

Testimony of Sharon Quick, MD, MA (Bioethics)
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In opposition to SB 845
Senate Committee on Judicial Proceedings, Annapolis Maryland
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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 criteria¹ 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 their 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 of 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://efaidnbmninnbpcjpcglclefindmkaj/<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.pccf.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://efaidnbmninnbpcjpcglclefindmkaj/<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](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. *Am J Geriatr Psychiatry* 2018; **26**(5): 523-31.
22. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD. Attitudes of Oregon psychiatrists toward physician-assisted suicide. *Am J Psychiatry* 1996; **153**(11): 1469-75.
23. Ganzini L, Leong GB. Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists. *American Journal of Psychiatry* 2000; **157**(4): 595-600.