensure the unused drugs stay out of the hands of children and prescription drug dealers. This is particularly irresponsible, as we are experiencing an opioid crisis nationwide.
- No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.
- Assisted Suicide laws make suicide socially acceptable. States which have legalized Assisted Suicide have experienced increased suicide rates.
- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.
- The poor as well as those with disabilities would be faced with choosing suicide as an option so as not to become a burden on their loved ones. To the most vulnerable, a right to die may become a responsibility to die.

Marco Colombini

17520 Doctor Bird Road, Sandy Spring MD 20860

2023 PAS testimony.pdf

Uploaded by: Maria Hayden

Position: UNF

SB845/HB933
End of Life Option Act – Oppose

I am a resident of Ellicott City, a wife and mother of 5, and a nurse of 37 years. I am writing to urge an unfavorable opinion on SB845 which would allow a doctor to provide lethal doses of pills to a patient. There are many serious reasons why this bill would be tragically harmful to Maryland.

We all want to alleviate suffering. In healthcare today, there is no reason for anyone with a terminal illness to be in pain. But there is little we can we do to end the cascade of pain *after* a suicide occurs, whether it was legal or not. When someone takes his own life, is it devastating to a family and a community. They suffer for generations. Families feel guilt that they were either unaware of the patient's despair, or unable to help. The ramifications of their suicide on a family can be a far greater burden than their illness was while alive. We know from studies in Oregon that the primary reason for PAS is that the patient feels they are a burden, not because they want to end their own pain. It is therefore a selfish solution on our part, who should be caring for this person. How many souls who died by physician assisted suicide may have lived the full life they were meant to live if they had had a moment of hope - a call from a friend or a caregiver's touch? We know that 30% of patients prescribed these drugs do change their minds.

This bill makes suicide too accessible, too easy, and too acceptable. Life expectancy is too difficult to determine (so many people have stories of loved ones who far out-lived their prognosis.) Depression will not be adequately evaluated or treated (doctors will not know patients well, as there will only be a few in the state willing to prescribe death, and patients will seek them out.) Families won't be notified (they may have been able to help the patient.) No one witnesses the ingestion of pills (Patients could suffer terribly from vomiting, seizing, and respiratory depression.) This is not an end of life that is peaceful, dignified, or compassionate.

In addition, do we want to be responsible for an *increased rate of suicide* among healthy people in Maryland? Historically this is what happens. The passage of SB845 will send a strong message to young people that suicide is a morally acceptable choice. This translates to more suffering for Maryland families. Suicide is the leading cause of death of 15 to 24 year olds. They are struggling to find value and purpose in life and need support, not further justification for acting upon despair. Why would we want to enact any bill that would further endanger our vulnerable citizens and our fragile youth when suicide, drug overdoses and crime are already rampant in our state?

It will also destroy the doctor/patient relationship. Who will trust that their doctor is really striving to extend their life when PAS is an easier, cheaper solution.

House bill SB845 would potentially enable horribly wrong, hurtful, fatal decisions. Let's do better in Maryland with treating the living, and support families and communities in caring for the sick both physically and emotionally. Death is too permanent and painful to get wrong.

Testimony Against Assisted Suicide_Virtual_Edit.pd

Uploaded by: Mary Hand

Position: UNF

SB 0845—OPPOSED—Mary Hand, Bethesda, Maryland

I am opposed to the End-of-Life Option Act because it threatens long-held medical practice and standards of ethics and has consequences that extend to other health care team members and I contend, to future patients and beyond (family, community). The proposed legislation distorts the role of healthcare professionals as healers who seek to "do no harm," and undermines the trust between doctor and patient, by requiring all doctors who assist those with terminal conditions to (at least) advise the patient that assisted suicide is a treatment option. Further, the proposed legislation provides an illusion of autonomy and seamless dying, threatens the most vulnerable among us, and changes the landscape of future medical, pharmacy and nursing recruitment, training, and research.

As a retired Registered Nurse and Army Nurse Colonel, I have trained and worked with physicians, nurses, pharmacists and other health care providers in hospitals, in the military, and on National Institutes of Health committees. I care these health care team members and desire to see future physicians, nurses, pharmacists be able to reach the fullest of their professional practice and satisfaction in many settings working with patients to prevent disease, manage risk factors for heart disease and cancer, control chronic conditions and treat acute disease early, and support patients are they transition to illness, disability, and dying.

This legislative body and all of us should be advocating for equality of care, that healthcare principle that seeks to offer the same access to health care regardless of their health condition. The medical profession already has science-based, sanctioned options (palliative care, hospice) that do not require doctors, pharmacists, and nurses to be accomplices to a patient's self-directed death. Instead of legalizing assisted suicide, we need to encourage more access to palliative (pain management) care and hospice care which are now incorporated into the litany of comfort measure at end-of-life. There is an urgent need for greater awareness and use of palliative care and hospice at the local and national levels, especially among the minority populations and the underserved. There are important publications including a National Institute of Aging paper, citing there are racial and ethnic disparities in palliative care and these should be a clarion call for broader more inclusive policies.

Proponents of assisted suicide, deceptively called medical aid in dying or death as an option, contend that the individual with a terminal illness would thereby be able to make the decision about when and how to die which suggests an autonomous process. It is far from autonomous and reaching ripple effects. It is not autonomous because the physician is necessarily enlisted to prescribe the lethal dose or to refer to those who would, requiring two physicians to witness. Pharmacists are needed to dispense the lethal medication. Nurses are cited as having a role as presiding on the day of death in. I am aware that some states have extended medical aid in dying legislation to permit advanced practice nurses to prescribe the lethal prescription, The American Medical Association has reaffirmed its opposition to doctor-assisted suicide though the proposed legislature uses a euphemistic term that waters down its meaning. could include denies the physician's role in the patient's suicide because it legalizes it. It is hardly an autonomous process and has far reaching ripple effects. It is not autonomous because the physician is necessarily enlisted to prescribe the lethal dose, and a pharmacist is needed to dispense it. The slippery slope or ripple effect extending to passing later legislation permitting advanced practice nurses to prescribe the lethal prescription, and gradually expanding it to include individuals with chronic illness or disability as has been seen in countries like Canada and Sweden that has passed these laws. The video "Shining the Light on Physician Assisted Suicide" which can be found here, shows better than I can convey, the health care professionals' perspectives' notably).

A current booklet with guidelines for medical aid in dying does not assure a smooth, neat, well-timed day of death and this option is not applicable for all terminal conditions or situations.
It now recommends that “a skilled clinician” (“most commonly a nurse”) be present on the day of death because of the complexities of mixing the lethal and the process described suggests there can be discomfort (burning, chest discomfort from the cocktail) and a range of times when death would occur and potential other side effects and uncertainties. With the lethal cocktail that must be carefully mixed, the booklet cautions that children and pets should not be around. (I am from Bethesda and I envision many patients with dogs or cats would want their pets at their bedside when they die.)

And there are many other reasons like having the “death with dignity” prescription in the patient's homes (to be used at some future time), when minors could get into them; the current suicide epidemic among youth and the military; the fact that a terminal illness diagnosis can be incorrect (numerous examples); that patients may be depressed or not want to be a burden to their families, perhaps feeling subtle pressure when they make the request; and the experience of Sweden and Canada where “terminal” becomes loosely defined which is why the disability community also fears passage of assisted suicide.

Although assisted suicide is fundamentally wrong for Christians, it is also wrong for those of other faiths Position Paper of the Abrahamic Monotheisic Religions on Matters Concerning the End of Life, Vatican City, October 28th, 2019. PositionPaper_ENG_OK.pdf (academyforlife.va) and for non-believers. Even though the proposed legislation would make it legal to facilitate a terminal patient's requested death, it does not make it MORAL for health care providers who practice their faith and deserve the right to their liberty to do so without being deprived of this right by their medical professional and desire to take care of patients.

Assisted suicide undermines what health care is about and the full extent of what it has to offer. This proposed legislation is the antithesis of what I deeply care about as a nurse, that is offering patients the range of evidence-based care options along their life's health journey, including their final journey. But not being an accomplice to their suicide.

Written Testimony of a Trial Lawyer on SB 845.pdf

Uploaded by: Matt Paavola

Position: UNF

WRITTEN TESTIMONY OF A TRIAL LAWYER ON SB 845

I have been a personal injury trial lawyer for over 40 years. This Bill at p 17 allows doctors to process an end-of-life option without any consequences for criminal or civil neglect. In pertinent part, 845 states:

> AN INDIVIDUAL'S REQUEST FOR AID IN DYING OR AN ATTENDING PHYSICIAN'S PRESCRIPTION OF MEDICATION MADE IN GOOD–FAITH COMPLIANCE WITH THIS SUBTITLE DOES NOT:
>
> (1) CONSTITUTE NEGLECT FOR ANY PURPOSE OF LAW;

In effect, the administering physician is immunized from liability for a mistake. This protection is unfair and unnecessary.

What if the doctor treats the wrong patient, or prescribes the wrong prescription or dosage, or chooses to overlook obvious signs of money motivated decision-making by those who are encouraging the patient to end life? Fear of consequences serves to keep physicians on the straight and narrow path of careful practices. The opposite is also true. Medical practitioners, like all professionals, can make costly mistakes. If there are no consequences, the practitioner can continue his practices with reckless abandon. And here, we are 100% of the times talking about human life. Why should the doctor in the context of this Bill receive so much more protection than when that same doctor performs his/her services in a different area of medicine?

Immunizing doctors is not only unfair, it is also unnecessary. It is not like they are operating as Good Samaritans. They are getting paid for their services. They expect to be held responsible for mistakes. That is the nature of their profession. One cannot imagine that any worthy professional would refuse to practice end-of-life options just because they are accountable for error. A doctor who refuses to help patients who seek to end their life should be banned from this field of medicine if he or she demands a shield from their acts of neglect.

Admittedly, the Bill also includes a sentence at the very which purports to maintain physician liability for negligence. But this sentence is, at best, confusing and, at worst, meaningless. How can a statute relieve a doctor of liability for neglect in one section but later declare that they can be held responsible for careless mistakes? How can it be both ways? It is totally confusing. Which is it?

We should not have such confusing language in a Bill. Fix this Bill to hold doctors fully accountable for end-of-life processing errors, or kill the Bill altogether.

Matt Paavola, Esq

Workers' Comp Law Firm, LLC

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Melissa Ortiz Testimony Against End of Life Option

Uploaded by: Melissa Ortiz

Position: UNF

My name is Melissa Ortiz and I have the honor of serving as the Senior Advisor of Able Americans, a program of the National Center for Public Policy Research. I am here today as a resident of Maryland to express my disapproval of the End-of-Life Option Act, also known as The Honorable Elijah E. Cummings & the Honorable Shane E. Pendergrass Act, that is now before this body.

I have read the legislation in its entirety. It neither ethical nor moral and it does not truly help people who are suffering with terminal illness, much less those with chronic illnesses or disabilities. The intended consequences are clear: asking those whose job it is to heal people to become killers as they "help" people who are thought to be terminally ill end their own lives. The unintended consequences are the far reaching applications that could be brought into play if the government decides to reinterpret the law or allow for exceptions to self determination through medical proxies.

The unintended consequences are something I have personally experienced. I am a cancer survivor and a person with a lifelong disability. That combination is not a good one to have in the place I once lived where end of life options are legal. Pressure is brought to bear, albeit subtly, to choose the less expensive option. To choose the option that takes the burden from family and friends. Fortunately, I am a strong self-advocate with a great support system. I refused those choices, got the treatment I needed and am here to tell the story.

But what about the most vulnerable among us who are not as able to self-advocate or who do not have strong support systems? Someone must speak for them. Fear of being coerced into making an unwanted choice could cause a person to not seek needed medical treatment or put it off until there is no hope of recovery.

Being able to control the manner and timing of one's death is thought to be the most attractive thing about this legislation. When the "best of" protocols are followed in medical aid in dying, the results are not assured to be smooth or peaceful. With the advances in palliative care, no one must be in agony while dying. Having been with several relatives in palliative care hospice, I can safely state that their dying process was pain-free and calm, even serene.

We have scientifically divorced ourselves from making necessary moral and ethical choices in the medical field. This is nowhere more evident than in the rise of so called compassionate caring laws known as Medical Aid in Dying. The ethics that govern the practice of medicine are no longer what they used to be, either. Since 1973, the Hippocratic Oath has become less commonly administered since SCOTUS decided that it was no longer a satisfactory guide to medical ethics and practice as it was not relevant to the most recent developments and methods of medical practice and research. It is now up to states to individually protect their citizens by continuing the practice of allowing patients to stop their treatment but not allow the opposite to happen: forcing a healer to become a killer. The argument for patient autonomy is hollow at best because it causes harm to the patient that the doctor is expected to participate in, lowering standards of medical professionalism with the sullying of the patient-doctor relationship. Ultimately, the result is the cost of a human life. A life that mattered and had something to offer from its conception to its natural death.

UNF SB845 pdf.pdf

Uploaded by: Nancy Paltell

Position: UNF

Senate Bill 845 - End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
March 7, 2023

Nancy E. Paltell, Ph.D.
North Beach, MD

OPPOSE

SB 845 should receive an unfavorable report because it is ***dangerous*** and ***unnecessary.***

I oppose SB 845 for many reasons. I'll discuss only two important reasons since many other witnesses will address the numerous other reasons why it should not become law.

SB 845 is UNNECESSARY

SB 845 is unnecessary because suicide is legal and widespread in Maryland. Fifteen years ago, my brother-in-law committed suicide in Maryland using the method described in SB 845. He went to a doctor and got a prescription for pain pills. But he didn't take them as prescribed. Instead, he swallowed all the pills at once, committing suicide by overdosing on pain pills, just as SB 845 allows. But committing suicide in this way ***is already legal in Maryland***. My brother-in-law ended his life this way ***in Maryland*** without enactment of SB 845.

It's also unnecessary because it's easy in Maryland to find advice on a myriad of ways to commit suicide. "Final Exit Network" has a website, https://finalexitnetwork.org/resources/fen-resources/options-for-hastening-death/ , that gives guidance on how to find ways to commit suicide. Committing suicide by the ways promoted on the website ***is already legal in Maryland***.

SB 845 is DANGEROUS

In 2022, both the MD Senate and House unanimously passed SB 94, "Public Health — Maryland Suicide Fatality Review Committee," and it became law. The preamble contained many important facts, such as that one-half of all people who die by suicide in Maryland have mental health problems, suicide deaths are significantly underestimated and inadequately documented, and between 2000 and 2018 the number of recorded suicide deaths in Maryland increased from 474 to 650, an increase of 37%.

One of the stated purposes of SB 94 was "to develop strategies for the prevention of suicide deaths in this State…." The overwhelming support for SB 94 leads to the conclusion that if suicide should be prevented, it is ***not*** something that should be promoted. SB 845 ***promotes*** suicide by trying to make it mainstream, legitimate, and acceptable. In fact, SB 845 promotes suicide by making it "health care."

SB 845 is dangerous because by legitimizing suicide in Maryland, the suicide rate in Maryland's general population will most likely increase dramatically. This is not an irrational fear but is based on the data that have come out of Oregon over the past 25 years. According to the Oregon Health Authority, the overall suicide rate in Oregon has increased every year since 2000. The rate of suicide in Oregon is higher than the national suicide rate for all age groups.[1] Just ten years after Oregon legalized physician assisted suicide, Oregon's conventional suicide rate was 35% above the national average.[2]

In closing, consider that the definition of "medication" is: a chemical compound used to treat or cure illness. The definition of "poison" is: a substance that harms or kills people or animals if they swallow or absorb it. SB 845 is about physicians writing prescriptions for poison, and making it legitimate health care. When my brother-in-law took his own life, he did not ingest medicine — because of the number of pills he swallowed all at once he ingested ***poison***. Suicide is a ***tragedy,*** NOT health care. I urge an unfavorable report.

Respectfully submitted,

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[1] Oregon Health Authority, "Suicide Trends," 2017.

[2] Oregon Health Authority News Release, 09/09/10

Nancy Weisman SB845 Opposition.pdf

Uploaded by: Nancy Weisman

Position: UNF

> "Rules in our moral code against actively causing the death of another person are not isolated fragments. They are threads in a fabric of rules that support respect of human life. The more threads we remove, the weaker the fabric becomes. If we also focus on the modification of attitudes, not rules only, the general attitude of respect for life can also be eroded by shifts in public policy. Prohibitions are often both instrumentally and symbolically important, and their removal could weaken a set of practices, restraints, and attitudes that we cannot replace."
> Principles of BioMedical Ethics, 4th ed, 1994, p. 230

Here we are changing our legal code - a public expression of our community values, impacting the entire community. By making killing through medical channels, by means of medical decisions, and carried out by health care providers **removes an important social and psychological barrier against killing**, corrupting medicine beyond recognition. Since Hippocrates, killing patients has been forbidden.

> "If the moral center collapses, if physicians become killers or are even licensed to kill, the profession - and, therewith, each physician - will never again be worthy of **trust and respect as healer and comforter and protector of life in all its frailty**." Gaylin, Siegler, Pellegrino, Kass. JAMA, 1988. Doctors must not kill.

We, in Maryland indirect medical killing - starvation, dehydration, asphyxiation - is already permitted and the consequences have been devastating. On the books, our medical killing serves autonomy, quality of life, and comfort. But that is not what happens in the hospital, or even at home in hospice.

The New England Journal of Medicine published a personal essay, "Death by Ableism," which tells of two patients, Michael Hickson, and the author's Uncle David, both disabled, who were denied life-saving treatment and life sustaining food and water. The authorities, not the family, determined that Mr. Hickson and Uncle David had "no quality of life," that is Hickson couldn't walk or talk, and therefore shouldn't "suffer" a feeding tube or a ventilator. By that standard, Stephen Hawkings had no quality of life, neither did authors Jean-Dominique Bauby (The diving bell and the butterfly book and movie) and Simon Fitzmaurice (It's not dark yet. Book and movie)

What is "ableism" if not utilitarianism, the basis of the Nazi medical killings. Who will judge some lives "unworthy of life?" When Melissa Hickson asked the doctor if he was ok with killing, he replied, "We don't call it killing." Perhaps it's time to call the thing by its' name.

Don't kill. Don't lie (primary cause is prescribed overdose; secondary cause - underlying disease).

PaulSb845.pdf

Uploaded by: Paul Okerblom

Position: UNF

SB845/HB933.

Oppose assisted suicide bills

On December 19,2022 the Supreme Judicial Court of Massachusetts decided to reject a challenge to the MA State prohibition of assisted suicide by finding that there is no right to assisted suicide in the MA Constitution. In a friend of the court brief Chris Schandevel of the non profit Alliance Defending Freedom argued that "patients should be able to trust their doctors to support and care for them. Offering terminally ill or disabled patients a 'quick exit' through death inducing drugs destroys that trust." The Supreme Judicial Court of MA Stated, "That although we recognize the paramount importance and profound significance of all end of life decisions,after careful consideration we conclude that the MA Declaration of Rights does not reach so far as to protect physician assisted suicide. We conclude as well that the law of manslaughter may prohibit physician-assisted suicide, and does so, without offending constitutional protections." They referred to the Feb. 2019 decision upholding the voluntary manslaughter conviction of Michelle Carter for assisting the suicide of Conrad Roy (18). Carter, who was 17 at the time of the death, pressured Roy to die by suicide by urging him during the act while on her cell phone.She was sentenced to 15 months in prison.The Court said...In sum, under our existing law, doctors who engage in physician- assisted suicide may risk liability for involuntary manslaughter. The question as to whether the MA Constitution could be interpreted to include a right to assisted suicide the Supreme Court of MA Stated: In sum, the history of suicide in general, and physician assisted suicide in particular, provides no support for the conclusion that physician- assisted suicide is an individual right protected by the MA Declaration of Rights.The Court further stated: Application of the law of manslaughter to PAS passes constitutional muster because the law is reasonably related to the state's legitimate interests in preserving life; preventing suicide; protecting the integrity of the medical profession; ensuring that all end-of-life decisions are informed, voluntary, and rational; and "protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives." We in Maryland would do well to follow their lead.

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AIMD Testimony - SB 845 - PAS 2023.pdf
Uploaded by: Rabbi Ariel Sadwin
Position: UNF

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Rabbi Ariel Sadwin
Executive Director

SENATE JUDICIAL PROCEEDINGS COMMITTEE

March 7, 2023

Senate Bill 845

End–of–Life Option Act

(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Testimony of Rabbi Ariel Sadwin

Oppose

Agudath Israel of America and its Maryland office speaks on behalf of the Orthodox Jewish community across Maryland – and nationally – on matters of government affairs and public policy. For the last 85 years, Agudath Israel has been the voice for "culturally sensitive health and end-of-life advocacy and counseling" for American Orthodox Jewry.

The Orthodox Jewish community of Maryland firmly and unequivocally opposes Senate Bill 845 – the Hon. Elijah E. Cummings and the Hon. Shane E. Pendergrass End-of-Life Option Act.

While the merits of this issue have been debated for more than two thousand years, classical Jewish tradition teaches us that **all** human life is sacred without any exception. Any laws that are enacted to undermine the sanctity of human life, sends a message that is profoundly dangerous for all of society.

It is of the most basic principles of Jewish law and ethics, that "man does not possess absolute title to his life or body", for that belongs to the Almighty G-D. We firmly believe that recognition of that fact has served as one of the pillars of civilized societies throughout all of the generations. That pillar is now in peril.

There are far too many people who suffer from terrible and dreadful illness, and we all know so many who have been affected by their suffering. Both proponents and opponents have shared many personal examples of loved ones who have suffered terribly for reasons man will never be able to comprehend. And while it may seem for some that they are better off dead than to remain alive, that is not a statement that ***any of us*** can firmly state.

However, for anyone to sanction a way for someone to hasten or bring about one's death prematurely – to that we are firmly opposed. Our community is emphatically supportive of advanced medical directives – where a person and their family can set their treatment preferences and when to decide when and how not to continue pursuing treatment to fight illness, etc., but that isn't the item being debated in this bill.

The Holy Talmud relates instances where a person is in the throes of death. It clearly and emphatically rules that one is not allowed to touch the person, lest he be involved in hastening the moment of death.

It is G-D himself who determines when we are to be born and when we are to die. It is not our doctor who takes the place of G-D to make those decisions. It is not our family members who make those decisions. And it is not ourselves.

On a very personal note, rarely does a day go by when I don't think about a person who had a profound impact on my own life, our family rabbi growing up in Silver Spring. He had just turned 60 when he was diagnosed with the ever-dreadful pancreatic cancer. After surgery and extensive treatment, the disease went into remission, only to return with a vengeance not long after. All of the treatment that he had sustained while he was still strong had taken a deadly toll on his body. All the while he continued to persevere and tried to remain as active and involved in the community as he was physically capable, and *beyond*.

In his own holy words delivered in his last public appearance, he said that if he was going to die it would be "with his boots on", i.e. still living life to its fullest – in as meaningful a way as possible. Now, several years later, an entire community of hundreds of households still draws strength from the way that man lived….and, how he died.

We request that you report unfavorably on Senate Bill 845 – Thank you.

SB 845 2023 End of Life Option Act Robert Murray.p

Uploaded by: Robert Murray

Position: UNF

SB0845 – End-of-Life Option Act - AGAINST

Submitted by:

Robert Murray

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Legalized suicide represents a devaluing of human life. Vulnerable Marylanders would be subject to coercion, inadequate oversight and expertise, and potentially horrific abuses inherent in telemedicine assisted suicide. SB0845 and HB0933 also alter the sacred space of the doctor-patient relationship where the physician heals instead of conferring death upon a patient. This proposed legislation would forever alter the practice of medicine and the nature of the physician-patient relationship in Maryland. Maryland has an unqualified interest in the preservation of human life and as such, Maryland should value all lives by continuing to prohibit assisted suicide.

There is no way to legislate adequate safeguards against the following major shortcomings of the proposed legislation.

- No mental health screening is required. There is nothing in the legislation to protect people with mental illness or depression.
- Individuals can become a victim of elder abuse under this legislation as one of the witnesses can be a family member. A family member who stands to gain after death could see this legislation as a means to an end and apply undue pressure. An heir can actually serve as a witness for the request for the lethal prescription.

- Individuals may not want to be viewed as a burden to family members and feel pressured to choose death.

- There are no safeguards for the disabled. This legislation poses serious danger to those with disabilities as these individuals often feel that they are a burden throughout their entire life and are frequently coerced into making decisions that are not in their best interest because they are lead to believe it will relieve a health care provider or family member.

- There is no way to predict accurately a 6 month lifespan. Terminal illness is often difficult to predict and patients frequently outlive them. Further there is evidence that many non-terminally ill patients receive the lethal prescription in states that have similar legislation.

- There is no one required to be present at the time of death and so there is no witness to ensure that an individual will not be pressured to take the pills or that the person that is going to take the pills is able to self-administer the lethal dosage willingly.

- This type of legislation is often presented as a solution to intense pain however in states that have this legislation pain is not given as the reason selected to terminate one's life. Palliative care and hospice services can and do alleviate the pain and suffering of patients. I have personally witnessed family members on palliative care and hospice care that have relatively unlimited access to pain killers including morphine as needed.

- Overdosing on barbiturates does not necessarily lead to a peaceful death. Overdosing on barbiturates has caused documented cases of persons vomiting while becoming unconscious and then aspirating the vomit. People have begun gasping for breath or begun to spasm. Overdosing on these drugs can cause feelings of panic, terror, and confusion. There have also been cases of the drugs taking days to kill the patient. There is no requirement for nurse or doctor to be present at time of death.

- It is nearly impossible to punish physicians for abuses under this legislation because the legal threshold is lowered from that of regular malpractice to good faith.

- Death certificates are falsified under this legislation, listing only the underlying illness as the cause of death, making the real number of suicides unknowable.

- People in poverty can be coerced into ending their lives when health insurance providers including Medicaid refuse to providing treatment and are able to recommend lethal prescriptions. Insurers continue to deny life-saving medical treatment and cover cheap lethal drugs where this type of legislation is legal.

- Pharmacists are not required to counsel patients on proper ingestion methods or on the safe disposal of the lethal barbiturates. There is no drug take-back plan for unused lethal pills. Highly addictive barbiturates go unaccounted for in a state already fighting against drug addiction.

- There is no family notification required.

- Overall suicide rates increase where states have this type of legislation.

- The state can't truly punish violations. Doctors are held to a 'good faith standard' which is far lower than the malpractice standard applied to other health providers.

There are better ways to help Marylanders improve their end-of-life care than this <u>dangerous legislation</u>.

Please vote against SB0845.

SB0845 Testimony for MFI 030723.pdf

Uploaded by: Robert Nelson

Position: UNF

SB0845–Oppose

Testimony by Robert Nelson to the Judicial Proceedings Committee

March 7, 2023

My name is Robert Nelson, Trustee, Maryland Family Institute.

I'm here today to testify in opposition to SB0845, the "End-of-Life Option Act."

I believe that every life is precious and is a gift from God. Dr. Peter Saunders, CEO of the Christian Medical and Dental Association covering over 60 countries, states,

> "The Bible tells us that human beings are unique amongst God's creatures in being made in the image of God (Genesis 1:26) and it is on this basis, after the flood, that God introduces to all humankind the death penalty for murder (Genesis 9:6,7). The prohibition against killing legally innocent people is later formalized in the sixth commandment, 'You shall not murder' (Exodus 20:13; Deuteronomy 5:17). Euthanasia clearly falls within this Biblical definition. There is no provision for compassionate killing, even at the person's request and there is no recognition of a 'right to die' as all human life belongs to God (Psalms 24:1). Our lives are not actually our own. Suicide and assisted suicide is therefore equally wrong."[1]

Dr. Paul McHugh, former psychiatrist in chief at Johns Hopkins Hospital said,

> "scientific publications from oncologists … who study patients with painful cancers, reveal that … most cancer patients want help with the pain so they can continue to live. Suicide is mentioned

> only by those patients with serious but treatable depressive illness, or by those who are overwhelmed by confusion about matters such as their burden on loved ones and therapeutic options. These patients are relieved when their doctors attend to the source of their psychological distress and correct them."[2]

My own personal experience is that estimates of length of life with a terminal disease are inexact. My Mother was given "two to six months" to live; she died at home three years later being lovingly attended to by my Dad. In 2013 my wife of 42 years was diagnosed with an aggressive cancer and I was present when she died very peacefully with palliative care in the hospital.

All life is precious from the moment of conception until the last breath of a natural death. I believe and have seen hundreds of times that the Lord does miraculously heal. I have heard of reports of people even being raised from the dead. Let's not get in the way of Divine intervention and healing.

Please vote in opposition to SB0845.

Robert Nelson
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[1] Dr. Peter Saunders, *Euthanasia: What Does the Bible Say?* LifeNews.com, November 13, 2013.

[2] Dr. Paul McHugh, *'Death with Dignity' Claims Another Victim, The Wall Street Journal*, May 25, 2013.

Sb845/Hb933

Oppose assisted suicide bills

The American Medical Association Code of Ethics states that: permitting physicians to engage in assisted suicide would ultimately cause more harm than good. PAS is fundamentally incompatible with the physicians role as healer, would be difficult or impossible to control, and would pose serious societal risks. It also obviously violates the Hippocratic oath to "do no harm".

Oregon the 1st state to legalize assisted suicide had certain "safeguards"at first.The suicide lobby later announced the restrictions were a problem. In 2019 the Oregon state legislature removed the 15 day waiting period. Some US states with AS bills have included a "do" or "refer" provision. The state of New Mexico requires a doctor to bring up AS to all "terminally ill" patients with 6 months or less to live whether they asked about it or not.Disregarding conscience rights of those in the medical profession is a huge concern. In Canada there have been 40,000 persons killed since Euthanasia was legalized there in 2016. Those laws first applied to "terminally ill" patients at the end of life.Then it expanded to include the disabled and chronically ill. Then those with mental health issues. And finally purposed for "mature" children.In 2018 the Delta Hospice Society in British Columbia was ordered by the Fraser Health Authority to provide euthanasia to their patients. The DHS resisted. In Dec. 2019 the FHA ordered them to provide euthanasia or lose their government funding. The DHS refused to comply saying that Medical Aid in Dying (MAiD) is not compatible with the DHS's purposes stated in the society's constitution, and therefore, will not be performed at the Irene Thomas Hospital.The Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Physicians sent the BC Minister of Health a joint statement saying, " MAiD is not part of hospice palliative care; it is not an 'extension' of palliative care nor is it one of the tools "in the palliative care basket". How could we stop a depressed type 1 diabetic from qualifying for AS in Maryland since an insulin dependent person would die in less then 6 months without insulin. What about "terminal anorexia", anorexia nervosa (intentional starvation), since death would come in less then 6 months.How do we provide suicide prevention for some people and suicide assistance using doctors, NPs,PAs, to prescribe barbiturates to end the lives of others? In the state of Washington inadequate pain control or concern did not rank in the top 5 reasons for requesting AS. The top 5 were 1. Loss of autonomy. 2. Being less able to engage in activities making life enjoyable 3. A loss of dignity 4. being a burden on family, friends, caregivers 5. Losing control of bodily functions.

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testimony sb845 pdf.pdf

Uploaded by: Rochelle Kane
Position: UNF

Please oppose SB845/HB933 Assisted Suicide.

Assisted Suicide legislation puts Maryland's most vulnerable populations at risk-including individuals with disabilities, minorities, those experiencing poverty, individuals being treated for or have a history of mental illness, our veterans, and those suffering from prescription or other drug addictions.

Lawmakers nationwide reject Assisted Suicide. The Maryland General Assembly has rejected some form of this bill at least five times. Your peers made their legislative intent very clear that Assisted Suicide is a criminal act and should remain so.

- Maryland's leading disability rights groups recognize the many dangers the bill poses to those with intellectual and developmental disabilities.
- There is no standard requirement that each patient receives mental health screening and counseling.
- No family notification is required.
- One in three patients who fill the lethal prescription-typically 100 pills, decide against taking it. There are no safeguards to ensure the unused drugs stay out of the hands of children and prescription drug dealers. This is particularly irresponsible, as we are experiencing an opioid crisis nationwide.
- No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.
- Assisted Suicide laws make suicide socially acceptable. States which have legalized Assisted Suicide have experienced increased suicide rates.
- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.

For these reasons, I respectfully ask that you protect Maryland's most vulnerable citizens. Please oppose legislation to legalize SB845/HB933 Assisted Suicide.

Margolis written testimony SB845 3-6-23.pdf

Uploaded by: Russell Margolis

Position: UNF

Russell L. Margolis, M.D.
Professor of Psychiatry and Neurology

Clinical Director, Johns Hopkins Schizophrenia Center
Director, Laboratory of Genetic Neurobiology
Director, Schizoaffective Disorders Precision Medicine Center of Excellence

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March 6, 2023

The Honorable William C. Smith, Jr, Chair
The Honorable Jeff Waldstreicher, Vice Chair
2 East, Miller Senate Office Building
Annapolis, Maryland 21401

Testimony in Opposition to Senate Bill 845: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Chair Smith, Vice Chair Waldstreicher, and Honorable Members of the Judicial Proceedings Committee:

My name is Dr. Russell L. Margolis. I am a Board-Certified Psychiatrist, and Professor of Psychiatry and Neurology at the Johns Hopkins University School of Medicine, where I have evaluated and treated individuals with severe mental illness, and investigated the causes and consequences of mental illness, for over 30 years. The views expressed here are my own and do not necessarily reflect the policies or positions of the Johns Hopkins University or the Johns Hopkins Health System. I am a member of the Maryland Psychiatric Society, and my position agrees with that of both the Maryland Psychiatric Society and the Washington Psychiatric Society.

I am testifying in strong opposition to Senate Bill 845, the End-of-Life Option Act.

1. Under the provisions of the Act, terminally ill individuals with treatable psychiatric disorders will inadvertently receive medical interventions that will lead to their death via assisted suicide.

A. Psychiatric disorders are common in people with terminal illnesses. Between 25 to 77% of individuals with terminal illnesses have treatable psychiatric disorders, including depression, anxiety, and delirium. The psychiatric disorders, rather than the underlying medical condition, are often the critical cause of suffering in these individuals. For instance, depression, especially in an older person, is often manifest not by overt sadness, but by overwhelming physical distress and pain. These conditions in the terminally ill respond to treatment, and the discovery of new, faster acting treatments, such as ketamine, psilocybin, and brain stimulation, makes detection of these conditions, even among those with days or weeks to live, imperative.

B. Physicians often do not detect psychiatric disorders in terminally ill individuals. Unfortunately, the capacity of non-psychiatric physicians to detect psychiatric illness is limited. In a study of patients with terminal illness admitted to a palliative care unit, 2/3 had a diagnosable psychiatric condition, but 1/3 had not been identified or treated adequately prior to admission (Ita, 2003). My own early research similarly demonstrated that non-psychiatrists cannot reliably distinguish between depression and delirium on inpatient medical wards (Margolis, 1994). 25 years later, little has changed (AlSalem, 2020).

C. The End-of-Life Option Act does not adequately address the problem of psychiatric illness in the terminally ill. Referral to a mental heath professional is voluntary. In Oregon, with a similar voluntary system, only 3.3% of individuals requesting prescriptions to end their lives were referred for a mental health evaluation (Oregon Annual Report, 2021). The rate is similar in Canada. Further, in a misguided effort to preserve individual confidentiality, the Act does not require information from treating mental health professionals or family members. Failure to seek such information would be considered substandard care, if not outright malpractice, in any other situation in which an individual comes to medical attention for wanting to end their life. Finally, it is clear in the web pages of advocacy groups in favor of assisted suicide that if an individual's own physician cannot or will not provide a lethal prescription, help in finding such a doctor is available. That help seems likely to meet with success. In Oregon in 2021, 133 different physicians wrote lethal prescriptions, most for 1 or 2 individuals, but one physician wrote 47 such prescriptions. In the Netherlands, a specialized clinic has developed for assisted suicide.

D. Example. Some years ago, before effective treatment was developed for HIV/ AIDS, I treated an individual with advanced AIDS who was barely eating and drinking, had become incontinent, and was in psychological agony. I have no doubt that if a law like the proposed Act had existed at the time, he would have requested assisted suicide, and most physicians would have readily acquiesced. Fortunately, he was referred to psychiatric treatment, where it was clear that he was profoundly depressed. With assistance from his partner, he was eventually persuaded to accept a standard treatment for depression. His previous optimism, good humor, and will-to-live returned. Before he died from AIDS some months later, in a large public ceremony, in the presence of family, loved ones, and friends, he gratefully received a long-delayed award for his prominent humanitarian efforts.

The Act should therefore be opposed on the basis that many individuals requesting assistance to end their life have treatable but unrecognized psychiatric conditions which lead them to seek death. With appropriate psychiatric care, the quality of life for these people can immensely improve, allowing them to maintain a dignified and meaningful life.

2. The reasons for which people seek to end their suffering by death can and should be managed by other means.

In Oregon, when asked why they sought help to end their life, 90.9% feared losing autonomy, 90.2% feared loss of ability to engage in activities that make life enjoyable, 73% feared loss of dignity, 48.3% feared being a burden on others, and 43.7% feared loss of control of bodily functions, 27.5% feared pain, and 5% were concerned about the financial implications of continued treatment (Oregon Annual Report, 2021).

These fears can and should be addressed by progressive means—providing high quality palliative care, including psychological support, pain management, better health care and health care insurance, and examples of those who have lived meaningful lives despite impaired function (Dore , 2022). A complicating factor, particularly in the setting of laws similar to the End-of-Life Option Act, is that physicians tend to underrate the quality of life of individuals with disabilities.

The role of medicine, and society, should be to instill hope and provide comfort, not to dodge social responsibilities. This is why almost all major disability rights groups oppose measures like the proposed Maryland Act.

3. Death as a solution to fear and despair becomes an accelerating self-fulfilling prophecy.

A. Increased rates of aided and non-aided suicide. In Oregon, the number of lethal prescriptions increased from 24 in the year after passage of the “Death with Dignity Act (DWDA)” in 1997, to 383 in 2021, the last year for which data is available. Similar increases have occurred in other countries. In the Netherlands, assisted-death accounts for ~4% of annual deaths, and in Canada, 3.3% of all deaths and rising (Frolic, 2022). Unlike the prediction of some advocates, typical deaths by suicide did not decrease, and if anything may have increased, as predicted by epidemiological analyses of the increased suicidality rates of those directly or indirectly exposed to the suicide (Maple, 2017). The effect is most detectable in marginalized and vulnerable populations. In Oregon, for instance, there has been a greater than 50% increase in suicide among elderly women since the enactment of the DWDA. The statement, by act of law, that assisted suicide is an option acknowledges that suicide is an acceptable life choice, plays into the fear of terminal illness, and increases the suicide rate.

B. Eligibility criteria for assisted suicide tend to become substantially less restrictive over time. The key eligibility criterion in most jurisdictions begins as “terminal illness with 6 month or less life expectancy”, or the equivalent, as in Maryland’s proposed Act. There is then pressure to broaden criteria: In Canada, within 7 years of the initial Medical Assistance in Dying (MAiD) legislation, the criterion requiring “forseeable death” was removed, with the explicit goal of providing individuals with psychiatric disorders access to MAiD even if natural death is not imminent (Frolic, 2022). In the Netherlands, the initial broad criteria of “hopeless and unbearable suffering” also included such suffering consequent to psychiatric disorders. In a bill introduced to the Netherlands legislature, the emotion of having lived “a complete life” is under consideration as an additional eligibility criterion for assisted-death (Van Veen, 2022).

C. The ultimate impact of assisted suicide is a shift in societal perspective in a very dangerous direction. As the use of assisted suicide increases, and the criteria for its use broaden, societies undergo a moral shift. Suicide become a reasonable option in the face of hardship, and pressure mounts on both the individuals facing the hardship, and the physicians caring for them, to take rapid and definitive action. The risk is that rather than seeking real solutions, which may be expensive and cumbersome, the pressure turns to assisted suicide, a fast and efficient solution. The health insurance system in the United States is a confounding factor; it is of concern that a single dose of lethal pills is likely much less expensive, from the standpoint of an insurer, than weeks or months of intense supportive care. And, as the evidence from Oregon is beginning to suggest, it is the most vulnerable in the population who will likely bare the brunt of this societal shift towards suicide as a solution for societal problems.

Conclusion: Assisted-death is a regressive policy, a “20th Century problem”, to paraphrase palliative care expert Matthew Dore. Maryland should be seeking progressive 21st Century solutions that provide hope, care, support, and quality of life, not discrimination, marginalization, and death.

Sincerely,

Russell L Margolis MD

Russell L. Margolis, M.D.

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Nettina testimony SB845 3.7.2023.docx.pdf

Uploaded by: Sandra Nettina
Position: UNF

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Oppose - Senate Bill 845
End-of-Life Option Act

Presented to the Judicial Proceedings Committee
March 7, 2023

I respectfully oppose this legislation for multiple reasons, a few of which I will explain to you here. My first point is that this legislation is not necessary. We have true medical options that are effective and far safer for end-of-life care. Why not expand on palliative care programs to improve the negative scenarios about death? Second, this legislation is inherently discriminatory, and would only expand the flaws in our health care system and culture that are discriminatory toward the poor and marginalized. Finally, it is impossible to enact safeguards on this policy. Expansion is likely to remove barriers so that more people might take advantage of it, as has already occurred in Oregon, California, and other countries.

Premeditated, intentional ending of one's life is not health care. The fact that this option is being introduced as a health care treatment, prescribed by physicians, is far outside of the standard of care that all health care professionals train for and are held to. Assistance with ending of one's life should not be offered as a medical treatment. There are effective, well researched, mainstream treatments available to care for the physical and emotional distress and other symptoms of end stage and terminal illness. This legislature has worked hard over years to put into place advance directives and the Maryland MOLST form which give people choices about their end-of-life experience.

I am passionate about the care of people faced with very serious diagnoses. As a nurse practitioner for over 30 years, I have designed my practice to provide palliative care in the home and utilize hospice services for a wide range of cases. I provide individualized care, bringing in other health resources, to meet the physical and emotional needs of people facing death. I provide treatment, education, and support with comfort medications and other symptom controllers to improve the quality of life, right up to the time of natural death. I also refer for home hospice care where a whole professional team is available for comfort and support. I have found individualized palliative care and hospice services to meet all of my patients' varied needs, no matter how intense or complex. And despite what many people think are the reasons for seeking aid in dying—becoming a burden and loss of control--families and loved ones, in my wide experience, do not feel the dying person is a burden, and the dying person does maintain dignity and sense of control through natural dying.

Despite the great strides we have made in Maryland and in this country to increase health care coverage, there is still racial and economic disparity in quality care access. Unfortunately, allowing for people to opt into ending life with a lethal dose of medication will be seen as desirable for people who have been made to feel undesirable, especially the disabled. This act, fully sanctioned by the state, will become a cultural norm. What a shift in culture that will be for us in Maryland, when there is already cultural bias against the weak and vulnerable—the poor, minorities, those with disabilities, the elderly, and the mentally ill. Do you want to make that happen? Even if it was not your intent, it will happen by unintended consequences.

This policy makes suicide socially acceptable, as evidenced by Oregon’s increased suicide rate, much higher than the national average (Oregon Health Authority, Suicide Trends 2017). Once acceptable, expansion is likely, including people with treatable conditions who refuse treatment, people living with chronic but non terminal illnesses, and people with difficult life situations and emotional suffering. This is happening across the country, with 5 states proposing expansion bills in the past year. Some will propose, with good intention, to try to relieve suffering for more people, but this is not the way.

During my career, I have walked with many people who are suffering, often on their final journeys. We can’t give up on our quest to relieve human suffering. Medical innovations, increased access to palliative care, and stronger socioeconomic support systems are needed. Advancements in medical technology allows us to relieve even the most agonizing pain. However, sometimes even simple measures can relieve sufferring. These include being physically present with someone who is suffering, listening, providing gentle physical care, gentle handholding or touching. Health care providers, caregivers, and loved ones who can do this, and not walk away, can ease pain and suffering certainly for the terminally ill, and across populations. Do you want to be the one offering a quick, easy, lethal prescription, or the one who stays and offers comfort measures? Marylanders deserve better than SB 845. I ask you to give SB 845 an unfavorable report.

Sincerely,

Sandra Nettina, Nurse Practitoner Sandra Nettina CRNP

2760 Wynfield Road, West Friendship, MD 21794

Additional Problems with Legalization of Assisted Suicide

It is not needed. Palliative care and hospice services can provide end of life care that is individualized, holistic, and hands-on until the very end.

There is no way to predict an accurate prognosis—many people outlive a 6-month prognosis and condition often improves.

The process is impersonal—the prescriber usually is meeting the terminally-ill person for the first time, and cannot verify that the person is of sound mind, free of depression or mental illness, and has a 6-month prognosis.

There is no involvement of medical professionals after the person receives the prescription. The person is left to ingest the lethal dose with no standby help if something goes wrong.

Dangerous controlled substances may be accidentally used by someone in the home, stolen, or diverted. No ID is required for pick up at pharmacy; there is no assurance on secure storage at home; there is no education about disposal of the drug or required take-back plan if not used. Newer medication cocktails in the form of powder are extremely dangerous! The preferred method being recommended by the American Clinicians Academy on Medical Aid in Dying (ACAMAID) includes the following:

Digoxin 1000x therapeutic dose, diazepam 200x, morphine 3000x, amitriptyline 800x, phenobarbital 300x. There is no conscience protection for pharmacist who do not feel it is professionally ethical to dispense these medications. Three of these are controlled substances—will the pharmacies be comfortable even stocking the shocking dosages of these medications?

There may be coercion by the family or friends.

Underlying depression and anxiety may be easily missed and not treated.

The terminally-ill person may perceive that they should take this option because it is the least expensive.

Insurance companies may deny more treatment options due to cost once this option is available.

Legalization changes the perception of suicide, which may influence more people to use it as an option to solve problems. Also gives the perception that drugs are a quick fix to problems.

Vulnerable populations may be unknowingly targeted due to inherent societal bias against those who may need more resources.

Loved ones often have regrets—what if the person would have had another remission, or started to feel better?—there is no turning back.

Death certificates will not reflect the true cause of death and natural history of underlying conditions, possibly skewing cancer survival statistics.

There is no transparency—impossible to know if there was any misconduct by the prescriber or family, or anyone involved in the process; and no recourse if abuse of the process is suspected.

The policy is inequitable—we cannot alleviate all suffering unless we allow anyone and everyone to take their own life when they experience suffering. But what we can do is offer comfort and support to everyone who suffers. Sometimes this will take a whole team of medical professionals investing time, money, and resources into complex cases. However, many times all it takes is someone to sit and list and hold a hand. We need to teach the next generation how to care. Everyone's future depends on it.

Sandra Nettina CRNP

Christiansen Written Testimony SB 845.pdf

Uploaded by: Sandy Christiansen

Position: UNF

Statement to the Senate Judicial Proceedings Committee
Re: SB 845

March 6, 2023
Unfavorable, oppose

My name is Dr. Sandy Christiansen and I'm a board-certified obstetrician/gynecologist licensed in the state of Maryland. I am opposed to SB 845 because it:

- Violates the sacred covenant between doctor and patient to first do no harm
    - Physicians are healers, not killers
    - Physicians have the right to practice in congruence with their moral framework
    - Physicians are not vending machines to dispense a requested product
    - Patients' trust in physicians is eroded if they cannot be certain the doctor will act in their best interest
- Gives physicians too much power over their patients
- Allows physicians' biases to enter into life/death decisions.[1] Studies show that physicians perceive disabled people to have a lower quality of life compared to how the disabled view themselves.[2]
- Lacks a requirement for a formal psychiatric evaluation
- Puts the lives of the disabled in jeopardy
- Opens the door for the elderly and infirm to seek physician assisted suicide to avoid being a "burden" to their families[3]
- Promotes a culture of death where it becomes acceptable to end one's life for treatable and random reasons; increases suicide among our youth are observed where PAS is legal

None of us here wish to see loved ones suffer, but there are better ways to accomplish this than to put in place a law that undermines the essence of the doctor-patient relationship. The bedrock that this relationship is founded upon, and the glue that holds it together is trust. Trust that your doctor will always act, will always act in your best interest, come what may. If physician-assisted suicide is legalized, patients won't know if their doctor's ultimate motive is to heal them or end their life. Doctors must remain healers, not killers. As a medical student, I was raised with the time-honored doctrine of "primum non nocere," above all, do no harm![4] This phrase is attributed to the English physician Thomas Sydenham and has been passed down through the years to physicians in training. Our duty is to eradicate the pain—not the patient. To give physicians that

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[1] *Physicians' personal limitations and biases can influence a terminally ill patient's request for hastened death. These factors included having little or no training in counseling and an attitude that the doctor would assist the patient to hasten death if requested. Guy, M. and T. A. Stern. "The desire for death in the setting of terminal illness: a case discussion." Prim Care Companion J Clin Psychiatry 8, no. 5 (2006): 299-305*
University Press; 2011.

[2] *Diekema DS, Mercurio MR, Adam MB, editors. Clinical Ethics in Pediatrics: A Case-Based Textbook. Cambridge: Cambridge*

[3] *Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. Am J Psychiatry 1995; 152(8): 1185-91.*

[4] Smith, C. (2005). Origin and uses of primum non nocere--above all, do no harm! *J Clin Pharmacol, 45*(4), 371-7. Retrieved March 5, 2015, from http://www.ncbi.nlm.nih.gov/pubmed/15778417#.

degree of power over their patient's health and well-being-and autonomy, is a fundamental conflict of interest.

The etymology of the word "professional" has at its root from Middle English, "*profes*," meaning to profess or confess vows[5]. Thus, true medical professionals subscribe to a set of values and precepts that undergird their practice of medicine. The principles backing the modern day doctor patient relationship are grounded in Hippocrates's Oath and other time-honored values, establishing a sacred trust where a physician's duty is to help and not harm their patients, explicitly prohibiting giving 'deadly drugs" if asked, or even suggesting such a thing.

Dr. Julie Balch states the following about the Oath: "The Hippocratic oath has set a standard for the field of medicine that has survived through the ancient world, the Middle Ages, the Renaissance and the Enlightenment, through two world wars, and through the greatest period of scientific discovery. The miracle of the oath is that it has been accepted, notwithstanding the minor changes, in culturally, religiously, and socially diverse communities worldwide."[6]

Excerpt from the classic Hippocratic Oath:

> *I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art…Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.*
> *—Translation from the Greek by Ludwig Edelstein. From The Hippocratic Oath: Text, Translation, and Interpretation, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.*[7],[8]

Do you know why this oath was created? Because physicians during Hippocrates day were abusing their power and taking advantage of their patients, sexually, financially, and more. Are we destined to repeat history, or can we learn from it? Physician-assisted suicide would revert the patient-doctor relationship back to pre-Hippocratic days, when patients didn't know if the doctor would heal them or kill them.

There is nothing to prevent someone from taking their own life, but to give a physician the power to end your life puts you, the patient, in an untenable position and at a severe disadvantage.

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[8] Greek Medicine (2002, Sept 16)- The Hippocratic Oath. (n.d.). Retrieved March 5, 2015, from http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

Imagine a scenario where your mother walks into my office with bloating and I diagnose her with stage IV ovarian cancer. After a full evaluation, her five year survival is estimated to be less than five per cent. I present her options, including assisting her suicide. Do you honestly believe that she will trust me, even if she opts for a full court press of surgery and chemotherapy? In the back of her mind, she will always wonder if I will do something, or want to do something to hasten her death.

Physician-assisted suicide allows doctors to be judge, jury and executioner. Does the patient really have a choice when the doctor gives the diagnosis, prognosis and tells them there is nothing more that can be done?

This is not the kind of physician I am or will ever be. The American Medical Association states in Medical Ethics opinion 5.7: 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.[9]

I few years ago, I read about Randy Stroup of Oregon who was diagnosed with metastatic prostate cancer. His application to the state for healthcare coverage was denied because they calculated that he had less than a five per cent chance of surviving his cancer. But, the State did offer to pay for his 'physician-assisted suicide'. In short, the state deemed his life not to be worth saving and in fact was prepared to put him to death. Brave New World here we come. We have fallen so far from the ethical and moral principles that the practice of medicine was founded on. In Francis Schaefer's and C. Everett Koop's 1979 book, Whatever Happened to the Human Race, they wrote of society being on "the edge of a great abyss."

Are you prepared to pave the way to a deconstructed society where the elderly, infirm, and disabled live in fear that their lives will be snuffed out? Where people stop going to their doctors because they can no longer trust that they are devoted to healing instead of managing healthcare and the bottom line? This bill may seem like a compassionate effort to allow individuals to control their last days on earth, but it will decimate the doctor-patient relationship, sending shock waves through the practice of medicine. Medicine will morph into an unseemly cross between vending machine doctors who are compelled to dispense whatever the patient wants and a dangerous game of Russian roulette, where the doctor fixes the results.

I think that our ride on the slippery slope has, in fact, taken us into the abyss and it is my profound hope that you, dear Delegates, will help stop the slide.

I'm asking for an unfavorable vote on SB 845.

Sincerely,

Sandy Christiansen, MD, FACOG
Care Net National Medical Director
Frederick, MD 21703

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[9] Opinion 5.7 - Physician-Assisted Suicide. (n.d.). Retrieved March 6, 2023, from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page.

SB845 Oppose End of Life Act.pdf

Uploaded by: Sarah Miicke

Position: UNF

BALTIMORE
JEWISH
COUNCIL

Senate Bill 845– End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
March 7, 2023

OPPOSE

Background: Senate Bill 845, if enacted, would repeal the State's ban on physician-assisted suicide. It would allow a patient's attending physician to determine if a person is terminally ill and decide whether the patient requires a psychological exam. If the patient meets the criteria, is over 18 years of age, and is a Maryland resident, they may request a prescription for life-ending drugs. The patient must request three times: request 1 is oral; request 2 is in writing and signed by the individual and two witnesses, one of whom may not work for the patient, be a relative, or in any way benefit by the death of the patient; request 3 is oral, at least 15 days after the initial oral request and at least 48 hours after the written request. At least one of the requests must be made in private with the doctor. The bill also requires a second opinion from a specialist or someone with "experience" to confirm the patient has a terminal illness and whether he or she requires a psychological exam. The patient must self-administer the prescription. Any pharmacist, doctor, or healthcare facility need not participate if they object, and there is no penalty for non-participation. If the patient takes the medication and dies, he or she is declared dead by *natural causes* on the death certificate.

Written Testimony: The Baltimore Jewish Council (BJC) has a long-standing policy position opposing assisted suicide. The policy position was adopted in 1997 and reaffirmed in 2015. While we understand that this is a personal issue for many people in Maryland, on significant life-impacting principles that are deeply rooted in Jewish heritage, doctrine and tradition, the BJC is directed by our Jewish spiritual leadership. We believe that all life is sacred and that we are all created in the image of God. Suicide is a violation of Jewish law, as is assisting in a suicide. We are extremely supportive of end-of-life planning, such as advanced directives, and withholding or withdrawing impediments to the natural process of dying.

With this in mind, the Baltimore Jewish Council asks for an **unfavorable** report on SB 845.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of THE ASSOCIATED: Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

BALTIMORE JEWISH COUNCIL
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410-542-4850 • fax 410-542-4834 • baltjc.org
Member of the Jewish Council for Public Affairs

Baltimore Jewish Council is an agency of The Associated
The Associated
Jewish Federation of Baltimore

SB0845-ACRWC-UNFAV.pdf

Uploaded by: Sarah Reichert-Price

Position: UNF

Senator William C. Smith, Jr., Chair
and Members of the Judicial Proceedings Committee
Maryland State Senate
Annapolis, MD

RE: SB0845- End-of-Life Option Act- OPPOSE

Dear Senator Smith and Members of the Committee,

I have seen, and opposed, many far-reaching, extremely outrageous, and, to be truthful, absolutely idiotic proposals for legislation over the past few years but, this is the most egregious to date! Why would anyone even consider making it legal to kill themselves? Not only that, but to put in place legal protection for any health care worker that assists in this process?! I cannot express how urgent it is that you oppose SB0845! Please consider the following:

- SB0845 opens the door for **legal** manslaughter! Even though this bill requires that the person asking for assistance in dying be able to self-administer the drugs, and that the request be voluntary, there is no way to be sure that a person is not pressured to take this action. It should be obvious that such a law will be misused by some dishonest medical personnel, or those who feel strongly about the issue and think their moral stance dictates that they break or stretch the law.
- Denying treatment to ill, elderly, or disabled individuals is inhumane. The broad language used in this bill has led to cases in some US states of people being denied treatment for cancer because it was deemed not appropriate for their condition. Instead, they were offered drugs, or psychologically pressured to take drugs, to end their lives. There have been instances of disabled individuals in other states who were pressured to end their lives through physician counseling

SB0845 is outrageously inhumane and widens the possibility of immoral acts against humanity! I pray that you reconsider SB0845 and render an UNFAVORABLE report for this bill.

Thank you for your time,

Sarah Price (ACRWC)
Westernport, MD (Allegany County)

3-6TestimonySB845.pdf

Uploaded by: SHARON HANSEN

Position: UNF

Written Testimony against the End-of-Life Option Act (SB 845)

Position: Opposed

Sharon Hansen, RN, CHPN

Billings, MT 59101

My name is Sharon Hansen and I am a Certified Hospice and Palliative Registered Nurse. I worked in this capacity for several years in California. ***That is until last year, when our first patient requested Medical Aid in Dying, which is where my testimony begins***…

I became a nurse, specifically to work in hospice care. It has been my true passion. Hospice has been a rewarding, difficult and a touching career all in one. As part of a hospice team, we help each patient and their loved ones as they prepare for the most difficult time of their lives. Hospice cares for the patient has a whole person-physically, emotionally, and spiritually. As the ending of their life becomes a reality, fear of the unknown and the anticipation of symptoms can be overwhelming-but there is hope for a beautiful transition. Many thoughts and feelings are shared from patients to the hospice team. For example, patients have shared "feeling like a burden" to their loved ones. When these feelings are addressed and recognized, amazing things happen time and time again! Through our hospice team, I have seen amazing transformations take place with patients and their loved ones during all my years-both emotionally, physically and spiritually. Each step of the dying process is a necessary and vital part of living.

To equate comfort and compassion with assisted suicide is a misnomer.

Pain and suffering not only accompany assisted suicide but also adds the unnecessary *complicated* grief and guilt for the family and loved ones left behind. Unfortunately, last year our hospice team was presented with an assisted suicide situation. To say that it put a very dark cloud over our mission as a hospice team would be an understatement. The moral distress was overwhelming! This dark cloud spread over to every member of our team. To support a patient who chose to take a poison with the intent to take their own life is simply not being a true nurse with compassion and negates the entire hospice philosophy and purpose of our mission. Instead, it is a true disservice to another human being.

This situation was anything but ideal. It had been several hours before this patient finally died. She suffered with vomiting and respiratory distress. Her husband, who thought he would be able to manage this situation (as this was his wife's decision) was tormented and now left to tell his kids-as she wanted to keep it hidden from them. Before the patient passed, she stated herself she just needed to "sign on" to hospice to complete her check-off list. This is what the assisted suicide community called the "death package"-which included hospice, mostly to ensure there would not be an autopsy initiated. This situation sadly led to significant unnecessary and complicated grief for the family and loved ones. This was a huge disservice to both the patient and their family. This is not nursing "care" or compassion and it certainly does not abide by the Hippocratic oath of "***First, do not harm"***.

I ended up having to leave the hospice field altogether because of the intense moral distress. This transition has, ironically, shown me the bigger picture of this issue. Let me explain…

As I was initially preparing for this testimony, the notion that others are striving to continue to push for the legalization of assisted suicide was just (I thought) within my own little world of hospice and its effect on me, our hospice community and the patient and their loved ones dealing with the unnecessary complicated grief, guilt and suffering. But, now it is even more clear to me that it is **vital** that this legalization DOES NOT PASS.

What message does this give to our youth and the next generations to come?

Currently, I am an RN providing physicals for donors wanting to donate their plasma. I have been astounded by HOW MANY young adults have had either frequent suicidal ideation and/or a history of several suicidal attempts already, and at such a young age. Just last week I was performing a physical for a young girl (early 20's) who was actively suicidal and had been begging for help. The soonest the mental care facility could see her was in April! She broke down in tears and was searching and begging for someone to hear her and **HELP** her. After connecting her with a nurse at the local hospital, she finally got help. That nurse was an absolute angel for that precious soul.

As a community of a whole, we should give an example for our next generation: they DO MATTER and their life is precious. THEIR life is NOT dispensable. No matter the situation, the pain or emotional hardships that arise, **<u>they still matter</u>**.

If it is OK to assist another to kill themselves when struggling with physical pain, emotional pain or feeling like a burden…then what is this saying to our next generation? I beg all of you who are deciding your vote right now, please look at the big picture and where this is leading. What message is this giving to our next generation! This is NOT compassion…it is an attempt to normalize the control of one's life when it feels unbearable or like a burden. Every life is precious and should be treated as such**. As a community as a whole, we can strive to ensure each one of us knows that our lives are precious ...even to our last breath.**

Quick Testimony MD SB 845.pdf

Uploaded by: Sharon Quick, MD, MA (Bioethics)
Position: UNF

Testimony of Sharon Quick, MD, MA (Bioethics)
President, Physicians for Compassionate Care Education Foundation
Email: squick.pccef@gmail.com
In opposition to SB 845
Senate Committee on Judicial Proceedings, Annapolis Maryland
March 7, 2023

Chair Smith and members of the Committee:

I am President of the Physicians for Compassionate Care Education Foundation (PCCEF), an organization without religious or political affiliation that promotes safeguarding vulnerable human lives, especially those at the end of life. I have expertise in pediatric anesthesiology, critical care, pain management, and medical ethics. As a physician residing in Washington State, where physician-assisted suicide was legalized in 2009, I urge you to oppose SB 845.

This bill gives new rights and powers to physicians, not patients, by creating subjective, error-prone criteria[1] by which they place people into two classes: a protected group (where the standard of care for those who wish to hasten their death is mental health services) or a marginalized group (who can be harmed, as they are not deemed worthy of such protection). Physicians expand their role to judge, jury, and assistant executioner. The prime witness is dead, and the physician accomplice is given immunity from civil and criminal charges. Financial forces favor death, and the balance of power is shifted away from the patient. With practices where doctors are given incentives to reduce costs or with government-sponsored health plans, physicians and/or government have conflicting goals—the primary responsibility to protect the weak and vulnerable is challenged by the enticement of killing them to save money. Barbara Wagner, for example, received a letter from the Oregon Health Plan refusing to pay for a chemotherapy agent to extend her life but offering physician-assisted suicide (PAS) as one of her options.[2]

The so-called "safeguards" have not prevented documented instances of physician noncompliance, coercion,[3] inappropriate selection,[4] botched attempts,[5] and active euthanasia.[6] Oversight of this process of lethal drug prescription is minimal, without any qualitative review as would be required in a hospital setting. Enforcement of compliance in submitting forms is non-existent. Hundreds of forms in WA are missing from physicians and for patient consent, yet nothing is done. In Oregon, patients are getting lethal prescriptions for diagnoses of anorexia, hernia, and arthritis—diagnoses that are not terminal by themselves—but there is no process for challenging physician actions. In spite of the high incidence of depression in the terminally ill which may be overlooked by up to 40 percent of physicians, less than 5 percent of patients in WA are referred for mental health evaluation before getting a lethal prescription. Evidence indicates that depressed patients are inappropriately getting lethal drugs.[7] In 2012 17% of all patients given lethal drugs lived longer than 6 months, with a maximum of over 3 years. How many patients might have lived longer if they had not taken lethal drugs is unknown. Since 2019, WA has now stopped reporting complications, survival time, and several other types of data that used to be recorded. Because no evaluation of patient capacity has to be done when patients actually take the lethal drugs and no one is required to be present, it is unknown if patients are ingesting drugs after they have lost capacity or how often a greedy heir might hurry death along in a frail, vulnerable patient. Unfortunately, tired caregivers or family sometimes express a desire to deny routine care to sick patients (with months or years of life remaining) to end <u>their</u> burden, not that of the sick patient.[8]

Wherever PAS has been legalized, the subjective criteria are changed, allowing expanding numbers of people to be classified into the marginalized group.[9] PAS creates distrust between patients and physicians and among physicians themselves. Studies show that physicians view persons with disabilities as having a lower quality of life than those persons do themselves, and the terminally ill often develop disabilities.[10] Doctors' biases can influence a terminally ill patient toward requesting a hastened death.[11] Some patients with serious illnesses in the northwest are beginning to fear physicians' motives, as they are unsure who are the death doctors and whether their options are portrayed as more bleak than they are. They want multiple opinions to ensure they are not being abandoned as a hopeless cause. Patients can be demoralized when physicians offer them lethal drugs, because it indicates that the physician does not value the patient's life. Physicians are increasingly distrustful of referring patients to colleagues, when some have had patients with depression inappropriately, and over their objections, killed by their colleagues' lethal prescriptions.[12] This bill fractures the physician-patient alliance and destroys the foundation of medical ethics.

Pain or inadequate symptom management should never be a reason for terminally ill patients to seek lethal drugs. Even a physician who advocates for lethal drug prescriptions admits this.[13] Testimonies about patients with excessive pain or other symptoms at the end of life indicate that these patients had inappropriate palliative care. One patient was told by his doctors said he was "maxed out on morphine," and lethal drugs were his only alternative.[14] However, there is no "maximum" for morphine in terminally ill patients. Most patients do not have intolerable pain as they approach death, and in the rare situation where various analgesics, nerve blocks, and other treatments are not sufficient, temporary sedation can be used to relieve pain. That patient's doctor failed him. Studies show that doctors may lack knowledge about palliative care possibilities.[15-17] Rather than removing safeguards to obtain lethal drugs, we should ensure that patients have access to good palliative care and physicians are not deficient in their use if it.

Patients' access to palliative care should not be taken as a given, as there is evidence that minorities, the uninsured, those on Medicaid, and those living in disadvantaged communities may encounter barriers to receiving palliative care.[18] It would be a tragedy for these populations if this bill made lethal prescriptions more accessible than palliative care.

Most dying patients are comfortable and do not seek lethal drugs because of pain. A wish to die might really mean "I'm afraid I'm a useless burden." Often this is a plea for help and assurance of their value, not a desire to kill themselves.[19] Despite developing disabilities, the terminally ill, if given sufficient time and support to adjust, often overcome despair to have meaningful experiences in the last months or even hours of their lives. A physician's role is to value a patient's inherent, unchanging dignity, no matter what that person's condition or social situation. This benevolent responsibility turns malevolent when physicians supply lethal drugs to patients—who may be in a vulnerable period of temporary despair. Offering lethal drugs to despondent patients implies agreement that their loss of function makes their lives expendable and not worth living. Because physician-assisted suicide is a condemnation of patients with disabilities, the National Council on Disability and many disability organizations oppose it.[20]

Autonomy has two parts: a right to make choices and the capacity to make choices. The terminally ill are vulnerable with a high likelihood of a compromised capacity to choose due to a myriad of complex circumstances. They have good and bad days, fluctuating and progressively declining decision-making capacity, grief, pain, depression, external pressures, changing relationships, etc. In one study of cancer patients, 90% had deficits in some subscale measurement of decision-making capacity, and physicians did not readily recognize these impairments.[21] Depression is common and treatable in the terminally ill, and it may manifest as a desire for a hastened death; it often goes unrecognized and untreated by physicians. In one study, only 6% of psychiatrists were "very confident" that they could "adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[22] Many psychiatrists feel that specialized forensic psychiatrists may be needed to determine a terminally ill patient's decision-making capacity.[23] If a patient's wishes are acted upon at face value, without recognizing underlying deficiencies in a person's capacity to choose, that person's autonomy has been violated. Patients need love and care from family and health care professionals, not cold abandonment to a lethal prescription.

Families and friends may be uninformed about normal aspects of the dying process and transfer their feelings of revulsion about patient disabilities or inadequacies as complaints that their loved one is "suffering." Some aspects of "suffering" seem to bother family members more than they could have bothered the patient. For example, patients are not usually aware or bothered by coma, but family sometimes labels a patient in a coma as "suffering." Family members do not like to see loved ones declining and losing function. Sometimes they transfer their own idea that they would not want to be like that to the patient and assume he/she would feel the same way—that the patient would rather be dead than disabled. Patients may sense when those around them are bothered by their appearance or disabilities, and this can contribute to making them feel like a burden and push them toward asking for lethal drugs. If patients are supported wholeheartedly through the onset and progression of disability, they often come to terms with their dysfunction and find renewed meaning in living (even when terminal). Lethal drugs are not a substitution for family education and support—which take time.

1. For example, prognoses of life expectancy are guesses. Some will live beyond what is expected even with low survival rates such as 5% in 5 years. Inaccurate prognoses are documented in states that have legalized physician-assisted suicide, with some patients living years beyond the 6-month prediction. For example, in 2012 in WA, 17% of patients lived 25 weeks or more, with a maximum time of 150 weeks—over 3 years. How many of the patients who took lethal drugs might have lived longer is unknown. Washington State Department of Health. 2013 Death with Dignity Act Report. 2014. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf?uid=63faaaafe406d
2. Christie T. A gift of treatment: When the Oregon Health Plan fails to cover a cancer drug, the drugmaker steps in. The Register-Guard. 2008 June 3;Sect. 1A.
3. Kate Cheney was denied a lethal prescription twice because of dementia and concern that Kate's daughter was the driving force behind her request. Kate's daughter took her doctor shopping until lethal drugs were prescribed. Kate died by lethal ingestion. Barnett, Erin Hoover. "Physician-assisted suicide: A family struggles with the question of whether mom is capable of choosing to die." The Oregonian. January 9, 2019.
4. Michael Freeland was given a prescription for lethal drugs without a mental health evaluation despite a history of depression. He was later hospitalized for suicidal behavior; before discharge, his guns were removed from his home, but not his lethal drugs. Doctors with an assisted suicide organization renewed his 6-month prognosis to make him his lethal drugs "legal." He lived two years beyond his original prognosis, and never took the lethal drugs. He reconciled with his estranged daughter prior to death, an opportunity he would have missed had he taken lethal drugs. Hamilton, N. Gregory and Catherine Hamilton. Competing paradigms of responding to assisted-suicide requests in Oregon: Case report. American Psychiatric Association Annual Meeting. New York, New York, 2004.
5. Ingestion of lethal drugs have complications including vomiting, aspiration, severe mouth burning, seizures, and not dying. David Prueitt, for example, woke up 65 hours after ingesting lethal drugs, and died of natural causes 13 days later. Seattle Times staff. "Oregon man woke up after assisted-suicide attempt." Seattle Times. March 4, 2005, https://www.seattletimes.com/nation-world/oregon-man-woke-up-after-assisted-suicide-attempt/.
6. Patrick Matheny and Barbara Houck both had neurological conditions who had problems with self-administering lethal drugs. Mr. Matheny was "helped" by his brother-in-law because of his trouble swallowing, and Mrs. Houck had to be spoon-fed. Kenneth Stevens testimony: https://www.pccef.org/articles/art40HouseOfLords.htm
7. Ganzini L, Goy ER, Dobscha SK. Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey. *Bmj* 2008; **337**: a1682.
8. Testimony of Robin A. Bernhoft, MD, retired cancer surgeon in WA, in opposition to SB 5179, March 2023.
9. In Canada in 2021, 10,064 people (3.3% of all Canadian deaths and an increase of more than 32% over 2020) died by lethal ingestion or injection at the hands of health care providers. One non-terminally ill Canadian with a severe disability recently applied for euthanasia because he feared homelessness, and Canada no longer requires terminal illness as a condition for eligibility. By contrast, 14,344 people died of COVID19 in 2021. 2021 Canadian MAID Report: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2021/annual-report-2021.pdf
10. Diekema DS, Mercurio MR, Adam MB, editors. Clinical Ethics in Pediatrics: A Case-Based Textbook. Cambridge: Cambridge University Press; 2011.
11. Physicians' personal limitations and biases can influence a terminally ill patient's request for hastened death. These factors included having little or no training in counseling and an attitude that the doctor would assist the patient to hasten death if requested. Guy, M. and T. A. Stern. "The desire for death in the setting of terminal illness: a case discussion." Prim Care Companion J Clin Psychiatry 8, no. 5 (2006): 299-305.
12. Dr. Charles Bentz referred a long-time patient to an oncologist for chemotherapy, and the patient became depressed. The oncologist asked Dr. Bentz to be a "second opinion" for physician-assisted suicide. Dr. Bentz told her no, that his patient needed treatment for documented depression. Two weeks later his patient was dead from lethal drugs. Dr. Bentz was appalled that a once-trusted colleague failed to recognize and treat depression, failed to listen to the patient's long-time physician, instead finding a willing accomplice, and preyed on a vulnerable patient. Bentz, Charles. Letter to WA Senate in Opposition to ESHB 1141. 2021.
13. "[No] patient should take medications to die because they're receiving inadequate symptom management at the end of their life. Hospice care is a way of assuring that patients aren't forced to consider aid in dying because of inadequate end-of-life-treatment." Shavelson, Lonny. Medical Aid in Dying: A Guide for Patients and Their Supporters. American Clinicians Academy on Medical Aid in Dying, 2022. (p. 36)
14. Testimony by a patient's family member in WA, 2021
15. Enguidanos S, Rahman A, Hoe D, Meyers K. Provider-Identified Barriers To Palliative Care For Medicaid Patients. *Innovation in Aging* 2019; **3**(Supplement_1): S689-S.
16. Kavalieratos D, Mitchell EM, Carey TS, et al. "Not the 'grim reaper service'": an assessment of provider knowledge, attitudes, and perceptions regarding palliative care referral barriers in heart failure. *J Am Heart Assoc* 2014; **3**(1): e000544-e.
17. Platt M. Pain Challenges at the End of Life - Pain and Palliative Care Collaboration. *Rev Pain* 2010; **4**(2): 18-23.
18. https://www.capc.org/blog/increasing-awareness-palliative-care-minorities/

19. Chochinov H, Wilson K, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995; **152**(8): 1185-91.

20. National Council on Disability. The Danger of Assisted Suicide Laws. Washington D.C., 2019. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf.
The executive summary is here: https://ncd.gov/newsroom/2019/federal-study-assisted-suicide-laws.

21. Kolva E, Rosenfeld B, Saracino R. Assessing the Decision-Making Capacity of Terminally Ill Patients with Cancer. A*m J Geriatr Psychiatry* 2018; 2**6(**5): 523-31.

22. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD. Attitudes of Oregon psychiatrists toward physician-assisted suicide. A*m J Psychiatry* 1996; 1**53(**11): 1469-75.

23. Ganzini L, Leong GB. Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists. A*merican Journal of Psychiatry* 2000; 1**57(**4): 595-600.

ReddochElectronicallysubmittedTestimony6MarchSB084

Uploaded by: Shirley Reddoch
Position: UNF

Shirley Reddoch
Columbia, MD
Written Testimony: **Unfavorable** of
SB0845(HB933) End of Life Option Act

As a physician clinician and educator of 40+ years experience, I am testifying in opposition to SB0845(HB933). Antithetical to the Mission of Medicine, this legislation is Dangerous to Society as a whole AND **works against the health and safety promoting efforts of members of this Assembly-- including some of you**.

You acknowledge the increasing depression and anxiety crossing all age groups and demographics, not to mention suicides and suicide attempts and speak to the need to improve and expand mental/behavioral health services, and recognize key drivers:

1) Ease of access—legal no less-- to increasingly efficient means of self-destruction: guns and drugs leading the day. There is no recovery or healing from one's own physical death.
2) Social messaging (any media) that reminds one constantly of being isolated, marginalized, anxiety ridden/depressed, and buying into feelings of being a burden, and --of being "less than."

Consider that this End of Life Option, now expands ease of legal access, to a promoted easier/neater means of **self-elimination** that is "doctor prescribed."

And **validates that a person's existential fears re worth, burden to family and society, and loss of satisfaction in living are actual reality**---hence, legitimizing self-termination, fully state supported and "aided" in this way.

No amount of legislation or funding, to boost mental health services, or promote gun safety, or offer more care to the unhoused, incarcerated, immigrant, un/undereducated, and aging --leading demographics of the vulnerable-- **can stay ahead of what End of Life Option promotes and has already opened doors more widely to**, wherever it is enacted.

Due diligence research on what has and is happening in states where this Option has been enacted, will tell you expansion in understanding and scope moves much faster where another state follows suit (not to mention countries in the global picture—cannot even adequately cover the sea change of care in Canada since this legislation was enacted there a mere 7 years ago).

Some of you may see this as a no fiscal cost, administrative accountability, or legal culpability issue on your part. But **this legislation further hammers away at the integrity of offered "healthcare", messaging a re-prioritization of covered services and a "revaluation" of the individual person, in a given situation. Our young and future generations will bear the weight and pay the price.**

This legislation will ultimately impact the numbers, make up and attitudes of those entering, not only medicine, but all the health care professions.

Respectfully Submitted,
Shirley Reddoch, MD
Pediatrician, Pediatric Hematologist/Oncologist

No Other Options — The New Atlantis.pdf

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Position: UNF

No Other Options

Newly revealed documents depict a Canadian euthanasia regime that efficiently ushers the vulnerable to a “beautiful” death.

Alexander Raikin

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Audio: Listen to this article. Available only to *New Atlantis* and Apple News+ subscribers.

“I find that the act of offering the option of an assisted death is one of the most therapeutic things we do,” Stefanie Green tells me. She sees it in the faces of her patients — they’re “relieved.” Sometimes it actually means they’ll choose to live longer, to keep fighting, because now they know they can end their suffering if it becomes intolerable.

I wanted to know if Green, a physician specializing in euthanasia in British Columbia, is finding her job easier now than she did at first. “Is it more normal for me to be writing scripts and picking up lethal drugs and driving across town and doing this?” she asks back. It’s a rhetorical question. “Yeah, it’s oddly okay for me to be doing that. I don’t find it shocking anymore, but the events are still extraordinary.”

Green has her own term for these extraordinary events, drawing on her prior experience as an obstetrician, when she helped bring people into the world. “At both ‘deliveries,’ as I call them, I am invited into a most intimate moment in people’s lives,” she writes in her book.

The procedure, she assures me on our call, is “100 percent effective.” If her patient asks to die, and if her schedule, her ethics, and the law permits it, she will administer a lethal injection.

Compassionate Action

Since Canada legalized euthanasia in 2016, there has been a strange balancing act at the heart of its medical system. There is a national suicide prevention hotline you can call 24/7, where sympathetic operators will try to talk you out of killing yourself. But today there are also euthanasia hotlines, where operators will give you the resources you need to carry out your wish. Doctors and nurse practitioners are now in the business of saving the lives of some patients while providing death to others.

Canada calls it Medical Assistance in Dying, or MAID. The term encompasses both assisted suicide, which is when providers give patients the means to end their own lives, and euthanasia, which is when a medical practitioner directly administers a patient's lethal injection. But virtually all such deaths — over 99 percent — are euthanasia.

Supporters insist that this is *not* state-sanctioned suicide. Rather, it's a dignified solution for those who no longer wish to suffer from terminal or chronic illness. MAID allows "for compassionate action, while also protecting those who are particularly vulnerable," claimed David Lametti, the attorney general and minister of justice, in 2021.

Prime Minister Justin Trudeau has long promised to strike just this balance. In 2019, while pressing the need to expand access to euthanasia, he assured that people will be able to choose assisted death "in a way that isn't because you're not getting the supports and cares that you actually need."

This is the promise of medical assistance in dying: that vulnerable people who want to die for the wrong reasons will be encouraged to live, as they always have been — while people who want to die for the right reasons will have their autonomous decision upheld. If even a single vulnerable person were pushed into assisted death, it would be a scandal to the system. That is why safeguards were put into place.

And yet stories describing just this — a system that does encourage the vulnerable to seek medical death — are coming fast and hard lately. A number of recent news articles have reported on Canadians who, driven by poverty and a lack of access to adequate health care, housing, and social services, have turned to the country's euthanasia system. In multiple cases, veterans requesting help from Veterans Affairs Canada — at least one asked for PTSD treatment, another for a ramp for her wheelchair — were asked by case workers if they would like to apply for euthanasia.


Prime Minister Justin Trudeau
European Parliament / Flickr

As this article will show, in internal meetings, those close to the system have long talked openly about red flags that many people *are* choosing euthanasia because they're not getting the "supports and cares" they need. The physicians in charge of the process not only know that this is happening, but they have discussed it in seminars, collected evidence, and then kept it quiet in public.

The safeguards promised by Trudeau and others to prevent vulnerable people from heading down the road to euthanasia turn out to be vague, pro forma, and easy to get around by doctor-shopping. And interviews with patients and their loved ones show that some of them, perhaps many, are making it to the end of that road.

One of the greatest reasons for concern is the sheer scale of Canada's euthanasia regime. California provides a useful point of comparison: It legalized medically assisted death the same year as Canada, 2016, and it has about the same population, just under forty million. In 2021 in California, 486 people died using the state's assisted suicide program. In Canada in the same year, 10,064 people used MAID to die.

Important people — prominent politicians, physicians, and judges — promised Canadians that their rights to autonomy would be expanded. But the picture that emerges is not a new flowering of autonomy but the hum of an efficient engine of death.

Clickbait?

By the time I spoke to her, Stefanie Green had performed more than three hundred MAID procedures, making her among the most prolific providers in Canada. Her last one was just weeks before I talked to her.

Green was hesitant to speak with me at first. She is busy, and her services are in demand. But more than that, she doesn't want to add any fuel to "unfounded opposition arguments," as she put it by email. Her line of work already invites controversy.

But there's no reason that it should, Green insists. Asked on a call about stories of abuse, she raises her voice and says, "you cannot access MAID in this country because you can't get housing. That is clickbait. These stories have not been reported fully."

The Supreme Court of Canada

Mike Alexander / Flickr

Green is echoing what from the beginning has been a refrain of euthanasia advocacy. In its ruling decriminalizing the practice, the Supreme Court of Canada echoed it too, asserting that "a permissive regime with properly designed and administered safeguards" would be "capable of protecting vulnerable people from abuse and error." And the Canadian Broadcasting Corporation in 2017 assured its readers that it is a "misconception" that "MAID puts vulnerable people at risk."

And advocates today insist that the safeguards are working. "We have four or five years of experience now, and absolutely no indications, that I'm aware of, of alleged misuse or poor decisions," said James Cowan in 2021. Cowan is a former senator who helped lead the passage of the original legislation. Helen Long, the CEO of Dying with Dignity Canada, offered this line in a May 2022 *Maclean's* essay, arguing that the stories that people "who are not able to access supports like safe and affordable housing are opting to have MAID instead" are "simply not true and there is no evidence that I'm aware of to support those claims."

An Open Secret

Yet even some euthanasia providers have expressed worry. In October, Madeline Li, a psychiatrist involved in drafting a national euthanasia training curriculum, testified to a parliamentary committee that the legislated safeguards are "impotent." She added, "I believe the Canadian populace and maybe even the legislators are not aware of who has been qualifying for MAID."

In fact, the evidence of abuse is there if advocates want to find it. The Canadian Association of MAID Assessors and Providers, the leading organization of Canadian euthanasia providers, has sat on credible evidence by its own members that people are being driven to euthanasia by credit card debt, poor housing, and difficulties getting medical care. These are people who do have some sort of medical condition but in many cases are using these conditions to check a box in the approval process, when the relief they are mainly seeking is from other forms of suffering. And the system is doing much more to help them down the path toward death than to protect them as the public was promised.

In addition to performing euthanasia procedures herself, Stefanie Green is president and co-founder of the organization, also known as CAMAP. It is not a government entity, but Green also stresses that it "is not an advocacy movement." Instead, she says, it exists to fill "an absolute void" of interpreting federal law to clinicians. The organization's website says it aims "to establish training resources, to create medical standards, and to encourage the standardization of care across the country." And filling the void it is: In July 2022, Health Canada, the agency that is responsible for national health care policies, announced a plan to outsource its voluntary euthanasia training standards to CAMAP.

The organization regularly holds virtual seminars aimed at training euthanasia assessors and providers. *The New Atlantis* has obtained video recordings of several seminars held from 2020 through 2022, along with slideshows and material used by the presenters.

One seminar was specifically devoted to how to handle euthanasia requests from poor patients. In one recorded seminar, held on May 5, 2021, the first speaker is Kevin Reel, a senior ethicist at Sunnybrook Hospital and former president of the Canadian Bioethics Society.

Reel talks as if it's a given that inadequate resources will drive people to request euthanasia — but he also sees a silver lining. He says that after decriminalization, "my first thought as an OT [occupational therapist] back then was, this could be an extraordinary lever to improve social supports in this country." He continues, "if we can gather the stories of people who would opt to die, because the social supports are so poor — ," and trails off. He says he wants to get a financial grant to get this project going.

"An extraordinary lever":
Kevin Reel in a 2021 CAMAP seminar

But, Reel warns at a different point, individual MAID providers do not have the power to fix the problems with social supports that are driving patients to euthanasia: "you simply cannot fix the system."

So while they wait for that distant day when society does solve poverty, how should MAID providers handle these cases?

Some providers are quite explicit about their answer. In response to "concerns voiced, that for some people, it is easier to access medical assistance in dying than to get the treatments they need to control symptoms," several CAMAP members conducted a 2022 study in which they interviewed twenty euthanasia providers about their experiences. One provider responds:

> I think we live in a society where we have structural inequities. And that really sucks.… But it doesn't mean that we should be sheltering people from the option of having an assisted death. I think we keep seeing death, and MAID in particular, as the wrong outcome. And … that's not my choice or my decision to make for someone.

Several of the seminars actually advise providers on how to handle the "moral distress" they will experience in such cases. Reel's is one of them. "What I cannot do is remove all that moral distress from this work," he begins. But "I can minimize it, help you minimize it and manage it through some tools that we'll talk about." Reel talks around and around this, evasively and emptily, never specifying why euthanizing poor patients might be morally distressing.

Residents of Edmonton, Alberta participate in a Bridge of Life Suicide Awareness/Prevention candlelight vigil on September 10, 2021. A suicide prevention barrier is visible behind them on the bridge.

Artur Widak / Alamy

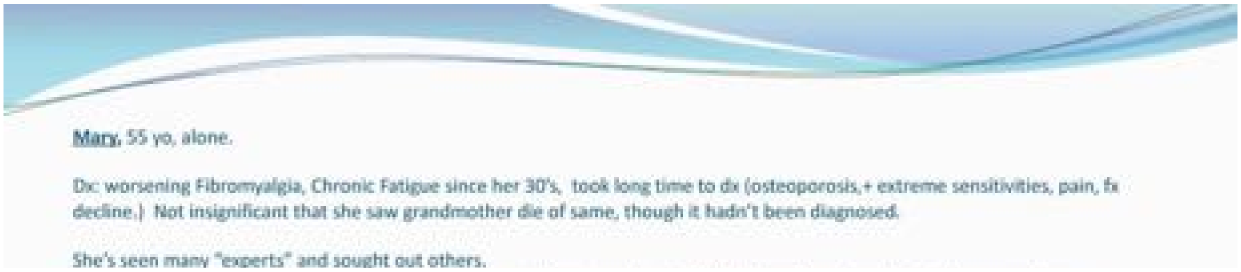
The Only Way Out

For another seminar speaker, euthanasia requests from poor people are just part of the job. Althea Gibb-Carsley recently retired as a care coordinator and social worker of Vancouver Coastal Health's assisted dying program. The title of her presentation asks, "What is the role of the MAID assessor when resources are inadequate?"

She describes several cases that she managed as a care coordinator.

"She wants to live":
Althea Gibb-Carsley in a 2021 CAMAP seminar

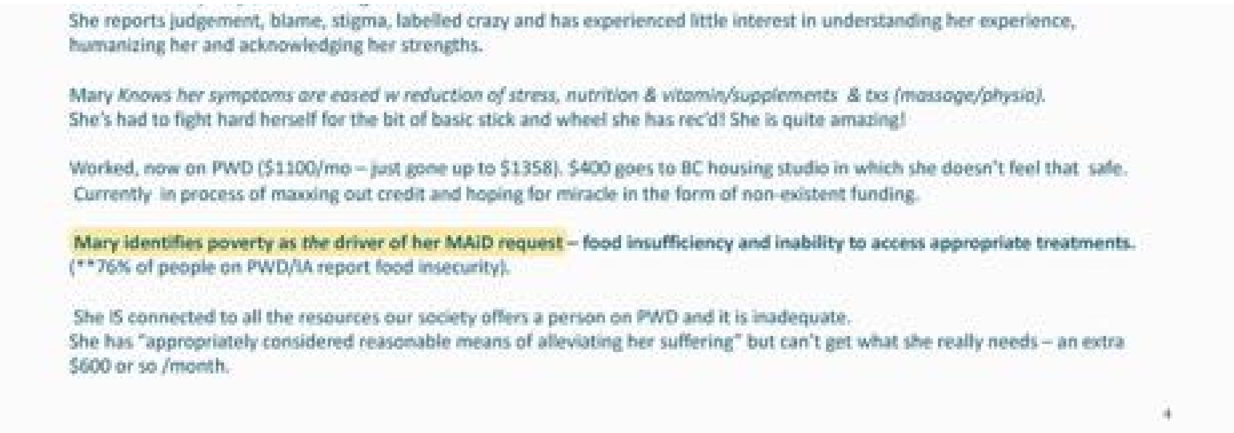
Take Mary, 55, who Gibb-Carsley says is "bright, creative, tenacious, determined" — "a dynamite person." Mary has worsening fibromyalgia and chronic fatigue, both non-terminal medical conditions. (Gibb-Carsley doesn't specify whether she is using real names or not.) Mary knows that she could control her pain if she could take vitamin pills, eat a special diet, and go to physiotherapy. She can't afford it. "Mary identifies poverty as *the* driver of her MAID request," Gibb-Carsley writes on a slide accompanying her talk, emphasizing *the*. "She does not want to die, but she's suffering terribly and she's been maxing out her credit cards. She has no other options."



Mary, 55 yo, alone.

Dx: worsening Fibromyalgia, Chronic Fatigue since her 30's, took long time to dx (osteoporosis,+ extreme sensitivities, pain, fx decline.) Not insignificant that she saw grandmother die of same, though it hadn't been diagnosed.

She's seen many "experts" and sought out others.



She reports judgement, blame, stigma, labelled crazy and has experienced little interest in understanding her experience, humanizing her and acknowledging her strengths.

Mary *Knows her symptoms are eased w reduction of stress, nutrition & vitamin/supplements & txs (massage/physio).*
She's had to fight hard herself for the bit of basic stick and wheel she has rec'd! She is quite amazing!

Worked, now on PWD ($1100/mo – just gone up to $1358). $400 goes to BC housing studio in which she doesn't feel that safe.
Currently in process of maxxing out credit and hoping for miracle in the form of non-existent funding.

Mary identifies poverty as *the* driver of her MAiD request – food insufficiency and inability to access appropriate treatments.
(**76% of people on PWD/IA report food insecurity).

She IS connected to all the resources our society offers a person on PWD and it is inadequate.
She has "appropriately considered reasonable means of alleviating her suffering" but can't get what she really needs – an extra $600 or so /month.

A slide from Althea Gibb-Carsley's CAMAP presentation (Enlarge)

Then there is Nancy, 68, a former physician: "bright, capable, she's tired, very, very tired." Following a car accident, Nancy now has chronic pain. "She believed she had a lot more years to work," so she didn't save enough money. And there is Greg, 57, a writer who has diabetes, cardiac problems, anxiety and depression, and a history of trauma. Both need housing, but they can't find any place that is accessible, safe, and affordable on an income mostly from disability benefits. The end is predictable. "Nancy has no other options," while Greg's "plan was to stretch his credit to the edges and then set a final date."

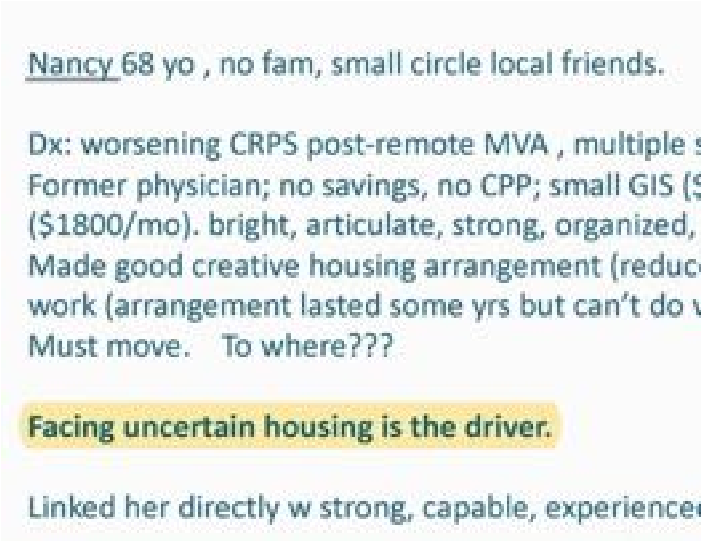
Lucy, a 38-year-old trans woman, is an immigrant who has pain, osteoarthritis, depression, and anxiety. Although Lucy is "clever" and her college program is funded, it's hard for her to concentrate on studies, and "people are so judgey." She lives in a new one-room studio that has "no air or light and creepy men all around."

Lucy was waiting for the law to expand to allow euthanasia not only for terminal illness, but for any "grievous and irremediable" condition. It is a vague standard, and some reporting suggests it could include osteoarthritis, the only diagnosed physical condition Lucy is described as having. We do not hear what happened to Lucy, but the expanded eligibility standard she was waiting on did take effect in 2021.

Gibb-Carsley says that these patients have "no other options" because of their poverty, their housing situations, their difficulty getting medical care. "I think you will find, and you know already," she says to her audience of euthanasia providers, that if you want to offer your patients some alternative to MAID, "this will often mean a referral to not very much, and certainly not very fast." It's not that they are terminally ill or truly beyond help, but that they can't get the help they need in the system right now, so euthanasia seems like the only way out.

Red Flags

Justin Trudeau made a clear promise to the public: that nobody would receive MAID "because you're not getting the supports and cares that you actually need." But the CAMAP recordings plainly suggest that exactly this is happening, that euthanasia workers know it, and that they are acting with no urgency to stop it.



Nancy 68 yo , no fam, small circle local friends.

Dx: worsening CRPS post-remote MVA , multiple
Former physician; no savings, no CPP; small GIS (
($1800/mo). bright, articulate, strong, organized,
Made good creative housing arrangement (reduc
work (arrangement lasted some yrs but can't do
Must move.   To where???

Facing uncertain housing is the driver.

Linked her directly w strong, capable, experience

A slide from the CAMAP seminar (Enlarge)

And just as important as what we hear on the recordings is what we don't. Of Mary, the patient who identified "poverty as *the* driver of her MAID request," we do not hear that the system discouraged and denied her application. Of Greg, who the slides say "identified housing as [a] driver" of his euthanasia request, we hear that he is "getting very close to needing to set a date" to be euthanized — and again, not that any effort is being made to stop him. Of Nancy, for whom "uncertain housing is the driver," we hear of no effort to stop her.

In effect, though it's not clear whether she recognizes it, Gibb-Carsley is an internal whistleblower. She is speaking directly to the organization whose mission is to guide Canada's euthanasia practice. She is an expert the organization considered credible enough to invite to its internal meeting. And she is telling them that exactly the kind of abuse the system promised to prevent seems to be happening, perhaps often.

Consider a different case: The reason that camp counselors are told never to be alone with a child is not just to avoid actual abuse but to avoid *the kind of situation* in which doubts arise over whether or not abuse could occur. A system that protects against abuse is one that methodically identifies these situations, and, when they do happen, treats them as big red flags. It warns others about them and reforms the system to help prevent them. If the MAID system were working as promised, the presenters should be warning attendees that they must be vigilantly on the lookout for just the kinds of cases described in the seminar, scrupulously ensuring that they are not approved for euthanasia.

Instead, what we hear from Canada's euthanasia professionals is vacillation, equivocation, delay, and excuses.

During the Q&A, no one in the seminar doubts that the stories are true. Nobody suggests strengthening the safeguards, alerting the public, or halting the system while the problem is worked out. Less than a decade into Canada's experiment in medicalized death, with over 31,500 people dead, the speakers feebly propose to start collecting data.

The presenters clearly understand that what they are describing is a terrible moral problem. "Our silence is our complicity," Gibb-Carsley writes on her last slide in a large font. But Gibb-Carsley and Kevin Reel do not present euthanasia driven by poverty as a problem for MAID. Actually, they suggest, it presents an opportunity to highlight the *real* problem: the inadequacy of the welfare state.

It's as if the situation offers a silver lining. Reel excitedly talks about the problem as an "extraordinary lever" to lobby for improved welfare. Gibb-Carsley's slideshow concludes, "trust in the evolution of this field of practice," meaning the practice of euthanasia. "Your Assessments provide a rare opportunity to hear from the typically disenfranchised patients about their experiences." The subtext of this sunny euphemism is that giving a voice to the voiceless will, for many, ultimately mean killing them.

The attendees understand too what they are hearing. "Given the vulnerability of patients who are maybe requesting MAID because of socioeconomic reasons," one asks, "do you save yourself that moral and ethical distress by withdrawing?" Reel responds: "If withdrawing is about protecting your conscience, you have [an] absolute right to do so." But he adds: "You'll then have to refer the person on to somebody else, who may hopefully fulfill the request in the end."

Justin Trudeau promised that the euthanasia system would not lead anyone to choose to end his or her life due to a lack of social support. But in private, even practitioners say that the support that Canada most efficiently provides to many vulnerable patients now is death.

Kevin Reel declined a request to comment on his recorded statements. Stefanie Green, president of CAMAP, was asked more than two days before this article went to press how she reconciles the seminar recordings with her earlier claim that stories of abuse are "clickbait" that "have not been reported fully." Green requested and was provided information on how to access the recordings discussed in this article, but she did not offer comment.

Death by Checklist

How is all this happening?

A core reason that Canada's assisted dying program has grown so much faster than any other program in the world is that it is the most permissive. Eligibility criteria began loose and are rapidly getting looser. You do not need to be terminally ill, only to have a "grievous and irremediable" condition, a standard that is open to significant differences in interpretation. In March 2023, mental illness alone will qualify as an acceptable medical reason to die. And the Quebec College of Physicians now suggests that Parliament expand euthanasia eligibility to minors and even newborns.

Despite all this, the MAID system was also supposed to be "carefully-designed" with "stringent limits" to prevent abuse. That was the charge put to the government by the Supreme Court of Canada in its 2015 ruling decriminalizing the practice. The court affirmed that "a permissive regime with properly designed and administered safeguards" would be "capable of protecting vulnerable people from abuse and error."

But under such broad, permissive criteria for eligibility, the safeguards that were actually put into place are clearly not working.

Recognizing the need for guidance, CAMAP developed generalized assessment forms. Many doctors now use these to evaluate whether a person is eligible for MAID. I sent them to Paul S. Appelbaum, a professor of psychiatry, medicine, and law at Columbia University in New York City. Appelbaum, a leader in his field, has been practicing for four decades. In 1998, he helped develop a now widely used test for assessing whether patients are mentally competent to make medical decisions. In 2022 an expert panel convened by the Canadian government recommended his competency test to euthanasia assessors, an indication that

Appelbaum's authority is recognized by the MAID system itself.

"All in all," says Appelbaum by email, "it doesn't strike me as a particularly well-thought-through evaluation process." Among other things, "it's not clear from these forms how an evaluator would decide that a condition is 'grievous and irremediable,'" he says, quoting one of the key legal criteria.

Moreover, the initial screening questions for depression and anxiety "are not detailed enough to result in a diagnosis, and even if they did, the impact the answers to these questions are supposed to have on the final decision about authorizing MAID is unspoken." This matters because another key criterion is that patients be mentally competent to request their own deaths. What Appelbaum is saying here is that a person who may be depressed and suicidal — who ought to be helped to find hope, not encouraged to die — cannot properly be identified with these forms.

I also sent the CAMAP forms to Mark Komrad, a clinical psychiatrist and ethicist who helped craft the American Psychiatric Association's statement against euthanasia for patients who are not terminally ill. His response was a single line: "Death by checklist!"

Part of what Komrad means is that the checklists are a tool available to MAID assessors, rather than a safeguard imposed upon them — they are not set by federal law. So in practice, the law leaves a great deal of latitude to euthanasia providers to decide whether the requirements are met.

For example, when I asked Stefanie Green how she decides whether a patient with a mental health condition has the competence to choose euthanasia, she said that she makes a judgment call about whether a patient has an "active" or "stable" case of mental illness. For "active"

A suicide prevention sign in Tennessee

Rex Hammock via Flickr

cases, she will consult a specialist; for "stable" cases, she proceeds on her own. Green is not a psychiatrist, so I asked Appelbaum about her framework. "It's not a distinction that makes any sense to me," he says.

This is a problem not only for Green. Under federal law, any physician or nurse practitioner can assess a patient and provide euthanasia, and in many provinces they can do so without any additional required training.

Now recall that in just a few months, mental illness will become a legal reason to receive MAID.

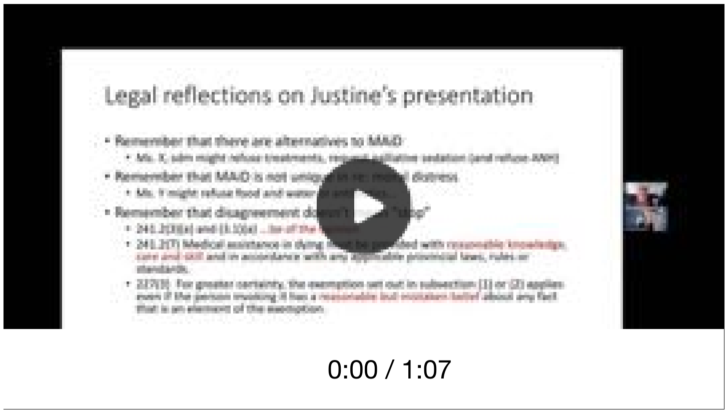
[*Editor's Note*: On December 15, 2022, the day before this article was published, two Canadian cabinet members, including Minister of Justice David Lametti, announced that the government was considering delaying, but not canceling, the mental illness expansion. They stated that the move was not due to concern over existing safeguards, which "are excellent."]

Easy to Die

Then there is the problem of doctor-shopping.

What if a doctor dutifully screens for eligibility, and rejects someone? Then the person can just go elsewhere.

In another CAMAP seminar recording, we learn of a man who was rejected for MAID because, as assessors found, he did not have a serious illness or the "capacity to make informed decisions about his own personal health." One assessor concluded "it is very clear that he does not qualify." But Dying with Dignity Canada connected him with Ellen Wiebe (pronounced "weeb"), a prominent euthanasia provider and advocate in Vancouver. She assessed him virtually, found him eligible, and found a second assessor to agree. "And he flew all by himself to Vancouver," she said. "I picked him up at the airport, um, brought him to my clinic and provided for him," meaning she euthanized him.



Legal reflections on Justine's presentation

"Disagreement doesn't mean you must stop": Jocelyn Downie in an April 27, 2022 seminar

Even doctors can doctor-shop. There is one final procedural safeguard: a second assessment by a clinician that agrees with the first. In practice, it's nearly impossible to not meet this requirement. Jocelyn Downie, a prominent law professor who was part of the legal team that won the court case decriminalizing euthanasia, tells assessors and providers during a seminar that "you can ask as many clinicians as you want or need," seemingly implying that you can do so until there is a concurring opinion. "Disagreement doesn't mean you must stop," she says in another seminar.

MAID assessments are highly subjective. We hear as much from the presenters in the CAMAP training seminars. Some physicians believe that advanced age should help qualify a person. Others don't. In one session, a presenter says that providers "have a lot of different ideas" about how to assess whether someone suffering from Alzheimer's has the capacity to choose euthanasia. It's as if there are as many views of rational suicide as there are assessors. "There is no certainty or unanimity required. There is not perfection required," says Downie. The result: There are many paths available to reach the end, and you only need to find one. The system makes it easy to die. (Asked by email how she would reconcile her statements in the seminars with the safeguard reassurances that have been offered to the public, Downie responded, "This is an inaccurate characterization of what I said and did at the two seminars." She did not specify the nature of the inaccuracy.)

And even if the safeguards were more rigorous, they wouldn't do much good, because the enforcement has been lax. Criminal investigations of MAID providers are exceedingly rare, and CTV News reported in 2022 that "federal officials don't keep statistics on when such cases are reported to police." Nancy Hansen, the Director of the Disability Studies program at the University of Manitoba, told me that in effect "there's no consequences for non-compliance" with the law.

"The most rewarding work":
Ellen Wiebe at a Friends at the End talk

And that's because the people doing the training, the assessments, the procedure, and informing the review are all the same people. These are the people, as Ellen Wiebe says often in her public speaking, for whom this is "the most rewarding work we've ever done."

Wiebe declined requests to be interviewed for this article. Asked for comment about her statements in the seminar, she responded: “It is rare for assessors to have patients who have unmet needs, but it does happen. Usually these unmet needs are around loneliness and poverty. As all Canadians have rights to an assisted death, people who are lonely or poor also have those rights.”

‘I Don’t Want to Die’

The clearest evidence that Canada’s euthanasia regime is failing to protect the vulnerable is the stories of patients themselves. They have spoken in a series of articles published in other outlets over the past year. They speak on social media. Some of them spoke to me for this article, as did the friends and confidants of another who is no longer with us to speak for herself.

The picture that emerges from them is of people who are in desperate circumstances and unable to get help, and are presented with an easy way out: to make it all go away through a medically assisted death.

Les Landry is in trouble. Why? Because he had the temerity to turn 65.

“I cannot afford to live,” he tells me over the phone from Medicine Hat, a small city in Alberta. “What do I do?” Even now he is thinking of solutions. He could move into his van or skip meals. He already stopped taking some of his prescriptions. But, he says, “MAID is the only choice I can see for a way out.” It just makes financial sense.

Les is surprised to find himself in this situation. He used to work as a truck driver, earning $85,000 a year. He married and had children. Then he got sick, developing an allergy to anesthesia during a routine hernia operation in 2009. His reaction was so severe that, for most patients, it would have been fatal. But he survived, and today, while he suffers from chronic medical problems, his

Les Landry, in a photo he provided

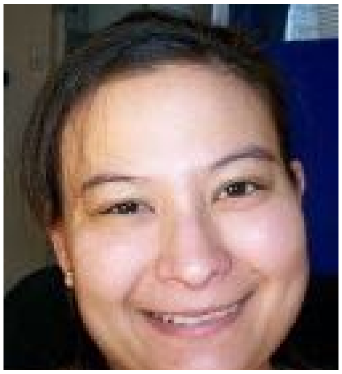
death is no longer imminent — except with creative accounting.

For many years, Les got by with payments from Alberta's disability welfare system. His fixed income was $1,820 a month, about 1,300 U.S. dollars. It was a modest sum, but "I was regularly comfortable." More importantly, his benefits included a specialized diet, a service dog, prescriptions, and modest travel for medical appointments. He was told it would be for life.

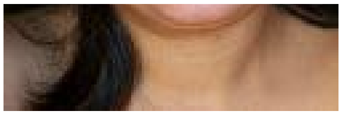
But Les just recently turned 65, the age at which his pension begins and all those disability benefits end. The result, he says, was a significant net loss of income. He no longer has the critical support he needs.

Les is a fighter. "Even at 65, I don't want to die," he says. He says it again and again. "I really don't want to die. I just can't afford to live." Les knows that he could end his life already, if he wanted to. He feels forgotten; he feels pushed to end his life. He doesn't need a government service to do that. "I have enough medication already to kill a horse," he says. "The only thing that MAID does is to make my suicide socially acceptable."

When Les emailed a MAID team to apply, he wrote, "I turned 65 [and] lost all m[y] disabilities benefits and now a senior in poverty. I am not going to live my life like this." On December 2, Les received his first approval for euthanasia. He is now waiting for the second and final approval. And he says he will doctor-shop until he gets it.



When Rosina Kamis decided that she could not take any more, she wrote up a list of reasons why she needed to be "euthanized ASAP." If all you knew about Rosina were her medical history, you could be excused for assuming that MAID was meant for someone like her. At 41 years old, she was in constant pain from her fibromyalgia, had chronic leukemia and a myriad of other mental and physical illnesses, a long list of medications, and a rotating cast of attending physicians and nurses. This is also what she told her assessors: that she had no quality of life, was confined to her bed, and in constant pain.



Rosina Kamis

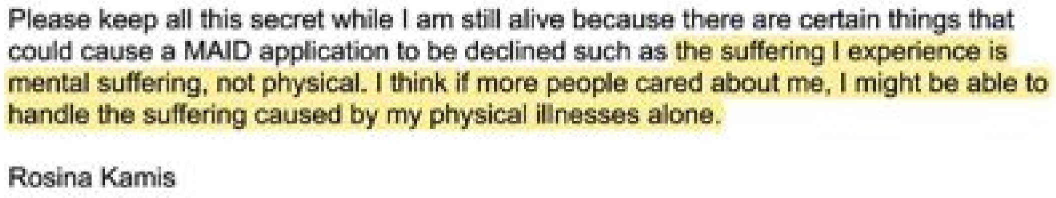
University of Toronto

But that is just one presentation of her story. Rosina was not dying: in ordinary circumstances her medical conditions were chronic, not terminal. And a wealth of material reviewed for this article — interviews I conducted with her friends and powers of attorney, emails she sent to her powers of attorney, emails to herself and to her physicians, emails to her abusive ex-husband, her Google Drive, a recording of her second MAID assessment, recordings of her doctor appointments, recordings of calls trying to get pain control, videos she posted to a tiny group of YouTube followers, and medical documents — paint a much messier picture than what she showed her assessors.

"Sometimes all the pain will go away just by having another human being here": Rosina Kamis on her YouTube channel

Oftentimes, Rosina was hungry. The artificial light in her room would make her migraines worse. It was loneliness driving her to MAID, that she "must suffer alone" with her service dog — which she could "easily lose," as her landlord was trying to evict her and she had nowhere else to go. It was that she didn't want her physicians to harm her by changing her pain medication, as they sometimes did. It was that she was "scared" of being institutionalized; that what she needed to live was not what she could reasonably expect to get; and that others would benefit from her death because MAID "is the best solution for all." Her choices seemed slim. When her fingers hurt, she couldn't make food. She would post a video of herself going to bed, in her dark room, hungry and crying.

Rosina showed one face of her suffering to the MAID system, and another to her confidants. To the latter, the reasons she gave for really wanting to die were not physical suffering. “Please keep all this secret while I am still alive because … the suffering I experience is mental suffering, not physical,” Rosina wrote in a message apparently intended for her powers of attorney. “I think if more people cared about me, I might be able to handle the suffering caused by my physical illnesses alone.” To her two dozen subscribers on YouTube, she said, “Sometimes all the pain will go away just by having another human being here.”



Please keep all this secret while I am still alive because there are certain things that could cause a MAID application to be declined such as the suffering I experience is mental suffering, not physical. I think if more people cared about me, I might be able to handle the suffering caused by my physical illnesses alone.

Rosina Kamis

An email from Rosina Kamis on July 11, 2021

She also saw herself as a burden. On a GoFundMe page that Rosina started to help buy food, she wrote, “Whenever I try very hard to get my needs met, I am seen as being manipulative.... I know I am hurting other people simply for having special needs. So, I have decided that the best thing for me and everyone else on this planet is for me to obtain Medical Assistance in Dying.”

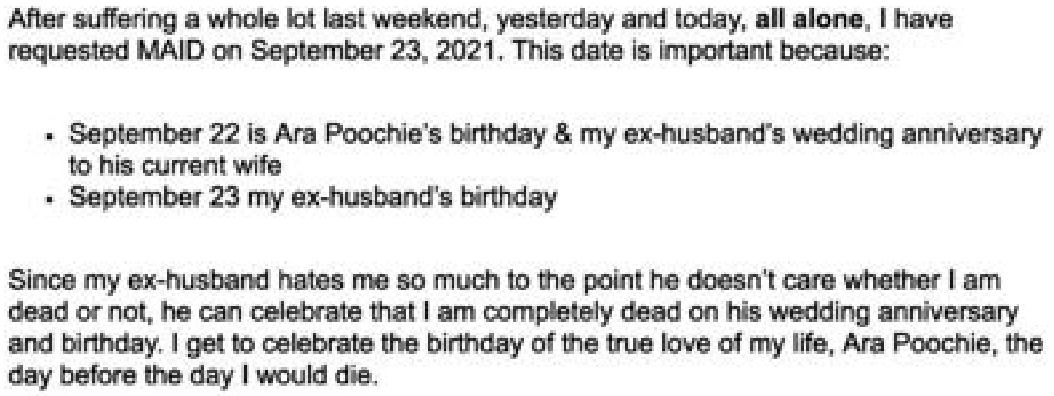

Rosina Kamis MAID assessment

“Is this your own decision?”:
An excerpt from one of Rosina’s MAID assessment calls

In a recording she made of her assessment, which happened over the phone, the assessor tells her, “I just wanted to reassure you that with MAID it is a very dignified death. Rosini,” — the assessor gets her name wrong — “it is. There’s nothing embarrassing about it. You don’t lose control of your bowels. It’s a very elegant, graceful, dignified death.”

"There's nothing embarrassing about it":
An excerpt from one of Rosina's MAID assessment calls

Rosina was approved, and specifically asked to die on the date of her ex-husband's birthday. Rosina died in her shared basement apartment on September 26, 2021, after a doctor gave her a lethal injection.



After suffering a whole lot last weekend, yesterday and today, **all alone**, I have requested MAID on September 23, 2021. This date is important because:

- September 22 is Ara Poochie's birthday & my ex-husband's wedding anniversary to his current wife
- September 23 my ex-husband's birthday

Since my ex-husband hates me so much to the point he doesn't care whether I am dead or not, he can celebrate that I am completely dead on his wedding anniversary and birthday. I get to celebrate the birthday of the true love of my life, Ara Poochie, the day before the day I would die.

An email from Rosina to her powers of attorney on July 16, 2021

A Good Death?

Whatever your view on euthanasia, stories like Les's and Rosina's are not entirely straightforward. In many cases it is hard to sort out the tangle of internal and external reasons someone might make a voluntary request to die. But that is precisely the problem. Canadians were promised a system that would distinguish a rational choice to die from a desperate cry for help. But in stories like Les's, Rosina's, and so many others, that distinction breaks down.

This is particularly true in cases where a patient seeking euthanasia has a history of depression. As the psychiatrist Paul Appelbaum told me: "People with depression can be extremely rational in explaining the reasons for the decisions that they're making. And what is most difficult is to separate the effect of the depression on that decision from what their underlying non-depressed motivations might be."

We see this problem in the dramatic changes in Rosina's stated reasons for wanting to die, and in the fact that she had been diagnosed with major depressive disorder. And we see it in the fact that Les has a history of suicidality.

There is a hard question, then, of what to do in ambiguous cases. Should we hold patients' autonomy as sacrosanct when they say they want to die — and shrug them off as unreliable when they say they really want to live?

Canadian law requires that a qualifying medical condition for MAID be "incurable" and "irremediable." But providers already have ample evidence that their patients' conditions might be remedied if they could access better resources and medical care.

According to an internal study of MAID assessments, presented to CAMAP in 2022, of 54 patients who were not terminally ill, two-thirds had concurrent mental illness. A fifth of the patients had difficulty finding "appropriate" treatment. And, most disturbingly, over a third of patients were "not offered appropriate / available treatments."

While many euthanasia providers pay lip service to saving those who can still be helped, others are more frank. Take Ellen Wiebe, the poster child for Canadian medical death — in 2016 *Maclean's* covered her as a visionary. She has since become one of the most prolific MAID providers, having personally euthanized over 400 patients. In testimony to a parliamentary committee, Wiebe said that she would consider a patient on a five-year waitlist for an effective treatment to have "irremediable suffering."

"Angry family members are our greatest risk": Ellen Wiebe at a Friends at the End talk

Elsewhere, in a public talk, Wiebe described a recent procedure she performed, saying, "It was a beautiful death." And she admitted that the real difficulty is not protecting the vulnerable from abuse: "Angry family members are our greatest risk," she says, and laughs.

Based on vague criteria and with precious little oversight, the MAID system has given enormous latitude to euthanasia providers to make the judgment calls about who should be helped to live and who should be helped to die. The result is a system that is highly efficient at finding reasons patients should qualify, not reasons they shouldn't.

Althea Gibb-Carsley did not respond to requests to be interviewed for this article. But, asked for comment about her statements in the seminar, she replied: "The people I was aware of whose decisions to apply for MAID were influenced by their poverty, and a long-lived experience of lack of access to respectful and appropriate resources, also had medical diagnoses that meant they met the legal criteria for assisted death in Canada. Poverty and lack of resource[s] was not the reason they were found eligible for MAID."

What this amounts to in practice is a very weak interpretation of the mandate to protect the vulnerable from abuse. We hear this in one of the CAMAP recordings, where, yes, Gibb-Carsley does tell her audience that people whose *sole* reason for requesting an assisted death is poverty should not be approved "in the absence of a chronic disease." But, as she quickly acknowledges, "they often go together."

Just so. For the poor and the vulnerable, for those who are "not getting the supports and cares" they need, as Justin Trudeau put it, all that doctors need to do is find some medical pretext to end their lives. Much as the man with a hammer comes to see everything as a nail, again and again Canada's euthanasia system looks at vulnerable people and sees good candidates for medical death.

A yard sign in Utah

harpazo_hope / Getty

In December, an ad video by the Canadian fashion company La Maison Simons, titled "All Is Beauty," went viral online. It told the story of Jennyfer Hatch, a 37-year-old-woman with Ehlers-Danlos syndrome who had chosen euthanasia. Slickly produced, the video showed slow-motion images of people gathered on beaches. At one point it describes "the most beautiful exit," apparently referring to MAID. Hatch was euthanized the day before the campaign launched. She had told friends and interviewers that she wanted to live, but couldn't afford it.

The tide has turned, and Canada's vulnerable patients know it. They know how Canada's system sees them. It shows up in how they see themselves, how they think about their choices.

Catherine Frazee, a disability scholar, told me by email about a doctor colleague who

> has observed patients who become fixated on MAID, who under different circumstances, before MAID was a part of our culture, would have carried on living through difficult times, or who would have pursued treatment options with a reasonable chance of success even though doing so would be temporarily unpleasant or uncomfortable. Many people who are not at risk of suicide are nevertheless at risk of MAID, especially so because it has been so quickly embraced as an honourable, "dignified," idyllic form of death.

You even hear this firsthand from some euthanasia providers — like Madeline Li, who told Parliament, "I've certainly had cases where I felt compelled to provide MAID against my better clinical judgment because the law did not adequately protect." You hear it too from psychiatrists like John Maher, editor of the *Journal of Ethics in Mental Health*, who told Parliament that he has patients who could get better but "are now refusing effective treatment to make themselves eligible for MAID."

Amy Hasbrouck, a disability advocate, told me that MAID is a way to “get rid of disabled people.” It’s an extreme view. Yet it is possible to imagine a euthanasia system that is set up without that intention, even one that is nominally set up to protect the vulnerable — and yet that, step by step, becomes indistinguishable from a system deliberately designed to usher them to their deaths.

From Rosina, Les, Mary, Nancy, Greg, Lucy, and so many others across Canada, what we hear are the cries of people in despair asking for help. Just a few years ago they would have been textbook candidates for what a just society would say: *Your life has value*. In Canada today they hear something else: *Your death will be beautiful*.

There Is Hope

If you are in crisis or experiencing suicidal thoughts, help is available to you at:

• The National Suicide Prevention Lifeline in the U.S. at (800) 273-8255 or by dialing or sending a text to 988

• Talk Suicide in Canada at (833) 456-4566 or by text at 45645

• Crisis Text Line for mental health and violence crises via text, phone, web chat, and WhatsApp in the U.S., Canada, UK, and Ireland

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Alexander Raikin *is a writer in Washington, D.C.*

Alexander Raikin, “No Other Options,” *The New Atlantis*, Number 71, Winter 2023, pp. 3–24; TheNewAtlantis.com, December 16, 2022.

Header image: Hannah Yoest

SB 845 Letter in Opposition.pdf

Uploaded by: Thomas Basil

Position: UNF

March 6, 2023

Dear Senators,

Please consider how euthanasia has played out in Canada per:

https://www.thenewatlantis.com/publications/no-other-options
https://www.thefp.com/p/scheduled-to-die-the-rise-of-canadas

Once euthanasia is enacted, those with difficult lives will increasingly see suicide as an option regardless of their health. Euthanasia will seep far beyond cases of severe medical suffering.

To pass this bill is to unleash suicide on those who are financially desperate, abandoned by family, mentally unstable, or otherwise vulnerable but not terminally ill.

These are the lessons of Canada. Please oppose SB 845, a lethal bill.

Sincerely,

Thomas Basil
843 Meadow Heights Lane
Arnold, MD 21012
basil.tom@gmail.com
410-440-8049

Scheduled to Die – Canada’s Assisted Suicide Progr

Uploaded by: Thomas Basil

Position: UNF

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Monday, March 6, 2023

9:31 AM

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Toronto after a storm. (Creative Touch Imaging Ltd./NurPhoto via Getty Images)

Scheduled to Die: The Rise of Canada’s Assisted Suicide Program

What do you do when you discover your son has made an appointment for his death?

By Rupa Subramanya
October 11, 2022

On September 7, Margaret Marsilla called Joshua Tepper, the doctor who planned to kill her son.

Marsilla is 46, and she lives outside Toronto with her husband and daughter, a nursing student. She had known that her 23-year-old son, Kiano Vafaeian, was depressed—he was diabetic and had lost his vision in one eye, and he didn't have a job or girlfriend or much of a future—and Marsilla asked her daughter to log onto Kiano's account. (Kiano had given his sister access so she could help him with his email.) He never shared anything with his mother—what he was thinking, where he was going—and Marsilla was scared.

That was when Marsilla learned that Kiano had applied and, in late July, been approved for "medical assistance in dying," aka MAiD, aka assisted suicide.

His death was scheduled for September 22.

In a September 7 email from Tepper, the doctor, to Kiano and Tekla Hendrickson, the executive director of MAiDHouse, the Toronto facility where Kiano's death would take place, Tepper mapped out the schedule:

"Hii," he emailed. (Apparently, Tepper did not use spell check.) "I am confirming the following timing: Please arrive at 8:30 am. I will ask for the nurse at 8:45 am and I will start the procedure at around 9:00 am. Procedure will be completed a few minutes after it starts."

The procedure entailed administering two drugs. First, a coma-inducing agent. Then, a neuromuscular blocker that would stop Kiano's breathing. He would be dead in five to ten minutes.

Apparently, Kiano wanted to bring a dog with him. In an email to him that same day, Hendrickson said: "Dogs are welcome in the space as long as there is someone there who will be responsible for them during the time at MAiDHouse."

Marsilla was terrified. She had tried to do everything for her son, but it had been rough for him. She and his dad had gotten divorced when Kiano was still a kid. On his sixteenth birthday, she had given him a BMW. When he was 17, he had been in a bad car accident. He wasn't up to college. He smoked a ton of weed. He'd lived with his dad, then with his mom, and now with her sister, Kiano's aunt.

Wherever he went, whatever he did—he was unhappy. Going blind in his left eye, this past April, was the tipping point.

The day after she discovered the email, Marsilla called Tepper. She pretended to be a MAiD applicant. She called herself Joann and said she "wanted to go through the whole process in general, from A to Zed, before the Christmas holidays—if you know what I mean." Tepper indicated he understood.

Tepper, sounding matter of fact, ran through the list of requirements: "You have to be over 18. You have to have an OHIP card." (He was referring to her Ontario Health Insurance Plan.) "You have to have suffering that cannot be remediated or treated in some way that's acceptable to you."

Marsilla, who recorded the conversation and shared the five-and-a-half-minute recording with Common Sense, told Tepper that she was diabetic and blind—more or less, her son's condition. Tepper said he'd "had patients a lot similar to you."

Then, the doctor said, "If you wanted, I could do a formal assessment with you." Marsilla asked if she should come in. Tepper replied: "We do them remotely, often by video of some type: WhatsApp, Zoom, FaceTime, something like that."

A few minutes later, Marsilla hung up. She had just over two weeks to stop her son from dying.

* * *

'Poised to Become the Most Permissive Euthanasia Regime in the World'

When we think of assisted suicide or euthanasia, we imagine a limited number of elderly people with late-stage cancer or advanced ALS in severe pain. The argument for helping them die is clear: Death is imminent. Why should they be forced to suffer?

In 2015, Canada's Supreme Court ruled that assisted suicide was constitutional. In June 2016, Parliament passed Bill C-14, otherwise known as the Medical Assistance in Dying Act. MAiD was now the law of the land. Anyone who could show that their death was "reasonably foreseeable" was eligible. In this respect, Canada was hardly alone: The Netherlands, Switzerland, Belgium, Spain, Australia, and New Zealand, among others, allow assisted suicide. So do ten states in the U.S.

In 2017, the first full year in which MAiD, which is administered by provincial governments, was in operation, 2,838 people opted for assisted suicide, according to a government report. By 2021, that figure had jumped to 10,064—accounting for more than 3 percent of all deaths in Canada that year.

There have been a total of 31,664 MAiD deaths and the large majority of those people were 65 to 80 when they died. In 2017, only 34 MAiD deaths were in the 18- to 45-year-old category. In 2018, that figure rose to at least 49. In 2019, it was 103; in 2020,118; and in 2021, 139.

Today, thousands of people who could live for many years are applying —successfully—to kill themselves.

Indeed, in some Canadian provinces nearly 5 percent of deaths are MAiD deaths. In 2021, the province of Quebec reported that 4.7 percent of deaths in the province were due to MAiD; in British Columbia, the number was 4.8 percent. Progressive Vancouver Island is unofficially known as the "assisted-death capital of the world," doctors told me.

Why the dramatic increase? Over the past few years, doctors have taken an increasingly liberal view when it comes to defining "reasonably foreseeable" death. Then, last year, the government amended the original legislation, stating that one could apply for MAiD even if one's death were not reasonably foreseeable. This second track of applicants simply had to show that they had a condition that was "intolerable to them" and could

not "be relieved under conditions that they consider acceptable." This included applicants like Margaret Marsilla's son, Kiano.
In 2023, those numbers are almost certain to rise.

Next March, the government is scheduled to expand the pool of eligible suicide-seekers to include the mentally ill and "mature minors." According to Canada's Department of Justice, parents are generally "entitled to make treatment decisions on their children's behalf. The mature minor doctrine, however, allows children deemed sufficiently mature to make their own treatment decisions." (The federal government does not define "mature," nor does it specify who determines whether one is mature. On top of that, the doctrine varies from one province to another.)

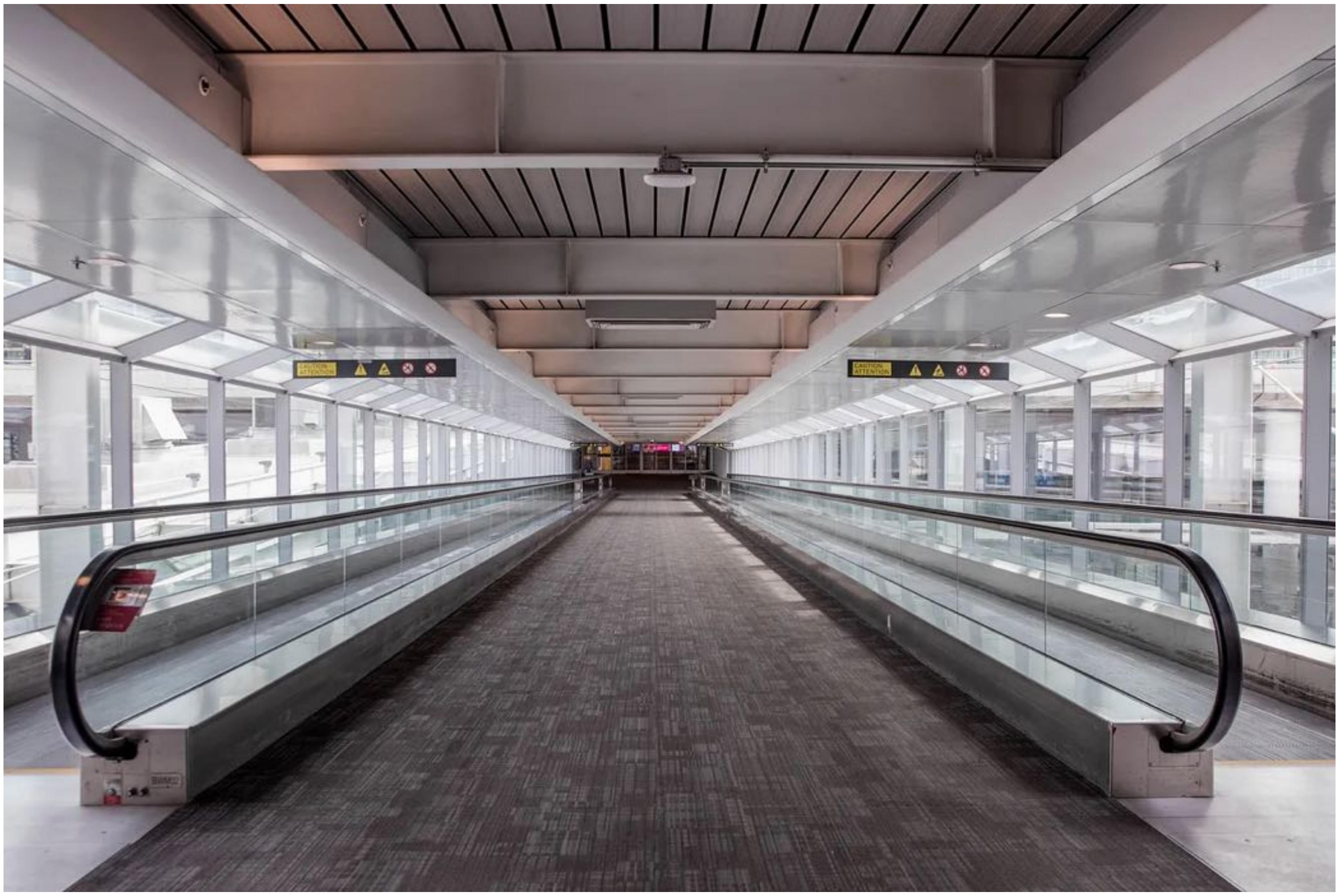
Dr. Dawn Davies, a palliative care physician who supported MAiD when it was first conceived, said she had "tons of worries" about where this might lead. She could imagine kids with personality disorders or other mental health issues saying they wanted to die. "Some of them will mean it, some of them won't," she said. "And we won't necessarily be able to discern who is who."

Hugh Scher, an attorney advising Margaret Marsilla, told me: "While other countries have explored extending assisted suicide to minors, those governments have insisted on substantial safeguards, including parental notification and consent. Canada is poised to become the most permissive euthanasia regime in the world, including for minors and people with only psychiatric illness, having already removed the foreseeability of death or terminal illness as an essential condition to access euthanasia or assisted suicide."

Dr. Ellen Warner is an oncologist at the prominent Sunnybrook Research

Institute, in Toronto, and a professor at the University of Toronto's medical school. "My objection to MAiD, from day one, was that there was no way we would be able to avoid this slippery slope, because these aren't black and white cases," she said. "I'm 100 percent against MAiD. I'm an old-fashioned Hippocratic Oath kind of doctor."

But Dr. Derryck Smith, a psychiatrist at the University of British Columbia, views the rise in MAiD deaths as progress. (Smith never took the Hippocratic Oath, he said, because he thought it was "archaic.") "MAiD is about relieving suffering, respecting human dignity, and recognizing the inherent right for individuals to make decisions affecting their health and even their death," Smith told me. Assisted suicide, he pointed out, had been happening for ages. "Before MAiD, patients who were going to die were assisted along the way with high doses of narcotics," he said. "The rationale was to 'make people comfortable.'"



Entrance leading into Terminal 1 at Toronto's Pearson International Airport. (Shawn Goldberg/SOPA Images/LightRocket via Getty Images)

'The New Social Safety Net'

Many of the people thinking about killing themselves in Canada are relieved that the government has made it easier to die.

"The nightmares have always been a problem," Mitchell Tremblay, 40, told me. "Since I was six-years-old, when my cousin molested me." I'd found Tremblay on Twitter. He had a small following, but he was active in #MAiD circles.

Tremblay was MAiD-curious. The MAiD-curious were lonely and scared, and they had coalesced into a growing, online community, mostly on Twitter and Facebook, and through the spread of death cafés. There were more than 1,300 death cafés in Canada and 14,000 worldwide. In the beginning, in 2012 or 2013, people mostly met in other people's homes to talk about the emotional and philosophical complexities of death. They ate cake and had coffee or tea. Since then, the number of virtual cafés had grown considerably. (There was also an expanding constellation of end-of-life doctors and "death doulas." Karry Sawatsky, a death doula at MAiDHouse, where Kiano Vafaeian was scheduled to die, is described on the MAiDHouse website as believing that "end-of-life planning leads to a meaningful and transformational experience.")

Tremblay was from outside Toronto, and he had been homeless, off and on, for more than two decades. He had spent years in and out of psychiatric facilities. He had prostituted himself, and he'd done tons of drugs, and he'd shuttled between dingy apartments and halfway houses.

For now, he had a place to live, but he expected to be evicted by spring. He planned to apply for MAiD as soon as it opened up to the mentally ill, in March 2023.

"MAiD is going to give me dignity," Tremblay said. "I need to go now, because I know it's gonna get worse."

Les Landry, 65, said he was in the middle of filling out his MAiD application. He was from Medicine Hat, Alberta, in the middle of nowhere, several hours southeast of Calgary and a little north of the Montana line. He received $1,238 every month from the government, but he was always short on cash. He said he'd been abused by his mother when he was four—she put his hand through the wringer of an old-fashioned washing machine. He'd suffered from PTSD, and he'd had three strokes, and he suffered from epilepsy, he said.

Like Tremblay, he was also active on Twitter.

"There's a tipping point where you can't afford to live," Landry told me. "MAiD is the new society safety net."

That was how Victoria and Joan Cowie saw things, too. (Victoria and Joan had become online friends with Landry and Tremblay.)

Victoria, 21, was a third-year engineering student from LaSalle, Ontario, on the other side of the river from Detroit. She suffered from epilepsy—including frequent seizures—and she had anemia, and she was getting three or four iron infusions intravenously every week. She also took care of her mother, Joan, 53, who was battling ovarian cancer and had been confined to a wheelchair by Guillain-Barré syndrome, a neuromuscular disease.

Both women received disability support from the provincial government, in Toronto—that brought in $1,361 every month. After paying rent and utilities, they usually had a little more than $70 to pay for food.

Sometimes, people would send them groceries or other essentials via Amazon Wishlist; sometimes, they'd get some canned goods at local food banks. Often, they'd get by on only one meal a day.

In May, Victoria took a hard look at their budget. They couldn't go on like this for long. "Mom," Joan recalled Victoria telling her, "I don't think we can survive. We have to apply for MAiD."

* * *

* * *

Few Options for Living With Dignity

It had not been lost on government officials that MAiD could save them a

It had not been lost on government officials that MAiD could save them a good bit of money.

In October 2020, the Office of the Parliamentary Budget Officer issued a report stating that MAiD would cut healthcare costs by over $66 million. In 2017, Aaron Trachtenberg, a research fellow and a doctor at the University of Manitoba, and Braden Manns, a health economist and nephrologist at the University of Calgary, published a paper predicting that MAiD could slash healthcare costs by as much as $100 million yearly.

"I do worry MAiD is an easy solution to bed shortages and the terrible lack of resources patients are facing," Dr. Ramona Coelho, a family physician in a suburb of Toronto, told me. She added that "the perverse disincentive that exists for administrators and governments with providing MAiD rather than care and resources to live can present a real danger to the lives of vulnerable or marginalized persons."

Coelho's comments jibed with a 2021 letter, from three UN officials to the Canadian government, about MAiD having "a potentially discriminatory impact on persons with disabilities and older persons who are not at the end of their life or nearing death from natural causes." The letter added that "there is a real risk" that those "who may be further marginalized by their racialized, indigenous, gender identity or other status, will be more vulnerable to being induced to access MAiD."

Dr. Sonu Gaind, a professor of psychiatry at the University of Toronto and a former president of the Canadian Psychiatric Association, said the expansion of MAiD was "built on a house of cards."

"While pretending to provide MAiD for an irremediable condition, we actually end up taking the lives of non-dying people—who could get better—for all sorts of other psychosocial suffering," Gaind told me. "That's not compassion."

He added: "When we have people who are genuinely suffering, and we don't provide them options for dignified living, but we provide them with what we label as a painless death, it provides these people with the enticement of a means to escape their suffering, when we could have helped them escape otherwise—by overcoming their problems and moving on and living."

Nor, Gaind said, is expanding MAiD about personal autonomy—at least, not for everyone. In a recent article, he wrote: "It is a myth that expanded MAiD is just about autonomy. Expansion may increase privileged autonomy for some to die with dignity, but it does so by sacrificing other marginalized Canadians to premature deaths for escaping painful lives that we failed to allow them to live with dignity."

The Canadian flag flies at half-mast over the Parliament Buildings in Ottawa. (Patrick Doyle/AFP via Getty Images)

When the Doctor Gives Your Son a Gun

On September 8, the day after Margaret Marsilla called Joshua Tepper, she took to Facebook to post about her son. "Can you F..... believe it!!! The doctor literlly has given him the gun to kill himself," Marsilla wrote.

Dr. Kristen Creek, in Winnipeg, messaged her. As it turned out, Creek was a family physician, and she provided MAiD. She was surprised to hear that a young man with diabetes had been approved for it. She urged Marsilla to call Tepper back and be up front about who she was.

Marsilla did just that. Soon after, Marsilla, Kiano, Kiano's aunt, and Tepper spoke on the phone. That call led nowhere, Marsilla said. By now, a right-wing, Canadian Catholic news site had picked up on Marsilla's post, which mentioned Tepper by name, and the doctor was getting pummeled by outraged readers.

On September 16, Tepper texted Marsilla to say that he'd postponed Kiano's death until September 28. Five days later, the doctor texted her again to say that, actually, he wasn't going through with it. He apparently wanted nothing more to do with Kiano Vafaeian.

Last week, after repeatedly trying to connect with Kiano, I managed to FaceTime with him. He had a dark beard and mustache, and special goggles to make it easier for him to see (he pushed those up onto his forehead during our conversation). He said he'd applied for MAiD a few years back, and then dropped it, and then thought about trying again. Then, in May, after learning that his eyesight was only going to get worse, he decided he did, in fact, want to die.

"I was so ready," he said. "I was actually very looking forward to ending my pain and suffering." He hated not being able to see. The unhappiness was exhausting. He was arrested for assaulting his father and, another time, for indecent exposure, which he blamed on some hallucinogenic drugs he'd been microdosing. "I tried to do as much as I can," he explained, "and, hopefully, in doing so, I might come across something or someone that could change my mind." He meant about dying. But his mind remained unchanged. He wanted to go.

"My thoughts are that I would be closer to God," he said. He was doing this, he declared, for himself, and for his family.

Kiano told me he was "baffled" by everything that had happened the past three weeks: his mother's social-media campaign, Tepper's decision not to help him die. "I didn't know what to say," Kiano said. "It's how she knows how to love me."

Still, he was furious with her. He didn't know what came next, whether he'd find another doctor. The MAiD people didn't want to touch his case.

On Facebook, he posted a screenshot of a series of texts between him and his mom (which he has since deleted).

"KIANO I love u," Marsilla wrote.

"No you don't," he wrote back. "You were adding to my pain and suffering, and for that I curse you."

"I love u And I want to talk to u," Marsilla wrote.

After a moment, he texted back: "You know what I need."

✦ ✦ ✦

Rupa Subramanya's last piece for us was about the lack of scientific basis for Canada's travel ban during Covid. Read it here.

If you are having thoughts of suicide, call the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK) or go to SpeakingOfSuicide.com/resources for a list of additional resources.

Monday, March 6, 2023

Comments 827

Write a comment...

Gordon Comstock's Plant Writes Gordon Comstock's Plant Oct 11, 2022

I've said it 1,000 times and will say it again...the unifying feature across all liberal ideology today is fundamentally anti-human.

♡ 287 Reply Collapse

110 replies

Ben Septer Oct 11, 2022

Looks like we've gone down the slippery slope again.

Abortion: safe, legal, and rare to shout your abortion and allow it to the moment of birth.

Gay marriage: love is love between two people to what is a woman, really?

Assisted suicide: only for terminally ill patients to if you really feel like it, the government will murder you.

Lastly, and probably most significant, if the Canadian healthcare system thinks that this program will help cut costs, you bet your life that they'll promote it. Imagine that: a government promoting suicide in order to save money.

♡ 207 Reply Collapse

201 replies

See all comments

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KATHERINE BOYLE

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Written Testimony of Thomas P. and Tina M. Wilson

RE: In Opposition to Senate Bill SB0845 - End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

March 6, 2023

We oppose **Maryland Senate Bill SB-0845.** This testimony seeks to express our concerns around **SB-0845**. Assisted Suicide legislation puts Maryland's most vulnerable populations at risk, including individuals with disabilities, minorities, those experiencing poverty, individuals being treated for or have a history of mental illness, our veterans, and those suffering from prescription or other drug addictions.

Lawmakers nationwide reject Assisted Suicide. The Maryland General Assembly has rejected some form of this bill at least five times, and their legislative intent very clear that Assisted Suicide is a criminal act and should remain so.

In their *"Assisted Suicide Laws and Their Danger to People with Disabilities"* report released in October 2019, the National Council on Disability (NCD), recommends that "states should not legalize any form of assisted suicide or active euthanasia", along with several other recommendations. Some of the key findings that support their recommendation are associated with safeguards and their limitations. As documented in the report, "assisted suicide laws contain provisions intended to safeguard patients from problems or abuse. However, research for this report showed that these provisions are ineffective, and often fail to protect patients in a variety of ways, including:

- Insurers have denied expensive, life-sustaining medical treatment but offered to subsidize lethal drugs, potentially leading patients toward hastening their own deaths.
- Misdiagnoses of terminal disease can also cause frightened patients to hasten their deaths.
- People with the disability of depression are subject to harm where assisted suicide is legal.
- Demoralization in people with disabilities is often based on internalized oppression, such as being conditioned to regard help as undignified and burdensome, or to regard disability as an inherent impediment to quality of life. Demoralization can also result from the lack of options that people depend on. These problems can lead patients toward hastening their deaths—and doctors who conflate disability with terminal illness or poor quality of life are ready to help them. Moreover, most health professionals lack training and experience in working with people with disabilities, so they don't know how to recognize and intervene in this type of demoralization.
- Financial and emotional pressures can distort patient choice.
- Assisted suicide laws apply the lowest culpability standard possible to doctors, medical staff, and all other involved parties, that of a good-faith belief that the law is being followed, which creates the potential for abuse."

The Maryland Assisted Suicide Bill appears to be modeled after the Oregon Assisted Suicide bill, which can be used as a proxy for what Marylander's can expect to unfold. We are strongly opposed to Assisted Suicide for the following significant reasons:

- Legalizing Assisted Suicide enables health insurance and medical providers to deny life sustaining care to patients and evade liability for the death of patients. There are multiple cases in California where people were denied life prolonging treatment and offered assisted suicide by insurance companies. Another example comes from Canada, where Christine Gauthier, a Canadian veteran and paraplegic Olympian asked the Canadian Department of Veteran's Affairs for a wheelchair ramp for her home. She received a letter offering her medical assisted suicide instead.
- There are no standard requirements that each patient receives mental health screening and counseling. A screening from a doctor untrained in mental health is not sufficient to assess a patient's true needs.
- There is no requirement in the law for the person to notify their family of plans to perform Assisted Suicide.
- One in three patients who fill the lethal prescription, typically 100 pills, decide against taking it. There are no safeguards to ensure the unused drugs stay out of the hands of children and prescription drug dealers. The patient, or a third party, picks up the prescription for what is a Class 1 controlled substance and can store it at home for an undetermined amount of time. In Oregon, 40% of the prescriptions are never used and up to 20% of the prescriptions are unaccounted for after the person dies.
- While a witness is required when the request for assisted suicide is made (the witness may be an heir to the estate), no witness is required at the time of death, making it impossible to know if depression or coercion played a part in the person's decision to die.
- No doctor or nurse is required to be present when the patient ingests the lethal dose. If something goes wrong, any physical or emotional complications must be handled solely by the patient and those witnessing the death.
- Assisted Suicide laws make suicide socially acceptable. States which have legalized Assisted Suicide, like Oregon, have experienced increased suicide rates.
- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.
- The poor as well as those with disabilities would be faced with choosing suicide as an option so as not to become a burden on their loved ones. To the most vulnerable, a right to die may become a responsibility to die. In Oregon in 2017, 68% of people applying for Physician Assisted Suicide were on Medicaid or Medicare.

The potential dangers presented by Assisted Suicide overshadow any perceived benefits offered by its proponents. For these reasons, we respectfully ask that you protect Maryland's most vulnerable citizens and oppose this SB0845 legislation to legalize Assisted Suicide.

Respectfully,

Thomas P. and Tina M. Wilson
Long-time residents of MD District 17

Tom Jones Testimony Against SB845 - With Attachmen

Uploaded by: Tom Jones

Position: UNF

SB845
"End of Life Options Act"
OPPOSSED – VOTE NO

Tom Jones
508 Post Oak Rd
Annapolis, MD 21401

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 SB845.

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

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

Dr Jones/Dr Paton

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

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

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

Thanks much for any help or insight you can provide.
Tom Jones
443-924-0360

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

Senate Testimony Opposing SB845 (3-7-23).pdf

Uploaded by: Tom Taylor

Position: UNF

As a Maryland voter and retired social service program administrator, I am writing to express my strong opposition to *SB845 End-of-Life Option - Assisted Suicide.*

I have spent my life providing compassionate care to society's most vulnerable individuals, most notably homeless and vulnerable elderly individuals. My experience has taught me time and again that compassionate care makes a huge difference in the quality of life for people experiencing extreme hardships. That is why I strongly believe that quality palliative end-of-life care, rather than assisted suicide, is the best way to achieve dignity for persons facing end-of-life illnesses.

Strong support for individuals at the end of life actually achieves a more dignified death than ending life through assisted suicide. I have heard over-and-over again how programs such as hospice care have helped to make death—despite the great sense of loss and grief involved--a more meaningful experience for both terminal patients and their loved ones.

Members of my own extended family have testified to this experience, and the hospice program in my home town has a reputation as one of the most cherished and well-supported local nonprofit organizations. As the daughter in one family that received hospice services put it: "Because of you my mother's death was as beautiful an experience as it could have been."

I believe that our responsibility as citizens is to make sure that quality end-of-life care is available for all, rather than to rely on artificial drug-assisted death. The proposed physician-assisted suicide legislation has too many downsides that will work against achieving authentic death with dignity.

Many cases have been documented where the supposed safeguards in physician-assisted suicide laws have not been followed. These cases involve concerns about doctor shopping, depression and psychiatric disability, economic pressures and coercion, denial of desired medical treatment for patients, cases of questionable patient consent, problems with self-administration, medical complications, and impacts on quality of care by doctors.

The proposed Maryland law has no standard requirements that each patient receives mental health screening and counseling. A screening from a doctor untrained in mental health is not sufficient to assess a patient's true needs.

My experience in working with homeless persons has shown me that individuals suffering from depression and seemingly debilitating problems can be helped and can significantly improve their outlooks.

Disability rights groups recognize the many dangers the bill poses to those with intellectual and developmental disabilities, such as falling prey to undue influence from doctors or family members, resulting in a lack of true informed consent.

Assisted Suicide laws make suicide socially acceptable. States which have legalized assisted suicide have experienced increased suicide rates.

For all these reasons, I strongly urge an “unfavorable” report on SB845. Instead, let us focus on making sure that quality palliative end-of-life care is readily available to all Maryland residents who need it.

Sincerely,

Tom Taylor
Greenbelt, MD

Senate bill 845 PAS testimony.pdf

Uploaded by: Vickie Hoffmann

Position: UNF

March 6, 2023

To the Senate Judicial Proceedings Committee:

This is my testimony in opposition to Senate Bill 845. I am sorry to see that such legislation is being introduced yet again and again I urge you to say no to this terrible legislation. Once Physician Assisted Suicide is legalized it will put tremendous pressure on the elderly, the handicapped and the mentally ill to end their lives.

I am a friend to many handicapped. I was a caregiver for elderly and sick people as a volunteer with the Missionaries for Charity in Washington DC for fourteen years. I can tell you what people in this situation need is care and appreciation their inestimable value as human beings, not drugs to take them out. It is not pain that makes people choose their own death, it is being unwanted. It is the care we give to each other when times get tough is what really sets us apart as human beings. Physician Assisted Suicide cheapens life by saying the old and handicapped are better off dead.

The other big issue is once you say the yes to some people killing themselves, it will continually expand. In Canada, medically assisted suicide has been expanded to include the mentally ill. Insurance companies and hospitals looking at the bottom line will be pushing suicide as a way to cut costs. I can tell you, when my brother had a stroke, the hospital treated him as “problem" not a person. This legislations will make such attitudes worse.

Again, I urge you to vote against this bill. Use the money that it would take to implement this legislation towards more life affirming care at the end of life and research in better pain control.

Thank you for your consideration

Vickie Hoffmann

Kensington, Maryland

SB0845 - Testimony.pdf

Uploaded by: Will Zwart
Position: UNF

Testimony in opposition of Senate Joint Resolution SB0845 - William Zwart.

Good afternoon, Honorable Chair and members of the Committee.

My name is Will Zwart, and I am testifying in opposition to this bill.

On the surface, it does not seem that there are any groups that would experience undue burdens from granting certain individuals the freedom to kill themselves or have themselves killed.

This is false.

Even giving the option for assisted suicide or lethal injection can create a large number of burdens to those who may be pressured to <u>choose death when they really do not want it.</u> This pressure can come from external parties who may purposefully or accidently suggest or propose assisted suicide. I shall list some examples now.

<u>Vulnerable Groups who may be made Victims by this Bill:</u>

1. People who are likely to be pressured to commit assisted suicide by relatives or others who may have something to gain.
    a. If euthanasia is made legal, it opens the door for mal-intended relatives to either subtly or blatantly suggest it as “the responsible thing to do,” “Your medical expenses are getting too high,” or “You are depriving the world of medical resources which could be used for much better purposes.” This pressure should be considered an “undue burden to die” because the vast majority of people want to live, and <u>most of those who make suicide requests reverse them when their pain and depression are treated properly.</u>

2. People with limited financial resources.
    a. If assisted suicide is an option, the government and insurance agencies may choose to curb payment for end-of-life treatments in favor of paying for assisted-suicide. If this happens, people with limited financial resources <u>will suffer discrimination</u> because they will be pressured to avail themselves of it merely because of their financial condition. <u>This is already happening in Oregon</u>.

3. People with low self-esteem who have no moral conviction against suicide
    a. Those with low self-esteem (especially of the younger generation) are more likely to hear and receive the most negative suggestion made by an authority figure, such as a doctor. If such a figure gives a person with low self-esteem the choice between palliative care and euthanasia, that person may hear a

subliminal message: “The doctor thinks I deserve to die, so I’ll kill myself.” Such a person is not mentally free to “choose” to die, and so the <u>supposed “choice” becomes an implicit imposition.</u>

4. People who are suffering from reversible depression.
    a. A common, reversible state most often found during terminal illness. The depression and anger generally subside or disappears altogether as depression is treated and patients move closer to succumbing to the terminal disease. We are not ourselves when upset or depressed, and should not be enabled in making rash decision.

5. People who see themselves as “stoic heroes.”
    a. Such people as these loathe dependency and weakness, and would rather die than admit either, preferring to “end it all while I’m still strong,” and could choose assisted suicide without consulting friends or family. This would load survivors with all the trauma of a suicide, while ignoring the possibility that the “hero” and his relatives and friends might together discover higher levels of purpose in life.

6. People who are victims of inadvertent cruelty.
    a. Perhaps a mother, given a terminal diagnosis and the option of assisted suicide, turns to her daughter for advice. The daughter, not wishing to impose her values on her other, says, “Choose whichever you think is right, Mom. We’ll support whatever you want to do.” The mother thinks, “That’s all I mean to her?! She doesn’t care if I live or die?! Then why go on? I’ll end it all.” What was intended to be supportive and nonjudgmental was construed as the ultimate rejection. Again, the option of assisted suicide can result in an unwelcome decision to die.

These are just six major groups of people who will be harmed by this bill, as taken from *Ten Universal Principles.* For these reasons and the many others that stand opposed to assisted suicide, I urge you to vote against this bill.

Thank you.

SB0845 End of LIfe Option.pdf

Uploaded by: William Lubas

Position: UNF

I am a physician with an adult child with developmental disabilities.

I worry that someday when I am no longer able to take care of her that someone could convince her that her life is meaningless, that she is a burden to others, and that the world would be better off without her.

As a physician, who is dedicated to healing others, I do not believe that our profession should play any role in purposely ending someone’s life during medical assisted suicide.

SB845_The Arc Maryland_LOI.pdf

Uploaded by: Ande Kolp

Position: INFO

The Arc
Maryland

The Arc Maryland
8601 Robert Fulton Drive, Suite 140
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T 410.571.9320
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www.thearcmd.org

SB845: End–of–Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Judicial Proceedings
March 7, 2023

Letter of Information <u>and</u> Request for Amendments

The Arc Maryland is a statewide disability advocacy organization that is dedicated to the preserving the rights, and improving the quality of life, of individuals with intellectual and developmental disabilities.

As per our National charter, The Arc of the United States, The Arc Maryland has historically come in with opposition testimony to the End of Life Options Act bills. Over the years however, and with a heightened recognition of the importance of preserving individual body autonomy, our Maryland membership has divided views on the matter. While some of our members oppose this legislation, some would like to see a form of this legislation pass, but **<u>only with adequate protections and data provisions</u>**.

SB845 components and safeguards address several of our concerns to which we have testified in the past. We appreciate the conversations we have had with sponsors that resulted in many of the changes made to bill language, definitions and procedures, and feel that the differences will matter to people with IDD and their families.

That said, and as we sit here today, many people with disabilities still face devaluation, a lack of understanding, and barriers to accessing appropriate medical treatment. While improvements have been made, we still have a long way to go before we can be confident that practices of discrimination, as well as disparate treatment practices that affect people with intellectual and developmental disabilities end.

In the first several months of the pandemic, NPR conducted an investigation into how and why people with IDD were denied care[i]. Sarah McSweeney was a young woman with cerebral palsy who loved shopping trips and hanging out with friends. She went to the hospital on April 21, 2020 with what she thought was Covid-19. She experienced fever and chills. The hospital determined that she did not have Covid, but had developed aspiration pneumonia. The pneumonia progressed to the point that Sarah needed a ventilator. The doctor questioned whether it was worth doing, however, citing Sarah's "quality of life." She was not put on a ventilator and later died of sepsis related to the aspiration pneumonia.

To safeguard against a person relying on the medical opinion of one doctor (or practice by extension), we recommend the addition of a requirement that stipulates that **<u>the consulting physician and or mental health professional may not be in the same practice as the attending physician.</u>** This is important as our members are not aware of a situation where doctors from the same practice have disagreed with the opinion of another doctor in their practice. It is unlikely to happen. We believe this is why, when someone wants a second opinion, they do not shop for that second opinion in the same practice. To truly be a safeguard, we believe the amendment below is needed (identical to 2019 bill as amended). While we understand some may consider this a barrier, we do not see it as a hindrance to exercising this option- rather, we see it as a necessary practice. As the "End of Life Option" would be an irreversible action, we should want to ensure this safeguard is in place.

Another amendment request relates to the **need for data collection and reporting**. According to a recently testimony given to the Massachusetts Legislature by Anne Sommers McIntosh, Executive Director, National Council on Disability[ii]**,** the top five reasons doctors give for their patients' assisted suicide requests are not pain or fear of future pain but psychological issues that are eerily familiar to many in the disability community: 95% fear a "loss of autonomy" and being "less able to engage in activities", 87% fear a loss of dignity", 56% said they feared "losing control of their bodily functions". Fifty-two percent (52%) reported feeling like a burden on family and caregivers was their reason for requesting lethal drugs.

These are all common feelings of many with disabilities and influenced by experiences of people with disabilities both by nature of their disability and related care needs, and societal representations and treatment of people with disabilities.

We request an **amendment to collect and report data on various points related to the exercise of this option.** We have concerns there may be disparate use of this option by people with disabilities, in addition to other marginalized populations. Where other states have failed to collect this data, we believe it is critical that Maryland commit to keeping an eye on who/what demographics of people are accessing this option. This information can inform future preventative care, training, and other interventions. The wording that was included in the 2019 bill as amended is what we request be added into the current bill (see below for amendment language.)

In closing, we implore our representatives to continue to work to address the marginalization of people with disabilities that persists and affects even basic access to quality healthcare. While we understand there is interest and momentum to advance the bill this year, we hope this committee ensures the safeguards contained in the bill, AND these two additional safeguards are put into place before considering a vote.

Respectfully submitted,
Ande Kolp, Executive Director

Reference for amendment language:
https://mgaleg.maryland.gov/2019RS/amds/bil_0001/SB0311_46867201.pdf

Amendment 1: Add:

THE ATTENDING PHYSICIAN, THE CONSULTING PHYSICIAN, AND THE LICENSED MENTAL HEALTH PROFESSIONAL MAY NOT:

(I) BE IN THE SAME GROUP PRACTICE, AS DEFINED IN § 1- 301 OF THE HEALTH OCCUPATIONS ARTICLE; OR

(II) HAVE ANY AGREEMENT OR SYSTEM INVOLVING REMUNERATION

Amendment 2: Add required reporting with specific data points:

THE REPORT PRODUCED BY THE DEPARTMENT UNDER THIS SECTION SHALL INCLUDE, FOR THE STATE AND DISAGGREGATED BY COUNTY:

(1) THE NUMBER OF PRESCRIPTIONS WRITTEN FOR AID IN DYING MEDICATION;

(2) THE NUMBER OF PHYSICIANS WHO WROTE PRESCRIPTIONS FOR AID IN DYING MEDICATION;

(3) THE NUMBER OF INDIVIDUALS WHO RECEIVED A PRESCRIPTION FOR AID IN DYING;

(4) FOR EACH INDIVIDUAL WHO REQUESTED AID IN DYING:

(I) THE INDIVIDUAL'S AGE AT DEATH;

(II) THE INDIVIDUAL'S EDUCATION LEVEL;

(III) THE INDIVIDUAL'S RACE;

(IV) THE INDIVIDUAL'S SEX; AND

(V) WHETHER OR NOT THE INDIVIDUAL HAD INSURANCE AND, IF SO, THE INDIVIDUAL'S TYPE OF INSURANCE;

(5) WHETHER OR NOT THE INDIVIDUAL WAS ENROLLED IN HOSPICE AT THE TIME THE REQUEST WAS MADE;

(6) WHETHER OR NOT THE INDIVIDUAL HAD DISABILITY, AS DEFINED IN 42 U.S.C. § 12102, BEFORE THE INDIVIDUAL WAS DIAGNOSED WITH A TERMINAL ILLNESS;

(7) THE INDIVIDUAL'S TERMINAL ILLNESS;

(8) THE NUMBER OF KNOWN INDIVIDUALS WHO DIED FOLLOWING THE SELF–ADMINISTRATION OF MEDICATION FOR AID IN DYING; AND

(9) THE INDIVIDUAL'S STATED REASON FOR SEEKING AID IN DYING.

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[i] https://www.npr.org/2020/12/21/946292119/oregon-hospitals-didnt-have-shortages-so-why-were-disabled-people-denied-care

[ii] https://www.ncd.gov/newsroom/2021/ncd-testimony-MA-legislature-assisted-suicide

SB0845_LOI_HPCNM_End-Of-Life-Option Act.pdf

Uploaded by: Danna Kauffman

Position: INFO

Hospice & Palliative Care Network
OF MARYLAND

Letter of Information
SB845/HB933: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act
Contact: Peggy Funk, Executive Director 410.891.5741

SB845/HB933 End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act), were recently introduced to the Maryland legislature. After discussion, the consensus of the HPCNM Board of Directors is that **the Network takes no position on this bill. However, HPCNM offers the following information concerning this proposed legislation:**

- ***Patients facing life-limiting illness and their families need honest information*** *about prognosis* ***early and frequently after their diagnosis.*** Armed with adequate information, patients have more access and choices for better pain management, palliative care, and enrollment in hospice. Patients are always encouraged to document their wishes to ensure their end-of-life decisions are well-known.

- ***Hospice care provides terminally ill patients and their families with compassion, comfort, and security that can replace suffering, desperation, and loneliness***. With timely hospice referrals, hospice can afford patients and their families the opportunity of reducing physical and emotional pain while making tender memories. Much individual growth and love can occur in the last months of life when symptoms are controlled and support is present, providing death with dignity for patients and closure for grieving families. However, fewer than half of eligible patients receive hospice care, and a third of those that do are referred in their final days of life-too late to enjoy many of the benefits of comfort, emotional counseling, volunteer friendship and spiritual care.

- ***A cultural shift needs to happen that emphasizes hospice care as "Affirming Life".*** Hospice is not "brink of death", or "when there is no hope" care. Patients redefine hope for themselves when they have honest information, realistic expectations, and the compassionate support of a team of professionals who are experts in relieving distress.

- ***Hospice and palliative care professionals believe in respect for patient decisions.*** It is not our job to judge a legal decision that a patient makes regarding how they want their life to end. Hospice and palliative care professionals provide expert physical, emotional and spiritual symptom management and relief with all available means, but never through intentional hastening or causing of death.

About Hospice & Palliative Care Network of Maryland (HPCNM)
HPCNM is a membership organization that includes hospice providers and palliative care partners across the state of Maryland. Our mission is to lead and advance quality hospice and palliative care by serving as an advocate and resource for all Marylanders. Empowering palliative care and hospice services, together we deliver comfort, resources and dignity to families during a poignant time – at the end-of-life. In 2022, Hospice providers served over 24,000 patients in the state of Maryland.

Updated February 16, 2023

SB845.DD Council.LOI.pdf

Uploaded by: Rachel London

Position: INFO

Maryland Developmental
Disabilities Council

EMPOWERMENT • OPPORTUNITY • INCLUSION

Judicial Proceedings Committee
March 7, 2023
SB 845: End-of-Life Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Letter of Information

The Maryland Developmental Disabilities Council (Council) creates change to make it possible for people with developmental disabilities to live the lives they want with the support they need. Examples of developmental disabilities include autism, intellectual disability, and cerebral palsy, among others.

The Council seeks to ensure that people with developmental disabilities have the same rights, opportunities, choices, and protections as other citizens. People with developmental disabilities may need support with activities of daily living, decision-making, and participating in the community in order to lead full lives integrated and included in society. Our goal is to ensure equality for all Marylanders with developmental disabilities.

There are as many strong and diverse opinions about this issue and this bill among people with developmental disabilities and their families and allies as there are within the general community. In their most basic sense, these arguments range from the perspective that if aid in dying is to be available, it should also be available to people with developmental disabilities, to the deeply held belief that it is not possible to ensure adequate protections for people with significant disabilities whose lives are too often undervalued.

The Council is not taking a position about whether a physician in Maryland should be permitted to aid someone in dying as defined in the bill. Instead we seek to outline concerns that some individuals with developmental disabilities, their families, and allies share:

- Fears are expressed about coercion, harm, and discrimination. Their concern is that some people with developmental disabilities could be led into making a life-ending decision because they are considered a burden financially or otherwise. One family explained, “My son is so trusting that he would take his own life without understanding what he was doing. We won’t always be here to protect him.” These families are concerned that there is not adequate protection from abuse.
- People with intellectual and developmental disabilities oftentimes receive support – both subtle and overt – with decision-making. Opponents of the bill believe this would leave people with significant disabilities more vulnerable, especially if the quality of their life is not valued
- Prognoses are not always definitive and accurate timelines are not always possible. Treatment that is not possible at one institution could be possible elsewhere. Science and medicine continue to evolve at a rapid pace.
- People with significant disabilities may be at particular risk within a for-profit health care system because of life-long disability-related costs. They can be viewed as a liability and opponents see no way to safeguard against this.
- Individuals and families who oppose the bill feel strongly that there is too much risk for people with developmental disabilities when these decisions have such a fatal consequence. They believe there is no way to ensure adequate protections to address their concerns.

Contact: Rachel London, Executive Director, RLondon@md-council.org

23 - SB - 845 -JPR - MDH - LOI.docx.pdf

Uploaded by: State of Maryland (MD)

Position: INFO

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

March 7, 2023

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

RE: SB 845 – End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act) – Letter of Information

Dear Chair Smith and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of information for Senate Bill (SB) 845 – End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act). This bill seeks to authorize an individual to request aid in dying and establishes the related requirements and prohibitions.

For the bill to be implemented in a comprehensive manner, MDH notes that there are impacts to the Vital Statistics Administration (VSA) and the Office of the Chief Medical Examiner (OCME) that should be considered, with amendments made within the statutes governing these two offices.

Currently, MDH does not possess the function to collect and report on medically-assisted deaths and would need to develop and implement an addendum to the death certificate system to be used by the attending physician to meet the reporting parameters of this bill. This process would require significant modifications to the electronic death registration system which are noted in the fiscal impact submitted.

In addition, according to the National Association of Medical Examiners, the manner of death is not considered to be “natural” when injury (e.g., ingestion of medication) hastened the death of an individual with a life-threatening disease. According to national standards for completing death records, the manner of death in these situations would be “suicide” and the cause of death fields would include the immediate cause (narcotic intoxication) followed by any other diseases or conditions that directly caused the death (e.g., lung cancer). As the bill is currently written, there are situations in which medically-assisted deaths could be added to the currently mandated cases to be investigated by OCME in Health-General § 5-6A-01 et seq. In the event that a case is erroneously referred for investigation or a rejected death certificate is referred from MDH, an investigation would be triggered and referred to OCME. Because the bill prescribes these cases to be ruled as a natural cause of death, this would result in the medical examiner needing to choose between violating the national accreditation standards for medical examiners and violating the contents of this bill when reporting on the cause of death.

To rectify these issues, MDH respectfully suggests the following amendments:

- Modify the effective date of the bill to provide VSA time to update their current electronic death registration system to capture the information required for the annual statistical report.

- Include language mandating the attending physician who collects the information required for reporting be the same physician who certifies the death.

- Include language that physicians are required to report aid in dying deaths to VSA at the time the death is entered into VSA's electronic death registration system.

- Modify Health General §4-212(b) to include the information required to be documented on the death certificate.

- Include language stating that medically-assisted deaths are not to be referred to the OCME for investigation. This could be accomplished with an addition to Health General § 5-309 (the statute requiring certain deaths, including suicides, be investigated by a medical examiner) clarifying that deaths which occur under Health Gen. § 5-6A-01 et seq. are not to be referred for investigation. The OCME recommends that a similar provision be included in the proposed language of Health Gen. § 5-6A-01 et seq. If a rejected death certificate is referred to OCME, and records indicate that the deceased chose a medically-assisted death, that case would be declined by the OCME.

If you would like to discuss this further, please do not hesitate to contact Megan Peters, Acting Director of Governmental Affairs at megan.peters@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, MD, MPH
Secretary