Prime Care
House Calls P.C.

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Oppose - Senate Bill 845
End-of-Life Option Act
Presented to the Judicial Proceedings Committee
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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,

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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.

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