Support - SB 443- MAID- Rev. Alexa Fraser UULM-MD

Uploaded by: Alexandra Fraser
Position: FAV

Testimony in Support of SB 443
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

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.

Then I testified here in 2019 after I had become a Unitarian Universalist minister.

And most recently I testified to ensure that disabled people receive the right that all of us should have to choose their own story at the end of life.

I follow the dictates of my faith, which treasures bodily autonomy and personal agency. Two of my faith's principles are relevant here. My faith calls on us to utilize the free and responsible personal search for truth; and the right to use conscience and democratic process for decision making. Over 60% of Marylanders support their the principles of MAID. Offering this option is a God given right.

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

Support - SB 443- MAID- Ashley, UULM-MD (1).pdf

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 443
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: February 8, 2024

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 443 - 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 443- MAID- Becca Forte, UULM-MD (2).p

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 443
End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair & members of the Judicial Proceedings Committee
FROM: Becca Forte, Unitarian Universalist Legislative Ministry of Maryland
DATE: February 8, 2023

Please support **SB 443 the End of Life Option Act for Maryland**. 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 and would have protected the rights of my grandmother over hers. I mention my grandmother because she is someone who recently grappled with these personal decisions, before passing this past year.

My grandmother, who I called "Omi," was a Holocaust refugee who lived to age 86 with multiple cancers and severe breathing problems.

Last year she submitted testimony that said:
"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."

Please grant Marylanders the autonomy, choice, and option that my grandmother asked for.

Thank you,
Rebecca Forte
District 33

Support- SB 443- MAID- Erin Forte, UULM-MD.pdf

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 443
End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair & members of the Judicial Proceedings Committee
FROM: Erin Forte, Unitarian Universalist Legislative Ministry of Maryland
DATE: February 8, 2023

I urge you to support **SB 443 End-Of-Life Option Act** on behalf of my grandmothers, both of whom have passed. While they died after protracted battles with cancer and lung/heart issues, these were ultimately NOT their causes of death. Both were in immense pain with little to no quality of life. Their treatment options had (separately) been exhausted, leaving them with little choices.

Both expressed a desire to live while they could appreciate life and to not live once their life was no longer in their control.

Their definitions of this differed, but similarities included:

1. not being able to feed themselves,
2. not being able to walk, not being able to complete their toilet functions independently, and
3. not being able to control their pain.

Despite all of these conditions being met–and being told that they were not expected to live longer than six months–their only options were to wait for a natural death or refuse food and liquids.

I sincerely hope that nobody else has to watch their grandmothers starve and dehydrate themselves to death. It was absolutely horrifying and there was very little we could do to help them in any way–besides bearing witness so they were not alone. They should have had the option of peaceful and pain free ends to their lives.

I hope to live many more years, but I hope that if–and when–I am in the same position that I will have a better end of life option than either of them.

Please support SB 443-End of Life Option Act for Maryland.

Erin Forte
District 33
Unitarian Universalist Legislative Ministry of Maryland

Support- SB 443- MAID- Kris Kornemann .pdf

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 443
End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair & members of the Judicial Proceedings Committee
FROM: Kris Korneman
DATE: February 8, 2023

Please support SB 443 and HB 403 , the End of Life Option Act for Maryland.
This bill is important to me personally as a granddaughter, a daughter, and as a close friend of someone who is withering away from pancreatic cancer (and more).
My grandmother just turned 103 and is in complete despair and demented with “zero” quality of life left. All she says when anyone sees her is “I want to die–I want to die–please won’t you let me die?”

This is cruel and unusual punishment. My grandmother, when she was of sound mind and body, expressed that she didn’t want any life sustaining measures, (especially when her quality of life had left her entirely).

There is no question of my grandmother’s status to her hospice workers, her geriatric care manager, her aides who’ve been with her for years, or her family. She is ready to transition and is awaiting it with open “arms”.

As someone who has researched this topic, I can tell you that the nearest place to have passed the End of Life Option Act in 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 could travel to for end of life autonomy is Vermont.

As a 30+ year financial planner, I see how our residents grapple with taxes and other similar matters that make Maryland unattractive to retirees. Many of them leave our state during retirement. For those that remain, they bear the additional burden of our lack of autonomy or access to end of life choices that carry any legal bearing. This bill aims to rectify that situation and provide legislative backing for them when they make these personal decisions (and for my grandmother who is now suffering as each day passes, as well).

Thank you,
Kris Kornemann, CFP®
Financial Advisor, Financial Advantage Associates
(and lifelong Maryland resident (Montgomery County)

Support- SB 443- MAID- Shari Chilbert .pdf

Uploaded by: Ashley Egan

Position: FAV

Testimony in Support of SB 443
End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

TO: Senator Will Smith, Jr, Chair & members of the Judicial Proceedings Committee
FROM: Shari Chilbert
DATE: February 8, 2023

I am writing this during my period of grief–my best friend, my confidant, my cheerleader, the very best person I've ever known–my mom–passed away a few months ago. Losing her is heartbreaking–but watching her suffer through cancer was agonizing in more ways than one can imagine!

My mom was of sound mind, and knew without hesitation that she didn't want to live her life if there was no quality, no independence. Yet, she had no control over her own body's end to life, so therefore, could not choose to die with dignity. She wanted to leave this world on her own terms. Yet, she was not legally allowed to make her own decisions regarding her own body. This does not make sense- why should her life choices be in the hands of others who cannot carry out her wishes?

This bill is important as it will help protect a person's right over his/her body.
I wish my mom was with me but I also wish she had total rights over her decision to end her life.

Please support the End of Life Option Act for Maryland. Please support SB 443.

Thank you,
Shari Chilbert
Montgomery County

Testimony for SB443.pdf

Uploaded by: Bonnie Weissberg
Position: FAV

Testimony Supporting SENATE BILL 443 End–of–Life Option Act

Judicial Proceedings Committee

February 8, 2024

Dear Senators Waldstreicher, Lam, Elfreth, Gile, Kelly, Lewis Young, Smith, West, and M. Washington

I am a resident of District 41 and wish to support this bill and encourage all the State Senators to approve this bill. I am a retired social worker who worked with people with severe illness for over 30 years in California and Maryland. I have seen suffering. I have witnessed debilitating illness of every kind that left people with poor quality of life and no hope of improvement.

There are many diagnoses that can cause the loss of each ability slowly but surely until the person is unable to move or feed him or herself while he or she waits until the heart stops. While palliative and hospice care can provide some pain control or symptom management, the people suffer while they are imprisoned in their own bodies. I have watched patients with ALS, Cancer, end stage Alzheimer's Disease and status/post strokes, etc., dependent on others for all care, including diapering. If an end of life patient or surrogate chooses to terminate the life of such a patient, it should legally be allowed with the assistance of health care professionals.

The End of Life Act is legal in the following states:

Oregon
Washington
Montana
Vermont
California
Colorado
Washington D.C.
Hawaiʻi
New Jersey
Maine
New Mexico

We need the End-Of-Life Act in Maryland. Please make it so.

Sincerely,
Bonnie Weissberg
1704 Mt. Washington Ct., Apt. H
Baltimore, MD 21209

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)

At the beginning of February 2024, my fiancé and I sat at the dinner table with a European friend of ours. He told us the stories of two of his friends, both of whom had been diagnosed with terminal cancer. One of them chose to fight for every last breath his body would allow him. The other opted to go to Switzerland in January 2024, where he spent a last week eating all of his favorite meals, surrounded by friends before he chose to end his life peacefully.

Each one had the autonomy to choose how they would spend their last days.

I believe that terminally ill Marylanders should have the choice to make this decision for themselves as well.

I'm here as a disabled resident of Maryland to call on you to pass the End–of–Life Option Act for the terminally ill.

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. One of those possibilities is suffocating to death should my lung function deteriorate to that point. This is my greatest fear.

Should my disease progress to a point where physicians say I have mere months to live, I believe I should have the choice to make the decision best for myself.

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 percent of pro-choice voters in Maryland support medical aid in dying, as do 49 percent of pro-life voters. Three-quarters of Americans (74 percent) 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, leading lawmakers and the broader community to believe there's overwhelming opposition to medical aid in dying legislation.

This could not be further from the truth.

A recent poll shows seventy-nine percent of those who self-identify as having a disability agree with the statement that medical aid in dying should be legal for terminally ill, mentally capable adults who choose 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 who identifies as living with a disability support patient-administered aid 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 medical aid in dying 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 medical aid in dying 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.

We must let the evidence and facts guide us.

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.

2024 Senate testimony.pdf

Uploaded by: Cathy Larner-Beckett

Position: FAV

Senate Judicial Proceedings Committee, February 8, 2024

Testimony in SUPPORT of End-of-Life Options Act

Senators, thank you for your time.:
My name is Dr. Cathy Larner-Beckett and I live in Heritage Harbour in Annapolis.
I am a retired special education teacher, principal, volunteer with people with disabilities, cancer survivor, person with a disability, and Catholic.

I am here to ask you to support the End-of-Life Options Act because it is the compassionate, right thing to do – to allow people with a terminal diagnosis to have some control and dignity, and the **option** for a peaceful death, at the end of their life. This bill is **very** personal for me.

Both of my parents, were lifelong Catholics, and I watched them die more than 20 years apart. My father was in hospice, but at the end, he was in intolerable pain despite the administration of morphine. I watched as this strong man, a combat veteran, teacher, member of the DC Boxing Hall of Fame, screaming in severe pain. Those who loved him stood by, horrified, helpless to stop it, waiting, and praying, for it to end. It was intolerable for all of us, dad and his whole family. It was a scene I will never forget and hope to never see again.

Despite being a Catholic who attended Mass at least once a week, my mother supported my advocacy for this end-of-life option prior to her death. She was in hospice for a year – twice the 6 months prognosis given her. Her body did not die in the 6-month window her doctors predicted, and there was **NO quality** of life in those extra 6 long months. That time was miserable for her, and for her family, who watched her **literally** waste away,. This 5-foot 7inch woman weighed **a mere 76 pounds** at her death.
Her living was not extended but her suffering, and her death, were.

Opponents of this bill use fabricated predictions of people with disabilities being coerced to use this option. Over a cumulative of more than 40 years of data from states with this option at the end of life, proves these fears are unfounded. Please do not deny all terminal Marylanders the **option** for a peaceful, dignified death. Support the End-of-Life Options Act.

SB0443_End–of–Life_Option_Act_MLC_FAV.pdf

Uploaded by: Cecilia Plante

Position: FAV

MARYLAND
LEGISLATIVE
COALITION

TESTIMONY FOR SB0443
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 SB0443, 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 SB443.pdf

Uploaded by: Dan Diaz

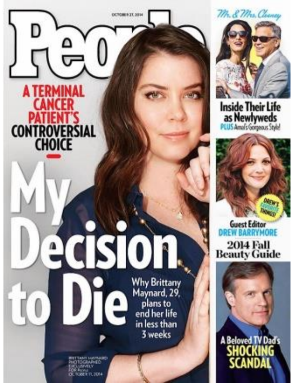
Position: FAV

Dan Diaz
TheBrittanyFund.org

February 5, 2024

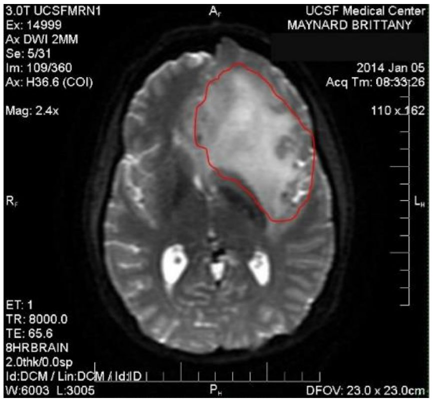
Support: Senate Bill 443 – End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

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 they experience a terrifying death,' Brittany refused to accept that.

After working on this legislation for the past 9 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 the opponents 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 overwhelming support this option.)

- The safeguards in this legislation protects <u>everyone</u> who applies for it, and it also protects individuals who don’t. The passage of this bill, will for the first time protect the most vulnerable in our society (the disabled and frail elderly) 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

Dr. Barnard Testimony Maryland 2-8-24.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

Regarding HB 403 and SB 443
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 the MAID bill before you. I have been a board-certified Family Medicine Physician for nearly 30 years. I am also board-certified in Hospice and Palliative Medicine. The past 15 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 more than 10 years. I regularly prescribe medications under the law and also support and educate other physicians who participate. The most recent legislative report (published in January, 2024) shows that our law is working well and as intended. 203 Individuals 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 must accept that they 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 (https://www.acamaid.org) , 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. In Vermont, we have developed our own educational website with information for patients and clinicians https://www.patientchoices.org

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 challenging 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 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 Delaware show that a large 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 HB 403/SB 443 in this session.

With Gratitude and Peace,

Diana Barnard, MD

Senate SB0443 Diane Kraus written testimony 020820

Uploaded by: Diane Kraus
Position: FAV

SB0443: End-of-Life Option Act **IN FAVOR** Diane L Kraus, Baltimore MD
February 8,2024

I worked as an Occupational Therapist in adult acute care, rehab, but mainly in homecare and hospice (25 years). I was a caregiver for my mother at her end – she died of what I have- metastatic breast cancer. I have seen the extent of what neurological diseases and cancer due to a person, their family, and the sense of loss of control over one's life that develops. I had cancer in 2011 with treatment into 2013, and once I passed the 5 -year mark cancer free, I never expected it again. But I found out I had cancer again in May 2021. And it was nearly everywhere: brain, skull, multiple bones, lungs, liver, and soft tissue.

One of the worst parts about my metastatic cancer this round is not just the cancer and all the damage it has done to my body, but the treatment itself. Brain radiation was the worst thing I have ever done. The first 3 types chemo were horrible, with difficult to control symptoms, and I continued to get worse. Now on chemo number 4, this miracle drug has kept me alive well past any expectations. It has improved my cancer and I had improved to no active cancer in my body for 4 months. Last month, though, I had a brain scan and they found one dormant tumor getting larger and a new tumor in new place. I am a chemo "lifer". I will need to continue every 3 weeks, until I die, or my body rejects it.

In my life and activities though, it means only the last 10 days of my 21-day cycle can I have a functional life, as the first 10 days are highly symptomatic and limiting. But I persevere. Because in spite of it all, I like life and choose to continue to fight, until I can't anymore.

But with all the cancer damage and treatment damage, as well as continued chemo, life is still a declining struggle. Having been a therapist, caregiver, and patient, I know what to expect. I want this bill for me. I had seen so many people die in pain and so many people have such a poor quality of life at the very end. And near the end of their Earth-bound journey, they would say, 'I just want to go home and be with God, and be with my relatives'. I don't want to suffer in pain the way my mother or my patients suffered near the end of their lives. I don't choose to participate with the loss of self, or put my family through the taking care of me, the suffering of the near-the-end pain, and the dying processes.

I know that even the best hospice cannot relieve every patient's suffering. That's why I want this gentle end-of-life option for myself.

I want people to remember me for the stubborn, fun-loving, caring, and protective person I have always been. I don't want them to remember me for my end-of-life struggles. And those last impressions are very lasting.

I choose Medical Aid in Dying.

Support SB 433 Diane Teichert .pdf

Uploaded by: Diane Teichert

Position: FAV

Support SB 433 Diane Teichert

Esteemed legislators, except for my facial droop, you can't tell that I am a stroke survivor with hemiplegia and therefore use a mobility scooter. So, I very much appreciate this chance, via video, to exercise my right to testify before you as able-bodied people do.

As a person with disabilities, I ask you to support Senate Bill 433. The medical aid-in-dying and disability rights movements share important core values, high among them: self-determination.

It is clear to me that the provisions spelled out in this bill carefully protect against the possibility that my death, or that of anyone with disabilities, could be hastened by those who deem our lives not worth living. If that's your concern, please read the bill again.

I also come before you today as the daughter-in-law of a Baltimore man who died last spring at the age of 104. As we shared in our holiday letter to family and friends, "Had Maryland passed its End of Life Option Act, his anxiety about a painful death from heart failure would not have been so acute."

Please support Senate Bill 433, and give terminally ill Marylanders of sound mind the right to choose a medically-assisted death. Thank-you.

Sincerely,
Rev. Diane Teichert
-

Rev. Diane Teichert (she/her)
4321 Van Buren Street
University Park, MD 20782
Minister Emerita, Paint Branch Unitarian Universalist Church in Adelphi, MD http://pbuuc.org/
Issues Lead, Unitarian Universalist Legislative Ministry of Maryland https://www.uulmmd.org/
Co-chair, Prince George's County Lynching Memorial Project Project https://pgclmp.org/
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Doug Heinrichs EOL Option Act SB0443 HB0403 FAV -

Uploaded by: Doug Heinrichs

Position: FAV

Testimony of Douglas W Heinrichs M.D. -- Favorable
Regarding SB0443/HB0403 -- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

I am Dr. Douglas Heinrichs, a psychiatrist who has practiced in Maryland for over 40 years. I am a member of the Maryland Psychiatric Society (MPS) legislative committee, but I am speaking here as a private individual. I strongly support this bill and wish to make three points as a psychiatrist.

Maryland psychiatrists and physicians nationwide support aid in dying.

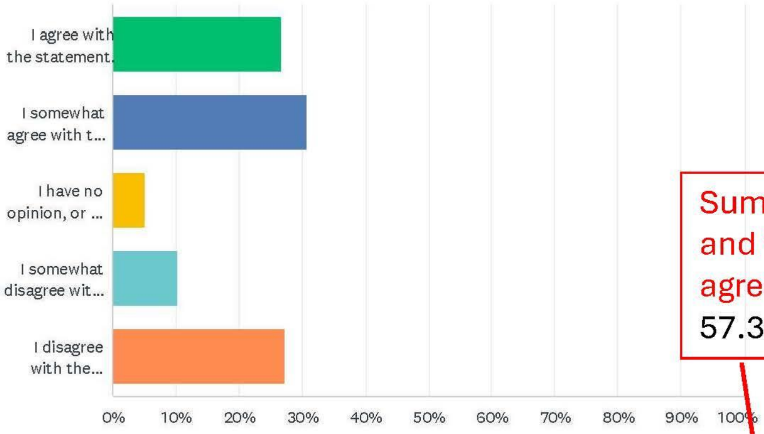
In a 2022 poll that the MPS leadership chose not to make public, MPS members were asked if physicians should be allowed to prescribe lethal medication to competent patients with a terminal condition. 57% agreed or somewhat agreed, while 37.5% disagreed or somewhat disagreed. (See page 2 insert) This is in keeping with the many polls of psychiatrists and other physicians nationally that have found that most physicians support medical aid in dying. The opposition of the MPS is out of step with its membership and the medical profession in general.

It is unreasonable to require psychiatric evaluation of everyone seeking aid in dying.

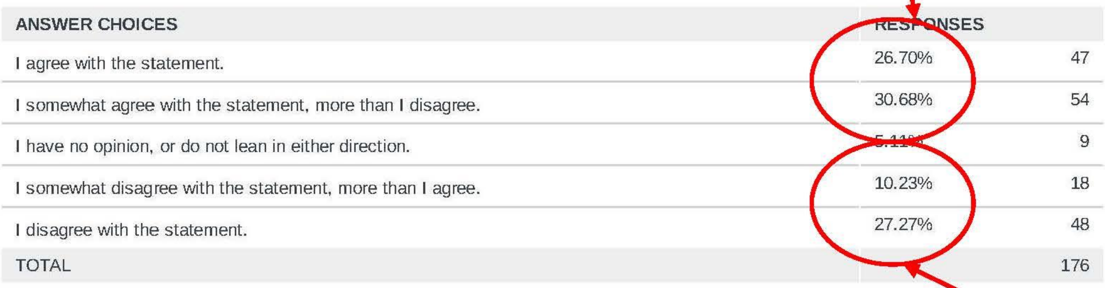
Two studies where mandatory evaluations by mental health professionals were required -- the University of California San Francisco and the state of Hawaii -- with a combined sample of 261 patients, found no patients who lacked capacity due to a psychiatric condition that impaired decision-making. (Bell BK, et al. 2022; Goodyear B. 2024) Both studies concluded that mandatory evaluations by mental health professionals should not be required unless the attending physician's evaluation raises a concern. Requiring such an assessment when mental health resources are so severely stretched is wasteful, and the inevitable delay would be an extreme burden for those seeking aid in dying, as well as being demeaning to a person with no past or present indication of mental illness, as if her mere request raises questions about her sanity.

MPS Survey

57% of 176 Psychiatrists who Responded "Agree" or "Somewhat Agree" that "Physicians should be allowed to prescribe lethal medication to these patients."*



Sum of "agree" and "somewhat agree" equals 57.38%



ANSWER CHOICES	RESPONSES	
I agree with the statement.	26.70%	47
I somewhat agree with the statement, more than I disagree.	30.68%	54
I have no opinion, or do not lean in either direction.	5.11%	9
I somewhat disagree with the statement, more than I agree.	10.23%	18
I disagree with the statement.	27.27%	48
TOTAL		176

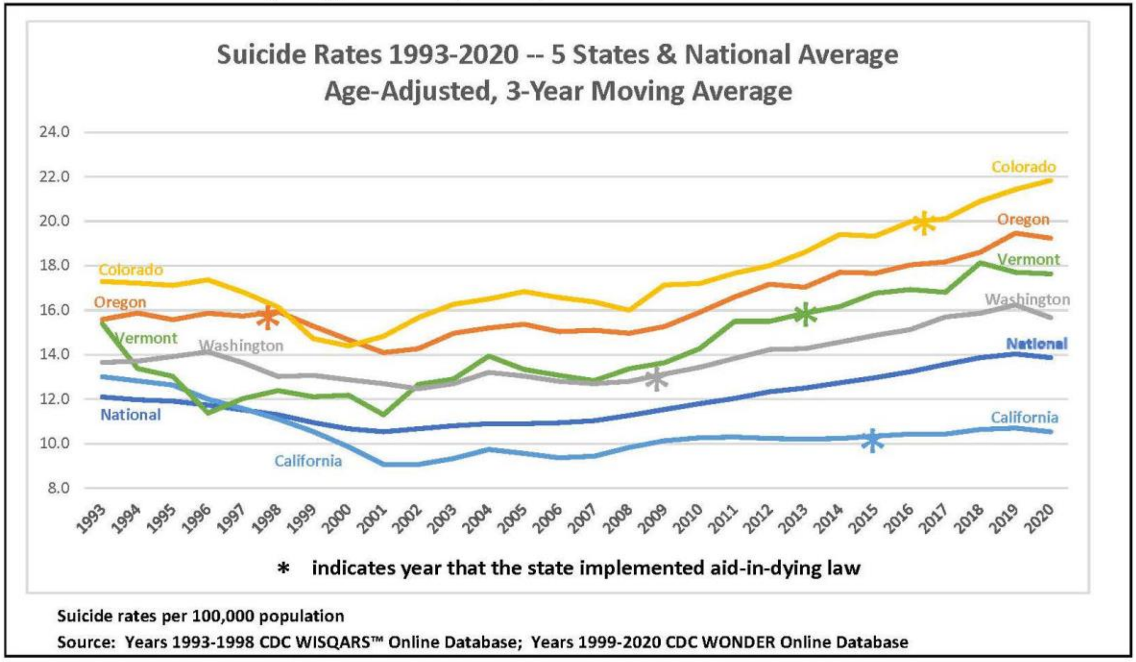
Sum of "disagree" and "somewhat disagree" equals 37.5%

* Question pertains to a competent person with a terminal condition who has significant pain, suffering and/or functional deterioration, despite adequate treatment. Terminal condition means an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life–sustaining procedures, there can be no recovery.

Aid in dying does not lead to increases in copycat suicides.

The data from states where it has been available indicate otherwise. No changes in the pattern of suicide rates are seen that correspond to the introduction of aid in dying legislation. States with higher rates of suicide than the national average had higher rates before the introduction of aid in dying legislation in those states. (See graph below.) This should be no surprise. The motivational structure for suicide and for aid in dying are totally different. Typically, people committing suicide choose, for whatever reason, to end their life when it would otherwise be continuing. People seeking aid in dying would love to keep living. It is their disease that is killing them. They are only seeking control over the process to maximize their dignity and minimize their suffering and that of their loved ones.

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

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Forensic Psychology

Commentary

Mandatory Mental Capacity Evaluations for Patients Requesting Medical Aid in Dying: Are They Necessary?

Brian Goodyear*

Private Practice, Clinical Psychology, Honolulu, Hawaii, USA

ABSTRACT

Medical aid in dying is now legally authorized in 11 jurisdictions within the United States of America. The State of Hawaii is the only jurisdiction in which mental capacity evaluations are mandatory for all patients who request medical aid in dying. Previous research and the results of the author's evaluations of 161 patients who requested medical aid in dying in the State of Hawaii between January 2019 and December 2023 support the conclusion that mental capacity evaluations should not be legally mandated for all patients who request medical aid in dying.

Keywords: Medical aid in dying; Mental capacity; Mandatory mental capacity evaluations

DESCRIPTION

A total of 11 jurisdictions within the United States of America currently allow medical aid in dying. Eligibility in all jurisdictions requires a patient to be a terminally ill adult with a prognosis of six months or less (hospice eligible), and to have the mental capacity to make an informed medical decision.

In April 2018, the State of Hawaii became the eighth jurisdiction in the USA to legalize medical aid in dying. In addition to evaluation by an attending and consulting provider, every patient requesting medical aid in dying in Hawaii must undergo a mental capacity evaluation performed by a licensed psychiatrist, psychologist, or clinical social worker.

The State of Hawaii is currently the only jurisdiction in which a mental capacity evaluation is mandatory. In all other jurisdictions, referrals for capacity evaluations are made at the discretion of the attending provider. Such referrals are rarely found to be necessary. Only 5.6% of 991 patients in Oregon who ingested legally prescribed lethal medication were sent for psychiatric evaluation to assess competence [1]. Similarly, a review of trends in Oregon and Washington found that only 4% of 3,368 patients were referred for mental health consultation [2]. And in a sample of patients in Washington and Oregon with ALS, only 2.7% required psychiatric consultation [3].

Other studies have not found significant relationships between the presence of mental health symptoms and end-of life medical decisions [4-7].

The largest body of research on patients who participate in medical aid in dying has been done by Dr. Linda Ganzini of Oregon Health and Science University and her associates. Their research indicates that mental disorders are not present in the majority of patients who request medical aid in dying [8,9]. Based on her experiences in Oregon, Ganzini has concluded that while all patients requesting medical aid in dying should be carefully screened for depression, requiring a psychiatric consultation in every case is burdensome, unnecessary and possibly unworkable [10].

Overall, the research findings seem consistent with the legal principles described by Grisso and Appelbaum, who emphasized that courts across the USA have made it consistently clear that the presence of mental illness, mental retardation, or dementia alone does not render a person incompetent, and that a patient may be psychotic, seriously depressed, or in a moderately advanced stage of dementia, yet still be found competent to make some or all decisions [11].

Between January 2019 and December 2023, the author conducted a total of 161 mental capacity evaluations for terminally ill patients who had requested medical aid in dying in the State of Hawaii. Evaluations consisted of a review of relevant medical records, a mental status examination, and a detailed clinical interview, which included a screening for symptoms of major depressive disorder and an assessment of decisional capacity based on the principles outlined by Grisso and

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Citation: Goodyear B (2023) Mandatory Mental Capacity Evaluations for Patients Requesting Medical Aid in Dying: Are They Necessary? J Foren Psy. 9:318.

Appelbaum [11], and subsequently incorporated into handbooks developed jointly by the American Bar Association and the American Psychological Association [12,13]. The principles involve the assessment of four functional abilities: The ability to understand information relevant to the decision; the ability to appreciate the significance of the information and the probable consequences of the available options; the ability to use reasoning to weigh the potential risks and benefits of the options; and the ability to communicate a voluntary decision. A checklist was developed to assist in the assessment of these abilities in medical aid in dying patients.

Consistent with the findings of the patients' attending providers, the author found that the vast majority of patients clearly had the mental capacity to request medical aid in dying. Only four of the 161 patients (2.48%) lacked the necessary decisional capacity, all because of rapid deterioration in cognitive functioning subsequent to the attending provider's initial visit. A total of 15 of the 161 patients (9.32%) were found to have a mental disorder (either a depressive disorder or adjustment disorder) at the time of the evaluation. In all cases the disorder was mild, and in no case was the disorder severe enough to impair decisional capacity. Mental health treatment was recommended as deemed necessary and appropriate for these patients. Another ten patients acknowledged a remote history of mental disorder that was not evident at the time of the evaluation.

Several conclusions can be drawn from the data reviewed above. First, a request for medical aid in dying should not be equated with the presence of a mental disorder. Second, mental disorders are found to be present in a minority of patients who request medical aid in dying. Third, even when a mental disorder is present, decisional capacity is rarely impaired. These conclusions strongly support the assertion that mental capacity evaluations are not clinically necessary for the great majority of patients who request medical aid in dying.

It thus seems reasonable to argue that mental capacity evaluations should not be legally mandated for all patients who request medical aid in dying. Referrals for such evaluations can be made at the discretion of the attending provider, consistent with the process that providers customarily follow when assessing patient's decisional capacity for other medical procedures. Patients who request medical aid in dying should be carefully screened by their attending and consulting providers for the possible presence of any mental disorders that might affect decisional capacity. Terminally ill patients should not, however, be required to undergo a potentially costly, time-consuming, and burdensome evaluation by a mental health specialist unless the attending or consulting provider finds that there is a clear reason to do so.

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Testimony End of Life Option Act 2024 Edna Hirsch

Uploaded by: Edna Hirsch

Position: FAV

Testimony of Dr. Edna Hirsch -- Favorable
Regarding SB0443/HB0403 -- The End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

My name is Dr Edna Hirsch and I support this bill.

I am a 2X Breast Cancer survivor. My husband has 4th-stage glioblastoma.

Every year this Bill has not been enacted means people have been forced to endure unnecessary suffering. I do not believe God wants us to suffer, not my God. If that were the case, then one should not take any medicine for any illness.

Two skilled physicians make a recommendation based on sound medical knowledge that further life would only be painful and full of unnecessary suffering, and there is no more that medicine can provide. Praying will not remove their suffering. To prolong the inevitable under those circumstances is like torturing someone. Hospice is available but often is a long, drawn-out process with weeks or months on a morphine drip that shuts the body down. The person drowns in their body fluids. It is not humane to leave people with only the option to starve themselves, put a gun to their head, or suffer needlessly. If people do not want to take advantage of this option, they do not need to. But for those who want this option, it should be available.

It is not that hope has run out, it is that hope for a better end of life is their only hope.

Medical Aid in Dying Testimony -- Final .pdf

Uploaded by: Elaine Shell
Position: FAV

Testimony in Support of SB 443
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: Elaine Shell, District 23
DATE: February 8, 2023

Death can happen for endless numbers of reasons and at any time in a person's life. It can be a scary thing to think about. It can also be a calming state to think about, depending on an individual's beliefs. I believe that death will be a state of nothing. I'll be gone. That's it. That's what my parents believed also. They lived in a small town on the West side of Michigan. Mom had a photograph of Doctor Kevorkian, who promoted medical aid in dying, on their living room wall and to the side of their bed. It was a clear statement of their desires. Then my Dad had a massive stroke at the age of 66. Back in 1977 there weren't many options for stroke recovery available. He was never again able to walk, get himself out of a chair, talk (except for Yes and No), read, write or clearly see the TV – and he was in pain. My Dad was fully aware of what his life had become. He lived for 12 years(!) in this state. He wanted to be dead every day of those 12 years! He ended up starving himself to death which is not a pleasant way to die. I realize that the legislation under consideration would not have helped my Dad, but **I wanted to share that some living situations are truly awful**.

A nurse once told me that she was against Medical Aid in Dying because she had experienced relatives pressuring the medical staff to end a parent's life to get their inheritance earlier. OK, this is possible, but I offer to you that a more reasonable explanation for the family's request is that the relatives didn't want the suffering and prolonged existence of their family member because the patient was very eager to "have it over with". Being alive, without being functional and probably in pain, may be ok for some people, but if I had told my doctors and family that I truly want help to end my existence, and it didn't happen, it would make my existence even harder on me, and for my family members who had no control to help me.

The Maryland End-of-Life *Advanced Directive* is a good step toward encouraging individuals and their families to think about, and communicate, the level of care that they choose for themselves when a death diagnosis occurs. Personal Choice is a very powerful element of human life. When people 'choose' their life decisions such as careers, life-time partners, places to live, etc., then following through on those choices is typically both satisfying and rewarding. Being told that you must live your end-of-life according to someone else's decisions, creates lingering anxiety, anger and fear.

If I know that the State of Maryland will honor my decision to choose medical aid to end my life, I will have the power to end my life when it makes sense to me (within the context of the law). **What a magnificent Choice you can provide to Marylanders. Please VOTE YES on SB-0443.**

Elaine Shell
8501 Montpelier Dr
Laurel, Md 20708

SB0443 JCRC testimony 2.8.24.pdf

Uploaded by: Elizabeth Singer

Position: FAV

JCRC JEWISH COMMUNITY RELATIONS COUNCIL
JEWISH FEDERATION OF HOWARD COUNTY

Committee: **Judicial Proceedings**
Testimony on: **SB0443 – End of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)**
Organization: **The Jewish Community Relations Council, Howard County, MD**
Submitting: **Betsy Singer and Laura Salganik, Co-chairs**
Position: **Favorable**
Hearing Date: **February 8, 2024**

Dear Chair and Committee Members:

The Jewish Community Relations Council of Howard County (JCRC) is submitting this testimony in support of SB0443. 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, and 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 has come from people of faith, stating that their religious tradition causes them to oppose end-of-life options. The JCRC is clarifying 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 recommend a **FAVORABLE** report for SB 0443 without hesitation or reservation.

SB 443

Uploaded by: Ethel Hill

Position: FAV

Testimony of Ethel B. Hill in Support of SB 443
February 8, 2024

Good afternoon.

I am here to provide testimony in support of Senate Bill 443. My name is Ethel B Hill, Esq. I am a long time Howard County resident and currently live at the Residences of Vantage Point retirement community. At 91 years old I have a lifetime of experience and a specific point of view to share.

My 56-year-old brother, District Justice William L. Brown Jr., died October 12, 1990, died six months after his terminal lung cancer diagnosis. He suffered hallucinations, excruciating pain, and pleaded for relief. His wife removed firearms from their home to prevent self-harm. The memory of watching my brother's suffering, as an incurable illness ravaged his body, is still fresh in my mind. I wish he had had the compassionate option to choose a peaceful transition.

No matter how present we are for our loved ones in their time of need, we cannot accompany them for their entire journey. They walk the last mile alone.

This bill gives them control over how and when they reach the final resting place, allowing them to act according to their own conscience as informed by their personal faith and beliefs.

I hear concerns that church affiliated African Americans do not support this bill. Not so. I am not a unicorn but represent the views of many in my community who believe legislators should not regulate this deeply personal decision or vote against the bill because of their or others' religious views.

Thank you for the opportunity to provide testimony. I urge your passage of Senate Bill 443.

Final Test Let G Norman Feb 2024 at the Md Gen Ass

Uploaded by: Gary Norman

Position: FAV

February 8 2024

Testimony of Gary C. Norman, Esq. L.L.M.

Maryland General Assembly
Annapolis, Maryland

Submitted electronically

Regarding: The End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act), S. 0443 & H. 0403, Reg. Sess. (2024)

Dear Chairs and Committee Members:

I provide these following remarks as a lawyer and as a person with a disability, who also serves as policy counsel at US for Autonomy. My public policy work has been infused with the “lived experience” of the benefits and the challenges of having a disability. I urge a favorable report.

I urge that choices exist throughout the life spans of all people, including, as to end-of-life care options. I have witnessed loved ones, including two guide dog partners, transition to that place from which no traveler returns. Those dying processes and transitions have typically not been dainty and pain free experiences for all involved. To refer to *A Christmas Carol*, I am a member of humanity. The dying process to be experienced by all beings must be de-medicalized and empowered with improvements in choice. If you pass these bills, this will enable an option that I may or may not pursue in the future. However, another person may select this option in consultation with their families, with professionals required in the bills, and indeed with their understanding of deity.

Arguably, these bills provide a set of notable processes and protections opponents want to ignore. Many witnesses have described these protections in detail. No grand scheme exists to abuse people with disabilities, as the thoughtful processes and protections in these bills show as a normative policy goal. I would, as a moderate and policy counsel, not support these bills, if I had concerns and also knew of long-term documented data reflecting negative outcomes to this policy decision.

In conclusion, the law must empower citizens to render their own medical and other intimate decisions. Thank you for this opportunity to share my thoughts on this important public policy question.

Sincerely,

Gary C. Norman, Esq. L.L.M.

SB443.LOS.OAG.hf.20240207.pdf

Uploaded by: Heather Forsyth

Position: FAV

CANDACE MCLAREN LANHAM
Chief Deputy Attorney General

CAROLYN A. QUATTROCKI
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LEONARD HOWIE
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ZENITA WICKHAM HURLEY
Chief, Equity, Policy, and Engagement

PETER V. BERNS
General Counsel

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

February 7, 2024

To: The Honorable William C. Smith, Jr., Chair

Senate Judicial Proceedings Committee

From: The Office of the Attorney General

Re: SB443 End-of-Life Option Act: **Letter of Support**

The Office of the Attorney General continues to strongly support End-of-Life options legislation. SB443 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.

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

Decisions around the 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 an appropriate context, with due gravity, and with the patient in control of this intensely private decision.

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.

Dr Bar-Levav - abbreviated testimony feb 8 2024.pd

Uploaded by: Ilana Bar-Levav

Position: FAV

Testimony of Ilana Bar-Levav, MD
Support for HB403 and SB443
The End-of-Life Option Act
February 2024

My name is Ilana Bar-Levav. I am a physician, board certified in Internal Medicine and a practicing psychotherapist in Bethesda for over 30 years. I am a former president of the Montgomery County Medical Society and a strong supporter of the MD End of Life Option Act, HB403 and SB443 bill. My comments are rooted in both personal and professional experience.

My dearest uncle was an aeronautics engineer. In the summer of 2016, after 20 years of treatment and monitoring, his prostate cancer spread throughout his body. A resident of California, he told me he planned to exercise his rights under the new Death with Dignity Law that had passed weeks before. He initiated the procedure required to obtain a lethal dose of medication and asked for my support and presence at the end.

Hospice nurses visited my uncle semi-weekly to offer pain medication which he generally refused as he did not want to feel "drugged", opting for physical pain from the bony metastases to the sense of powerlessness and frailty brought on by his inability to perform mentally or basic bodily functions.

Physicians regularly counsel their patients on life-or-death decisions regarding treatments and patients assess the risks and benefits in order to come to a reasoned decision. As a matter of course, these life and death decisions do not require psychiatric evaluation. When my uncle sought my support, I did not need to wear my psychotherapist hat to see that he knew clearly what lay ahead, was of sound mind and was fully capable of making decisions with respect to the limited number of days left of his life. My offer to be with him as he took his lethal dose helped him have the courage and strength to face death directly, as he remained to his last day, a man who loved life. We gathered his family, children and grandchildren and had a final day all together. At the time he designated, I put on the music he requested, and sat with him while he drank the solution. He fell asleep quickly and died peacefully within a few hours surrounded by family.

Senators/Delegates, I urge you to vote in favor of HB 403/SB 443 to allow a death with dignity for those with a terminal illness and who desire it. While death is inevitable, terminal suffering is not.

November 10, 2016.

My uncle is in the center. This photo was taken within hours of his death. May his memory be a blessing.

Janice Bird -SB0443 HB0403 - Favorable.pdf

Uploaded by: Janice Bird

Position: FAV

Testimony of Janice Bird, MD
Support for SB443/HB403 The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

I am Dr. Janice Bird, a board-certified obstetrician and gynecologist, retired after 35 years of practice in Annapolis.

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 controlled.</u>**

I cared for thousands of patients in my career as an obstetrician gynecologist.
It was a privilege to provide the best medical care I could. Ob/Gyns provide care over one's lifetime – "from cradle to grave." In the small minority of my patients with terminal cancer, such as ovarian cancer, they experienced profoundly debilitating pain and suffering, begging for a peaceful end. They wanted a dignified, peaceful way to bring an end to their inevitable death for themselves and their loved ones. I have been present at deaths that were prolonged by pain and suffering that was not alleviated with the best of hospice and palliative care. 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 if they chose to do so. Patients are asking for this law. We need and deserve this law.

2. **<u>It is reasonable and ethical for physicians to choose 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.

Now 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, and requires a conversation, an interaction, an evaluation, informed consent and, perhaps, a prescription within legally defined standards. It is ethical. It is compassionate. These are components of any modern or ancient version of the Hippocratic Oath. Physicians may choose to participate in treating these patients. There is no requirement. Deciding to take the drug is the patient’s option. I am one of many physicians who fully support this law that ensures patients have the legal process to choose a means to end their pain and suffering when their inevitable death is near.

S 443 End of Life Option Act Julie Reiley Testiomo

Uploaded by: Julie Reiley
Position: FAV

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FAV: Testimony in Support of S443

I am submitting this testimony in support of Senate Bill 443, 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.

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

FINAL_KC Written Testimony_MD_Senate02.08.24.pdf

Uploaded by: Kimberly Callinan

Position: FAV

compassion & choices
Care and Choice at the End of Life

compassion & choices
ACTION NETWORK

Written Testimony of Kim Callinan, President & CEO, Compassion & Choices and Compassion & Choices Action Network Regarding SB 443, In Support of the Maryland End of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Maryland Senate Judicial Proceedings Committee
February 8, 2024

Introduction

My name is Kim Callinan. I am a long-time Maryland voter, having lived in Greenbelt and then Kensington with my husband and two children for 25 years.

I am also the President & CEO of Compassion & Choices and the Compassion & Choices Action Network. We are the nation's oldest and largest national consumer-advocacy 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.

On behalf of hundreds of thousands of Maryland residents and supporters nationwide, the Compassion & Choices Action Network supports SB 443, the Maryland End of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

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. Today, more than one in five people have access to this end-of-life care option.

Ten states (Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, Montana, and New Mexico), and the District of Columbia have authorized the compassionate option. Seven of these jurisdictions have authorized this end-of-life care option since 2015. The legislation includes time-tested safeguards. 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 providers 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 <u>in addition to</u> the education, training, and oversight that govern the practice of medicine for any medical procedure.

Medical aid in dying is entirely optional -- for both the provider and the patient. Nobody is forced to participate, and the availability of the option brings people comfort during the very worst, the very last part of the dying process.

The Growing Movement

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.

In Maryland, more than seven out of 10 voters (71%) support medical aid in dying, including majorities across the geographic, political, racial, and political spectrums, according to a 2023 poll by Gonzales Research & Media Services.[1] The support in Maryland mirrors the support at the national level.

In addition, voters are eight times "more likely" (51%) than "less likely" (6%) to vote for a candidate that sponsors or supports medical aid-in-dying legislation, according to a national survey conducted in 2021.[2]

A 2023 nationwide poll by Susquehanna Polling & Research reported that nearly eight out of 10 of U.S. residents (79%) who self-identify as having a disability agree that "medical aid in dying (MAID) should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully.[3] A 2021 nationwide poll by Susquehanna Polling & Research reported that 68% of voters support medical aid in dying as an end-of-life care option. Additionally, when respondents were asked if they want the option of medical aid in dying personally for themselves, 67% said yes.[4] Gallup's 2020 Values and Beliefs poll shows that a majority of respondents have consistently favored medical aid in dying since Gallup first asked about it in 1996.[5] 2018)[6]

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[1] Poll conducted from January 9th through January 14th, 2023. A total of 823 registered voters in Maryland were queried by live, person-to-person telephone interviews, including both landline and cell phone numbers. Accessed at: bit.ly/GonzalesPollMDEndOfLifeOptionsAct2023

[2] Nationwide Poll Shows Strong Support for Advance Care-Dementia Planning, Medical Aid in Dying. USA SURVEY OVERVIEW, NOV. 24, 2021. Accessed at: susquehannapolling.com/wp-content/uploads/2023/06/PollMemo-CandC-SPR-Nov-24-21.pdf

[3] USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023. Accessed at: https://bit.ly/SPRNatDisabilityPoll2023

[4] *Nationwide Poll Shows Strong Support for Advance Care-Dementia Planning, Medical Aid in Dying*, Susquehanna Polling & Research, Omnibus Survey (2021). Available from: https://compassionandchoices.org/docs/default-source/default-document-library/usa-omnibus-cross-tabulation-report-final-november-2021-2.pdf?sfvrsn=74705b4b_1

[5] Prevalence of Living Wills in U.S. Up Slightly. Jones, Jeffrey (2020) Gallup. Available from: https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx

[6] Brenan, Megan, Americans' Strong Support for Euthanasia Persists, May 31, 2018. Available from: https://news.gallup.com/poll/235145/americans-strong-support-euthanasia-persists.aspx?g_source=link_NEWSV9&

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

Among U.S. physicians, support for medical aid in dying is also strong. A 2020 Medscape poll of 5,130 U.S. physicians from 30 specialties demonstrated a significant increase in support for medical aid in dying from 2010.[7] A 2021 Gynecologic Oncology survey showed 69% of respondents believed that medical aid in dying should be legalized, a 15 point increase from 2020, when 55% of oncologists believed it should be legalized.[8] A 2022 study of Colorado physicians noted "those who have participated in [medical aid in dying] largely report the experience to be emotionally fulfilling and professionally rewarding," despite barriers to offering the end-of-life care option.[9] And 55% of physicians surveyed endorse the idea of medical aid in dying, agreeing that "Physician-assisted death should be allowed for terminally ill patients."[10]

Additionally, a 2022 survey of nurses demonstrated that most nurses would care for a patient contemplating medical aid in dying (86%).[11] 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 medical community is coming together, and providers are sharing their experiences and fine-tuning their collaborative efforts to serve dying patients better.

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 have more than 25 years of data since Oregon first implemented its law in 1997 and years of experience from the ten 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

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[7] Medscape Ethics Report 2020: Life, Death, and Pain, (2020). Available from: https://compassionandchoices.org/docs/default-source/fact-sheets/medscape-ethics-report-2020-life-death-and-pain.pdf

[8] Polling on Medical Aid in Dying (2022). Available from: https://compassionandchoices.org/resource/polling-medical-aid-dying

[9] Campbell EG, Kini V, Ressalam J, Mosley BS, Bolcic-Jankovic D, Lum HD, Kessler ER, DeCamp M. *Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey.* J Gen Intern Med. 2022 Oct;37(13):3310-3317. doi: 10.1007/s11606-021-07300-8. Epub 2022 Jan 11. PMID: 35018562; PMCID: PMC8751472.

[10] *Medscape Ethics Report 2020: Life, Death, and Pain*, (2020). Available from: https://compassionandchoices.org/docs/default-source/fact-sheets/medscape-ethics-report-2020-life-death-and-pain.pdf

[11] Polling on Medical Aid in Dying (2022). Available from: https://compassionandchoices.org/resource/polling-medical-aid-dying

support and, in fact, dispel the concerns of opponents."[12] None of the dire predictions that opponents raised have come to fruition. 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. Public health departments in nine authorized jurisdictions have issued reports regarding the use of medical aid-in-dying laws: Oregon,[13] Washington,[14] Vermont,[15] California,[16] Colorado,[17] Hawai'i,[18] the District of Columbia,[19] Maine,[20] and New Jersey.[21] 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.

- Cumulatively, for the past 25+ years, across all jurisdictions, just 8,729 people have taken the prescription to end their suffering.[22]
- Up to 37% of people who go through the process and obtain the prescription may never take it. This group consists of people who die from their underlying illness, another cause of death, or an unreported cause of death.[23] Even those who don't take the medication derive peace of mind simply from knowing they have the option if their suffering becomes too great.

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[12] *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

[13] *Oregon Death with Dignity Act Annual Reports* (1998-2022) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[14] *Washington Death with Dignity Data* (2009-2022). Available from: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[15] *Vermont Report Concerning Patient Choice at the End of Life.* (2018-2022) Available from: https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.

[16] *California End of Life Option Act Annual Report* (2016-2022) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

[17] *Colorado End of Life Options Act Annual Report* (2017-2022) Available from: https://www.colorado.gov/pacific/cdphe/medical-aid-dying

[18] *Hawai'i Our Care, Our Choice Act Annual Report* (2019-2022) Available from: https://health.hawaii.gov/opppd/ococ/

[19] *District of Columbia Death with Dignity Act Annual Report. (*2017-2022) Available from: https://dchealth.dc.gov/publication/death-dignity-annual-reports

[20] *Maine Patient Directed Care at End Of Life Annual Report.* (2019-2022) Available from: https://www.maine.gov/dhhs/data-reports/reports

[21] *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary* (2019-2022) Available from: https://nj.gov/health/advancedirective/maid/

[22] 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 (2024) Available from: https://www.compassionandchoices.org/docs/default-source/default-document-library/final_maid-utilization-report_1-24-2024.pdf?sfvrsn=5a81525d_6

[23] *Id.*

- Fewer than 1% of the people who die in each jurisdiction use the law annually.[24]
- The majority of terminally ill people who use medical aid in dying — more than 87% — received hospice services at the time of their deaths.
- There is nearly equal utilization of medical aid in dying among men and women. There is no data on the 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 die at home.[25] According to various studies, most Americans would prefer to die at home.[26]

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 legal protection for the care providers who practice this patient-driven option. SB 443 contains the same time-tested, evidence-based safeguards that have protected patients in other authorized jurisdictions.

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.” [27] Vulnerable groups included the “elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people

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[24] 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

[25] 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 (2024) Available from: https://www.compassionandchoices.org/docs/default-source/default-document-library/final_maid-utilization-report_1-24-2024.pdf?sfvrsn=5a81525d_6

[26] 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/

[27] 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

with psychiatric illnesses, including depression, or racial or ethnic minorities, compared with background populations."[28]

For Some, Comfort Care and Pain Management Is Not Enough

The vast majority of individuals who use medical aid in dying are also receiving hospice and palliative care, but they still want the option of medical aid in dying for a variety of reasons.[29] In other words, good hospice services and palliative care do not eliminate the need for medical aid in dying as an end-of-life care option. Breakthrough pain — severe pain that occurs even when a patient is already medicated — remains a nightmare experience for too many. In the National Breakthrough Pain Study, among respondents who had cancer (at all stages), 83.3% reported breakthrough pain. For those cancer patients who experienced breakthrough pain, only 24.1% reported that using some form of pain management worked every time.[30]

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, and loss of dignity. It is not any one reason, but rather 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. Others want the option of medical aid in dying because they want to try that one last, long-shot treatment with the peace of mind of knowing that if it results in unbearable suffering, they have an option to die peacefully.

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.

In Conclusion

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[28] 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/

[29] 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 (2024) Available from: https://www.compassionandchoices.org/docs/default-source/default-document-library/final_maid-utilization-report_1-24-2024.pdf?sfvrsn=5a81525d_6

[30] *Impact of breakthrough pain on community-dwelling cancer patients: results from the National Breakthrough Pain Study.* Katz, N.P, Gajria, K.L, Shillington, A.C., et. al. (2016). Postgraduate Medicine, 129(1), 32-39. Available from: https://pubmed.ncbi.nlm.nih.gov/27846789/

Authorizing the full range of end-of-life options, including medical aid in dying, allows people to engage in open conversations with their healthcare providers, their loved ones, and their faith leaders about their physical and spiritual needs at the end of life. Without the authorization of medical aid in dying, people nearing the end of life are unable to die in Maryland in the manner of their choosing, which for most is at home, surrounded by their loved ones.

We have over 25 years of experience since the first such law was enacted in Oregon, demonstrating that medical aid-in-dying laws provide an additional end-of-life option for many constituents while also protecting patients and providers. Allowing this legislation to become law brings peace of mind to terminally ill people at or near the end of their lives and their community. Furthermore, the cost of inaction is high.

Terminally ill people:

- May not try that one last miracle treatment out of fear it will be too painful.
- Need the peace of mind that having access to the full range of end-of-life options provides.
- Could experience needless suffering when they die, while families and healthcare providers remain powerless with no legal way to respond to pleas for help.

Furthermore, society also fails to gain from the benefits of medical aid in dying implementation, including:

- Better palliative care training.[31]
- Better hospice usage.[32]
- More open conversations and essential planning for the end of life.[33]

Maryland can realize these benefits for terminally ill people and their families right now by joining the growing number of jurisdictions that authorize this end-of-life option.

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[31] Singer, J., Daum, C., Evans, A., Schneider, S., Vugrin, M., & Loggers, E. (2023). An examination and proposed theoretical model of risk and protective factors for bereavement outcomes for family members of individuals who engaged in medical aid in dying: A systematic review. Palliative medicine, 37(7), 947–958. https://doi.org/10.1177/02692163231172242

[32] *Geographic Variation of Hospice Use Patterns at the End of Life.* Journal of Palliative Medicine, S.Y. Wang, M.D, Aldridge, C.P. Gross, et al. (2015). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696438/

[33] *Id.*

The debate quite simply comes down to who decides and who is in a better position to determine the care a patient receives at the end of life: the terminally ill patient in consultation with their provider and loved ones or the government.

We urge you to review the evidence, experience, data, and strong public support for this end-of-life care option to guide your policymaking. Thank you again, Chair and Members of the Committee, for your leadership on this important issue.

Kimberly Callinan
Maryland resident
President/Chief Executive Officer, Compassion & Choices Action Network
kcallinan@compassionandchoices.org
www.compassionandchoices.org

The Compassion & Choices family comprises two organizations: Compassion & Choices (the 501(c)(3)), whose focus is expanding access, public education and litigation; and Compassion & Choices Action Network (the 501(c)(4)), whose focus is legislative work at the federal and state levels.

Paid for by Compassion & Choices Action Network

LRogers testimony SB0443 FAVORABLE.pdf

Uploaded by: Lorraine Rogers

Position: FAV

SUBJECT: **SB0443 End-of-Life Option Act**
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

COMMITTEE: Judicial Proceedings, The Honorable William C. Smith, Jr., Chair

DATE: Thursday, February 8, 2024

POSITION: FAVORABLE

I speak on behalf of myself and 271 other seniors, residents of Collington Lifecare Community, a CCRC in Prince George's County (plus 45 other Marylanders, staff, friends and family, and visitors who signed our petition). We, who are closer to the end of our lives than the beginning, believe that each of us should have the right to make our own decisions, in accordance with our own situations and our own faith and values, when it comes to our final days.

The End of Life Option Act will permit a physician to prescribe lethal meds to a mentally competent, terminally ill patient who wishes to forgo their final days of suffering and have a peaceful passing. This provides an option for those who wish they could live but know that treatments have failed and that they are dying and they are ready.

A request for such meds is patient-initiated and includes both oral and witnessed written requests. Both an attending and a consulting doctor are involved. The Act includes multiple safeguards, mandating that the patient be informed of all available options for treatment, palliative care, hospice, and pain management, and that there be at least one private meeting of the patient and doctor to be sure that the patient's request is purely voluntary and not coerced in any way. Participation of everyone involved – patient, doctors, pharmacists – is purely voluntary. Patients can change their minds at any time.

Data from other states shows that roughly two-thirds of those who initiate the process do not end up taking the meds – some die before they complete the process, others become too ill to be able to self-administer the meds by the time they get the prescription. Others just wanted the meds on hand in case their pain became uncontrollable and it never reached that point – but the peace of mind that it brings them to know that they could take if needed is a gift. Unused meds are disposed of as required by law (as are all the meds in the sickroom including morphine and other opioids).

Voluntarily stopping eating and drinking is legal but takes days and the end is uncertain. There is indeed dignity and peace in being able to name the day and potentially say one's goodbyes and pass on surrounded by loved ones, if that is what one wishes.

Many of us want Medical Aid in Dying to be an available option for ourselves. Others of us don't know if we'd ever use the option, while others of us know for a certainty that Medical Aid in Dying would never be an option that we would choose. **But all of us know that each of us should have the right to make that decision for ourselves.**

For these reasons we support Senate Bill 443 and ask for a favorable report.

For further information or copies of our petition, please contact: Lorrie Rogers, rogers1515@aol.com

Support - SB 443- MAID- Lynn Cave (1).pdf

Uploaded by: Lynn Cave

Position: FAV

Testimony in Support of SB 443
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: Lynn Cave
DATE: February 8, 2024

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 a cancer that will claim my life. I don't want my disease to choose when I die. I want to make that decision for myself when pain and suffering are all I have left.

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 National Cancer Institute that ran cancer clinical trials.

Ironically, I'm now in a clinical trial 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. Eventually, the cancer will choke out the normal liver cells, which would normally cleanse toxins from my body. I expect there to be terrible pain. Once this cancer destroys my liver, most likely I will have about two weeks before all my internal systems slowly collapse, and I pass away.

Would you want to wait two weeks knowing you're going to die? Does pain ever enhance life? 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 days and days of watching me die.

Believe me, I'm doing everything I can to live. I spend nearly five hours on the road between my home and Philadelphia every month for my treatment because a world renowned team there works to tame this cancer. And, If this clinical trial stops working, there are some limited options. 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. It would be such a kindness for the Maryland legislature to pass this act. Some of us will thank you sooner, some later, but many of us with deadly illnesses will be glad for the opportunity to choose the time we die. Having the promise of a dignified death on my own terms is my greatest comfort for what's ahead.

So, I plead with you to follow the compassionate will of the Governor and the people of Maryland, over 70% 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.

Lynn Cave
3116 Gracefield Rd, Apt 214,
Silver Spring, MD 20904

Testimony - SB0443 2024 End-of-Life Option Act (Th

Uploaded by: Marvin Silver

Position: FAV

Testimony Prepared for the Senate Judicial Proceedings Senate Bill 0443
End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 7, 2024
Position: Support

We write to you to urge a favorable report for SB0443, End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act), which authorizes a qualified patient to request aid in dying by making specific requests. The bill is consistent in principle with a *Resolution of Witness in Support of Legislation Authorizing Medical Aid in Dying* adopted by the Central Atlantic Conference (CAC) of the United Church of Christ (UCC), a regional judicatory comprised of over 475 clergy and 180 congregations, including 64 congregations and over 9300 members in the State of Maryland. By affirming this resolution, we in the CAC-UCC join a growing chorus of religious voices who are convinced that their respective faith commitments require the affirmation and advancement of human dignity at all stages of the life process, including and especially the end-of-life stage, and who have therefore concluded that those commitments necessitate support for this bill.

To be sure, there are some in the religious community who have come to a different conclusion. Indeed, opposition to the proposed legislation has arisen in part from those who aver that it amounts to government-sanctioned permission to foreshorten a person's divinely allotted life span. While we also avow the sovereignty of God, we respectfully disagree with our religious sisters and brothers who take such an avowal to mean that the fate of our lives is divinely predetermined. On the contrary, our faith requires us to affirm that we have been called not only to live but also to lead our lives and thus to cultivate and exercise our decisions with authentic self-understandings, informed as they can and should be by the divine purpose. In this sense, we are truly made in the image and likeness of God and so are gifted to be co-creators with the divine and are thus ultimately responsible for what we make of our own lives.

Such responsibility also extends to what we make of our own deaths in circumstances in which we both *can* and *should be permitted to* exercise some autonomy over how and when they occur. When a legally competent individual is dealing with a medically diagnosed terminal illness in the six or fewer months likely left to her, she should be lawfully allowed – in good conscience and with full knowledge of the associated risks, probable consequences, and available alternatives – to end her suffering. We think this especially holds true when that person is enduring periods of severe, debilitating, and intolerable physical pain. Indeed, we reject the notion – sometimes offered by certain religious adherents – that suffering for suffering's sake is a divinely sanctioned means of ennobling the sufferer and edifying the observer. On the contrary, it is the common impulse of people of good will everywhere to prevent or at least mitigate all forms of such suffering, and we can surely think such a disposition is no less characteristic of the divine reality that, because it sympathetically shares in the joys and pains of each of us, wholeheartedly embraces in unbounded love all of us.

Undergirding our reasoning here is the idea that considerations of the *kind* of life we are called to lead are paramount to our moral deliberations and should inform matters of public policy. We certainly agree that a person's life as such has value to God. Yet we also believe that the *quality* of that life is important to God, and when that quality declines irreversibly to the point at which a person can no longer be a significant co-creator of her destiny and, moreover, at which life has become both relatively purposeless and extraordinarily painful to her, then she may morally choose to end that life by means that are, in their own way, an affirmation of divinely endowed human intelligence and dignity. Moreover, the sanctity of life as such does not preclude but rather must presuppose such qualitative considerations if the sacred trust that bonds humanity and the divine is not to run the risk of yielding to an idolatrous reverence for mere biological sustainment.

The foregoing argument, we believe, is bolstered by our conviction that both in the divine economy – whose aim to found the beloved community of mutuality entails individual autonomy – and in a democratic polity – whose purpose to establish the sovereignty of the people requires personal liberty – the burden of the argument lies upon those who would deny an individual the capacity to choose in a way that she deems consistent with an affirmation of her own dignity. And they do not relieve themselves of that burden who argue that the end-of-life option that is being considered creates a "slippery slope" whereby our culture's respect for human life itself is fundamentally threatened. The careful and comprehensive safeguards required by SB0443 prevent the formation of such a slope; moreover, by properly extending the permissible range-of-options in desperate end-of-life circumstances, the bill enhances, rather than diminishes, respect for human life. Nor does it help to say that such legislation disproportionately affects vulnerable people, since no empirical study has concluded that any already enacted medical-aid-in-dying law in this country has done so.

In sum: This bill permits a mentally capable individual confronting imminent death because of a terminal illness to make an informed decision to end her own life. We think religious (i.e., theistic) and political-ethical (i.e., democratic) considerations strongly counsel such permission. **We, therefore, respectfully urge a favorable report for Senate Bill 0443.**

On behalf of the Central Atlantic Conference, United Church of Christ:
Rev. Marvin M. Silver, Associate Conference Minister

SB0443_FAV_mgoldstein 2024.pdf

Uploaded by: Mathew Goldstein

Position: FAV

SECULAR Maryland

Secular Maryland https://secularmaryland.dorik.io secularmaryland@tutanota.com

February 08, 2024

SB 443 - FAV

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

Dear Chair William C. Smith Jr., Vice-Chair Jeff Waldstreicher, and Members of the Judicial Proceedings Committee,

Under the proposed, carefully crafted, law, 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 potential prosecution and imprisonment. Limiting one's end-of-life options to suffering terrible physical emotional agony and the loss of personal dignity, or to starvation that can take several weeks, is not humane There is no divinity who assumes responsibility for ensuring that our suffering is ultimately just or compensated for, that responsibility falls entirely on ourselves alone.

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

Michael Strauss -SB0443 HB0403 - Favorable.pdf

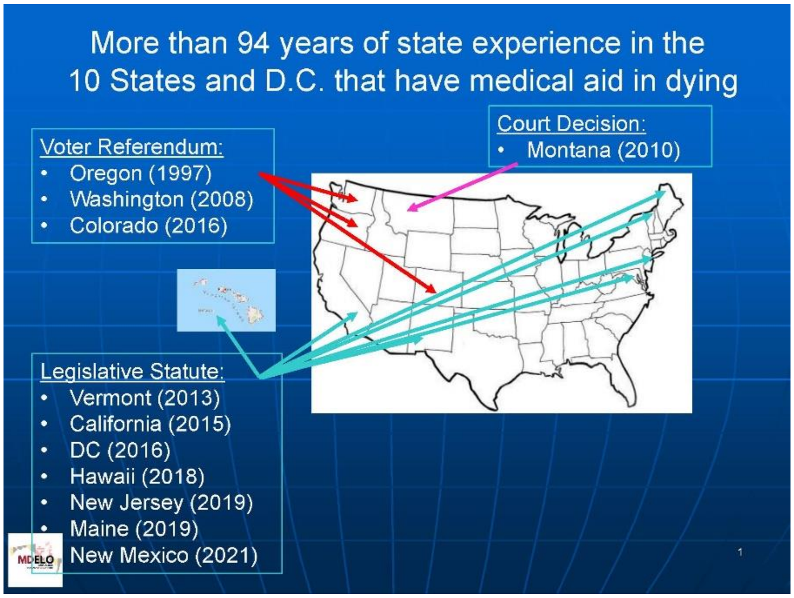
Uploaded by: Michael Strauss

Position: FAV

Testimony of Michael Strauss, MD, MPH -- Favorable
Regarding SB0443/HB0403-- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

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 likely misstatements or unrealistic hypothetical issues that opponents will describe. Because we now have **<u>94 years of experience in the 10 states and District of Columbia</u>** that have medical aid in dying, you need to understand what has not happened in these states.



More than 94 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)

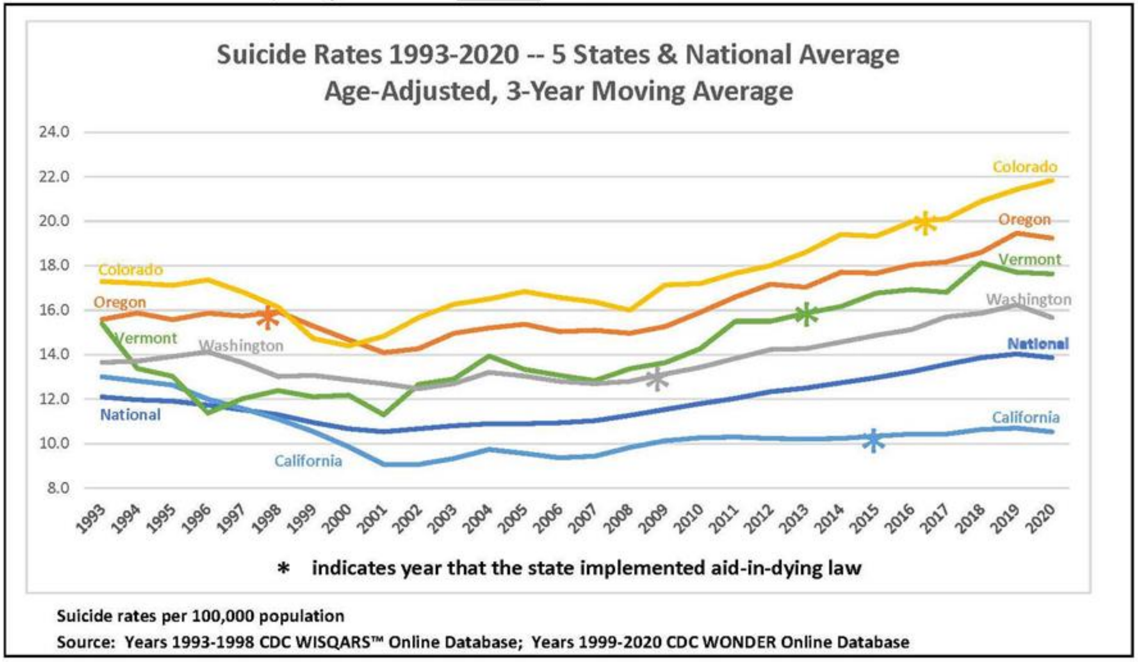
	Years with Aid in Dying
Oregon	26
Washington	15
Colorado	8
New Mexico	3
California	9
Vermont	11
New Jersey	5
Maine	5
DC	7
Hawaii	5
Total	94

- No cases of unused drugs being abused because patients do not fill their costly prescriptions until they are about to take them, and because the drug powders are now mixed together and realistically cannot be abused.
- No documented cases of patients being coerced into using aid in dying.
- 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.
- No problem of attending physicians evaluating capacity. Credible studies from California and one published 2 weeks ago in Hawaii document that attending physicians are 100% accurate in assessing mental capacity of aid-in-dying patients, including any patients with psychiatric conditions.

- 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 end of life in a specific controlled location. 95% of deaths happen in the home; 5% in nursing homes.
- It is misleading to say physicians oppose aid in dying. MedChi is neutral with 58% of its physicians supporting aid in dying. National polls show similar results.
- No increases in a state suicide rate beyond increases that have happened across all states.
- No credible cases of an insurance company denying medical coverage of a treatment because the patient has access to an aid-in-dying program.

So please, as you hear hypothetical claims later today, ask whether the identified concern has ever occurred in the 94 years of state experience with medical aid in dying laws.

Aid in Dying Does <u>NOT</u> 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

End-of-Life Option Bill.pdf
Uploaded by: Miner Brown
Position: FAV

Senate Bill #0443 Miner L. Brown Favorable

Sponsored by Senator Waldstreicher

Title: End-of-Life Option Act

Testimony

I strongly support the passage of Senate Bill #0443, entitled, "the End-of-Life Option Act". The alternative names on this Bill says it all-Elijah Cummings and Shane Pendergast!

As a retired long-term care administrator and watching my father-in-law, a proud man, die 22 years after his Alzheimer Disease diagnosis, I know how he didn't want to die and I know how I don't want to die. My very specifically-worded Health Care Directive is quite clear-I want the choice of a peaceful and dignified end-of-life.

This should be a personal human right for each person. A person's religious beliefs are their personal choice. So to, the legal ability to allow a person to make this last important decision in their life to be honored is long over-due.

If you have not read the book, Finish Strong by Barbara Coombs Lee, you should. It's insightful, and will have a significant impact on importance of personal choice. As quoted in the Afterword of her book, she states, "When history is written, this period will be defining for end-of-life care: a more aware electorate, more engaged policymakers, and a more diverse and inclusive movement. Ultimately, we will see continued and accelerated policy change to improve care, expand options and create greater access to the full range of end-of-life care options."

It's time for the Maryland legislative leadership to make it happen.
Thank you.

Miner L. (Moe) Brown
Member, District 11B

SB 443- LWVMD- FAV- End-of-Life Options Act.pdf

Uploaded by: Nora Miller Smith

Position: FAV

LEAGUE OF WOMEN VOTERS®
OF MARYLAND

TESTIMONY TO THE JUDICIAL PROCEEDINGS COMMITTEE

SB0443: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

POSITION: Support

BY: Linda Kohn, President

DATE: February 8, 2024

The League of Women Voters is a nonpartisan organization that works to influence public policy through education and advocacy. **The League believes that 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.**

The League thus supports **Senate Bill 443: End-of-Life Option (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).**

Every individual should have the right to choose how much unrelievable suffering they are willing to endure at the end of their life. Electing to end that suffering, to maintain some degree of self-determination and control over one's final days, to preserve one's dignity, should be an option for those Marylanders who choose to exercise it. With numerous important safeguards built in to the process, it would provide an option for a terminally ill, capable, and 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.

Regarding those who morally object to this option, Elijah Cummings, in a February 12, 2019 letter to Delegate Clippinger, Delegate Pendergrass, and Senator Zirkin in support of the proposed 2019 End of Life Option Act, **wrote:**

> …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….
>
> It seems to me, however, that the critical issue addressed by *The End of Life Option Act* 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 sensibility of others**.[1]

Ten states and the District of Columbia have already passed legislation legalizing medical aid in dying, and eighteen additional states have introduced legislation for consideration this year. Marylanders support this.[2] Per the 2023 Gonzales Maryland Poll, **71% of Maryland voters support medical aid in dying**.

Maryland has a long history of considering, but not passing aid in dying legislation. The first attempt was made in 1995, with House Bill 933. After multiple attempts over 29 years, and with broad popular support, **it is time now to pass this important legislation.**

The League of Women Voters Maryland, representing 1,500+ concerned citizens throughout Maryland, strongly urges a favorable report on Senate Bill 443.

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[1] https://www.compassionandchoices.org/docs/default-source/maryland/rep.cummings-hb399-sb311-2019.pdf?sfvrsn=354ad242_1

[2] https://candc.org/docs/default-source/maryland/cc_mdpolling_onesheet_8.5x11_2023_02.pdf?sfvrsn=d6fd24a4_1

Testimony 443 MAID.pdf

Uploaded by: Renee Cantori

Position: FAV

Testimony by Renee Cantori in Support of

Maryland End-of-Life Option Act (H.B. 403/SB443)

Hello -

My name is Renee Annette Cantori. I have spent much of my life in Pasadena and Annapolis, Maryland, and I support the Maryland End-of-Life Option Act (SB443).

I would like to thank Senate Judicial Proceedings Committee Chair, Senator William C. Smith, Jr., and committee members for considering my testimony. I am writing this testimony for myself, as well as for my children, my grandchild, who live in Maryland. I also am writing this testimony on behalf of other family members and my friends and any terminally ill Marylander who wishes to have autonomy in this most important, personal choice. Additionally, ever since this legislation was first introduced in Maryland, at the request of my mother, I have written testimony on her behalf. My mother, however, recently passed in hospice. She was 100 years old.

I mention hospice because I think it's important for legislators to know that supporters of medical aid and dying (MAID) are not adverse to hospice. In fact, my mother-in-law, in addition to my mother, my mother-in-law, and my father used hospice services.

I, like many supporters, view MAID as one additional tool to allow mentally capable, terminally ill adults additional end-of-life care options, in this case the option to obtain prescription medication they can decide to take to peacefully end their suffering if it becomes unbearable.

In many cancer patients towards the end of life, there is breakthrough pain that cannot be managed through pain medicine.

This happened to the husband of a friend of mine in Maryland, as well as to a relative of mine in New Jersey. They died in complete agony. It was very difficult to hear the stories, especially when realizing that had MAID been legal, they could have had the option to avoid this suffering. However, this option was denied to both of them. Cancer - the same form that my relative in NJ had - is what runs in my own family.

You likely know there has been no evidence in any of the 10 states and Washington, DC, that authorize a form of medical aid in dying, that this legislation has ever been abused. As you can see, the way the bill is written there are multiple safeguards to ensure that only those who are capable of making a decision and physically capable of taking this prescription medicine can opt for MAID.

I also don't have to tell you that there is overwhelming support in Maryland for MAID. Even if you personally would not choose to use this option, I ask that you allow it for those who potentially would wish to do so.

Thank you.

Respectfully,

Renee Cantori

Maryland Senate Testimony - Richard Shermanski.doc

Uploaded by: Richard Shermanski

Position: FAV

Testimony of Richard Shermanski
In Favor of Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End of Life Option Act

Thank you for providing me with the opportunity to address you today on a matter of profound importance—the Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass End of Life Option Act (SB0443 and HB0403). I stand before you not only as an advocate for this legislation but also as an Attorney who has faced the challenges of learning disabilities and ADHD. My personal journey has shaped my perspective on the values we hold dear—autonomy, independence, and self-determination. However, my story takes on an even deeper dimension as I now advocate not only as an Attorney with disabilities but also as a father of a son with autism. Additionally, I proudly serve on the Montgomery County Commission for people with disabilities, currently in my second term.

In my capacity on the Commission, I have had the privilege of working directly with individuals who navigate the complexities of disabilities daily. This experience has further deepened my commitment to disability rights advocacy. As we discuss the End of Life Option Act today, it is vital to acknowledge the interconnectedness of the medical aid in dying and disability rights movements, both of which I actively champion.

A recent national poll found that 79% of those with disabilities support medical aid in dying for terminally ill, mentally capable adults. This resounding endorsement reinforces the interconnectedness of our shared values, irrespective of the diverse challenges we may face. It is a call to uphold the dignity and agency of every individual, echoing the principles of autonomy and independence that are at the heart of both movements.

My role on the Montgomery County Commission for people with disabilities has provided me with firsthand insight into the daily challenges faced by individuals in our community. It has been an honor to contribute to the advocacy and policy initiatives that aim to create a more inclusive and supportive environment for everyone. The End of Life Option Act aligns with the principles I champion within the Commission, emphasizing inclusivity and recognizing the diverse human experiences that shape our society.

The legislation we discuss today is not a mere legal matter; it is a profound reflection on our humanity and the values that define us. It invites us to consider the broader implications of compassion, empathy, and the inherent dignity of every human being, regardless of their abilities or health condition.

As a father and a member of the Montgomery County Commission for people with disabilities, I am acutely aware of the importance of fostering a society that respects the rights and agency of every individual, regardless of their abilities. The End-of-Life Option Act, by acknowledging the agency of terminally ill, mentally capable adults, aligns with this vision of inclusivity and compassion.

Moreover, I want to take a moment to emphasize the significance of the End of Life Option Act in the context of my personal journey. Faced with learning disabilities and ADHD, I navigated a challenging path to becoming an Attorney. The experience of overcoming my own perceived limitations has fueled my commitment to advocate not only for the rights of those facing end of life decisions but also for the broader principles of inclusivity and empowerment.

In discussing the End of Life Option Act, we delve into the very essence of our humanity. This legislation is an opportunity for us to reevaluate our societal values and ensure that our laws reflect a commitment to individual autonomy and dignity. It challenges us to confront preconceived notions, dismantle barriers, and pave the way for a more compassionate and inclusive society.

In conclusion, I urge each one of you to consider the significance of the End of Life Option Act . This legislation is not only a reflection of our commitment to the autonomy and dignity of those facing the end of their lives but also a testament to our dedication to a society that embraces diversity and recognizes the agency of every member. Thank you for your time and consideration.

Richard E. Shermanski, Jr., Esq.

Robert Landau - SB0443 HB0403 - Favorable.docx (1)

Uploaded by: Robert Landau

Position: FAV

Testimony of Robert Landau -- Favorable
Regarding SB0443/HB0403-- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

My name is Robert Landau, a Maryland resident and attorney, and I strongly support this bill. I only have one point to make to the Committee: I am concerned that if the bill is **not** passed this year, then Maryland State's Attorneys may be compelled to prosecute family members of individuals who legally acquire life-ending medications in other states and bring them back to Maryland to be with their loved ones to self-administer those medications. Those prosecutions would be a serious miscarriage of justice.

Let me explain how this travesty might happen. Vermont and Oregon already recognize the right of persons from other states to go there to qualify for their aid-in-dying programs. If Marylanders goes there and qualify for either of those states' medical aid-in-dying programs, they could obtain life-ending medications in those states and bring those medications back to Maryland to use in the comfort of their homes in the presence of their loved ones – despite those states recommending (but not requiring) medications be self-administered in those states. Even closer to home, a New Jersey court may be on the verge of recognizing every person's constitutional rights under the Equal Protection and Privileges and Immunities Clauses to New Jersey's program.

In these situations, if a family member or loved one in Maryland helps the individual at all in the process, it is entirely possible or even likely that the Maryland State's Attorneys will be expected to prosecute that family member under the Maryland Criminal Code. Section 3-104 provides that any individual who knowingly assists another person's suicide or suicide attempt is guilty of a felony and subject to a fine of up to $10,000, imprisonment for up to one year, or both.

Prosecuting even one person in connection with a dying loved one exercising their rights under another state's laws would be a serious miscarriage of justice, which can only be prevented by your passing this bill now this Session.

Neptune Society Obituary - Susan Azama.pdf
Uploaded by: Rodney Azama
Position: FAV

OBITUARY

Susan Jane Azama

JANUARY 10, 1955 – MARCH 8, 2023

Susan Jane Azama of Silver Spring, Maryland passed away from cancer on March 8, 2023. She was born in January 1955 in Abington, Pennsylvania to Edward A. and Jane Turner Edgar. Susan grew up in Doylestown in Bucks County, Pennsylvania. She often fondly mentioned her memories as a child and young adult in Pennsylvania. Susan studied while working and earned a Bachelor of Science degree from Arcadia University and later a Masters degree in Computer Science from Johns Hopkins University. During her career, she worked at Leeds & Northrop, EOSAT, Lockheed Martin, Computer Sciences Corporation, and Praxis

Engineering. Susan worked on programs for the Department of Defense, the National Flood Insurance Program, Immigration & Naturalization Service, and NASA. She was commended for her work on the Hubble Space Telescope program.

She was a deep lover of animals and a mother to Sid, Beauty & Beast, Morticia and Sunny. Susan adopted Sid and Morticia, obedience-trained Beauty & Beast, and trained Sunny as a therapy dog, visiting nursing homes. She was open, authentic, decent, believed in the Golden Rule, and led a committed spiritual and ethical life. Susan lived life fully and enjoyed classic movies, European history and the outdoors.

Susan is greatly missed by her husband of over 31 years, Rodney Azama; her sisters Jenny (Doug) D'Amore of Lockhaven, PA; and Jane (Al) Choinski of Doylestown PA; as well as many members of her family and friends. Susan will be interred at a future date at the Hawaii State Veterans Cemetery in her husband's hometown of Kane'ohe, Hawaii. She blessed us with her presence and left this world a better place. We celebrate her Life and her time with us with the hope of being re-united again. .

Seth Morgan EOL Option Act SB0443 HB0403 FAV.pdf

Uploaded by: Seth Morgan
Position: FAV

SB0443/HB0403 FAVORABLE

Testimony of Seth A. Morgan, MD, FAAN

5417 Center Street, Chevy Chase, MD 20815-7123

End-of-Life Option Act

(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

February 8th, 2024 (Senate) and February 16, 2024 (House)

My name is Seth Morgan. I am a Board-Certified Fellow of the American Academy of Neurology, a cancer survivor, a person living with disabilities and an advocate for people with disabilities. I strongly support the passage of this bill.

The alarmist claims of the legislation's opponents that people with disabilities are against medical aid in dying is wrong.

People with disabilities are not a monolithic group. Many are capable of making self-care decisions and do not need an umbrella advocacy group to speak for them. The disability rights and end-of-life care movements share the core values of self-determination, personal autonomy, and the right to independence. Concerns that medical aid in dying would lead to a "slippery slope" of abuse and coercion of people with disabilities are unfounded and disproven by over 26 years of experience since Oregon's Death with Dignity Act passed in 1997. (1) The safeguards in the legislation are rigorous and preclude any individual with a cognitive disability from being eligible to use it.

Activists in the disability community (such as *Us for Autonomy*) are some of the strongest supporters of medical aid in dying. A recent study determined that one in ten politicians in the United States have disabilities underscoring that not all people with disabilities are unable to self-advocate or make personal health care decisions. (2)

Yes, there are individuals both with and without disabilities for whom the proposed legislation is not one they would want to avail themselves of. But, others might. The decision would be, and should be, solely in control of the dying individual.

79% of U.S. residents who self-identify as having a disability agree that "medical aid in dying should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully". (3)

We are asking to be allowed a decision if the situation arose in which medical aid in dying was a legal option we could consider. For anyone for whom this is not an option they would want, no one will be forced to use it.

CITATIONS

1. **Letter from Bob Joondeph, Executive Director, Disability Rights Oregon, February 14th 2019; Copy attached. Available from: https://compassionandchoices.org/letter-from-disability-rights-oregon-dro/**

2. **Rutgers School of Management and Labor Relations: https://smlr.rutgers.edu/sites/default/files/fact_sheet_elected_officials_disabilities_2013_2917.pdf**
3. **USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023. Available from: https://bit.ly/SPRNatDisabilityPoll2023**

MD_ Written Testimony Dr. Sonja Richmond 02.07.24.

Uploaded by: Sonja Richmond
Position: FAV

compassion & choices | ACTION NETWORK

Written Testimony in Support of SB443: End of Life Option Act,
Dr. Sonja Richmond, National Medical Director, Compassion & Choices and Compassion & Choices Action Network
Maryland Senate Committee on Judicial Proceedings
February 8, 2024 1:00 p.m. Eastern

Dear Chair Smith and members of the Senate Committee on Judicial Proceedings,

My name is Dr. Sonja Richmond and I am a Board-Certified Internist and Board-Certified Hospice Medical Director. I'm licensed to practice medicine in Virginia, Maryland and the District of Columbia. I attended the University of Virginia and The George Washington University School of Medicine for both medical school and residency. I also serve as National Medical Director for Compassion & Choices and Compassion & Choices Action Network. We are the nation's oldest and largest consumer-centered 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.

Over my nearly two decades of caring for patients in the Greater D.C. area, I have become acutely aware of the challenges that both doctors and patients face. As a hospitalist and physician in long-term care centers, I observed the revolving door of frequent hospitalizations, numerous medications and procedures, and the patient's lack of voice in their own care/treatment. I've seen great suffering and poor quality of life.

I've also had the honor of serving as an advocate for my terminally ill patients, giving them a voice and honoring their wishes. I've been able to put my patients first and treat them as unique human beings, not as diseases or conditions. With that goal in mind, I've worked alongside colleagues in Washington D.C. providing medical aid in dying to terminally ill patients of sound mind who were able to request and ingest the medication of their own volition. Accompanying patients through the medical aid-in-dying process has been among the most profound and meaningful experiences I've had in my role as healer.

I've also had the unfortunate experience of having to deny patients medical aid in dying because it was not legal in Maryland. That's why I'm here to urge you to pass SB 443.

There is no need to speculate. Decades of data and experience from colleagues in 11 jurisdictions demonstrate that medical aid-in-dying laws work as designed. Most patients who opt for medical aid in dying are enrolled in hospice, suffering from terminal diseases where the trajectory toward death is predictable: end-stage cancers, neurodegenerative diseases and some heart and lung conditions. They have endured maximum tolerable treatment regimens and are hoping now simply for a peaceful death. Their disease is killing them and their end is inevitable.

I am pleased that the Maryland State Medical Society, acknowledging that members hold a range of views about medical aid in dying, has a neutral stance, allowing doctors and patients to make ethical decisions within the bounds of safety parameters. Because no one is obligated or mandated to participate in medical aid in dying, physicians, like the patients we care for, may act according to their own conscience.

Even the American Medical Association, in Opinion 5.7 of the Code of Medical Ethics confirmed that physicians may practice medical aid in dying without violating their professional obligations. I invite you to read the carefully crafted language of the Code which concludes that the pro and anti positions both embody moral insights and that neither can claim to be the one and only moral truth.

There is one important piece of misinformation that I'd like to clarify as someone who has seen health disparities up close. Medical aid in dying laws pose no threat to underserved communities, such as the Black community. Health and healthcare disparities are the result of long-term, deeply rooted systemic factors that cause Black patients to be less inclined to use hospice care and less inclined to participate in end-of-life planning.[1] They are more likely to receive aggressive treatment at the end of life and more likely to suffer.[2] Medical aid in dying laws will have no impact on this reality. In fact, if one looks at the data, Black patients are much less likely to choose medical aid in dying. Those most likely to opt for medical aid in dying are white, well educated and insured.[3] The factors that contribute to health disparities are large and must be addressed. Denying dying patients access to a peaceful death will do nothing to address those disparities.

Thank you for considering this important legislation. As questions arise, please feel free to contact me. Medical aid in dying is a new concept for some, but many clinicians have decades of experience. Please let us provide accurate, data-driven and clinically-reliable information as you study and learn more.

Please pass SB 443.

Thank you for your public service

---

[1] Shi-Yi Wang, Sylvia H. Hsu, Melissa D. Aldridge, Emily Cherlin, and Elizabeth Bradley. Racial Differences in Health Care Transitions and Hospice Use at the End of Life. Journal of Palliative Medicine.Jun 2019.619-627.http://doi.org/10.1089/jpm.2018.0436

[2] Addressing Inequities in End-of-Life Planning and Care: Advancing Equity at Life's End. Available at: https://www.compassionandchoices.org/docs/default-source/default-document-library/research-scan-addressing-inequities-in-end-of-life-planning-and-care-final-1.6.22.pdf?sfvrsn=4c1f4085_1

[3] Medical Aid-in-Dying Data Across Authorized States, 2023. Compassion & Choices. Available from: https://www.compassionandchoices.org/docs/default-source/default-document-library/final_maid-utilization-report_1-24-2024.pdf?sfvrsn=5a81525d_2

compassion
& choices
ACTION
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Sonja Richmond, M.D.
Reston, VA

Stan Bliden - SB0443- Favorable *.pdf
Uploaded by: Stanley Bliden
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Testimony of Stanley Bliden -- Favorable
Regarding SB0443/HB0403-- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
February 2024

Hello. My name is Stan Bliden, and I am here in support of this bill. I am a lifelong resident of Maryland and currently reside in Harford County.

As Kenny Rogers sings in The Gambler. "The best that that you can hope for is to die in your sleep."

I come before you today to ask you to pass a bill that will allow me to do just that. I have an incurable brain cancer called Glioblastoma for which the 5-year survival rate is 7 in a hundred. I am about to complete year one. I may need this help, or I might not be brave enough to administer it when the time comes. But the option should be there. For those of you who have witnessed loved ones suffer immensely at the ends of their lives as I have, it is a horrible thing, much more so for the person dying than the loved ones. I do not know what it will be like for me at the end of my life, but I hope you can grant me the help I may need to die peacefully in my sleep.

Thank you.

Support - SB 443- MAID- Stephen Buckingham, UULM-M

Uploaded by: Stephen Buckingham

Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of SB 443
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: February 8th, 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

FAV SB 443 Lyon 2024 Testimony PDF.pdf

Uploaded by: Susan Lyon
Position: FAV

FAV: Testimony in Support of SB 443

End-of-Life Option Act 2024

The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act

I'm Susan Lyon of Rockville and I'm asking you to champion the rights of the terminally ill. I've been with a loved one who chose to die with medical aid.

Leah lived in DC where medical aid in dying is legal.

Leah was a wife, a teacher, and an artist. For six years, cancer ravaged her body. In her final three months, she couldn't eat or move, as her body consumed itself. There is pain *so* debilitating, it's beyond the reach of any drug.

Fortunately, Leah could choose her fate. *She* chose -- not the cancer, or anyone else.

She died how she lived --- with agency, dignity, and resolve.

NO ONE *is* forced to choose medical aid in dying, but for those who need it—and for those who love them—it's a godsend.

SB 443 End-of-Life Liberty

Uploaded by: Thaddeus Mason Pope
Position: FAV

STATEMENT IN SUPPORT OF S.B. 443 BEFORE THE MARYLAND SENATE JUDICIAL PROCEEDINGS COMMITTEE - FEBRUARY 8, 2024

Thaddeus Mason Pope, JD, PhD
www.thaddeuspope.com

I am a law professor at Mitchell Hamline School of Law in Saint Paul, Minnesota. I have published over 300 articles and two books on end-of-life decision making. I write in favor of the bill in my personal capacity.

Maryland Law and Practice Supports End-of -Life Liberty. Over 50,000 Marylanders will die this year. Many of them want to control the timing and the manner of their death. And many already do that: (1) through withholding life-sustaining treatment, (2) through withdrawing life-sustaining treatment, (3) through palliative sedation, and (4) through VSED - voluntarily stopping eating & drinking. Medical aid in dying is just one more option.

Medical Aid in Dying Is Not New. Medical aid in dying is a tested and proven option with a long track record, with a solid track record. S.B. 443 is closely modeled on the Oregon Death with Dignity Act passed by a ballot initiative in 1994 - 30 years ago. Over the past 3 decades, 9 more states and Washington, DC have authorized medical aid in dying based on that same model. 73 million Americans live in those 11 jurisdictions about one-fourth of the entire country.

Medical Aid in Dying Is Safe. Today, we have over 104 years of combined experience with more than 15,000 patients using medical aid in dying in the United States. And that experience shows a solid patient safety track record.

First, each state's department of health publishes an annual report that describes who, where, when, and why patients use medical aid in dying. Second, many health services researchers have conducted their own studies published in peer reviewed medical literature. All that data shows: these laws are working as intended and there is no evidence of abuse.

Indeed, while medical aid in dying has always been safe, it is even safer today. From 2020, we have a professional medical society that offers training, CME, and resources for clinicians. The practice is robust and has a standard of care for everything from patient counseling to pharmacology.

We do not need to speculate or hypothesize about the effects of passing this bill. It includes the same core elements as medical aid in dying laws already in effect in 11 other jurisdictions. It includes the same core elements as medical aid in dying laws in California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, Washington, and Washington DC.

Medical Aid in Dying Has Not Changed. We hear about laws in other countries like those in Europe. Those laws have changed in fundamental ways concerning the eligibility criteria. That has not happened in the United States. In all 11 U.S. jurisdictions, all core elements have remained the same. They have not changed. The patient must:

- Be terminally ill (with a 6 month or less prognosis).
- Have decision making capacity.
- Ingest the medications herself.

Over the past 30 years, only two things have changed. One is the types of licensed clinician. Three states now permit not only physicians but also - APRNs to participate. This follows a broader trend in expanding the scope of practice. The second change is the waiting period. The original model required the patient to make 2 requests separated by 15 days. But substantial evidence showed a large fraction of patients either died - or lost capacity before the end of the 15 days. So, most states have now ether shortened or permit waiver of the waiting period.

Medical Aid in Dying is Optional for Both Patients and Providers. One last point. Medical aid in dying is completely optional for patients, for clinicians, and for healthcare entities. In over 100 years of combined experience in 11 states no patient got MAID who did not want it. No clinician had to participate who did not want to. No entity had to participate that did not want to. Medical aid in dying is opt-in only.

Conclusion. Terminally ill Maryland patients already control the timing and manner of their deaths. Medical aid in dying is another important option. One with a proven track record.

Attachments. In case it might aid the committee, I attach two of my articles reviewing the legal history of medical aid in dying.

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Medical Aid in Dying:
Key Variations Among U.S. State Laws

Thaddeus Mason Pope

ABSTRACT: Medical aid in dying (MAID) is legal in eleven U.S. jurisdictions representing one-fourth of the U.S. population, but despite its legality, MAID is practically available to only a subset of qualified patients in these states. MAID's eligibility requirements and procedural safeguards may impede a patient's access. In response, state legislatures have begun to craft more flexible rules as they recalibrate the balance between safety and access. There is already significant variability among U.S. MAID statutes in terms of eligibility requirements, procedural conditions, and other mandates. While the Oregon Death with Dignity Act has served as the template for all subsequent MAID statutes, the states have not copied the Oregon law exactly. Furthermore, this nonconformity grows as states continue to engage in an earnest and profound debate about the practicality of MAID.

Thaddeus Mason Pope, *Medical Aid in Dying: Key Variations Among U.S. State Laws*, J. Health and Life Sci. L., Oct. 2020, at 25.

MAID Variations Among U.S. State Laws

ARTICLE CONTENTS

INTRODUCTION

Medical Aid in Dying (MAID) is an end-of-life option that has been spreading across the United States.[1] It provides assurance that a terminally ill patient can die when she wants based on her own criteria and enjoy life for a longer period of time. Twenty years ago, MAID was available in only one state.[2] Ten years ago, it was available in only two states.[3] Today, MAID is available in eleven U.S. jurisdictions that comprise 25% of the U.S. population.[4]

The expansion of MAID is notable not only for its size but also for its pace. States have been legalizing MAID at an increasingly accelerated speed. Five of today's eleven MAID jurisdictions enacted their statutes in the past four years. Six jurisdictions enacted statutes within the past five years. Two states enacted statutes in 2019 alone,[5] and half of the remaining forty states considered MAID legislation in 2020.[6]

Because of growing public and legislative interest in MAID, it is useful to identify and assess lessons that can be drawn from the existing laws. The eleven MAID jurisdictions have taken three different legal paths to legalization: (1) legislative, (2) judicial, and (3) standard of

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[1] MAID is also known as "aid in dying," "physician assisted death" "death with dignity," and "voluntary assisted dying." Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04 (3rd ed. 2020). MAID is sometimes referred to as "physician assisted suicide," but that term is generally disfavored because of the strong association of suicide with mental illness. In addition, suicide is typically compulsive, not planned, and suicidal individuals are typically not terminally ill. Press Release, Am. Ass'n of Suicidology, Statement of the American Association of Suicidology: "Suicide" Is Not the Same As "Physician Aid in Dying" (Oct. 30, 2017), https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf.

[2] In 1994, Oregon voters approved a ballot initiative enacting the Orgon Death with Dignity Act. *See* Thaddeus Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. Rev. 267 (2018), https://digitalrepository.unm.edu/nmlr/vol48/iss2/6/; Alan Meisel, *A History of the Law of Assisted Dying in the United States* 73 SMU L. Rev. 119 (2020), https://scholar.smu.edu/smulr/vol73/iss1/8/.

[3] In 2008, Washington voters approved a ballot initiative enacting the Washington Death with Dignity Act. *See* Pope, *supra* note 2.

[4] *See infra* notes 9, 42, and 47 (collecting citations for California, Colorado, Hawaii, Maine, Montana, New Jersey, North Carolina, Oregon, Vermont, Washington, and Washington, DC). The population of these eleven states totals 82 million. That is 25% of the U.S. population, 330 million. *QuickFacts: United States,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/map/US/PST045219 (last visited Sept. 8, 2020).

[5] Maine Death with Dignity Act, Me. Stat. tit. 22, § 2140 (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-1 to -20 (2020).

[6] Eighteen state legislatures considered bills to legalize MAID in 2020. Ariz. H.B. 2582 (2020); S.B. 1384, 54th Leg., 2nd Sess. (Ariz. 2020); H.B. 5420, Gen. Assemb., Feb. Sess. (Conn. 2020); H.B. 140, 150th Gen. Assemb. (Del. 2020); S.B. 1800 (Fla. 2020); Ga. S.B. 291 (2020); H.B. 1020, 121st Gen. Assemb., 2nd Reg. Sess. (Ind. 2020); Iowa S.F. 2156 (2020); S.B. 2156, 88th Gen. Assemb. (Iowa 2020); H.B. 224, Reg. Sess. (Ky. 2020); Md. H.B. 643 (2020); Md. S.B. 701 (2020); H.B. 2152, 91st Leg. (Minn. 2020); S.B. 2286, 91st Leg. (Minn. 2020); N.H. H.B. 1659 (2020); A.B. 2694, Reg. Sess. (N.Y. 2019); H.B. 2033, Reg. Sess. (Pa. 2020); H.B. 7369, Gen. Assemb. (R.I. 2020); H.B. 93, Gen. Sess. (Utah 2020); H.B. 1649 (Va. 2020); A.B. 552 (Wis. 2019); S.B. 499 (Wis. 2020). Some of these bills might have been enacted but for the COVID-19 pandemic. *Legislative Sessions and the Coronavirus,* Nat'l Conference of State Legislatures (Sept. 10, 2020), https://www.ncsl.org/research/about-state-legislatures/legislative-sessions-and-the-coronavirus.aspx. Commentators expect that the next states to enact MAID statutes will be Maryland, Massachusetts, New Mexico, and New York.

care[7]—but most have taken a legislative approach.[8] Nine jurisdictions authorize and regulate MAID through a detailed statute.[9] All nine of these statutes have many common features.

Commentators incessantly emphasize this resemblance. Referencing Oregon, the first state to enact a MAID statute, commentators frequently say that all U.S. MAID laws "have similar provisions based on the Oregon model."[10] Some law professors write that the states have taken a "follow the leader approach."[11] Some write that the states mimic the Oregon "model" or "template."[12] Others write that U.S. MAID laws "closely mirror," "follow" "parrot," or "pattern" the Oregon Act.[13]

However, these commentators overstate the point with this Xerox-like language. While U.S. MAID statutes may copy the Oregon model, they do not copy it exactly. Their approach is better described as "imitation" rather than as "duplication." The nine MAID statutes are not identical. There are material variations among them.[14] This Article identifies and contrasts these differences.

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[7] *See* Pope, *supra* note 2.

[8] *Id.*

[9] End of Life Option Act, Cal. Health & Safety Code §§ 443.1–.22 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. §§ 25-48-101 to -123 (2020); Death with Dignity Act of 2016, D.C. Code §§ 7-661.01–.16 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-1 to -25 (2020); Me. Stat. tit. 22, § 2140; N.J. Stat. §§ 26:16-1 to -20; Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800–.897 (2020); Vt. Stat. Ann. tit. 18, §§ 5281–93 (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.010-.220–.904 (2020). One of the best places for tracking the history and status of MAID law is the website of the Death with Dignity National Center and Death with Dignity Political Fund: Death with Dignity, http://www.deathwithdignity.org (last visited Sept. 10, 2020).

[10] Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 35 (2020), https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2020/5620T490.pdf [hereinafter Rep. No. 34].

[11] Ben White & Lindy Willmott, *Now that VAD Is Legal in Victoria, What Is the Future of Assisted Dying Reform in Australia?*, ABC, June 24, 2019, https://www.abc.net.au/religion/the-future-of-assisted-dying-reform-in-australia/11242116.

[12] *See, e.g., id;* Anita Hannig, *Assisted Dying Is Not the Easy Way Out*, The Conversation, Feb. 18, 2020; Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017), https://theconversation.com/assisted-dying-is-not-the-easy-way-out-129424.

[13] Cody Bauer, *Dignity in Choice: A Terminally Ill Patient's Right to Choose*, 44 Mitchell Hamline L. Rev. 1024, 1036 (2018), https://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1138&context=mhlr; Edward Davies, *Assisted Dying: What Happens after Vermont?*, 346 Brit. Med. J. f4041 (2013); Arthur Svenson, *Physician-Assisted Dying and the Law in the United States: A Perspective on Three Prospective Futures, in* Euthanasia and Assisted Suicide: Global Views on Choosing to End Life 13 (Michael J. Cholbi ed. 2017), https://publisher.abc-clio.com/9781440836800/14; Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 181 n.154 (2020), https://digital.sandiego.edu/cgi/viewcontent.cgi?article=3207&context=sdlr; Mary C. Deneen, *Bioethics—"Who Do They Think They Are?": Protecting Terminally Ill Patients Against Undue Influence by Insurers in States Where Medical Aid in Dying Is Legal*, 42 W. New Eng. L. Rev. 63, 76 (2020), https://digitalcommons.law.wne.edu/cgi/viewcontent.cgi?article=1832&context=lawreview ("All nine jurisdictions with MAiD statutes provide similar provisions . . . ."). *See also* Rep. No. 34, at 35 ("Eight other states followed Oregon with similar laws….").

[14] This exemplifies the role of states as "laboratories" that try novel social experiments. *See* Wash. v. Glucksberg, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

In Section One, the author defines MAID and describes its place in end-of-life health care. Section Two describes non-statutory approaches to legalizing MAID that two states have taken. The remainder of the Article focuses on the nine statutes and describes three types of variations.

Section Three describes two variations in eligibility requirements. These differences concern which patients are qualified to receive MAID. The states vary both in how they assess the patient's state residency and in how they assess the patient's decision-making capacity. Section Four describes three variations in procedural requirements. These differences concern how patients obtain and take MAID prescriptions. The states vary in the permitted routes of drug administration and in the duration of the oral and written request waiting periods. Section Five describes five other variations. The states vary in how they permit clinicians and facilities to opt-out; how they permit telehealth; and how they collect and report data. The states also vary in whether they include a sunset clause.

Finally, in Section Six, the author identifies imminent variations in U.S. MAID laws. During the first two decades of U.S. MAID, policymakers placed heavy emphasis on safety at the expense of access. Today, more states are working to recalibrate the balance between safety and access. Consequently, over the next several years, one can expect additional variations among state MAID laws.

Two innovations are particularly likely. First, all states now require the attending and consulting clinician to be a physician; however, some states will probably extend MAID to advanced practice registered nurses (APRNs). Second, all states now require that the patient be terminally ill with a prognosis of six months or less, but some states will probably extend that to twelve months or longer.

MEDICAL AID IN DYING

Before comparing differences among MAID laws, it is important to first clarify what MAID is. Why would someone hasten their own death? How do they do that with MAID? Who is using this end-of-life option?

Why Hasten One's Death?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[15] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death.[16] For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[17]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[18] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely.[19] Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer period of time.[20]

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[15] *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, 2008 Hematology 475, 475 (2008), https://ashpublications.org/hematology/article/2008/1/475/95873/Patient-and-Family-Requests-for-Hastened-Death ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 Archives Internal Med. 489, 489 (2009), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/414824 ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. Pain & Symptom Mgmt. 100, 104 (2006), https://www.jpsmjournal.com/action/showPdf?pii=S0885-3924%2805%2900631-7; Joan McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. Med. Ethics 454, 456 fig. 2 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med. 1193, 1195 (1998), https://www.nejm.org/doi/pdf/10.1056/NEJM199804233381706?articleTools=true.

[16] For years, the three most frequently reported end-of-life concerns of patients using MAID have been (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy, and (3) loss of dignity. Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 6 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf.

[17] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

[18] Peter M. Marzuk, *Suicide and Terminal Illness*, 18 Death Stud. 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. Clinical Oncology 4720, 4722 (2008), https://ascopubs.org/doi/pdf/10.1200/JCO.2007.14.3990.

[19] Ladislav Volicer et al., *Assistance with Eating and Drinking Only When Requested Can Prevent Living with Advanced Dementia*, 20 J. Am. Med. Directors Ass'n 1353 (2019).

[20] *See* Benzi M. Kluger, *Medical Aid in Living*, JAMA Neurology (Aug. 24, 2020); Stanley A. Terman, The Best Way to Say Goodbye: A Legal Peaceful Choice at the End of Life 326 (Ronald B. Miller & Michael S. Evans eds., 2007).

Certainly, life is valuable, and societal values reinforce attempting to extend life indefinitely. However, death is unavoidable. People suffering from the diseases that cause the most deaths in this country will often experience significant suffering and/or loss of independence.[21] In this situation, the preference, for some, may be to hasten death so that death can be on the individual's own terms and with some predictability, rather than risk the unknown and potential loss of comfort and dignity.[22] Advocates often remark that MAID does not result in more people dying, just in fewer people suffering.

What Is MAID?

MAID is one key last resort "exit option."[23] With MAID, a physician writes a prescription for life-ending medication for an adult patient who is terminally ill and mentally capacitated.[24] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient.

Indeed, since the practice is so tightly regulated, the standard of care maps onto the statutory requirements. All nine U.S. MAID statutes have nearly identical conditions and safeguards.[25] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to take the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[26]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that

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[21] Judith K. Schwarz, *Stopping Eating and Drinking*, 109 Am. J. Nursing 52, 53–54 (2009).

[22] Hastening Death by Voluntarily Stopping Eating and Drinking: Clinical, Ethical, and Legal Dimensions (Timothy Quill et al. eds., Oxford Univ. Press, forthcoming 2021); Thaddeus Mason Pope & Lindsey E. Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 Widener L. Rev. 363 (2011). Most suffering can be alleviated through palliative care. Therefore, MAID is really for the subset of cases where palliative care is insufficient. As palliative care's toolbox expands, the demand for MAID may diminish. *Cf.* Kathryn L. Tucker, *Oregon's Pioneering Effort to Enact State Law to Allow Access to Psilocybin, a New Palliative Care Tool*, Willamette L. Rev. (forthcoming 2020).

[23] *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, *in* Giving Death a Helping Hand: Physician-Assisted Suicide and Public Policy: An International Perspective 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

[24] David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259, 259 (2016).

[25] Thaddeus Mason Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, ASCO Post (Dec. 25, 2017); Thaddeus M. Pope, *Current Landscape: Implementation and Practice*, Nat'l Acads. of Scis., Eng'g, & Med. Health & Med. Div. (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM. While Montana and North Carolina have no MAID statute. But the conditions and safeguards are similar. *See infra* notes 65 to 71.

[26] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 12.04[C] (3rd ed. 2020).

the patient's judgment is impaired, then they must refer the patient for a mental health assessment by a third clinician.[27]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[28] However, price increases and supply problems have led physicians to prescribe other drugs.[29] These include compounded ones like D-DMA or DDMP2.[30] Importantly, the patient must ingest the drugs herself.[31] The patient alone takes the final overt act that causes her death.[32]

Who Uses MAID?

The United States has over sixty years of experience with MAID, when one sums the experience of each state where MAID has been available.[33] Data on most of that experience has been systematically collected and reported by both state departments of health and by academic researchers.[34] They show that physicians wrote prescriptions for over 5,000 individuals. Many

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[27] *Id. But see infra* notes 75 to 78 (explaining how Hawaii requires an automatic mental health assessment for everyone).

[28] April Dembosky, *Drug Company Jacks Up Cost of Aid-In-Dying Medication*, NPR (Mar. 23, 2016, 3:24 PM), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

[29] Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, Scientist (Aug. 16, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

[30] D-DMA entails Digitalis 30 minutes before Diazepam, Morphine, and Amitriptyline. DDMP2 uses Propranolol but results in a longer average time to death. *See, e.g.,* Anita Hannig, *The Complicated Science of a Medically Assisted Death*, Quillette (Mar. 18, 2020), https://quillette.com/2020/03/18/the-complicated-science-of-a-medically-assisted-death/; Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018), https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf.

[31] Amanda M. Thyden, *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 Chapman L. Rev. 421, 421 (2017).

[32] *See infra* notes 97 to 101.

[33] California (2015); Colorado (2016); DC (2017); Hawaii (2018); Maine (2019); Montana (2009); North Carolina (2019); New Jersey (2019); Oregon (1997); Vermont (2017); Washington (2008). There is a longer history of "underground" physician-assisted death. *See generally* Diane E. Meier et al., *A National Survey of Physician-assisted Suicide and Euthanasia in the United States*, 338 New Eng. J. Med 1193 (1998); Ezekiel J. Emanuel et al., *Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide*, 133 Annals Internal Med. 527 (2000); Damien Pearse, *Michael Caine: I Asked Doctor to Help My Father Die,* Guardian (Oct. 8, 2010, 7:56 PM), https://www.theguardian.com/film/2010/oct/09/michael-caine-father-assisted-suicide#:~:text=Sir%20Michael%20Caine%20has%20revealed,he%20agrees%20with%20voluntary%20euthanasia. Because this practice is not transparent, it is not properly described as "MAID."

[34] *See infra* notes 168 to 173. *See also* Luai Al Rabadi et al*., Trends in Medical Aid in Dying in Oregon and Washington*, 2 JAMA Network Open 1/7 (2019), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747692; Charles Blanke et al., *Characterizing 18 Years of the Death with Dignity Act in Oregon*, 3 JAMA Oncology 1403 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5824315/; Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

patients get MAID prescriptions for their peace of mind, to have as "insurance" just in case their condition becomes intolerable. Since that intolerability often does not happen, only 70% of patients take their prescription.[35]

Nearly 90% of these 5,000 terminally ill patients had cancer or amyotrophic lateral sclerosis (ALS).[36] Other terminally ill patients with cardiovascular, respiratory, or other illnesses have rarely used MAID. The average age has been 74, and over 90% were on hospice.[37] Most were college educated.[38] Patients receiving MAID prescriptions have been almost evenly split male and female, but they have been overwhelmingly white even in racially diverse states like California.[39]

NON-STATUTORY APPROACHES

Most states have legalized MAID through a statute enacted either through the legislature or through a ballot initiative.[40] Those nine statutes are the primary focus of this Article. For the sake of completeness, however, the reader should recognize that two other states took a non-statutory approach. Montana legalized MAID through a court decision, and North Carolina took a "standard of care" approach.[41]

Montana

Montana law has long permitted one individual to help another person hasten death with consent, so long as that assistance is not against public policy.[42] In 2009, the Montana Supreme Court held that this exception in the homicide law applies to MAID. Therefore, a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent terminally ill patient.[43] Relying upon this decision, patients and physicians participate in MAID in Montana.[44]

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[35] COMPASSION & CHOICES, MEDICAL AID IN DYING: A POLICY TO IMPROVE CARE AND EXPAND OPTIONS AT LIFE'S END (2020), https://compassionandchoices.org/wp-content/uploads/Medical-Aid-in-Dying-report-FINAL-2-20-19.pdf.

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] *See supra* notes 9, 42, and 47; Pope, *supra* note 2.

[41] The Montana court only removed the criminal prohibition. It did not supply any standards or rules. Therefore, the practice in Montana is properly described as a standard of care approach. *Cf.* Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 MONT. L. REV. 207 (2020); Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-of-Life Choice in Massachusetts*, 58 N.Y. L. SCH. L. REV. 259 (2013/14). North Carolina is different because there is no statute, regulation, or court decision authorizing MAID. North Carolina might be described as taking a "pure" standard of care approach.

[42] MONT. CODE. ANN. § 45-2-211 (2020).

[43] Baxter v. State, 224 P.3d 1211 (Mont. 2009).

[44] *Hearing on H.B. 284 Before the H. Judicial Comm.* (Mont. 2019); Eric Kress, *Thoughts from A Physician Who Prescribes Aid in Dying*, MISSOULIAN (Apr. 7, 2013), https://missoulian.com/news/opinion/columnists/thoughts-from-a-physician-who-prescribes-aid-in-dying/article_07680d28-9e0b-11e2-84f1-001a4bcf887a.html; Kathryn L. Tucker, *Aid in Dying in Montana: Ten Years after State v. Baxter,* 81 MONT. L. REV. 117 (2020).

The Montana Supreme Court declared the permissibility of MAID for capacitated, terminally ill adult individuals, but it otherwise provided no rules or standards. In the following eleven years, neither the legislature nor the health care licensing boards filled this gap and provided rules and standards. The notable consequence is that Montana does not formally require the procedural requirements that are present in the nine statutory states.[45] Still, since MAID, like any medical practice, is governed by the standard of care, Montana guidelines are probably similar to the rules in the statutory states.[46]

North Carolina

Montana is not the only state to take a non-statutory approach to legalizing MAID. Some commentators argue that MAID is legal in North Carolina for the same reason that it is legal in Montana.[47] While there is no state supreme court decision addressing the question in North Carolina, there is arguably no need for such a decision. In North Carolina, as in Montana, MAID is not prohibited under current law. Therefore, like most areas of medical practice, it is permitted so long as it complies with the standard of care.[48]

Given the well-known legal risk averseness of clinicians, a standard of care approach might seem quixotic. Will physicians really write lethal prescriptions without the bright line clarity and permission of black letter law? In fact, the answer may be "yes." In closely analogous areas of end-of-life medicine such as Physician's Orders for Life-Sustaining Treatment (POLST), legal experts also recommend a non-statutory, standard of care approach.[49] Such an approach has been working in states like Minnesota where clinicians both write and follow these transportable do-not-resuscitate orders.[50]

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[45] *See infra* §§ III to V.

[46] David Orentlicher et al., *Clinical Criteria for Physician Aid-in-Dying*, 19 J. Palliative Med. 259 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/pdf/jpm.2015.0092.pdf.

[47] *See, e.g.,* John Carbone et al., *Aid in Dying in North Carolina,* 80 N.C. Med. J. 128 (2019), https://www.ncmedicaljournal.com/content/ncm/80/2/128.full.pdf; Kathryn L. Tucker, *Aid in Dying in North Carolina*, 97 N.C. L. Rev. Addendum 1 (2019); Jeffrey Segal, *Can NC Physicians Legally Prescribe Meds to Suffering Terminally Ill Patients to Precipitate a Peaceful Death?*, Med. Just. (Jan. 12, 2019), https://medicaljustice.com/can-nc-physicians-legally-prescribe-meds-to-suffering-terminally-ill-patients-to-precipitate-a-peaceful-death/. *But see* Bryant A. Murphy et al., *No Consensus on AID, But We Can Agree on Palliative Care*, 81 N.C. Med. J. 213 (2020), https://www.ncmedicaljournal.com/content/81/3/213.

[48] Kathryn L. Tucker, *Vermont Patient Choice at End of Life Act: A Historic Next Generation Law Governing Aid in Dying*, 38 Vt. L. Rev. 687 (2014); Daniel Schweppenstedde et al., RAND Europe, Regulating Quality and Safety of Health and Social Care International Experiences 13 (2014), https://www.rand.org/pubs/research_reports/RR561.html. Of course, North Carolina physicians must also comply with many other rules like those from the state Board of Medicine.

[49] Charles P. Sabatino & Naomi Karp, AARP Pub. Policy Inst., Improving Advanced Illness Care: The Evolution of State POLST Laws 17, 45 (2011), https://polst.org/wp-content/uploads/2016/06/POLST-Report-04-11.pdf; National POLST Paradigm, POLST Legislative Guide 24 (2014).

[50] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020) [hereinafter The Right to Die].

Other Non-Statutory Approaches

While Montana and North Carolina are the only current MAID states that have taken a non-statutory approach, other states previously attempted to follow this pathway.[51] For example, before enacting a statute in 2018, Hawaii attempted to follow a standard of care approach like North Carolina.[52] Vermont nearly took the opposite approach of following a standard of care approach ***after*** enacting a statute. The Vermont Patient Choice at End of Life Act originally included a sunset clause for the procedural requirements. Had that clause not been later repealed, Vermont MAID would have been governed by the standard of care.[53] Finally more than a dozen other states tried (albeit unsuccessfully) to legalize MAID through a court decision like Montana.[54]

VARIATIONS IN ELIGIBILITY REQUIREMENTS

Montana and North Carolina are the exceptions. Nine of eleven U.S. MAID jurisdictions authorize MAID with a statute. Because all nine of these statutes are based on the Oregon "model," they are quite similar, but these nine MAID statutes are not 100% identical. They vary along three dimensions in terms of (1) eligibility requirements, (2) procedural requirements, and (3) other dimensions. Eligibility requirements are addressed in this section, and other variations are addressed in the next two sections.

To qualify for MAID a patient must satisfy several eligibility requirements. She must be (1) an adult, (2) who is terminally ill, (3) a state resident, (4) with decision-making capacity. Every MAID statute includes these four requirements, but they differ in how they measure the last two and in how they mandate assessment of the patient's residency and capacity.

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[51] Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, ADVOCATE, at 1-8 (2010); S.B. 1070, 61st Leg., 1st Reg. Sess. (Idaho 2011), https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2011/legislation/S1070E1.pdf.

[52] Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices,* 8 J. HEALTH & BIOMED. L. 9 (2012), https://cpb-us-e1.wpmucdn.com/sites.suffolk.edu/dist/e/1232/files/2016/12/Aid-in-Dying-An-End-of-Life-Option-Governed-by-Best-Practices.pdf. *See also* Morris v. Brandenburg, 356 P.3d 564, 570 (N.M. 2015); Kevin B. O'Reilly, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, AM. MED. NEWS (Apr. 17, 2012), https://amednews.com/article/20120417/profession/304179996/8/. *But cf.* Jim Mendoza, *AG Denounces Aid in Dying Ad*, HAW. NEWS NOW (Sept. 24, 2013), https://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad/.

[53] THE RIGHT TO DIE, § 12.02.

[54] *See* Pope, *supra* note 2. One such lawsuit is currently on appeal. Kligler v. Healey, No. 2016-03254-F (Mass. Super. Ct. Dec. 31, 2019), https://compassionandchoices.org/wp-content/uploads/Kliger-Memorandum-of-Decision-and-Order-wm.pdf.

State Residency: How to Prove It?

Every MAID statute requires that the terminally ill, adult patient be a resident of that state.[55] For example, the California End of Life Options Act (EOLOA) provides that only "qualified individuals" can access MAID and that only residents of California are qualified individuals.[56]

While every state requires residency, they vary in terms of what evidence is enough to prove it. Most states permit the following four documents to prove state residency:

1. Possession of a driver license or other state-issued identification
2. Registration to vote
3. Evidence that the person owns or leases property in the state
4. Filing of a state return for the most recent tax year[57]

Some statutes specify fewer types of evidence as sufficient to establish residency. For example, Washington permits only the first three.[58] Other states specify more than these four types of evidence, such as Maine, which permits five additional types of evidence.[59] Washington, D.C. lists twelve additional types of evidence, and requires that the patient submit at least two of them.[60]

The ease with which a patient can prove state residency is important. Because only nine jurisdictions have MAID statutes, patients regularly move from non-MAID jurisdictions to MAID jurisdictions.[61] For example, Brittany Maynard, one of the most famous people to use

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[55] End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443.1(o), 443.2(a)(3) (2020); Colorado End-of-life Options Act, COLO. REV. STAT. § 25-48-102(13) (2020); Death with Dignity Act of 2016, D.C. CODE § 7-661.01(13) (2020); Our Care, Our Choice Act, HAW. REV. STAT. § 327L-1 (2020); Maine Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140(2)(K), (15) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. § 26:16-3 (2020); Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800(11), .805 (2020); VT. STAT. ANN. tit. 18, § 5281(8) (2020); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.010(11), .020(1) (2020).

[56] CAL. HEALTH & SAFETY CODE §§ 443.1(o), 443.2(a)(3).

[57] *Id.* § 443.2(a)(3); COLO. REV. STAT. § 25-48-102(14); HAW. REV. STAT. § 327L-13; N.J. STAT. § 26:16-11; OR. REV. STAT. § 127.860. The Vermont statute does not specify what makes someone a Vermont resident, but the state Department of Health specifies these same four factors. VT. DEP'T OF HEALTH, ACT 39 FREQUENTLY ASKED QUESTIONS https://www.healthvermont.gov/sites/default/files/documents/pdf/Act39_faq.pdf.

[58] WASH. REV. CODE § 70.245.130. While Washington lists only three documents, it also permits other "[f]actors demonstrating Washington state residency". *Id.*

[59] ME. REV. STAT. ANN. tit. 22, § 2140(15) (also including: the location of a dwelling currently occupied by the person; place where a motor vehicle is registered; address where mail is received, address shown on a hunting or fishing license, receipt of public benefits conditioned upon residency, and any other objective facts tending to indicate a person's place of residence).

[60] D.C. HEALTH, DEATH WITH DIGNITY: PATIENT EDUCATION MODULE (Apr. 26, 2018), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/Death%20with%20Dignity%20-%20Education%20Modules.Patient.DC%20HEALTH%20Version.04.26.18.pdf (including: utility bill, telephone bill, mail from a government agency, or student loan statement).

[61] *See, e.g.,* Kevin Roster, Opinion, *I'm Dying from Cancer. I Have to Move Across the Country to Die on My Own Terms*, USA TODAY, June 7, 2019, https://www.usatoday.com/story/opinion/2019/06/07/medical-aid-dying-face-death-own-terms-column/1365567001/.

MAID, moved to Oregon specifically for the purpose of establishing residency and thus eligibility for MAID.[62] This is a form of medical tourism.[63] Because these patients are terminally ill, they must quickly acquire the necessary documents to prove state residency.

Capacity Assessments: Two or Three?

Every MAID statute requires not only that the patient be a terminally ill adult state resident but also that the patient have decision-making capacity. This means two things: first, it means that the patient can understand the significant benefits, risks, and alternatives to MAID, and second, it means that the patient can make and communicate an informed health care decision.[64]

To confirm the patient's capacity, every statute requires at least two assessments by two different physicians.[65] Both an attending physician and a consulting physician must "[d]etermine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision."[66]

If both the attending and consulting physicians are sure that the patient has capacity, then she is qualified. If either the attending or consulting physician is sure that the patient lacks capacity, then she is not qualified. However, if either the attending or consulting physician is unsure or has concerns about the patient's capacity, then they must refer the patient for a third capacity assessment.[67]

For example, the California End of Life Options Act states: "If there are indications of a mental disorder, refer the individual for a mental health specialist assessment."[68] The District of Columbia statute mandates referral when the attending or consulting physician suspects a "psychiatric or psychological disorder or depression causing impaired judgment."[69]

The clinician who performs this third capacity assessment is a mental health specialist, usually a psychiatrist, psychologist, or clinical social worker. They must determine whether

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[62] Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, PEOPLE, May 9, 2017, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/.

[63] *See* I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM, LAW, AND ETHICS ch.8 (2014).

[64] End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.1(c) (2020).

[65] Our Care, Our Choice Act, HAW. REV. STAT. §§ 327L-4, -5 (2020).

[66] CAL. HEALTH & SAFETY CODE §§ 443.6(c), .8(c)-(d). Some states use the terms "competent" or "capable."

[67] CAL. HEALTH & SAFETY CODE §§ 443.5(a)(1), .6(d); Colorado End-of-life Options Act, COLO. REV. STAT. §§ 25-48-106, -107 (2020); Death with Dignity Act of 2016, D.C. CODE § 7-661.03–.04 (2020); HAW. REV. STAT. § 327L-1; Maine Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140(6)–(7) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-6, -8 (2020); Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.815, .820, .825 (2020); VT. STAT. ANN. tit. 18, § 5283(a)(8) (2020); Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.040, .060 (2020).

[68] CAL. HEALTH & SAFETY CODE §§ 443.5(a)(1)(A)(ii), .6(d).

[69] D.C. CODE § 7-661.03–.04.

the patient "is mentally capable and making an informed decision."[70] They do this by determining whether the patient is suffering from impaired judgment due to a mental disorder.[71]

However, decades of government-collected and reported data show that physicians rarely refer patients for this third capacity assessment. Attending and consulting physicians refer only 4% of patients who receive a MAID prescription.[72] Consequently, few MAID patients receive a mental health specialist capacity assessment.[73] Some commentators suggest that this rate may be too low.[74]

But not in Hawaii, where capacity assessment works differently. In Hawaii, every MAID patient gets a third capacity assessment.[75] It is not contingent or conditional on the judgment of the attending or consulting physician. It is automatically and always required.[76] Recognizing that making a terminally ill patient obtain a third clinical assessment could be burdensome, Hawaii

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[70] Colo. Rev. Stat. § 25-48-108.

[71] Cal. Health & Safety Code § 443.7; Colo. Rev. Stat. § 25-48-108; D.C. Code § 7-661.01(4); Haw. Rev. Stat. § 327L-6; Me. Rev. Stat. Ann. tit. 22, § 2140(8); N.J. Stat. Ann. § 26:16-8; Or. Rev. Stat. § 127.825; Vt. Stat. Ann. tit. 18, § 5283(8); Wash. Rev. Code § 70.245.060.

[72] Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Wash. State Dep't of Health, Disease Control & Health Statistics, Ctr. for Health Statistics, DOH 422-109, 2018 Death with Dignity Act Report (2019), https://www.doh.wa.gov/YouandYourFamily/ IllnessandDisease/DeathwithDignityAct/DeathwithDignityData. Notably, Canada has a similarly low referral rate. James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7043822/pdf/192e173.pdf. Not every state reports data on the rate of mental health referrals. *See infra* note 170.

[73] *See generally* Lois A. Weithorn, *Psychological Distress, Mental Disorder, and Assessment of Decisionmaking Capacity Under U.S. Medical Aid in Dying Statutes*, 71 Hastings L.J. 637 (2020), http://www.hastingslawjournal.org/wp-content/uploads/Weithorn_Psychological-Distress-Mental-Disorder-and-Assessment-of-Decisionmaking-Capacity-Under-U.S.-Medical-Aid-in-Dying-Statutes.pdf; Brian D. Carpenter & C. Caroline Merz, *Assessment of Capacity in Medical Aid in Dying, in* Assessing Capacities of Older Adults: A Casebook to Guide Difficult Decisions 243 (Jennifer Moye ed., 2020).

[74] *See, e.g.,* Linda Ganzini, *Legalised Physician-Assisted Death in Oregon*, 16 QUT L. Rev. 76 (2016), https://www.deathwithdignity.org/wp-content/uploads/2015/11/623-2243-1-PB-1.pdf; Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA Intern Med. 427 (2016); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 11-12, 16 (2017).

[75] While not legally required in any state except Hawaii, some institutions in other states automatically require a third capacity assessment in their own policies. For example, while California law does not automatically require a third capacity assessment, individual facilities like UCSF do. *See, e.g.,* Barbara Koenig, *Reflections on Preparing for And Responding to Legalization in California, in* Physician-Assisted Death: Scanning the Landscape: Proceedings of a Workshop 89–98 (2018); James A. Bourgeois et al., *Physician-Assisted Death Psychiatric Assessment: A Standardized Protocol to Conform to the California End of Life Option Act*, 59 Psychosomatics 441 (2018), https://escholarship.org/uc/item/7xj942bb.

[76] Haw. Rev. Stat. §§ 327L-4(a)(5), -4, -6.

permits it to be performed not only by a physician but also by a psychologist or clinical social worker.[77] Hawaii also permits this third capacity assessment to be performed through telehealth.[78]

VARIATIONS IN PROCEDURAL REQUIREMENTS

MAID statutes vary not only in their eligibility requirements (like residency and capacity) but also in their procedural requirements that dictate how qualified patients may access MAID. Every state requires that the patient: (1) make two oral requests, (2) make one written request, and (3) take the prescription drug themselves. However, the states differ on the details. They vary on the duration of mandated waiting periods between oral requests, the duration of mandated waiting period after the written request, and on the routes by which the drug may be administered.

Oral Request Waiting Period: 0, 15, or 20 Days?

Every MAID statute requires that the patient make two oral requests for MAID. Every statute further requires that those two requests be separated by at least fifteen days.[79] For example, California mandates that "[a]n individual seeking to obtain a prescription for an aid-in-dying drug . . . shall submit two oral requests, a minimum of 15 days apart. . . ."[80] This is designed to assure that the request reflects a considered and voluntary choice by the patient.[81]

While 15 days is the most common duration, some states have longer waiting periods, and some have potentially shorter waiting periods. For example, the Hawaii Our Care, Our Choice

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[77] *Id.* § 327L-1. Some propose extending this to also include psychiatric mental health nurse practitioners. *Testimony Before the S. Comm. on Commerce, Consumer Protection, and Health* (Haw. 2020), https://www.capitol.hawaii.gov/Session2020/Testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF.

[78] Haw. Rev. Stat. § 327L-1.

[79] End of Life Option Act, Cal. Health & Safety Code § 443.3(a) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104(1) (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02(a)(1) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(11)–(13) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-10 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.840, .850 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(2) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.090, .110(1) (2020).

[80] Cal. Health & Safety Code § 443.3(a). Some clinicians have taken the patient's request on the fifteenth day after the first request, but the plain language of every statute requires that the patient make the second request on the sixteenth day or later. Colo. Rev. Stat. § 25-48-104(1) ("separated by at least fifteen days"); D.C. Code § 7-661.02(a)(1) ("separated by at least 15 days"); N.J. Stat. Ann. §§ 26:16-10 ("at least 15 days shall elapse"); Or. Rev. Stat. §§ 127.840, .850 ("no less than 15 days after"); Vt. Stat. Ann. tit. 18, § 5283(a)(2) ("[n]o fewer than 15 days"); Wash. Rev. Code §§ 70.245.090, .110(1) ("at least fifteen days after").

[81] State laws often require waiting periods for major life-impacting decisions like abortion, sterilization, marriage, divorce, and adoption. *See* Paul Stam, *Woman's Right to Know Act: A Legislative History*, 28 Issues L. & Med. 3, 66 (2012).

Act requires that the patient's oral requests be separated by at least twenty days, instead of just fifteen days.[82] Hawaii has the longest required waiting period in the United States.[83]

Oregon took the opposite approach, shortening rather than lengthening its waiting period. Between 1994 and 2019, the Oregon Death with Dignity Act required a 15-day waiting period, and this was the model followed by every other state except Hawaii. Effective January 1, 2020, however, Oregon amended its statute to permit waiver of the entire 15 days when the patient will not survive that long.[84]

> [I]f the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician ***at any time*** after making the initial oral request.[85]

Consequently, an imminently dying patient in Oregon could make both her first and second oral requests on the same day (with no waiting period).

Other states are looking to follow Oregon's lead.[86] They are apparently motivated by significant evidence demonstrating that the 15-day waiting period impedes patient access to

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[82] Haw. Rev. Stat. §§ 327L-2, -9 & -11.

[83] Mara Buchbinder & Thaddeus M. Pope, *Medical Aid in Dying in Hawaii: Appropriate Safeguards or Unmanageable Obstacles?*, Health Aff. Blog (Aug. 13, 2018) [hereinafter Buchbinder & Pope]. In fact, it often takes Hawaii patients 34 days to navigate the process. *See, e.g., Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/HB2451_TESTIMONY_HLT_01-31-20_.PDF [hereinafter *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*]; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020) (statement of the State of Hawaii Department of Health), https://www.capitol.hawaii.gov/session2020/testimony/SB2582_TESTIMONY_CPH_02-04-20_.PDF [hereinafter *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*]. A significant number of patients die before the end of the 20-day waiting period. *Id.* (statement of Charles F Miller, Director, Kaiser Hawaii Medical Aid in Dying Program).

[84] S.B. 579, 80th Leg. Assemb., Reg. Sess., 2019 Laws Ch. 624, https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB579/Enrolled.

[85] Or. Rev. Stat. § 127.840(2) (emphasis added); see also *id.* § 127.850(2).

[86] *See, e.g.,* H.B. 2739 (Haw. 2020), https://www.capitol.hawaii.gov/session2018/bills/HB2739_HD1_.pdf; Dep't of Health Office of Planning, Policy, & Program Dev., Report to the Thirtieth Legislature State of Hawaii 2020: Pursuant to Act 2 Session Laws of Hawaii 2019 (HB2739 H.D. 1) (2019), https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-3.pdf; H.B. 2419, 66th Leg., Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200913182845; H.B. 171, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf; S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf, https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252.pdf. *See also* Voluntary Assisted Dying Act 2019 § 48(2)(b) (W. Austl. 2019), https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42491.pdf/$FILE/Voluntary%20Assisted%20Dying%20Act%202019%20-%20%5B00-00-00%5D.pdf?OpenElement.

MAID.[87] Many terminally ill patients do not begin exploring the option until late in their illness trajectory. By that point, they have little remaining time and cannot survive 15 days.[88] For example, one California study shows that one-fourth of patients died or lost capacity during the waiting period.[89] Similarly, in Canada, which has only a 10-day waiting period, more than one-fourth of patients cannot wait even that long.[90]

Written Request Waiting Period: 0 or 48 Hours?

Every MAID statute requires not only that the patient make two oral requests but also that they make a written request.[91] Patients must make this written request on a specified form.[92] Furthermore, just as there is a waiting period between the two oral requests, some states require a 48-hour waiting period between the written request and the writing of the prescription.[93] For example, the New Jersey statute provides: "[A]t least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription . . . ."[94]

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[87] *See, e.g.*, *Testimony in SUPPORT of HB 2451 RELATING TO HEALTH*; *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH*.

[88] Buchbinder & Pope, *supra* note 83.

[89] Huong Q. Nguyen et al., *Characterizing Kaiser Permanente Southern California's Experience with the California End of Life Option Act in the First Year of Implementation*, 178 JAMA Internal Med. 417 (2018).

[90] James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020). *See also* Debbie Selby et al., *Medical Assistance in Dying (MAiD): A Descriptive Study from a Canadian Tertiary Care Hospital*, 37 Am. J. Hospice & Palliative Med. 58 (2020) (10 days reduced 39% of the time). Lori Seller et al., *Situating Requests for Medical Aid in Dying Within the Broader Context of End-of-Life Care: Ethical Considerations*, 45 J. Med. Ethics 106 (2019); Health Canada, First Annual Report on Medical Assistance in Dying in Canada: 2019, at 6 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf (26.5% did not result in a MAID death, because the patients died before receiving MAID). Canadian law permits a waiver of the waiting period if the patient will die or lose capacity before that. S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

[91] End of Life Option Act, Cal. Health & Safety Code § 443.3(b) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-104 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.02 (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-2, -9 (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(4)–(5), (24) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-4 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.810 (2020); Vt. Stat. Ann. tit. 18, § 5283(a)(4) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.030, .090 (2020).

[92] Cal. Health & Safety Code § 443.11; Colo. Rev. Stat. § 25-48-112; D.C. Code § 7-661.02(b)–(c); Haw. Rev. Stat. §§ 327L-2, -23; Me. Rev. Stat. Ann. tit. 22, § 2140; N.J. Stat. Ann. §§ 26:16-5, -20; Or. Rev. Stat. §§ 127.810, .897; Wash. Rev. Code § 70.245.220. The Vermont statute does not specify a form, but the state Department of Health has designed forms. https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life. There is variability regarding who may serve as a witness.

[93] D.C. Code § 7-661.02(a)(2); Haw. Rev. Stat. § 327L-11; Me. Rev. Stat. Ann. tit. 22, § 2140(13); N.J. Stat. Ann. § 26:16-10; Or. Rev. Stat. § 127.850(1); Wash. Rev. Code § 70.245.110(2). California and Colorado do not require a 48-hour waiting period after the written request. Oregon's waiver of the oral request waiting period also permits waiver of the written request waiting period. Or. Rev. Stat. §§ 127.840(2), .850(2).

[94] N.J. Stat. Ann. §§ 26:16-10(a)(6).

Unlike the oral request waiting period, this 48-hour requirement typically does not delay patient access, because this waiting period can run concurrent to the oral request waiting period. For example, the patient could make both her first oral request and her written request on January 1.[95] She could make her second oral request on January 16 and receive a prescription that same day. In this example, the patient satisfies ***both*** the oral and written request waiting period requirements in just 15 days.

However, this is not possible in Vermont. There, the written request waiting period runs consecutively to, not concurrently with, the oral request waiting period. The Vermont Patient Choice at End of Life Act requires that the physician not write the prescription until at least 48 hours "after the last to occur" whether that is the patient's written request or the patient's second oral request.[96] Therefore, the minimum total waiting period in Vermont is 17 days. This is the second longest mandatory waiting period after Hawaii's 20 days.

Route of Drug Administration: GI or IV?

MAID statutes vary not only on the duration of oral and written request waiting periods but also in exactly how the patient can take the prescription drug. Every MAID statute requires that the patient herself take the lethal medication. The patient must take the final overt act causing her death. Accordingly, the California End of Life Options Act requires that the patient "has the physical and mental ability to self-administer the aid-in-dying drug."[97] After all, nobody else may administer it to her or for her.[98]

If the physician or another individual administered the lethal medication to the patient, that would be euthanasia.[99] That is not permitted in any U.S. jurisdiction. Legalizing euthanasia has not even been proposed in any U.S. jurisdiction for over thirty years.[100] Self-administration is a consistent centerpiece of U.S. MAID laws.[101]

But while the MAID statutes uniformly require patient self-administration, they use different verbs to describe how the patient may take the drug. Five statutes use the word

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[95] There is some variability regarding when the patient may make her written request. Most states permit it after both physicians have confirmed eligibility. New Jersey permits it at the time of the first oral request. *Id.* §§ 26:16-10(a)(3). The District of Columbia permits it between the first and second oral requests. D.C. Code § 7-661.02(a)(2).

[96] Vt. Stat. Ann. tit. 18, § 5283(a)(12).

[97] Cal. Health & Safety Code § 443.2(a)(5).

[98] Confusingly, the term "MAID" in Canada refers to both patient self-administration and to clinician administration (euthanasia). *See* S.C. 2016, C-14 (Can.), https://laws-lois.justice.gc.ca/PDF/2016_3.pdf.

[99] Compassion in Dying v. Wash., 79 F.3d 790, 840 (9th Cir. 1996) (Beezer, J., dissenting) ("Euthanasia occurs when the physician actually administers the agent which causes death.").

[100] Pope, *supra* note 2.

[101] In contrast, Belgium, Canada, and the Netherlands also permit clinician administration. Australian jurisdictions permit clinician administration only when self-administration is not possible. *See Legislative Background: Medical Assistance in Dying (Bill C-14, as Assented to on June 17, 2016)*, Can. Dep't of Justice, https://www.justice.gc.ca/eng/rp-pr/other-autre/adra-amsr/toc-tdm.html (last modified Jan. 23, 2017).

"ingest."[102] California, for example, requires that the individual "self-administer" the drug which means the "individual's affirmative, conscious, and physical act of administering and ***ingesting*** the aid-in-dying drug to bring about his or her own death."[103] Indeed, the California's End of Life Option Act (EOLOA) uses the term "ingest" fifteen times to refer to the manner by which the patient must take the drug.[104]

This language is legally and practically significant. The term "ingest" indicates that the route of administration is gastrointestinal.[105] This usually means the patient will drink the medication from a cup or straw.[106] But some patients cannot consume the medication orally. Fortunately, for them, there are two other ways to "ingest" drugs. Patients dependent upon clinically assisted nutrition and hydration can press a plunger on a feeding tube.[107] Other patients can press the plunger on a rectal tube.[108]

With any of these three modes of ingestion, clinicians or family members can assist the patient (for example, by opening the medication, by mixing it in a cup, or by inserting a tube), but the patient herself must make the drug enter her body. The California End of Life Options Act emphasizes the distinction between preparing the drug and ingesting the drug. "A person who is present may, without civil or criminal liability, ***assist*** the qualified individual by ***preparing*** the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug."[109] Without this language, preparing the drugs would probably constitute felony assisted suicide.[110]

The remaining four states do not use the word "ingest." Instead, they use broader language like "take"[111] "administer"[112] or "self-administer."[113] Again, this language is legally and practically

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[102] End of Life Option Act, CAL. HEALTH & SAFETY CODE § 443.1(p); Death with Dignity Act of 2016, D.C. CODE §§ 7-661.05(f) & (h)–(i), .09(b), .12, .13(b) (2020); Oregon Death with Dignity Act, OR. REV. STAT. § 127.875 (2020); Maine Death with Dignity Act, ME. REV. STAT. ANN. tit. 22, § 2140(2)(L) (2020); Washington Death with Dignity Act, WASH. REV. CODE § 70.245.010(12) (2020).

[103] CAL. HEALTH & SAFETY CODE § 443.1(p) (emphasis added).

[104] *Id. passim.*

[105] United States v. Ten Cartons, 888 F. Supp. 381, 393–94 (E.D.N.Y. 1995), *aff'd*, 72 F.3d 285 (2d Cir. 1995).

[106] This is usually a powder mixed with liquid. David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259 (2016); McGehee v. Hutchinson, No. 4:17-cv-00179, ¶ 310 (E.D. Ark. May 31, 2020).

[107] *Id.* ¶ 309.

[108] Email from Kimberly Kirchmeyer, Executive Director of the Medical Board of California, to Gary Johanson, MD (Sept. 6, 2016); Thalia DeWolf, *Rectal Administration of Aid-in-Dying Medications*, AM. CLINICIANS ACAD. ON MED. AID IN DYING, https://www.acamaid.org/rectal-administration-of-aid-in-dying-medications/ (last visited Sept. 14, 2020).

[109] CAL. HEALTH & SAFETY CODE § 443.14(a) (emphasis added).

[110] *See* CAL. PENAL CODE § 401 (2020) ("Any person who deliberately aids . . . another to commit suicide is guilty of a felony.").

[111] Our Care, Our Choice Act, HAW. REV. STAT. § 327L-1 (2020) (defining "self-administer" to means an "individual performing an affirmative, conscious, voluntary act to ***take into the individual's body*** prescription medication to end the individual's life") (emphasis added).

[112] Medical Aid in Dying for the Terminally Ill Act, N.J. STAT. ANN. §§ 26:16-3 (2020).

[113] Colorado End-of-life Options Act, COLO. REV. STAT. § 25-48-102(7), (15) (2020); VT. STAT. ANN. tit. 18, § 5284 (2020).

significant. These verbs permit routes of administration other than gastrointestinal.[114] Most notably, these other statutes permit intravenous administration. So, rather than having to administer the medication through the gut, the patient can inject it with a needle into a vein.[115]

This is important for two reasons. First, some patients cannot effectively take the drugs through a gastrointestinal route.[116] They may have a bowel obstruction, poor absorption, or uncontrolled vomiting. While ingestion may be possible it is not as effective as intravenous administration, especially for these patients.[117] Second, intravenous administration is safer and faster. The rate of complications (like regurgitation) from ingestion is significant in "ingest only" states like Oregon.[118] These complications could be substantially reduced with intravenous administration.[119]

Furthermore, IV administration is workable. Patients self-administer antibiotics and other medications through IV at home.[120] Evidence on this practice shows that home IV therapy is

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[114] *See, e.g.,* Texas Controlled Substances Act, Tex. Health & Safety Code § 481.002 (2020) (defining 'administer" to include "injection, inhalation, ingestion, or other means").

[115] Bettie Lilley Nosek & Deborah Trendel-Leader, IV Therapy For Dummies (2012). Note that intravenously administered medication would not be the same medication as that which patients orally ingest. Indeed, U.S. clinicians have not yet worked out protocols and procedures for IV self-administration.

[116] *Hearing on H.B. 2217 Before the S. Comm. on Judiciary* (Ore. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198434 (statement of Charles Blanke); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 426 (1994).

[117] H.B. 2217, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2217/A-Engrossed (hearing on May 19, 2019). *See also* Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 43 (2020) (noting that 9 of 52 people to receive MAID in Victoria needed clinician administration because self-administration was not possible).

[118] Oregon Health Auth., Public Health Div., Oregon Death with Dignity Act: 2019 Data Summary 11 (2020), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf; Washington State Department of Health, 2018 Death with Dignity Act Report 13 (July 2019), https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf. These problems were anticipated from the beginning. *See, e.g.,* Timothy Egan*, Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. Times (Nov. 25, 1994), at A1. They even threatened to cause the repeal of the Oregon Death with Dignity Act in 1997. *See, e.g.,* H.B. 2954 (Or. 1997); *Basics on Ballot Measure 51*, Or. Legis. Pol'y & Res. Off. (1997), https://digital.osl.state.or.us/islandora/object/osl%3A4732/datastream/OBJ/view.

[119] Notably, in jurisdictions where both MAID and euthanasia are available, almost no patients use MAID. Health Can., Fourth Interim Report on Medical Assistance in Dying in Canada (2019), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf. In those rare cases when ingestion is used, Canadian clinicians are prepared to offer "IV rescue" as a backup in case oral self-administration is unsuccessful. Christopher Harty et al., Canadian Ass'n of MAiD Assessors & Providers, The Oral MAiD Option in Canada: Part 1: Medication Protocols: Review and Recommendations (2018).

[120] *See generally* Antonella Tonna et al., *Home Self-Administration of Intravenous Antibiotics As Part of an Outpatient Parenteral Antibiotic Therapy Service: A Qualitative Study of the Perspectives of Patients Who Do Not Self-Administer*, 9 BMJ Open 1 (2019), https://bmjopen.bmj.com/content/bmjopen/9/1/e027475.full.pdf; Deepak Agrawal et al., *Patients Welcome IV Self-Care; Physicians Hesitate*, NEJM Catalyst (Dec. 6, 2017); Elizabeth D. Mitchell et al., *Clinical and Cost-Effectiveness, Safety and Acceptability of Community Intravenous Antibiotic Service Models: CIVAS Systematic Review*, 7 BMJ Open 1 (2017), https://bmjopen.bmj.com/content/bmjopen/7/4/e013560.full.pdf.

safe and cost-effective. Consequently, hospitals are increasingly discharging patients with prescriptions for home IV medications.[121] Still, many physicians are uncomfortable with allowing patients to self-administer IV medications. So, the practice is not yet widespread.[122]

Even with MAID specifically there are precedents for patient intravenous self-administration. Physician advocates Jack Kevorkian and Phillip Nitschke created mechanical devices and used them with patients.[123] Note that while Kevorkian set up the IV line for his first patient, "Mrs. Adkins was the one who pushed the button, which began the flow of pain killer and potassium chloride into her system."[124]

Some object that intravenous administration is prohibited even in states that use broad language to define the permissible routes of drug administration.[125] They point to the following language in every MAID statute: "Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia."[126]

However, this prohibition does not apply on its face. It does not prohibit lethal injection ***by the patient***.[127] The prohibitory language proscribes only lethal injection by "a physician or any

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[121] *Discharge Instructions: Administering IV Antibiotics,* Fairview, https://www.fairview.org/patient-education/86488 (last visited Sept. 15, 2020).

[122] Kavita P. Bhavan et al., *Achieving the Triple Aim Through Disruptive Innovations in Self-Care* 316 JAMA 2081 (2016).

[123] Nicole Goodkind, *Meet the Elon Musk of Assisted Suicide, Whose Machine Lets You Kill Yourself Anywhere*, Newsweek (Dec. 1, 2017 8:00 AM), https://www.newsweek.com/elon-musk-assisted-suicide-machine-727874; George J. Annas, *Physician Assisted Suicide: Michigan's Temporary Solution*, 328 New Eng. J. Med. 1573 (1993). Gary Schnabel, a pharmacist with the Oregon Board of Pharmacy, also developed a device. Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997).

[124] Jennifer Zima, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needs*, 23 Rutgers L.J. 387, 387 n.4 (1992). *See also* Susan Clevenger, Dying to Die - The Janet Adkins Story: A True Story of Dying with the Assistance of Doctor Jack Kevorkian (2019).

[125] Personal communications to author after NCCMAID. Lethal injection was proposed and rejected in early MAID bills and ballot initiatives. Pope, *supra* note 2. However, that was lethal injection by the clinician, not by the patient. *See, e.g.,* Washington Physician-Assisted Death, Initiative 119 (1991).

[126] End of Life Option Act, Cal. Health & Safety Code § 443.18 (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-121 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.15(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-18(a) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(20); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-15(a) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.880 (2020); Vt. Stat. Ann. tit. 18, § 5292 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.180(1) (2020).

[127] Pamela S. Kaufmann, Death with Dignity: A Medical-Legal Perspective, AHLA Long-Term Care and the Law Meeting (Feb. 22, 2017); Council on Psychiatry and Law, APA Resource Document on Physician Assisted Death 8 (2017) (interpreting the "other" as a third person). The language of the prohibition may also not extend to intravenous "infusion" into the blood which is distinct from "injection" which may be intermuscular or subcutaneous.

other person." It references "the individual" as the subject of the injection but not as the agent of the injection.[128] Therefore, this prohibitory language is irrelevant to self-administered MAID.

Legislative history confirms this reading. This "lethal injection" language originated with the 1994 Oregon Death with Dignity Act. The voter pamphlet for the ballot initiative included this language indented under a bold heading that stated: "Under Measure 16, only the dying person may self-administer the medication."[129] This clarifies that "lethal injection" was focused on the agent of administration and not the manner of administration.

An even broader look at the legislative history confirms this. Before 1994, bills and ballot initiatives aimed to legalize both MAID and euthanasia.[130] Those efforts failed because having the physician be the final agent was comparatively more controversial. Therefore, reform efforts since 1994 have focused only on MAID.[131] In short, the point of the prohibition was to authorize MAID yet prohibit euthanasia.[132]

Self-administered IV MAID is consistent with this requirement. It changes only the route of administration, not the agent of administration. The patient ***herself*** pushes the lethal medication. The patient herself causes the "lethal injection." With self-administered IV MAID, the physician only establishes the intravenous line. This is analogous to a third person preparing the medication that the patient then drinks herself.[133] As a recent government report describes it, "the person who provides the assistance, such as a relative or doctor, does not perform the final act that causes the death. The death is caused by the person themselves."[134]

This has already been judicially tested. In December 1990, a Michigan court dismissed criminal charges against Jack Kevorkian for assisting in the death of Janet Adkins. While

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[128] Contrast a new law in Victoria, Australia that permits physician administration when the patient cannot self-administer. That changes not only the *route* of administration but also *who* administers the lethal medication. Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020), http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/06/02-WHITE-ET-AL.pdf.

[129] State of Or. Sec'y of State, Voter's Pamphlet 127 (1994) (although the booklet also says the Measure does not allow "suicide machines").

[130] *See, e.g.,* Initiative 119 (Wash. 1991); S.B. 1141 (Or. 1991); Proposition 161 (Cal. 1992); Allan Parachini, *Bringing Euthanasia Issue to the Ballot Box: Group Sponsors State Initiative to Legalize 'Physician-Assisted Suicide'* , L.A. Times (Apr. 10, 1987), https://www.latimes.com/archives/la-xpm-1987-04-10-vw-165-story.html.

[131] Timothy E. Quill et al., *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

[132] Several authors of the Oregon Death with Dignity Act opined that it did not prohibit self-administered IV MAID. *See, e.g.,* Mark O'Keefe & Tom Bates, *Hearings Reveal Confusion about Committing Suicide*, Oregonian (Mar. 15, 1997) ("Peter Goodwin . . . a co-author of Measure 16, said, 'My own belief is that medication would cover intravenous medication.'"'); Mark O'Keefe, *House Takes Up Assisted Suicide*, Oregonian (May 13, 1997) ("Cheryl Smith, who helped write Measure 16 . . . said, `I believe that Measure 16 allows a machine like Kevorkian's.'"). There were later extensive hearings about routes of administration. H.B. 2954 (Or. 1997).

[133] *Cf.* Baxter v. State, 224 P.3d 1211, 1217 (Mont. 2009) ("[A] physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision").

[134] Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 12 (2020).

Michigan has not affirmatively authorized MAID, it had not yet prohibited it. The court explained that "Mrs. Adkins was the proximate cause of her own death."[135] For the same reason, other Michigan courts dismissed charges against Kevorkian in the deaths of Shery Miller and Marjorie Wantz.[136]

The prohibition on lethal injection is written to require self-administration and thereby prohibit euthanasia. It does not address the route of administration.[137] MAID statutes are silent as to the specific means of self-administration. Consequently, commentators have concluded that despite the prohibition on "lethal injection," "self-administered lethal intravenous infusion . . . may not be prohibited."[138] It is permissible if the patient "pushes a switch to trigger a fatal injection after the doctor has inserted an IV needle."[139]

Furthermore, we can look to Swiss law for guidance. Like U.S. MAID laws, Swiss law requires self-administration. "The final action in the process leading to death must always be performed by the patient."[140] Swiss providers have reconciled this self-administration requirement with IV administration. They openly and regularly have patients administer MAID through IV drips.[141] Some have even developed an "easy to handle remote control" that the patient can "activate through a small movement (e.g. a finger, toe, or jaw) to start the

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[135] George J. Annas, *Physician Assisted Suicide -- Michigan's Temporary Solution*, 20 Ohio N.U. L. Rev. 561 (1993-1994); People v. Kevorkian, No. CR-92-115190 (Mich. Cir. Ct. Oakland Cnty. July 21, 1992).

[136] *Michigan v. Kevorkian*, 9 Issues L. & Med. 189, 200 (1993) ("Ms. Miller pulled the screwdriver which caused the flow of carbon monoxide to commence . . . Ms. Miller took her own life."). *Cf.* Sanders v. State, 112 S.W. 68, 70 (Tex. Crim. App. 1908) (distinguishing furnishing poison from "placing it in the mouth or other portions of the body"), *overruled on other grounds,* 277 S.W. 1080 (Tex. Crim. App. 1925).

[137] *But see Hearing on H.B. 2217 Before the S. Judiciary Comm.*, Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/198274 (statement of Geoff Sugerman, Death with Dignity National Center).

[138] Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death with Dignity Act: Review and Proposals for Improvement*, 27 J. Legis. 269, 287 (2001), http://www.ethesis.net/cohen/Oregon.pdf.

[139] Lynn D. Wardle, *A Death in the Family: How Assisted Suicide Harms Families and Society*, 15 Ave Maria L. Rev. 43, 47 n.11 (2016-2017).

[140] Swiss Acad. of Med. Scis., *Medical-Ethical Guidelines: Management of Dying and Death*, 148 Swiss Med. Weekly w14664 § 6.2.1 (2018), https://smw.ch/article/doi/smw.2018.14664.

[141] *See, e.g., Swiss Law & Requirements*, Pegasos Swiss Ass'n, https://pegasos-association.com/requirements/ ("Pegasos offers VAD using intravenous transfusion, and even though it is a doctor who will insert the cannula into the person's arm, it is the person, themselves, who must activate the drip delivering the drug."); Dignitas, Dignitas Brochure 7 (15th ed. 2019), http://www.dignitas.ch/images/stories/pdf/informations-broschuere-dignitas-e.pdf ("In every case, for legal reasons, the patient must be able to undertake the last act . . . to open the valve of the intravenous access tube") [hereinafter Dignitas]. *See also* Luke Harding, *A Little Sightseeing, a Glass of Schnapps, then a Peaceful Death in a Suburban Flat*, Guardian (Dec. 4, 2004), https://www.theguardian.com/society/2004/dec/04/health.medicineandhealth1 (interview with Ludwig Minelli, founder of Dignitas Clinic); Susan Stefan, Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law (American Psychology-Law Society Series 190 (1st ed. 2016); Daniel Sperling, Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions 33 (2019); Queensland Parliament, Health, Cmtys., Disability Servs. & Domestic & Family Violence Prevention Comm., Rep. No. 34, 56th Parliament, Voluntary Assisted Dying 34 & n.182 (2020).

attached pump."[142] They even videotape the procedure to document that the patient opened the valve all by herself.[143] There is no legal obstacle to administering MAID the same way in Colorado, Hawaii, New Jersey, and Vermont.

OTHER VARIATIONS AMONG U.S. MAID STATUTES

We have examined five ways in which U.S. MAID statutes vary. Two concern patient eligibility requirements: (1) how to assess the patient's state residency, and (2) how to assess the patient's decision-making capacity. Three differences concern the manner of accessing MAID: (3) the duration of the oral request waiting period, (4) the duration of the written request waiting period, and (5) the permitted route of drug administration.

But the nine MAID statutes vary not only in terms of eligibility and procedural requirements but also along five other dimensions.[144] These include: (a) how clinicians can assert conscience-based objections, (b) how facilities can assert conscience-based objections, (c) whether assessment and counseling can be done through telehealth, (d) how death certificates are completed, (e) how states collect and report data, and (f) whether the statute includes a sunset clause.

Conscience-Based Objections by Clinicians

Every MAID statute makes participation voluntary not only by patients but also by clinicians and facilities.[145] Individual clinicians may assert a conscience-based or personal objection and they cannot be punished for refusing to participate.[146] This means that clinicians can refuse to discuss or educate the patient on eligibility or process. They can refuse to conduct eligibility

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[142] Dignitas, How Dignitas Works 16 (May 2014), http://www.dignitas.ch/images/stories/pdf/so-funktioniert-dignitas-e.pdf.

[143] George Mills, *What You Need to Know About Assisted Suicide in Switzerland*, Local (May 10, 2018), https://www.thelocal.ch/20180503/what-you-need-to-know-about-assisted-death-in-switzerland.

[144] There are also other variations. For example, will state Medicaid (or other insurance) pay for MAID consultations and prescriptions? Must facilities post their policies on MAID? How should patients and families dispose of unused drugs? Yet, many of these rights and obligations come from other sources of law, not from the MAID statutes themselves. *See, e.g.,* H.B. 2326, 66th Leg., Reg. Sess. (Wash. 2019), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Bills/2326-S.pdf?q=20200915125826. *But cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf.

[145] End of Life Option Act, Cal. Health & Safety Code § 443.14(e) (2020); Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-117 (2020); Death with Dignity Act of 2016, D.C. Code § 7-661.10(a) (2020); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-19(a)(2) (2020); Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(21) (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.885(2), (4) (2020); Vt. Stat. Ann. tit. 18, § 5285 (2020); Washington Death with Dignity Act, Wash. Rev. Code § 70.245.190(1)(b), (d) (2020).

[146] While physicians play a central role, MAID also involves pharmacists, non-physician mental health specialists like social workers and psychologists. Cal. Health & Safety Code § 443.1(l); Colo. Rev. Stat. § 25-48-102(6); Me. Rev. Stat. Ann. tit. 22, § 2140(2)(E) (also including clinical social workers and clinical professional counselors); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. §§ 26:16-3 (2020) (including clinical social worker).

assessments, write prescriptions, or fill prescriptions for MAID. They can even refuse to make or assist referrals to participating providers.

But the right to refuse is not unlimited. When the patient finds a new physician who is willing to participate, the original objecting physician must transfer the patient's medical records and must do that even if they think it makes them complicit in what they judge to be an immoral act.[147]

The scope of permitted refusal is narrower in Vermont. Most MAID statutes permit objecting physicians not to inform a patient regarding his or her rights and not to refer the patient to a physician who participates.[148] But Vermont has a separate end-of-life informed consent rights statute.[149] A federal court interpreted this statute to require that objecting physicians must either inform patients about their MAID rights or refer them somewhere they can learn their options.[150]

Conscience-Based Objections by Facilities

Not only individual clinicians but also health care entities assert conscience-based objections—many facilities have opted-out. For example, few religiously affiliated institutions participate with MAID.[151] But what about non-objecting individual clinicians that work for such entities (as either employees or independent contractors)? May they participate when their hospital or health care system has opted out?

MAID statutes in every state permit health care facilities to prohibit their employees and staff from participating with MAID while on the premises or while acting within the purview of the entity.[152] The general understanding has been that such clinicians may participate in MAID on their own time. In Colorado, however, a large Catholic system is litigating a claim

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[147] Cal. Health & Safety Code § 443.14(e)(3); Colo. Rev. Stat. §§ 25-48-113(2), -117; D.C. Code § 7-661.10(b); Haw. Rev. Stat. § 327L-19(a)(4); Me. Rev. Stat. Ann. tit. 22, § 2140(21); N.J. Stat. Ann. § 26:16-17(c); Or. Rev. Stat. § 127.885(4); Wash. Rev. Code § 70.245.190(1)(d).

[148] *See, e.g.,* Cal. Health & Safety Code § 443.14(e)(2).

[149] Vt. Stat. Ann. tit. 18, § 5282.

[150] Vt. All. for Ethical Health Care v. Hoser, 274 F. Supp. 3d 227 (D. Vt. Apr. 5, 2017) (citing Vt. Stat. Ann. tit. 18, § 1871 and Vt. Stat. Ann. tit. 12, § 1909(d)). *Cf.* Mara Buchbinder, *Aid in Dying Laws and the Physician's Duty to Inform,* 43 J. Med. Ethics 666 (2017).

[151] Cindy L. Cain et al., *Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California*, 179 JAMA Internal Med. 985 (2019). With mergers and consolidation, fewer health systems may participate in the future. *See* Ian D. Wolfe & Thaddeus M. Pope, *Hospital Mergers and Conscience-Based Objections — Growing Threats to Access and Quality of Care,* 382 New Eng. J. Med. 1388 (2020); Harris Meyer, *Proposed Virginia Mason-CHI Franciscan Merger Increases Worry about Catholic Limits on Health Care in Washington State*, Seattle Times (Aug. 3, 2020, 8:24 AM), https://www.seattletimes.com/seattle-news/health/proposed-virginia-mason-chi-franciscan-merger-increases-worry-about-catholic-limits-on-health-care-in-washington-state/.

[152] Cal. Health & Safety Code §§ 443.15–.16; Colo. Rev. Stat. § 25-48-118; D.C. Code § 7-661.10(c)-(e); Haw. Rev. Stat. § 327L-19(b)–(e); Me. Rev. Stat. Ann. tit. 22, § 2140(22); Or. Rev. Stat. § 127.885(5); Vt. Stat. Ann. tit. 18, § 5286; Wash. Rev. Code § 70.245.190(2). The New Jersey statute does not contain this language.

that it can prohibit its physicians from participating in MAID even when they act outside the purview of their employment.[153]

Telehealth Assessment and Counseling

Particularly since the COVID-19 pandemic, there has been an increased interest in and use of telehealth.[154] This includes MAID.[155] Indeed, a new professional society, the American Clinicians Academy on Medical Aid in Dying (ACAMAID) released guidance on how to provide MAID through telehealth.[156]

The Hawaii MAID statute addresses telehealth explicitly in the context of the mental health counseling. This is the third clinical assessment for determining that the patient is capable and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with her ability to make an informed decision.[157] The Hawaii law states that these mental health consultations with a psychiatrist, psychologist, or clinical social worker "may be provided through telehealth."

But what about the attending and consulting physician who assess terminal illness and capacity?[158] No U.S. MAID statute specifically says that may be done by telehealth, and none specifically prohibits it. Consequently, one might conclude that clinicians may provide MAID through telehealth to the same extent as they can provide other health care services through telehealth.

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[153] Morris v. Centura Health Corp., No. 2019-CV-31980 (Arapahoe Cnty. Dist. Ct., Colo., Dec. 20, 2019). Relatedly, the U.S. Supreme Court is hearing a case that questions the thirty-year old rule that government can enforce laws that burden religious beliefs or practices as long as the laws are "neutral" or "generally applicable." Fulton v. City of Phila., Pa., No. 19-123 (U.S. Nov. 4, 2020) (oral argument). Federal regulations may permit an even broader scope of conscience-based refusal. Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88). These regulations have been enjoined and those injunctions are on appeal. New York v. U.S. Dept. Health & Human Servs., No. 19-4254 (2d Cir. 2020); City and County of San Francisco v. Azar, No. 20-35044 (9th Cir. 2020).

[154] Cathleen Calhoun, *Strategic Perspectives: Telehealth Has Taken a Giant Step Forward, But Will the Momentum Continue?*, WOLTERS KLUWER HEALTH L. DAILY (May 20, 2020).

[155] *See* Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 HEALTH MATRIX 325 (2020), https://scholarlycommons.law.case.edu/cgi/viewcontent.cgi?article=1650&context=healthmatrix.

[156] Comm. to Evaluate Telemedicine for Aid-in-Dying Requests in the Context of the Coronavirus Epidemic, *Telemedicine Policy Recommendations*, AM. CLINICIANS ACAD. ON MED. AID IN DYING (Mar. 25, 2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf. Medical licensing boards in other jurisdictions have also issued telehealth guidance during the COVID-19 pandemic. *See, e.g.,* COLL. OF PHYSICIANS & SURGEONS OF N.S., TEMPORARY AMENDMENTS TO THE COLLEGE'S MAID STANDARD (2020), https://cpsns.ns.ca/wp-content/uploads/2020/09/Medical-Assistance-in-Dying-Standard-Temporary-Amendment-Mar-27-2020-Sept-18-2020.pdf; College of Physicians and Surgeons of British Columbia, *Practice Standard: Medical Assistance in Dying* (Mar. 26, 2020).

[157] HAW. REV. STAT. § 327L-1.

[158] *Cf.* S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf (allowing telehealth for all clinicians when the patient is unable to leave her residence).

On this analysis, telehealth for MAID is not equally available in every state. For example, in Vermont, telehealth can only be provided in the context of a "[b]ona fide physician-patient relationship."[159] That requires not only assessment of the patient's medical history and current medical condition but also a "personal physical examination."[160] So, both the attending and consulting physician must have visited with the patient in person before or concurrent with providing MAID.

Other constraints may also be manageable. For example, California requires that the physician "[c]onfirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, ***outside of the presence*** of any other persons."[161] While it may be more difficult to know that the patient is alone when meeting through a phone or computer camera, the physician can confirm this by asking the patient to move the camera around the room.[162]

Death Certificate Completion

While most provisions in MAID statutes focus on how patients may obtain MAID, some provisions address what happens ***after*** MAID. One perennially controversial issue concerns whether the patient's death certificate identifies MAID as the cause of death. Here, the states take three different approaches.[163]

Four MAID statutes prohibit MAID from being listed as the cause of death on the patient's death certificate. Instead, the death certificate must list the underlying terminal illness.[164] In four other states the statute is silent, but state agency guidance directs listing the underlying terminal illness.[165] For example, the California Department of Public Health states:

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[159] Vt. Stat. Ann. tit. 18, § 5281(1) (2020).

[160] *Id.*

[161] End of Life Option Act, Cal. Health & Safety Code § 443.5(a)(4) (2020).

[162] Konstantin Tretyakov, *Medical Aid in Dying by Telehealth*, 30 Health Matrix 325, 343 (2020).

[163] Canadian provinces also vary in whether they require or prohibit MAID from being listed as the cause of death. Janine Brown et al., *Completion of Medical Certificates of Death After an Assisted Death: An Environmental Scan of Practice*s, 14 Healthcare Pol'y 59 (2018).

[164] Colorado End-of-life Options Act, Colo. Rev. Stat. § 25-48-109(2) (2020); D.C. Code § 7-661.05(h); Our Care, Our Choice Act, Haw. Rev. Stat. §§ 327L-4(b) (2020); Washington Death with Dignity Act, Wash. Rev. Code §§ 70.245.040(2) (2020). Many bills in prospective MAID states also require listing the terminal illness. *See, e.g.,* A.B. 2694 § 2899-p, Reg. Sess. (N.Y. 2019), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A02694&term=2019&Summary=Y&Text=Y.

[165] New Jersey Medical Aid in Dying for the Terminally Ill Act Frequently Asked Questions 3–4 (July 31, 2019), https://www.state.nj.us/health/advancedirective/documents/maid/MAID_FAQ.pdf ("NJDOH Office of Vital Statistics and Registry recommends that providers record the underlying terminal disease as the cause of death and mark the manner of death as 'natural'."); Or. Health Auth., *Frequently Asked Questions: Oregon's Death with Dignity Act (DWDA),* Oregon.gov, https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx#deathcert (last visited Sept. 14, 2020) (same); Vt. Dep't of Health, Report to the Vermont Legislature: Report Concerning Patient Choice at the End of Life 4 (2018), https://legislature.vermont.gov/assets/Legislative-Reports/2018-Patient-Choice-Legislative-Report-12-14-17.pdf ("100% of the death certificates listed the appropriate cause (the underlying disease) and manner of death (natural), per Act 39 requirements.").

"Certifiers . . . report the underlying terminal disease as the cause of death on the death certificates. This approach complies with applicable law . . . and effectuates the California Legislature's intent to maintain the confidentiality of individuals' participation in the Act."[166] Only Maine offers no guidance on whether to list MAID on the patient's death certificate.[167]

Data Collection and Reporting

Conscience-based objection and telehealth affect how patients access MAID, but the states also vary in how they collect and report data. Every MAID statute requires that state agencies publish annual reports on usage.[168] The data reports from the first two states (Oregon and Washington) demonstrate a strong safety record that paved the way for enactment of legislation in the subsequent seven states.[169]

But the states vary in terms of what information they collect and report.[170] Oregon and Washington collect and report the broadest range of data. California does less.[171] Colorado, Vermont, and Washington, DC collect and report the least.[172] This variability is unfortunate, because reform is more difficult when one knows less about how the law is working.[173]

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[166] Cal. Dep't of Public Health, California End of Life Option Act 2019 Data Report 5 (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf. *But see Document #3459: The California End of Life Option Act* ¶ 26, CMA Legal Counsel (2016), https://www.uclahealth.org/workfiles/eol/cma-guidance-end-of-life-option-act-on-call.pdf (directing physicians to list the cause "they feel is the most accurate").

[167] Maine legislation originally followed the approach taken in Colorado, DC, Hawaii, and Washington, but as in California and Vermont, that was amended in later versions of the bill.

[168] End of Life Option Act, Cal. Health & Safety Code §§ 443.9, .19 (2020); Colo. Rev. Stat. § 25-48-111(2); D.C. Code § 7-661.07; Haw. Rev. Stat. §§ 327L-14, -25; Maine Death with Dignity Act, Me. Rev. Stat. Ann. tit. 22, § 2140(17) (2020); Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-13 (2020); Oregon Death with Dignity Act, Or. Rev. Stat. § 127.865 (2020); Wash. Rev. Code § 70.245.150.

[169] N.J. Stat. Ann. § 26:16-2(b). Oregon and Washington data were also important to reform in jurisdictions around the world. *See, e.g.,* Carter v. Canada (Attorney General), 2013 BCCA 435, https://www.canlii.org/en/bc/bcca/doc/2013/2013bcca435/2013bcca435.html.

[170] Jean T. Abbott et al., *Accepting Professional Accountability: A Call for Uniform National Data Collection on Medical Aid-In-Dying*, Health Aff. Blog (Nov. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171109.33370/full/ [hereinafter Abbott et al.]. This study was published before Maine and new Jersey enacted their statutes, but that would not change the analysis, although the state agencies could promulgate regulations that promote the collection ad reporting of broader data. *See* Me. Rev. Stat. Ann. tit. 22, § 2140(17); N.J. Stat. Ann. § 26:16-13.

[171] But in addition to the annual DOH reports, the California Assembly holds periodic hearings on the implementation of the EOLOA. *See, e.g.,* Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video.

[172] Abbott et al.

[173] *See* Thaddeus M. Pope, *Extrajudicial Resolution of Medical Futility Disputes: Key Factors in Establishing and Dismantling the Texas Advance Directives Act*, *in* International Perspectives on End of Life Reform: Politics, Persuasion, and Persistence (Ben White & Lindy Wilmott eds., forthcoming 2021); Health Canada, First Annual Report on Medical Assistance in Dying in Canada, 2019 9 (2020), https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf ("Nearly all countries that permit some form of medically assisted dying consider public reporting to be a critical component to support transparency and foster public trust in the application of the law.").

Sunset Clauses

The future of most MAID statutes has been threatened by litigation or legislation.[174] But as enacted, those laws were intended to be permanent options. None was enacted on a trial or pilot basis.[175]

In contrast, when California enacted its End of Life Option Act during an extraordinary legislative session in October 2015, it included a sunset clause.[176] "This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date."[177] Unlike other MAID statutes, the EOLOA expires.[178] Therefore, unless reauthorized, MAID will cease to be a legal practice in California.[179]

FORTHCOMING VARIATIONS

The previous sections described current differences among U.S. MAID laws, but the variability will likely continue to grow as states continue studying "barriers to access."[180] Many are already seeking to recalibrate the balance between safety and access.[181]

Two aspects of MAID laws are especially primed for change: scope of practice and terminal illness. The states are currently uniform in permitting only physicians to provide

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[174] *See, e.g.,* Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal.), https://compassionandchoices.org/legal-advocacy/recent-cases/ahn-v-hestrin/; Glassman v. Grewal, No. MER-C-53-19 (Mercer Cnty. Sup. Ct., NJ), https://compassionandchoices.org/legal-advocacy/recent-cases/glassman-v-grewal/.

[175] While the Vermont statute's legalization of MAID was permanent, the procedural safeguards were initially designed to sunset. *See* ALAN MEISEL ET AL., THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 12.05 (3rd ed. 2020).

[176] A.B. 15 (Cal. 2015), codified at End of Life Option Act, CAL. HEALTH & SAFETY CODE §§ 443 to 443.22 (2020). The law went into effect on June 9, 2016.

[177] CAL. HEALTH & SAFETY CODE § 443.215.

[178] *Id.*

[179] Without the EOLOA, MAID would be a felony in California. CAL. PENAL CODE § 401(a) (2020) (Any person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.").

[180] H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915155130 (passed both chambers but vetoed on April 3, 2020 because of COVID-19); Cal. State Assembly, Assembly Select Committee on End of Life Health Care, Tuesday, February 25th, 2020, https://www.assembly.ca.gov/media/assembly-select-committee-end-life-health-care-20200225/video. *See also* Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417, 442–43 (2020) (noting that many patients "find the process overwhelming and too difficult to navigate" and that "few medical practitioners will agree to be involved"); Rosalind McDougall & Bridget Pratt, *Too Much Safety? Safeguards and Equal Access in the Context of Voluntary Assisted Dying Legislation*, 21 BMC MED. ETHICS 1 (2020), https://bmcmedethics.biomedcentral.com/track/pdf/10.1186/s12910-020-00483-5 (arguing that aiming to maximize safety has negative implications for access).

[181] Not every new bill seeks to expand access. For example, one of the newer MAID statutes, in Hawaii, added or increased several procedural requirements. Buchbinder & Pope, *supra* note 83. More recently, a Maryland bill would have significantly constrained access. Md. S.B. 311 / H.B. 399 (2019). On the other hand, states can also expand access through non-legal means like public education and provider outreach.

MAID. However, some states are likely to allow APRNs to provide MAID. The states are also currently uniform in how they define terminal illness, but some states are likely to define terminal illness more broadly than a six-month prognosis. The states may also diverge along several other dimensions.

Scope of Practice: MD or APRN?

Every U.S. MAID statute now requires that both the attending and the consulting clinician (who assesses eligibility, provides counseling, and writes the prescription) be a physician. While most statutes are more flexible about who can perform the mental health assessment (*e.g.* clinical social worker or psychologist), none permit a non-physician to otherwise determine eligibility or write the prescription.

But limiting MAID to physicians constrains access to MAID, especially in rural areas where there is a shortage of physicians. In response, some states have proposed legislation that would allow APRNs to perform these tasks.[182] Already, 6% of MAID in Canada is performed by APRNs,[183] and this makes sense. Across the United States, many states have already expanded scope of practice to permit APRNs to assess capacity and write POLST orders regarding life-sustaining treatment.[184]

Terminal Illness: Six Months or Longer

Every U.S. statute now requires that the patient have a terminal illness. This is typically defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[185] Both the attending and consulting physician must certify a prognosis that the patient has a terminal disease that will cause her death within six months.

At first glance, the six-month prognosis seems reasonable. It aligns with the eligibility for hospice under Medicare.[186] Hospice, a program of care and support for people who are

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[182] S.B. 2582, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB2582_SD1_.pdf; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf; H.B. 171, Reg. Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/house/HB0171.pdf (also extending to physician assistants); S.B. 252, 53rd Leg., 1st Sess. (N.M. 2017), https://www.nmlegis.gov/Sessions/17%20Regular/bills/senate/SB0252JUS.pdf (same); A.B. 10059 (N.Y. 2016), https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A10059&term=2015&Summary=Y&Text=Y. MN. *See also* Western Australia Voluntary Assisted Dying Act of 2019 § 54(1)(a), http://www.austlii.edu.au/cgi-bin/viewdb/au/legis/wa/consol_act/vada2019302/. *See also Testimony in SUPPORT of HB 2451 RELATING TO HEALTH* Before the H. Comm. on Health (Haw. 2020); *Testimony in SUPPORT of SB 2582 RELATING TO HEALTH Before the S. Comm. on Commerce, Consumer Protection, & Health* (Haw. 2020).

[183] James Downar et al., *Early Experience with Medical Assistance in Dying in Ontario, Canada: A Cohort Study,* 192 Canadian Med. Ass'n J. E173 (2020).

[184] Alan Meisel et al., The Right to Die: The Law of End-of-Life Decisionmaking § 7.10A (3rd ed. 2020).

[185] Our Care, Our Choice Act, Haw. Rev. Stat. § 327L-1 (2020).

[186] 42 C.F.R. §§ 418.3, .20 (2020).

terminally ill, focuses on comfort (palliative care) rather than curing illness. Because there are over 4000 hospices used by more one million patients each year, this six-month terminal illness requirement is familiar and salient.[187]

But the six-month requirement has been a big limit on MAID access.[188] Among other things, it wrongly assumes that life expectancy can always be accurately predicted.[189] The arbitrary time scale has meant that patients with cancer are the primary users of MAID. While cancer deaths comprise just 20% of total deaths, cancer accounts for 80% of MAID. Canadian studies have found that an even more flexible standard substantially limits access.[190]

In response, current MAID states have sought to amend their statutes to relax the temporal limit.[191] For example, Oregon has considered bills to extend the terminal illness requirement from six months to ***twelve months***.[192] Bills in other states go even further, eliminating the temporal requirement altogether. For example, a New Mexico bill defines terminal illness as a "disease or condition that . . . will result in death ***within a reasonable time***."[193] Such a standard has proven workable in Canada for years.[194]

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[187] *National Center for Health Statistics*: *Hospice Care,* CDC, https://www.cdc.gov/nchs/fastats/hospice-care.htm (last visited Sept. 15, 2020).

[188] QUEENSLAND PARLIAMENT, HEALTH, CMTYS., DISABILITY SERVS. & DOMESTIC & FAMILY VIOLENCE PREVENTION COMM., REP. NO. 34, 56TH PARLIAMENT, VOLUNTARY ASSISTED DYING 120 (2020); Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020).

[189] *See* ALL-PARTY PARLIAMENTARY GRP. FOR TERMINAL ILLNESS, SIX MONTHS TO LIVE?: REPORT OF THE ALL-PARTY PARLIAMENTARY GROUP FOR TERMINAL ILLNESS INQUIRY INTO THE LEGAL DEFINITION OF TERMINAL ILLNESS (2019), https://www.mariecurie.org.uk/globalassets/media/documents/policy/appg/all-party-parliamentary-group-for-terminal-illness-report-2019.pdf.

[190] Truchon v. Procureur Général du Canada, 2019 QCCS 3792, https://www.canlii.org/fr/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html [hereinafter Truchon].

[191] H.B. 2419, Reg. Sess. (Wash. 2020), http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/House%20Passed%20Legislature/2419-S.PL.pdf?q=20200915162544 (commissioning a study on barriers to access).

[192] H.B. 2232, 80th Leg. Assemb., Reg. Sess. (Or. 2019), https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/HB2232/Introduced [hereinafter Or. H.B. 2232].

[193] H.B. 171 § 2(F), 53rd Leg., 1st Sess. (N.M. 2017) (emphasis added).

[194] *Truchon*, *supra* note 190. Even though this is a comparatively flexible standard compared to the U.S. terminal illness requirement, the Quebec court held it unconstitutional, since it is more restrictive than the Supreme Court of Canada judgment that declared a right to MAID.

Other Future Variations

Variability along other dimensions is not as likely as variability in terms of scope of practice and terminal illness. However, there are ongoing academic and policy debates concerning whether MAID should be available: (1) to mature minors,[195] (2) through advance requests,[196] and (3) through third party administration.[197]

CONCLUSION

Medical aid in dying is a legal end-of-life option for one in four Americans. It is, however, one of the most heavily regulated health care services. The scope and manner of that regulation already varies materially across the eleven U.S. MAID jurisdictions. As more states enact MAID statutes and as current states amend their existing statutes, variability is likely to increase. Innovation and non-conformity are positive developments. States considering reform are now less likely to blindly copy and paste older statutes and more likely to engage in "critical review."[198]

In 1997, the U.S. Supreme Court observed: "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[199] More than two decades later, the debate is continuing. Innovation is continuing in the "laboratory of the states."[200] Over the next five years, we will see more states legalize MAID.[201] We will also see more differences among MAID states as some move to recalibrate the balance between access and safety.

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[195] Council of Canadian Acads., The State of Knowledge on Medical Assistance in Dying for Mature Minors: The Expert Panel Working Group on MAID for Mature Minors (2018), https://cca-reports.ca/wp-content/uploads/2018/12/The-State-of-Knowledge-on-Medical-Assistance-in-Dying-for-Mature-Minors.pdf .

[196] S.B. 893, 79th Leg. Assemb., Reg. Sess. (Or. 2017), https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB893/Introduced [hereinafter Or. S.B. 893]; S.B. 3047, 30th Leg. (Haw. 2020), https://www.capitol.hawaii.gov/session2020/bills/SB3047_.pdf. *See also* Council of Canadian Acads., The State of Knowledge on Advance Requests for Medical Assistance in Dying: The Expert Panel Working Group on Advance Requests for MAID (2018), https://cca-reports.ca/wp-content/uploads/2019/02/The-State-of-Knowledge-on-Advance-Requests-for-Medical-Assistance-in-Dying.pdf. *Cf.* Nicholas Goldberg, *California's Aid in Dying Law is Working: Let's Expand It to Alzheimer's Patients*, LA Times (July 15, 2020); Elie Isenberg-Grzeda et al., *Legal Assistance in Dying for People with Brain Tumors,* Annals Palliative Med. 1, 4 (2020), http://apm.amegroups.com/article/view/48382/pdf ("Patients with neurologic disease . . . sought MAID earlier in their illness trajectory than if the law allowed for an advanced directive to choose MAID.").

[197] *See, e.g.,* Or. S.B. 893 (2017) (allowing request by agent); Or. H.B. 2232 (2019) (changing definition of "self-administration").

[198] Ben P. White et al., *Does the Voluntary Assisted Dying Act 2017 (Vic) Reflect Its Stated Policy Goals?*, 43 UNSW L.J. 417 (2020); Taimie Bryant, *Aid-in-Dying Nonprofits*, 57 San Diego L. Rev. 147, 185, 217 (2020). *Cf.* Ed Longlois, *Efforts to Expand Assisted Suicide Underway,* Catholic Sentinel (Oct. 9, 2020).

[199] Wash. v. Glucksberg, 521 U.S. 702, 735 (1997).

[200] *Id.* at 737 (O'Connor, J., concurring).

[201] These states will probably include Maryland, Massachusetts, New Mexico, and New York.

SUMMARY OF VARIATIONS AMONG MAID LAWS

	CA	CO	DC	HI	ME	NJ	OR	VT	WA
Indicia of residency	4	4	16	4	9	4	4	4	3
Minimum capacity assessments	2	2	2	3	2	2	2	2	2
Minimum total waiting period (days)	15	15	15	20	15	15	0	17	15
Route of administration	GI	Any	GI	GI	Any	Any	GI	Any	GI
Conscience based objection by clinicians	B	B	B	B	B	B	B	N	B
Conscience based objection by institutions	B	XB	B	B	B	B	B	B	B
Death certificate	TI	TI	TI	TI	MAID	TI	TI	TI	TI
Data collection & reporting	B	N	N	M	TBD	TBD	B	N	B
Sunset clause	Yes	No	No	No	No	No	No	No	No

B (broad), GI (gastrointestinal), M (medium), N (narrow), X (extra)

Author Profile

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LEGAL HISTORY OF MEDICAL AID IN DYING: PHYSICIAN ASSISTED DEATH IN U.S. COURTS AND LEGISLATURES

Thaddeus Mason Pope*

TABLE OF CONTENTS

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I. INTRODUCTION

Terminally ill patients in the United States have four medical options for controlling the time and manner of their death.[1] Three of these are legally available to certain clinically qualified patients. First, all patients may withhold or withdraw life-sustaining treatment. Second, all patients may voluntarily stop eating and drinking. Third, patients with intractable suffering may receive palliative sedation to unconsciousness.[2] In contrast, the fourth option is available in only seven U.S. jurisdictions.[3] Only there may patients legally obtain a prescription for a lethal medication that they can later self-ingest.

Medical aid in dying (MAID) is not yet legally available in 49 of 56 U.S. jurisdictions.[4] But its legal status has been in a state of rapid change across the country over the past ten years.[5] Before 2008, MAID was legal only in Oregon. Today, it is explicitly lawful in seven U.S. jurisdictions. Moreover, the rate and pace of legalization has been accelerating. Three of the now seven MAID jurisdictions enacted their statutes within only the past two years.[6] Moreover, there are widespread and ongoing legislative and judicial efforts to legalize MAID in more than thirty other states.[7]

I have designed this Article to help inform and guide these expanding law reform efforts. Because a "page of history is worth a volume of logic,"[8] it summarizes earlier efforts (both successful and unsuccessful) to legalize MAID in the United States.[9] In other words, this Article provides a descriptive legal history. It does not normatively assess either whether any efforts to legalize MAID were good public policy. Nor does it assess whether advocates grounded their arguments on

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[1] There are also non-medical options of hastening death. *See generally, e.g.*, PHILIP NITSCHKE & FIONA STEWART, PEACEFUL PILL HANDBOOK (Exit International, 2017); Michael Majchrowicz, *The Volunteers Who Help People End Their Own Lives,* THE ATLANTIC (July 6, 2016), https://www.theatlantic.com/health/archive/2016/07/the-volunteers-who-help-people-end-their-own-lives/489602.

[2] *See, e.g.*, Thaddeus M. Pope & Lindsey Anderson, *Voluntarily Stopping Eating and Drinking: A Legal Treatment Option at the End of Life*, 17 WIDENER L. REV. 363 (2011).

[3] *See infra* Sections IV.C, IV.D, and VII.A.

[4] MAID is legal in California, Colorado, District of Columbia, Montana, Oregon, Vermont, and Washington. *See infra* Sections IV and VII.A.

[5] Other writers have described the same exit option with other terms. These terms include "physician assisted suicide," "physician assisted death," "death with dignity," "aid in dying," and "physician aid in dying." I use "MAID," because that term seems to have the most currency in the primary literature. *See, e.g., Compassion & Choices, Understanding Medical Aid in Dying,* https://www.compassionandchoices.org/understanding-medical-aid-in-dying *(last visited Jan. 31, 2017).*

[6] California legalized MAID in October 2015. Colorado legalized MAID in November 2016. Washington DC legalized MAID in 2017. *See infra* Sections IV.B and IV.C.

[7] *See infra* Section IV.E.

[8] New York Trust Co. v. Eisner, 256 U.S. 345, 349 (1921) (Holmes, J.).

[9] *Cf.* Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84 (2016) (discussing exploratory approach in addressing relevant legal pathways).

solid legal analysis. Instead, this Article offers an objective, systematic, and thorough account of what those efforts were.[10]

In Section One, I describe MAID. We must first understand what MAID is before examining attempts to legalize it. Once we grasp the nature of MAID, it starts to become clear why law reformers have concluded that they must affirmatively legalize it. In Section Two, I explain that MAID falls within the prohibitory scope of criminal assisted suicide statutes in almost every state. In other words, MAID is "assisted suicide." Assisted suicide is a crime. Therefore, MAID is a crime. Moreover, in addition to its actual legal status, MAID is widely perceived to be illegal.[11] Therefore, both patients who want to access MAID and physicians who want to provide MAID have strong incentives to change (or at least clarify) its legal status.

In the remainder of the Article, I examine five different paths that reformers have taken to legalize MAID. In Section Three, I start with the most successful approach, statutory enactment. Six states have enacted MAID statutes: three through ballot initiatives and three through legislation. I discuss these six states. I also briefly discuss a few more states that have come close to enacting MAID statutes. Furthermore, more than one-half of the remaining states have recently considered legislation. They are likely to continue this deliberation and debate throughout the 2020s.

In Section Four, I examine attempts to legalize MAID through federal constitutional litigation. Because the U.S. Supreme Court definitively rejected such arguments in 1997, advocates have since refocused their litigation arguments using state law theories. In Section Five, I review cases seeking to legalize MAID through state constitutional litigation. Unfortunately, like federal constitutional claims, state constitutional claims have also been uniformly unsuccessful.

In Section Six, I discuss attempts to legalize MAID through state statutory interpretation litigation. These lawsuits argue that MAID does not even constitute "assisted suicide" in existing criminal statutes. Finally, in Section Seven, I examine two final paths toward "legalizing" MAID: constraining prosecutorial discretion and jury nullification. Unlike other approaches, these do not change the legal status of MAID. Yet, they do change whether prosecutors will or can penalize patient or physician participants.

In sum, the expanded legalization of MAID seems inevitable. Surveys consistently show that more than 70 percent of the American public supports

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[10] This Article focuses on only affirmative efforts to legalize MAID. It does not address state efforts to criminalize MAID. *See, e.g.*, SB 202, 64th Leg., Reg. Sess. (Mont. 2015); SB 220, 63d Leg. Reg. Sess. (Mont. (2013); S.B. 167, 62d Leg., Reg. Sess. (Mont. 2011). Nor does it address federal efforts to challenge the legitimacy of state MAID statutes. *See, e.g.,* Assisted Suicide Funding Restriction Act, 42 U.S.C. § 14401 (2012): Gonzales v. Oregon, 546 U.S. 243 (2006); Assisted Suicide Prevention Act, S. 3788, 109th Cong. (2006); Pain Relief Promotion Act, H.R. 2260 & S. 1272, 106th Cong. (1999); Lethal Drug Abuse Prevention Act, H.R. 4006 & S. 2151 105th Cong. (1998).

[11] *But cf.* Kathyrn L. Tucker, *Aid in Dying: An End-of-Life Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9 (2012); Scott Foster, *Expert Panel Concurs: Hawaii Physicians Can Provide Aid in Dying*, HAWAII REPORTER (Oct. 5, 2011), http://www.hawaiireporter.com/expert-panel-concurs-hawaii-physicians-can-provide-aid-in-dying.

MAID.[12] But the battle will be fought bill-by-bill and lawsuit-by-lawsuit in each state. I hope to inform these efforts with lessons from the legal history of MAID described below.

II. WHAT IS MEDICAL AID IN DYING?

There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[13] What exactly comprises a "poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death. For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world. As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[14]

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have access to a medically supervised, peaceful death. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[15] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients hasten their deaths prematurely. Medical aid in dying (MAID) provides an alternative: the assurance that terminally ill patients can die when they want based on their own criteria and can enjoy life for a longer time.[16]

Certainly, life is valuable; and societal values reinforce attempting to extend life indefinitely. But death is unavoidable. People suffering from the diseases that cause most deaths in this country will often experience significant suffering and loss

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[12] *Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults*, COMPASSION & CHOICES, https://www.compassionandchoices.org/wp-content/uploads/2016/07/FS-Medical-Aid-in-Dying-Survey-Results-FINAL-7.21.16-Approved-for-Public-Distribution.pdf (last visited Feb. 23, 2017).

[13] *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death,* HEMATOLOGY 475, 457 (2008) ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying,* 169 ARCHIVES INTERNAL MED. 489, 489 (2009) ("One in 10 dying patients will, at some point, wish to hasten death."); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study,* 31 J. PAIN & SYMPTOM MGMT. 100, 104 (2006); J. McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. MED. ETHICS 454, 456 (2010) (finding that a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States,* 338 NEW ENG. J. MED. 1193, 1195 (1998).

[14] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

[15] Peter M. Marzuk, *Suicide and Terminal Illness,* 18 DEATH STUDIES 497, 500 (1994); Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. CLINICAL ONCOLOGY 4720, 4722 (2008).

[16] *See* STANLEY A. TERMAN, THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 326–27 (2007).

of independence.[17] In this situation, the preference, for some, may be to hasten death so that death can be on an individual's terms and with some predictability, rather than risking the unknown and potential loss of comfort and dignity.

MAID is one key "exit option."[18] With MAID, a physician writes a prescription for life-ending medication for a terminally ill and mentally capacitated adult.[19] The practice has long-standing and well-defined conditions regarding patient eligibility, the role of physicians, and the role of the patient. All six statutes have nearly identical conditions and safeguards.[20] Regarding eligibility, the patient must: (1) be over 18 years of age, (2) have decision making capacity, (3) be able to self-ingest the medication, and (4) be terminally ill, meaning that they have a prognosis of six months or less.[21]

Regarding physician practice, both the treating physician and a consulting physician must: (1) confirm that the patient satisfies all the eligibility conditions; (2) inform the patient about risks, benefits, and alternatives; and (3) confirm the patient's request for the medication is a settled and voluntary decision. If either the treating or consulting physician suspects that the patient's judgement is impaired, then they must refer the patient for a mental health assessment.[22]

Once the physician writes the prescription, the patient may obtain the medication. Traditionally, the medication has been secobarbital or pentobarbital, a barbiturate originally developed as a sleeping pill.[23] However, price increases have led physicians to prescribe other drugs including compounded ones.[24] Importantly, the patient must ingest the drugs herself.[25] The patient alone takes the final overt act that cases her death.

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[17] Judith K. Schwarz, *Stopping Eating and Drinking*, AM. J. NURSING, Sept. 2009, at 53, 54.

[18] *See* Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia, in* GIVING DEATH A HELPING HAND: PHYSICIAN-ASSISTED SUICIDE AND PUBLIC POLICY: AN INTERNATIONAL PERSPECTIVE 49 (Dieter Birnbacher & Edgar Dahl eds., 2008).

[19] David Orentlicher, Thaddeus M. Pope & Ben A. Rich, *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259 (2016).

[20] Thaddeus M. Pope, *Medical Aid in Dying: When Legal Safeguards Become Burdensome Obstacles*, THE ASCO POST (Dec. 25, 2017), http://www.ascopost.com/issues/december-25-2017/medical-aid-in-dying-when-legal-safeguards-become-burdensome-obstacles/; National Academies of Science, Engineering, and Medicine, *Physician Assisted Death: Current Landscape: Implementation and Practice*, YOUTUBE (Feb. 12, 2018), https://www.youtube.com/watch?v=yI58KsPl-HM (presentation by Thaddeus M. Pope). While Montana has no statute, the conditions and safeguards are similar.

[21] ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 12.04[C] (3d ed. 2017 Supp.) [hereinafter THE RIGHT TO DIE].

[22] *Id.*

[23] April Dembosky, *Drug Company Jacks Up Cost Of Aid-In-Dying Medication*, NPR (Mar. 23, 2016), https://www.npr.org/sections/health-shots/2016/03/23/471595323/drug-company-jacks-up-cost-of-aid-in-dying-medication.

[24] Catherine Offord, *Accessing Drugs for Medical Aid-in-Dying*, THE SCIENTIST (Aug. 17, 2017), https://www.the-scientist.com/?articles.view/articleNo/49879/title/Accessing-Drugs-for-Medical-Aid-in-Dying/.

[25] Amanda M. Thyden: *Death with Dignity and Assistance: A Critique of the Self-Administration Requirement in California's End of Life Option Act*, 20 CHAPMAN L. REV. 421, 421 (2017).

III. MOST STATES CRIMINALLY PROHIBIT ASSISTED SUICIDE, AND THEREFORE MAID

Almost every U.S. jurisdiction criminally prohibits assisting another person to commit suicide.[26] Moreover, as the Supreme Court has observed, these assisted suicide prohibitions are deeply rooted in our nation's legal history.[27] In fact, those roots date back 150 years. As early as 1868, most states held that assisting suicide was a criminal offense. The criminal status of assisted suicide has persisted ever since. Nearly one hundred years later, the American Law Institute included the crime in its 1962 Modern Penal Code, the seminal work on substantive criminal law.[28] Most recently, many states have reexamined and reaffirmed their bans on assisted suicide.[29]

Assisted suicide statutes typically include plain yet broad language. For example, the New Mexico statute provides: "Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth-degree felony."[30] Similarly, the California Penal Code states: "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."[31] Penalties for violation include felony probation, up to three years in state prison, and/or a fine up to $10,000.[32]

In addition, for physicians, assisted suicide also constitutes "unprofessional conduct" that may result in state medical board discipline up to and including

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[26] Alaska Stat. § 11.41.120 (2006); Ariz. Rev. Stat. Ann. § 13-1103 (2014); Ark. Code Ann. § 5-10-104 (2007); Cal. Penal Code § 401 (1995); Colo. Rev. Stat. § 18-3-104 (2012); Conn. Gen. Stat. § 53a-56 (1971); Del. Code Ann., tit. 11, § 645 (1995); Fla. Stat. Ann. § 782.08 (1971); Ga. Code Ann. § 16-5-5 (2015); Hawaii Rev. Stat. § 707-702 (2006); Idaho Code § 18-4017 (2011); 720 III. Comp. Stat. Ann., § 5/12-34.5 (2012); Ind. Code Ann. § 35-42-1-2.5 (2014); Iowa Code Ann. § 707A.2 (1996); Kan. Stat. Ann. § 21-3406 (2011); Ky. Rev. Stat. Ann. § 216.302 (1994); La. Stat. Ann. § 14:32.12 (1995); Md. Code, Crim. Law, § 3-102 (2002); Me. Rev. Stat. Ann. tit. 17-A, § 204 (1977); Mich. Comp. Laws Ann. § 750.329a (1998); Minn. Stat. Ann. § 609.215 (1998); Miss. Code Ann. § 97-3-49 (2013); Mo. Ann. Stat. § 565.021(2017); Mont. Code Ann. § 45-5-105 (1981); Neb. Rev. Stat. § 28-307 (1977); N.H. Rev. Stat. Ann. § 630:4 (1973); N.J. Stat. Ann. § 2C:11-6 (1979); N.M. Stat. Ann. § 30-2-4 (1963); N.Y. Penal Law § 120.30 (1965); N.D. Cent. Code § 12.1-16-04 (1991); Ohio Rev. Code § 3795.02 (2003); Okla. Stat. Ann., tit. 21, § 813 (1910); Or. Rev. Stat. § 163.125 (1999); 18 Pa. Consol. Stat. Ann. § 2505 (1973); P.R. Laws Ann., tit. 33, § 4738 (2005); R.I. Gen. Laws § 11-60-3 (1996); S.C. Code Ann. § 16-3-1090 (1998); S.D. Codified Laws § 22-16-37 (2005); Tenn. Code Ann. § 39-13-216 (1993); Tex. Penal Code Ann. § 22.08 (1994); Va. Code § 8.01-622.1 (2015); V.I. Code, tit 14, § 2141 (1993); Wash. Rev. Code Ann. § 9A.36.060 (2011); Wis. Stat. Ann. § 940.12 (2001). Statutes in other states imply criminal prohibition of assisted suicide. ***See, e.g.,*** Ala. Code § 22-8A-10 (1997); D.C. Code § 7-651.13 (2016); Nev. Rev. Stat. § 449.670 (1995); W. Va. Code § 16-30-15 (2000); Wyo. Stat. § 6-2-107 (1985).

[27] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring).

[28] Model Penal Code § 210.5 (Am. Law Inst., Proposed Official Draft 1962).

[29] Washington v. Glucksberg, 521 U.S. 702, 716 (1997) ("Though deeply rooted, the States' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed.").

[30] N.M. Stat. Ann. § 30-2-4.

[31] Cal. Penal Code § 401.

[32] Cal. Penal Code § 18(a) (2011); Cal. Penal Code § 672 (1983).

revocation of the license.[33] For example, in Minnesota "aiding suicide or aiding attempted suicide" is "prohibited and is grounds for disciplinary action" even without a criminal conviction, guilty plea, or other judgment under the assisted suicide statute.[34]

While most states have only a "general" assisted suicide statute, six states have enacted statutes that target MAID specifically. Alabama, Arkansas, Georgia, Idaho, Ohio, and Rhode Island do not just outlaw assisted suicide. They expressly outlaw MAID specifically.[35] For example, Arkansas provides that "it is unlawful for any physician or health care provider to commit the offense of physician-assisted suicide by . . . prescribing any drug, compound, or substance to a patient with the express purpose of assisting the patient to intentionally end the patient's life."[36]

Specifically targeting MAID in a penal statute eliminates any residual uncertainty. It sends a clear, strong message to both patients and clinicians. Yet, this degree of precision is probably unnecessary. Even broad, general assisted suicide statutes probably also cover MAID.[37] First, courts have specifically held that criminal assisted suicide statutes cover MAID.[38] Second, almost all legislative and litigation efforts to legalize MAID have assumed that MAID is illegal. Moreover, advocates imply (though certainly do not concede) MAID's illegality by their efforts to legalize it affirmatively. If the penal code does not now prohibit MAID, then why do we need legislation to permit it?

Notably, during the 1980s and 1990s, clinicians were concerned that even long-accepted treatment decisions like Do-Not-Resuscitate (DNR) orders and withholding or withdrawing life-sustaining treatment might fall within the scope of assisted suicide prohibitions.[39] This fear of criminal liability is logical. "[W]hen life-sustaining treatment is withheld or withdrawn, the patient's death results from the acts or omissions of those who have withheld or withdrawn treatment and those who have authorized this conduct."[40] The Washington Supreme Court summed up the reasoning this way:

> Under Washington's criminal code, homicide is "the killing of a human being by the act, procurement or omission of another" and it is murder in the first degree when, "with a premeditated intent to cause the death of another person, [one] causes the death of such person." Thus, the potential for criminal liability for withdrawing life-sustaining mechanisms appears to exist.[41]

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[33] THE RIGHT TO DIE, *supra* note 21, § 12.04[C]; *see, e.g.*, VA. CODE ANN. § 8.01-622.1(D) (2015); *In re* Egbert, No. 2011-0870 (Md. State Bd. Physicians Dec. 12, 2014) (revoking physician license for assisted suicide).

[34] MINN. STAT. § 147.091(1)(w) (2017).

[35] Assisted Suicide Ban Act, Ala. H.B. 96 (2017); ARK. CODE ANN. § 5-10-106(b) (2007); GA. CODE ANN. § 16-5-5(b) (2015); IDAHO CODE § 18-4017(1) (2011); N.D. CENT. CODE ANN. § 12.1-16-04(1) (1991); OHIO REV. CODE § 3795.04 (2003); 11 R.I. GEN. LAWS § 11-60-3 (1996).

[36] ARK. CODE ANN. § 5-10-106(b)(1) (2007).

[37] In addition, many states have enacted civil legislation that provides for the issuance of an injunction, an award of damages, and attorneys' fees. THE RIGHT TO DIE, *supra* note 21, § 12.04[B].

[38] *See infra* Part VII.

[39] *Cf.* Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *In re* Farrell, 529 A.2d 404, 411 (N.J. 1987); *In re* Requena, 517 A.2d 886, 887 (N.J. Super. Ct. Ch. Div. 1986).

[40] THE RIGHT TO DIE, *supra* note 21, § 12.01.

[41] *In re* Colyer, 660 P.2d 738, 751 (Wash. 1983) (en banc) (internal citations omitted).

To eliminate uncertainty or fear of criminal liability, many state legislatures amended their healthcare decision-making acts to exclude such acts.[42] For example, the Virginia Code provides: "This section shall not apply to a . . . health care [professional] who . . . withholds or withdraws life-prolonging procedures."[43]

MAID statutes are designed to offer this same type of clear exemption. For example, a 2017 New Mexico bill redefined "assisted suicide" to exclude "an attending health care provider who provides medical aid in dying, in accordance with the provisions of the End of Life Options Act, to an adult patient who has capacity and who has a terminal illness."[44]

IV. LEGALIZING MAID THROUGH STATUTE

Before 1990, there were few serious efforts to legalize MAID.[45] After all, policymakers were focusing their attention on other end-of-life medical decision-making issues. Specifically, during the 1970s and 1980s, courts and legislatures across the country were still struggling with defining a right to die. They were articulating a right to refuse 1960s medical technology such as CPR, mechanical ventilation, and dialysis. By 1990, the patient's "right to die" through passive refusal was substantially settled.[46] Therefore, policymakers turned their attention to active means of hastening death like MAID.

Since the early 1990s, the most successful strategy for legalizing MAID has been through enacting a statute. Six states have enacted nearly identical statutes. These statutes have two types of distinctive features. First, they specify detailed procedures for accessing life-ending medication. Second, they offer civil, criminal, and disciplinary immunity for compliance.

Three key events accelerated the public policy discussion of MAID by drawing massive academic and community attention to the issue. First, in January 1988, the Journal of the American Medical Association published a provocative op-ed. In *It's Over, Debbie*, the anonymous physician author described administering a lethal dose of morphine to a terminally ill patient.[47] The article stimulated "substantial reaction from the medical profession, the public, the media, and legal authorities."[48]

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[42] THE RIGHT TO DIE, *supra* note 21, § 12.02[C][5].

[43] VA. CODE ANN. § 8.01-622.1(E) (2015); *see also* N.M. STAT. ANN. § 24-7A-13(B)(1) (1997) ("Death resulting from the withholding or withdrawal of health care in accordance with the Uniform Health-Care Decisions Act does not for any purpose . . . constitute a suicide, a homicide or other crime.").

[44] H.B. 171, 53d Leg., 1st Sess., § 10 (N.M. 2017).

[45] *But cf. DEATH WITH DIGNITY An Inquiry into Related Public Issues: Hearing Before the Special Committee on Aging*: *Hearings Before the Special Committee on Aging*, 92d Cong. 2d Sess. (1972).

[46] The Supreme Court issued its decision in *Cruzan decided on June 25, 1990. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).*

[47] *Name Withheld by Request, It's Over, Debbie,* 259(2) JAMA 272, 272 (1988).

[48] George D. Lundberg, *'It's Over, Debbie' and the Euthanasia Debate*, 259(14) JAMA 2142, 2142 (1988).

Second, in June 1990, Jack Kevorkian received enormous media attention when he helped Janet Adkins commit suicide.[49] Over the following three and a half years, Kevorkian was present at the deaths of 20 other individuals.[50] Michigan state attorneys prosecuted him (unsuccessfully) four times.[51] Through these and other newsworthy events, Kevorkian received "international attention" and "provoked a national discussion."[52] MAID pervaded the public consciousness.

Third, in 1991, Derek Humphry published Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. This how-to guide for terminally ill people who wish to kill themselves remained on the New York Times bestseller list for 18 weeks.[53] In short, both through high-profile publications and through high profile, colorful advocates, the issue of MAID was placed squarely on the public policy table by the early 1990s.

A. Very Early Efforts in the 1900s

Long before and wholly unconnected with contemporary efforts to legalize MAID were several bills in the early 20th century.[54] In 1906, the Ohio legislature considered a bill titled "An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons."[55] The bill applied to "any person of lawful age and of sound mind" who is "so ill of disease that recovery is impossible or who is suffering great pain or torture."[56] If "three reputable physicians" concurred with the patient's request to "be put to death," then clinicians could administer an anesthetic until death ensures.[57]

That same year, Iowa considered a similar bill titled "A Bill for An Act Requiring Physician to Take Human Life."[58] In 1937, Nebraska considered an even

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[49] *See, e.g.*, Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES (June 6, 1990), http://www.nytimes.com/1990/06/06/us/doctor-tells-of-first-death-using-his-suicide-device.html.

[50] Silvia Sara Canetto & Janet D. Hollenshead, *Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990–1997*, 40(1) OMEGA - J. DEATH & DYING 165, 170–71 (2000).

[51] Charles H. Baron, *Assisted Dying: As the Population Ages, Assisted Suicide—With the Help of a Physician or Loved One—Will Continue to be Controversial*, 35-JUL TRIAL 44, 50 (1999). Kevorkian was eventually convicted for active euthanasia, not MAID. *See infra* Section VIII.

[52] *Jack Kevorkian: How He Made Controversial History*, BBC NEWS (June 3, 2011), http://www.bbc.com/news/world-us-canada-13649381.

[53] MICHAEL R. LEMING & GEORGE E. DICKINSON, UNDERSTANDING DYING, DEATH, AND BEREAVEMENT 273 (Wadsworth Cengage Learning, 7th ed.).

[54] These bills extended an earlier debate about the ethics of euthanasia. The most notable contribution to that debate was Samuel Williams' widely printed proposal in 1870. *See* Ezekiel J. Emanuel, *Whose Right to Die?*, THE ATLANTIC (Mar. 1997); *see also* Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121(10) ANNALS INTERNAL MED. 793, 794 (1994).

[55] *See* GIZA LOPES, DYING WITH DIGNITY: A LEGAL APPROACH TO ASSISTED DEATH 20 (2015) (citing H.B. 145 (Ohio 1906)); *Euthanasia*, 8 ST. LOUIS MED. REV. 66, 66 (1906).

[56] *See id.*

[57] Jacob M. Appel, *A Duty to Kill? A Duty to Die? Rethinking the Euthanasia Controversy of 1906*, 78(3) BULLETIN HIST. MED. 610, 618 (2004).

[58] *See* LOPES, *supra* note 55, at 21 (citing H.F. 367 (Iowa 1906)); *see also* DEMETRA M. PAPPAS, THE EUTHANASIA/ASSISTED-SUICIDE DEBATE 444 (2012).

broader MAID bill.[59] All three of these Midwestern state bills were soundly defeated. MAID legislation then entered a nearly fifty-year dormancy. Expectedly, interest in this type of legislation waned after World War II.[60] Euthanasia had become too closely associated with Nazi eugenics and involuntary killing.

B. Early Efforts in the 1980s and 1990s

Interest in MAID reemerged in the late 1980s and early 1990s as a logical extension of the then newly established right to refuse life-sustaining treatment. Initially, efforts to enact MAID statutes focused on the ballot initiative process. Available in half the states, this process allows a public vote on a proposed statute based on a petition signed by a certain minimum number of registered voters.[61] Between 1988 and 1994, advocates proposed MAID ballot initiatives in California, Washington, and Michigan.[62]

In 1988, California organizers did not get enough signatures to place the "Humane and Dignified Death Act" on the ballot.[63] Apparently, the inclusion of both euthanasia and MAID dissuaded voters. Therefore, organizers later removed "mercy killing" from the ballot language and required the patient to take the final overt at causing death. They obtained enough signatures, and placed Proposition 161 on the 1992 ballot. Still, the initiative was defeated 54% to 46 percent.[64] In 1991, Washington placed Initiative 119 on the ballot. Like the California initiative, it was also defeated 54 to 46 percent.[65]

In January 1994, Jack Kevorkian launched a petition drive to place MAID on the November ballot in Michigan. Kevorkian's petition offered an amendment to the state constitution that read: "The right of competent adults, who are incapacitated by incurable medical conditions, to voluntarily request and receive medical assistance with respect to whether or not their lives continue, shall not be restrained or abridged."[66] Like the 1988 California ballot initiative that similarly included both MAID and euthanasia, Kevorkian's effort did not obtain enough signatures.[67]

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[59] *See* IAN DOWBIGGIN, A CONCISE HISTORY OF EUTHANASIA: LIFE, DEATH, GOD, AND MEDICINE 85 (2005); LOPES, *supra* note 55, at 48 n.14 (2015).

[60] *But cf.* Morton L. Yanow, Letter to the Editor, *Continue the Debate* N.Y. TIMES (July 25, 1997), http://www.nytimes.com/1997/07/27/opinion/l-continue-the-debate-335681.html (noting the Connecticut Act to Legalize Euthanasia in 1959, the Idaho Voluntary Euthanasia Act in 1969 and the Oregon Voluntary Euthanasia Act and the Montana Euthanasia Act in 1973). *See also* JOEL FEINBERG, HARM TO SELF 367 (1986).

[61] *Initiative Process 101,* NATIONAL CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/research/elections-and-campaigns/initiative-process-101.aspx (last visited Jan. 25, 2018).

[62] *See infra* notes 64–68 and accompanying text.

[63] SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 138 (2016).

[64] *The California Propositions in Brief*, LONG BEACH PRESS- TELEGRAM, Nov. 5, 1992, 1992 WLNR 1033302.

[65] *See* Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at A10.

[66] *Kevorkian Begins Ballot Drive for Suicide Measure*, N.Y. TIMES, Jan. 31, 1994, http://www.nytimes.com/1994/01/31/us/kevorkian-begins-ballot-drive-for-suicide-measure.html.

[67] *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, http://www.nytimes.com/1994/07/06/us/kevorkian-s-ballot-drive-on-suicide-aid-stumbles.html.

C. Three Successful Ballot Initiatives

The earliest ballot initiative efforts in California, Washington, and Michigan failed. Yet, three other ballot initiatives successfully passed. Oregon, Washington, and Colorado all legalized MAID through the ballot initiative process. Furthermore, other states have come very close, and more states are still trying to emulate Oregon, Washington, and Colorado.

1. Oregon 1994 Ballot Initiative

Building off the earlier experience in California and Washington, Oregon placed a ballot measure in the November 1994 election. In contrast to the earlier ballot initiatives, the citizens of Oregon approved Measure 16 by a vote of 51 to 49 percent.[68] Two factors leading to success included avoiding the term "mercy killing" and reframing the legislation as the "Death with Dignity Act."[69]

Before the Death with Dignity Act became effective, litigation delayed its implementation for three years.[70] Nevertheless, the delay did not dampen enthusiasm. In November 1997, the margin of approval grew even wider when Oregon citizens rejected a ballot measure to repeal the law 60 to 40 percent.[71] Subsequently, while the Oregon Death with Dignity Act was the subject of several (ultimately unsuccessful) federal challenges for years, it has remained in effect since 1998.[72] Notably, once those federal challenges stopped in 2006, remaining "clouds" of legal uncertainty lifted. Other states began more seriously to consider copying the Oregon model.

The Oregon Death with Dignity Act is so carefully crafted, so narrowly drawn, and so laden with procedural safeguards, that it may well demand more energy and fortitude to comply with it than some terminally ill people are likely to have.[73] To qualify for "death with dignity," a person must be a resident of the state,[74] over age 18,[75] "capable"[76] (that is, in possession of decision-making capacity),[77] and suffering from a terminal disease that will lead to death within six months.[78]

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[68] DEPARTMENT OF HUMAN RESOURCES, OREGON HEALTH DIVISION, CENTER FOR DISEASE PREVENTION AND EPIDEMIOLOGY, OREGON'S DEATH WITH DIGNITY ACT: THE FIRST YEAR'S EXPERIENCE 1 (Feb. 18, 1999).

[69] Kathryn L. Tucker, *In the Laboratory of the States: The Progress of Glucksberg's Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1594 (2008).

[70] Lee v. Oregon, 869 F. Supp. 1491 (D. Or. Dec. 27, 1994) (issuing preliminary injunction), 891 F. Supp. 1429 (D. Or. Aug. 3, 1995) (issuing permanent injunction), *vacated and remanded*, 107 F.3d 1382 (9th Cir. Feb. 17, 1997) (lack of federal jurisdiction), *cert. denied sub nom.* Lee v. Harcleroad, 522 U.S. 927 (Oct. 14, 1997).

[71] William Claiborne & Thomas B. Edsall, *Oregon Suicide Law May Spur Movement*, WASH. POST, Nov. 6, 1999, http://www.washingtonpost.com/wp-srv/politics/daily/nov99/suicide6.htm.

[72] THE RIGHT TO DIE, *supra* note 21, § 12.06[A][1] (citing federal cases).

[73] *See* OR. REV. STAT. §§ 127.800 to .897 (1995). *See also* OR. ADMIN. R. 333-009-0000 to -0030 (2001).

[74] OR. REV. STAT. §§ 127.805, .860.

[75] *Id.* §§ 127.800, .805.

[76] *Id.* § 127.805.

[77] *Id*. § 127.800.

[78] *Id.* § 127.805, .800.

The patient must make one written[79] and two oral requests[80] for medication to end his life. The written request must be "substantially in the form" provided in the Act, signed, dated, witnessed by two persons, in the presence of the patient, who attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request."[81] There are stringent qualifications as to who may act as a witness.[82]

The patient's decision must be an "informed" one.[83] Therefore, the attending physician is obligated to provide the patient with information about the diagnosis, prognosis, potential risks and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control."[84] Another physician must confirm the diagnosis, the patient's decision-making capacity, and voluntariness of the patient's decision.[85] There are requirements for counseling, if either the attending or consulting physician thinks the patient is further suffering from a mental disorder.[86] There are requirements for documentation in the patient's medical record,[87] for a waiting period,[88] for notification of the patient's next of kin,[89] and for reporting to state authorities.[90] The patient has a right to rescind the request for medication to end his life at any time.[91]

Having complied with these requirements, the patient is entitled only to a prescription for medication. The Act does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."[92] In other words, the statute accepts MAID but rejects what the law calls active euthanasia.

The Oregon legislature amended the Death with Dignity Act in 1999.[93] The definitional sections clarified that an "adult" is a person 18 years of age or older[94] and that pharmacists fall within the definition of "health care provider."[95] The amendments expanded and clarified the responsibilities of attending physicians. One important added responsibility is to counsel patients "about the importance of having another person present when the patient takes the medication . . . and of not taking the medication in a public place. . . ."[96] Some pharmacists have wished to refrain

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[79] *Id.* § 127.805, .840.

[80] *Id.* § 127.840, .897.

[81] *Id.* §127.810.

[82] *Id.*

[83] *Id.* § 127.815, .830.

[84] *Id.* § 127.815.

[85] *Id.* § 127.820.

[86] *Id.* § 127.825.

[87] *Id.* § 127.855.

[88] *Id.* § 127.850.

[89] *Id.* § 127.835.

[90] *Id.* § 127.865.

[91] *Id.* § 127.845.

[92] *Id.* § 127.880.

[93] 1999 Or. Laws 1098.

[94] OR. REV. STAT. §127.800(1).

[95] *Id.* §127.800(6).

[96] *Id.* §127.815.

from dispensing lethal prescriptions.[97] In recognition of this, the legislation included a provision in the Act expressly authorizing physicians to dispense the lethal medications rather than having pharmacists do so.[98]

To address the concerns that have been raised that people will be motivated by depression to seek a physician's assistance in ending their lives, the 1999 amendments to the Act added "depression causing impaired judgment" to the generic "psychiatric or psychological disorder" that the attending physician must determine the patient does not have before medications may be prescribed.[99]

A concern about the original statute was that although its provisions were limited to Oregon residents, there was no definition of "residence." Thus, the 1999 amendments specified factors demonstrating Oregon residence.[100] The amendments also added an important new reporting requirement: any health care provider who dispenses medication under the statute must file a copy of the dispensing record with the state health division.[101]

Finally, the 1999 amendments included several provisions expanding immunities. The Act now permits a health care provider to prohibit another health care provider from participating in "death with dignity" on the premises of the first health care provider if they gave prior notice of such prohibition.[102] This is probably the most far-reaching aspect of the amended legislation.

If a health care provider violates this prohibition, the provider issuing the prohibition may impose sanctions including loss of medical staff privileges, termination of a lease or other property contract, and termination of employment contract.[103] However, even if prohibited from doing so under one of the preceding provisions, a health care provider may provide assistance under the statute if he does so outside the course of employment.[104]

The Death with Dignity Act requires the state health division to issue an annual report summarizing the experience with the statute.[105] The statistics summarized in these reports do not seem to bear out the fears of the opponents of "death with dignity." Individuals availing themselves of this statute were insured, were disproportionately white rather than racial minorities, were better educated than the general population, and were not disproportionately female.[106] Individuals who requested lethal prescriptions were concerned with loss of autonomy, their

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[97] *See* Jennifer Fass & Andrea Fass, *Physician-assisted Suicide: Ongoing Challenges for Pharmacists*, 68(9) AM. J. HEALTH SYS. PHARMACISTS 846, 848 (2011).

[98] *See* OR. REV. STAT. §127.815.

[99] *See id.* §127.825.

[100] *Id.* §127.860.

[101] *See id.* §127.865; *see also* Or. Admin. R. 333-009-0000 to -0030 (2011) (regulations implementing the reporting requirements).

[102] OR. REV. STAT. §127.885; *see also* 49 Or. Op. Att'y Gen. 161, No. 8264 (1999) (interpreting OR. REV. STAT. §127.885).

[103] OR. REV. STAT. §127.885.

[104] *Id.*

[105] *See id.* §127.865(3).

[106] PUB. HEALTH DIV., OREGON HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT DATA SUMMARY 2017 (Feb. 9, 2018); *see also* Barbara Coombs Lee, *Oregon's Experience with Aid in Dying: Findings from the Death with Dignity Laboratory*, ANN. N.Y. ACAD. SCI. 94, 96 (2014).

decreasing ability to participate in activities that made their lives enjoyable, and loss of bodily functions.[107]

2. Washington 2008 Ballot Initiative

Based on the thorough and virtually unblemished record from Oregon, other states have followed. The first state to copy Oregon was its northern neighbor, Washington. In November 2008, Washington State voters approved an initiative modeled closely on Oregon's law. Initiative 1000 passed by a 58 to 42 percent margin.[108] The Washington Death with Dignity Act became effective in early 2009.[109] Data from Washington State's annual published reports show operation and usage very similar to that in Oregon.[110]

3. Colorado 2016 Ballot Initiative

In 2016, Colorado voters approved an initiative modeled closely on Oregon's law by a 65 to 35 percent margin.[111] The Colorado End of Life Options Act went into effect on December 16, 2016.[112] Data from Colorado's first annual report is consistent with Oregon and Washington data.[113]

D. Three Successful Legislative Enactments

After Oregon and Washington legalized MAID through ballot initiatives in 1994 and 2008, many commentators thought that direct democracy voting was the only viable path.[114] They determined that the issue was just too controversial for the political process. It turned out that this assessment was too pessimistic. Since 2013, three states have legalized MAID through a legislative process: Vermont, California, and Washington, DC. Furthermore, several other states have come close.

1. Vermont 2013 Legislation

In 2013, Vermont joined the list of states affirmatively approving the practice of MAID, this time through legislation rather than a ballot initiative

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[107] *Id.*

[108] Robert Steinbrook, *Physician-Assisted Death — From Oregon to Washington State*, 359 NEW ENG. J. MED. 2513, 2513 (2008).

[109] WASH. REV. CODE §§ 70.245.010 to .220, 70.245.901 to .903 (effective Mar. 5, 2009); WASH. ADMIN. CODE §§ 246-978-001 to -040 (2009). *See generally* Linda Ganzini & Anthony L. Back, *The Challenge of New Legislation on Physician-Assisted Death*, 176 JAMA INTERNAL MED. 427 (2016).

[110] *See* WASH. STATE DEP'T OF HEALTH, WASHINGTON STATE 2016 DEATH WITH DIGNITY ACT REPORT (Sept. 2017).

[111] Jennifer Brown, *Colorado Passes Medical Aid in Dying, Joining Five Other States*, DENVER POST (Nov. 8, 2016), https://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results.

[112] COLO. REV. STAT. §§ 25-48-101 to -123 (effective Dec. 16, 2016); 6 COLO. CODE REGS. § 1009-4 (effective June 14, 2017).

[113] *See Medical Aid in Dying,* COLO. DEP'T OF PUB. HEALTH AND ENV'T, https://www.colorado.gov/pacific/cdphe/medical-aid-dying (last visited Jan. 31, 2018).

[114] *But see* GUENTER LEWY, ASSISTED DEATH IN EUROPE AND AMERICA: FOUR REGIMES AND THEIR LESSONS 127 (Oxford Univ. Press) (2011) (Oregon State Senator Frank Roberts introduced legislation in 1987, 1989, and 1991).

process.[115] Uniquely, as originally enacted, the Vermont MAID law would have diverged from those in California, Oregon, and Washington after July 1, 2016. As originally enacted, on that day, the section of the Vermont statute imposing stringent procedural safeguards would sunset.[116] In 2015, the Vermont legislature repealed that sunset provision.[117] Like the Oregon Death with Dignity Act, opponents attacked the Vermont law in court.[118] Those challenges have been unsuccessful.

2. California 2015 Legislation

On October 5, 2015, California became the fourth state to enact a statute allowing physicians to prescribe terminally ill patients medication to end their lives.[119] The California End of Life Option Act is virtually identical to MAID statutes in Oregon, Washington, and Vermont. [120] Still, unlike the other MAID statutes, the California law will sunset on January 1, 2026.[121] The first published report from California shows operation and usage very similar to that in Oregon and Washington.[122]

Finally, reminiscent of the post-statute litigation in Oregon and Vermont, physicians and advocacy groups filed suit to enjoin the operation of the California statute, arguing that the law was unconstitutional for a variety of reasons.[123] The court refused to enjoin operation of the law, but also refused to dismiss the case.[124]

3. Washington, DC 2017 Legislation

In 2017, the District of Columbia enacted a statute also modeled closely on Oregon's law.[125] Just as there was federal interference with the Oregon legislation, there has also been federal interference with the D.C. legislation. Given the District of Columbia's unique status in the federal system, Congress sought to exert its authority to disapprove the law. Nevertheless, the D.C. law became effective in February 2017, after Congress failed to pass a "resolution of disapproval."[126] In

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[115] VT. STAT. ANN. tit. 18, §§ 5281–5293 (effective May 20, 2013). *See* Kathryn L. Tucker, *Vermont's Patient Choice at End of Life Act: A Historic "Next Generation" Law Governing Aid in Dying*, 38 VT. L. REV. 687, 687 (2014).

[116] 2013 Vt. Acts & Resolves 292, 296.

[117] 2015 Vt. Acts & Resolves 296.

[118] Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2017 WL 1284815 (D. Vt. Apr. 5, 2017); *see also* Vt. All. for Ethical Healthcare, Inc., v. Hoser, 2016 WL 7015717 (D. Vt. Dec. 1. 2016).

[119] *Assemb. B 15, Stats. 2015, Ch.1 (2015).*

[120] *See* CAL. HEALTH & SAFETY CODE §§ 443.1 to 443.22 (effective June 9, 2016).

[121] *See* CAL. HEALTH & SAFETY CODE § 443.215 (2016) ("This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.").

[122] *See* CAL. DEP'T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT 2016 DATA REPORT (2017).

[123] Ahn v. Hestrin, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 8, 2016) (Complaint).

[124] Ahn v. Kestrich, No. RIC-1607135 (Riverside Cnty. Sup. Ct., Cal. June 9, 2017) (Order denying preliminary injunction but allowing lawsuit to proceed).

[125] D.C. Act 21-577 (Dec. 19, 2016).

[126] H.R.J. Res. 27, 115th Cong. (2017). The law went into effect in February 2017 after Congress failed to pass resolution of disapproval within 30 legislative days after the city government passed the law.

September 2017, the House of Representatives passed a bill that would repeal the D.C. Death with Dignity Act.[127]

E. Other Notable Efforts to Enact MAID Statutes

By the end of 2017, only Oregon, Colorado, and Washington have successfully passed ballot initiatives. Yet, other states have come very close. For example, a 2012 Massachusetts ballot initiative failed on a 49 to 51 percent vote.[128] Similarly, a 2000 Maine ballot initiative also failed on a 49 to 51 percent vote.[129] A 1998 Michigan ballot initiative did not do as well, failing on a 71 to 29 percent vote.[130] Additional states are continuing to explore the ballot initiative process to legalize MAID.[131]

By the end of 2017, only California, Vermont, and Washington, DC have enacted legislation. Yet, other states have come very close. For example, in 2017, the Hawaii Senate passed a MAID bill on a vote of 22 to 3. The Hawaii House later deferred the bill.[132] Also in 2017, the Maine Senate passed a MAID bill that died in the House.[133] Likewise, in 2015 the Maine Senate passed a bill that died in the House.[134] In 2016, the New Jersey Assembly passed a MAID bill on a vote of 41 to 28. That bill even then passed a key Senate committee.[135] As in Maine, this was not the first time that legislation advanced in New Jersey. In 2014, the Assembly passed a bill by a vote of 41 to 31.[136]

Recent near successes in Hawaii and Maine are not the only reason to expect more states to legalize MAID. First, nearly half of the states considered MAID legislation in 2016 and 2017.[137] Second, proponents are introducing more and more bills in more and more states. Third, today, there is more support from the public, healthcare professionals, medical societies and medical associations.[138]

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[127] H.R. 3354, 115th Cong. § 818 (2017); J. Portnoy, *House Votes to Repeal D.C.'s Death with Dignity Law; Senate Has Yet to Act,* WASH. POST, Sept. 14, 2017.

[128] *See* Carolyn Johnson, *Assisted Suicide Measure Narrowly Defeated; Supporters Concede Defeat,* BOSTON GLOBE, Nov. 7, 2012.

[129] Michael Moore, *Suicide Opponents Claim Win*, BANGOR DAILY NEWS (Nov. 8, 2000).

[130] *1998 Michigan Election Results*, MICH. DEP'T OF ST., http://miboecfr.nictusa.com/election/results/98gen/ (last visited Mar. 12, 2018).

[131] *See, e.g.*, *Voters May See Cannabis, Tobacco Tax on South Dakota Ballot,* ARGUS LEADER, Nov. 6, 2017. Some states have considered ballot initiatives not only to enact a MAID statute but also to amend the state constitution.

[132] *See* S.B. 1129, 29th Leg. (Haw. 2017).

[133] *See* Legis. Doc. 347, 128th Leg., 1st Sess. (Me. 2017).

[134] *See* Legis. Doc. 1270, 127th Leg., 1st Sess. (Me. 2015).

[135] Assemb. B. 2451, 217th Leg. (N.J. 2016).

[136] Assemb. B. 2270, 216th Leg. (N.J. 2014).

[137] Two public websites appear to collect state-by-state legislation comprehensively and accurately. DEATH WITH DIGNITY NATIONAL CENTER, https://www.deathwithdignity.org/take-action/ (last visited Jan. 31, 2018); PATIENT RIGHTS COUNCIL, http://www.patientsrightscouncil.org/site/laws-issues-by-state/ (last visited Jan. 31, 2018).

[138] *See* COMPASSION & CHOICES, *supra* note 12; Michael Ollove, *Aid in Dying Gains Momentum as Erstwhile Opponents Change their Minds,* STATELINE, (Mar. 9, 2018), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/03/09/aid-in-dying-gains-momentum-as-erstwhile-opponents-change-their-minds.

V. LEGALIZING MAID THROUGH FEDERAL CONSTITUTIONAL LITIGATION

While the most successful method of legalizing MAID has been by enacting statutes, the most prominent early method was by seeking a right under the U.S. Constitution. During the 1990s, physician and patient plaintiffs brought several cases in state and federal courts. Several even sought certiorari from the U.S. Supreme Court. That court ultimately agreed to adjudicate the issue. In 1997, the Court ruled that state criminalization of MAID does not violate constitutional due process or equal protection rights.[139]

A. Early Efforts before 1997

Before the U.S. Supreme Court issued its decisions in June 1997, four other courts had already ruled that there was no federal constitutional right to MAID.

1. Donaldson v. Lundgren *(Cal. App. 1992)*

The earliest case was not a typical MAID case. Indeed, it was so unusual that it was not really a MAID case at all. Mathematician and computer software scientist, Thomas Donaldson, suffered from an incurable brain disease. He wanted to cryogenically preserve his body in hopes that sometime in the future, when a cure for his disease is found, his body may be brought "back to life."[140] Since the process would require Donaldson's death, the court interpreted the request for declaratory and injunctive relief for "pre-mortem cryogenic suspension" as seeking a right to assisted suicide. The trial court dismissed the action and the court of appeals affirmed.[141]

2. State v. Kevorkian *(Mich. 1994)*

Jack Kevorkian was one of the most prolific litigants in the MAID movement. Most of his lawsuits were criminal prosecutions and not actions for declaratory and injunctive relief like most other cases discussed in this article. Yet, in at least one of these cases, Kevorkian raised constitutional arguments before the Michigan Supreme Court.

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions

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[139] Washington v. Glucksberg, 521 U.S. 702 (1997). Coincidentally, the same year that the U.S. Supreme Court found no constitutional right to MAID, the Constitutional Court in Colombia found there was such a right. Mariana Parreiras Reis de Castro et al., *Euthanasia and Assisted Suicide in Western Countries: A Systematic Review,* 24(2) REV. BIOETHICS 355 (2016); *see also* Carter v. Canada, [2015] S.C.R. 331 (Can.).

[140] Donaldson v. Lungren, 4 Cal. Rptr. 2d 59, 60 (Ct. App. 1992). The television series, *LA Law,* dramatized the case. *LA Law: The Good Human Bar*, YOUTUBE (Jan. 31, 2018), https://www.youtube.com/watch?v=Rzpda6cpYQU.

[141] *Donaldson*, 4 Cal. Rptr. 2d 59. The court rejected claims under both the U.S. Constitution and the California Constitution. *Id.*

and in an action for declaratory relief.[142] Kevorkian met with some success at the trial level. In 1994, the Court of Appeals consolidated those several cases. The appellate court then overturned the new statute outlawing assisted suicide. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[143]

The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[144] The court held that there was a valid distinction between the right to refuse life-continuing treatment and the right to insist on life-ending treatment.

3. Kevorkian v. Arnett *(C.D. Cal. 1996)*

While most of Kevorkian's cases were in Michigan state courts, he had two in federal court. He filed one in Los Angeles.[145] There, he asserted claims under the Fourteenth Amendment Due Process clause and the Equal Protection clause. He also asserted privacy and equal protection claims under the California Constitution. Notably, the U.S. District Court for the Central District of California decided the case after the favorable federal appellate decisions in *Glucksberg* and *Quill*.[146] Nevertheless, the court still denied all of Kevorkian's claims.[147] The Ninth Circuit dismissed the appeal because by then the U.S. Supreme Court had already adjudicated the issues in other cases.[148]

4. Kevorkian v. Thompson *(E.D. Mich. 1997)*

Kevorkian filed his second federal action in Michigan with Janet Good, a patient with terminal pancreatic cancer.[149] Like the California federal court, the U.S. District Court for the Eastern District of Michigan declined to follow the still-standing federal appellate decisions in *Glucksberg* and *Quill*.[150] The court held that a mentally competent, terminally ill or intractably suffering adult does not have a liberty interest protected by the Fourteenth Amendment's Due Process Clause in MAID. The court further held that the Equal Protection Clause of the Fourteenth Amendment is not violated by denying a mentally competent, terminally ill or intractably suffering adult not on life support the right to MAID.

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[142] *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959 (1995).

[143] Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. App. 1994).

[144] People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied*, 514 U.S. 1083 (1995).

[145] Kevorkian v. Arnett, 939 F. Supp. 725 (C.D. Cal. Sept. 11, 1996).

[146] *See infra* Sections V.B & V.C.

[147] *See Kevorkian*, 939 F. Supp., at 731–732. *The court also rejected an asserted right under the California constitution, citing Donaldson* v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992). *Id.*

[148] Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. Mar. 31, 1998) (vacating judgment and dismissing appeal).

[149] Kevorkian v. Thompson, 947 F. Supp. 1152 (E.D. Mich. Jan. 6, 1997).

[150] *See infra* Sections V.B & V.C.

B. SCOTUS 1: *Quill v. Vacco*

During the early 1990s, several cases in California and Michigan had sought a federal constitutional right to MAID. Still, the most notable constitutional rights cases were out of Washington and New York. In 1994, advocates filed two federal lawsuits challenging the constitutionality of Washington and New York statutes criminalizing aiding suicide.

The Washington and New York lawsuits claimed that criminal assisted suicide statutes constituted denials of due process and equal protection as applied to terminally ill, competent persons voluntarily requesting assistance from licensed physicians. These claims met some success. In both cases, federal courts of appeals upheld the claims and held the statutes unconstitutional. Nevertheless, the U.S. Supreme Court reversed, holding that there is no constitutional barrier to states criminalizing MAID.

The specific question presented in the Second Circuit case was whether New York's ban on MAID violated the Fourteenth Amendment's Equal Protection Clause.[151] The plaintiffs alleged that the law treats similarly situated terminally ill patients disparately. On the one hand, New York law (like laws in almost every state) allows competent terminally ill adults to hasten their death by withholding or withdrawing their own lifesaving treatment. On the other hand, New York law denies the same right to patients who could not withdraw their own treatment even if they are terminally ill or in great pain.

The District Court rejected these claims and ruled for the State of New York.[152] The Second Circuit reversed, holding that New York's ban was unconstitutional.[153] The court of appeals held that the statute treated similarly situated terminally ill patients differently. On the one hand, those who required life-sustaining treatment were entitled under New York law to die by having that treatment withheld or withdrawn. On the other hand, patients whose suffering might be equal or greater, but who did not require life-sustaining treatment, were denied the same right to die because New York statutory law made it a crime to provide them with the assistance necessary to die.

The U.S. Supreme Court reversed, holding that there was no fundamental liberty interest and that New York's distinction between active and passive means of death was legitimate. Having determined that there was no fundamental right at stake, the Court needed only to apply a minimal scrutiny test and was able to accord the statute a strong presumption of validity. Thus, the Court would uphold the law so long as it bore a rational relation to some legitimate end.

Employing a rationality test to examine the guarantees of the Equal Protection Clause, the Court held that New York's ban bore a rational relationship to the state's legitimate interest in protecting medical ethics, preventing euthanasia, shielding the disabled and terminally ill from prejudice that might encourage them to end their lives, and, above all, the preservation of human life. Moreover, while acknowledging the difficulty of its task, the Court distinguished between the refusal of lifesaving treatment and assisted suicide, by noting that the latter involves the

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[151] Quill v. Vacco, 521 U.S. 793 (1997).

[152] Quill v. Vacco, 870 F. Supp. 78 (S.D.N.Y. 1994).

[153] Quill v. Vacco, 80 F.3d 716, 718 (2d Cir. 1996).

criminal elements of causation and intent. It found the distinction between assisting suicide and withdrawing life-sustaining treatment to be a rational one because it is "a distinction widely recognized and endorsed in the medical profession and in our legal traditions."[154]

C. SCOTUS 2: *Washington v. Glucksberg*

While the New York case presented an equal protection question, a parallel case from Washington State presented the question whether Washington State's ban on MAID violated the Fourteenth Amendment's Due Process Clause. The plaintiffs alleged that the same principle that grounded the right to refuse treatment also encompassed a right to choose the time and manner of one's death. Therefore, they argued, Washington's law denied competent terminally ill adults this fundamental liberty.

The District Court ruled for the plaintiffs.[155] While a three-judge panel of the U.S. Court of Appeals for the Ninth Circuit reversed,[156] a rare en banc Ninth Circuit affirmed the district court.[157] The U.S. Supreme Court granted certiorari to the state of Washington, and upheld the constitutionality of the state law.[158]

The Supreme Court concluded that no fundamental right was at stake. It further concluded that the state's interests were legitimate and that the statute bore a rational relationship to furthering those interests. Accordingly, the Court held that the Washington statute making assisted suicide a crime "does not violate the Fourteenth Amendment, either on its face or as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."[159]

D. Later Efforts after 1997

By June 1997, the U.S. Supreme Court had rejected both due process and equal protection arguments. Nevertheless, some litigants continued to press such claims in federal courts. Predictably, those courts denied the claims.

1. Mahorner v. Florida *(M.D. Fla. 1998)*

Unlike the patient plaintiffs in most other MAID lawsuits, James Mahorner was not terminally ill. Instead, the seventy-six-year-old former practicing attorney was suffering increasing "diminished mental capacity."[160] Mahorner sought judicial approval to "hire a physician to inject him with 'a lethal pain-relieving' drug to hasten his demise."[161] The court expectedly held that to the extent that the complaint

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[154] *Quill,* 521 U.S. at 800.

[155] Compassion in Dying v. Washington, 850 F. Supp. 1454, 1467 (W.D. Wash. May 3, 1994).

[156] Compassion in Dying v. Washington, 49 F.3d 556 (9th Cir. Mar. 9, 1995).

[157] Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. Mar. 8, 1996) (en banc).

[158] Washington v. Glucksberg, 521 U.S. 702 (1997).

[159] *Id.* at 732.

[160] *See* Mahorner v. Florida, No. 3:08-cv-300-J-33TEM, 2008 WL 2756481 (M.D. Fla. July 14, 2008).

[161] *See id.* Technically, the plaintiff was seeking active euthanasia and not MAID.

sought relief under the Fourteenth Amendment, it was subject to dismissal under *Glucksberg*, *Vacco*, and *Krischer*.[162]

2. Calon v. United States *(D. Kan. 2009)*

In 1999, John Calon asserted a constitutional right to MAID in a claim for benefits before the U.S. Court of Appeals for the Tenth Circuit.[163] That court held that Calon could not state a cognizable claim that state laws prohibiting MAID violated the First Amendment, the Due Process Clause, or the Equal Protection Clause. The court further ruled that any other constitutional claim challenging state laws regarding assisted suicide was too vague to confer federal question jurisdiction.

Nearly ten years later, Calon made similar claims in the U.S. District Court for the District of Kansas.[164] He asserted various violations of federal law, including the First, Eighth, Ninth, Thirteenth, and Fourteenth Amendments to the United States Constitution. Yet, Calon did not assert any such claims in his complaint. Nor did he allege sufficient facts to allege a real and immediate threat of injury to support any claim for prospective relief.

VI. LEGALIZING MAID THROUGH STATE CONSTITUTIONAL LITIGATION

Because the U.S. Supreme Court decided that there is no constitutional right to MAID, litigation efforts after June 1997 have focused elsewhere.[165] Specifically, they have focused either on grounding the right in state constitutions or on establishing that MAID falls outside the scope of assisted suicide statutes. This section examines cases asserting state constitutional claims. The next section examines cases asserting statutory interpretation claims.

Initially, advocates identified the most promising theories to be state constitutional privacy claims. After all, some state supreme courts had previously given rather expansive readings to the privacy clauses in their state constitutions. Nonetheless, the courts have proved unwilling to strike down criminal prohibitions on assisted suicide as a violation of a terminally ill person's right to privacy.

Admittedly, some plaintiffs have obtained favorable state constitutional judgments from trial courts.[166] Yet, no plaintiff has ever obtained an appellate court ruling that the prohibition of MAID violates a right afforded by state constitution. Indeed, "not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban."[167]

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[162] *See supra* Sections V.B-C & *infra* Section VI.A.2.

[163] Calon v. Apfel, No. 98-3190, 1999 WL 415340, at *1 (10th Cir. Apr. 26,1999).

[164] Calon v. United States, No. 08–2608–JWL, 2009 WL 248430 (D. Kan. Feb 3, 2009) (dismissing for lack of jurisdiction).

[165] Litigation has appeared an attractive pathway, because ballot initiatives are cumbersome and legislation is controversial. *See* Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URBAN L.J. 817, 819 (1997).

[166] *See* discussion of the state constitutional litigation in Florida, Montana, and New Mexico *infra* Section VI.A.2, 4, 5

[167] Myers v. Schneiderman, 85 N.E.3d 57, 92 (N.Y. Ct. App. 2017) (Garcia, J., concurring).

A. State Supreme Court Rulings

Six constitutional rights cases have reached the state supreme courts in Michigan, Florida, Alaska, Montana, New Mexico, and New York. I discuss those six cases immediately below. In the next section, I discuss constitutional rights cases decided by trial courts or intermediate appellate courts.

1. Michigan v. Kevorkian *(Mich. 1994)*

In February 1993, the Michigan legislature enacted a ban on assisted suicide. Kevorkian challenged that statute both in defense to criminal prosecutions and in an action for declaratory relief.[168] Several circuit court judges held that MAID was a constitutional right.[169] As discussed above, neither the intermediate court of appeals nor the Michigan Supreme Court found there was a federal constitutional right.[170]

Nevertheless, the Court of Appeals overturned the new statute outlawing assisted suicide on state constitutional grounds. While the court did not hold that there was a constitutional right to assisted suicide, it held that the statute violated a provision in the Michigan Constitution that "no law shall embrace more than one object."[171] The Michigan Supreme Court reversed, upholding the assisted suicide statute. It held that the act was not constitutionally defective for having more than one object. Like the court of appeals, the state supreme court denied that the Fourteenth Amendment included a constitutional right to die.[172]

2. Krischer v. McIver *(Fla. 1997)*

Charlie Hall was terminally ill with AIDS. Along with his physician, Hall sought a declaratory judgment that Florida's assisted suicide statute was unconstitutional as applied to MAID. Hall contended that Florida's statutory prohibition on assisted suicide violated the state constitutional right of privacy.[173] The trial court rejected the fundamental liberty interest but accepted the equal protection argument and enjoined the attorney general.[174]

The Florida Supreme Court reversed.[175] The court held there was no fundamental right and that there were compelling state interests in any case. The court's analysis was a straightforward rejection of the application of the

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[168] *See* Janet M. Branigan, *Michigan's Struggle with Assisted Suicide and Related Issues as Illuminated by Current Case Law: An Overview of People v. Kevorkian*, 72 U. DET. MERCY L. REV. 959, 962 (1995).

[169] *See, e.g.*, Hobbins v. Attorney General, No. 93-306-178CZ, 1993 WL 276833 (Mich. Cir. Ct. May 20, 1993), *aff'd in part, rev'd in part,* 518 N.W.2d 487 (Mich. Ct. App. May 10, 1994), *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. December 13, 1994).

[170] *See* discussion *supra* Section V.A.2.

[171] Hobbins v. Attorney General, 518 N.W.2d 487, 489 (Mich. Ct. App. 1994) (quoting MICH. CONST. art. 4, §24) *rev'd sub nom.* People v. Kevorkian, 527 N.W.2d 714 (Mich. Dec. 13, 1994).

[172] *See* People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994), *cert denied sub nom.* Hobbins v. Kelley, 514 U.S. 1083 (1995).

[173] FLA. CONST. art. I, §23; *see also* Eryn R. Ace, *Krischer v. Mciver: Avoiding the Dangers of Assisted Suicide,* 32 AKRON L. REV. 723, 724 (1999).

[174] *See* McIver v. Kirscher, No. CL-96-1504-AF, 1997 WL 225878 (Fla. Cir. Ct. Jan. 31, 1997).

[175] *See* Krischer v. McIver, 697 So. 2d 97 (Fla. 1997).

constitutional privacy provision to permit terminally ill patients to obtain the aid of physicians in actively ending their lives. Central to the holding was the court's acceptance of the conventional distinction between passive and active means of dying, reaffirming its commitment to the former while rejecting the latter.

The Florida Supreme Court followed the U.S. Supreme Court's analysis in *Glucksberg* in finding that important state interests justify the differential treatment of actively and passively hastening death. Specifically, the court held that "three of the four recognized state interests are so compelling as to clearly outweigh Mr. Hall's desire for assistance in committing suicide"[176] These interests are preserving life,[177] preventing suicide,[178] and protecting the ethical integrity of the medical profession.[179]

3. Sampson v. Alaska *(Alaska 2001)*

In 1998, a patient with breast cancer and a patient with AIDS sought a declaratory judgment that Alaska's assisted suicide statute was unconstitutional as applied to MAID. The trial court rejected the plaintiffs' claims. The Alaska Supreme Court affirmed. The court held there was no fundamental right and that the state had a rational basis for prohibiting MAID. The court also denied the equal protection claim holding that the active passive distinction was valid. Furthermore, the court concluded that this was a "quintessentially legislative matter" and it would not make social policy.[180]

The Alaska Supreme Court found that, "[t]o the extent that the . . . statute's general prohibition of assisted suicide prevents terminally ill patients from seeking a physician's help in ending their lives, . . . the provision substantially interferes with [patients'] general privacy and liberty interests, as guaranteed by the Alaska Constitution."[181] Nevertheless, the court determined that the state's ban on such assistance, through its manslaughter statute, was constitutional because it both served a legitimate governmental purpose and bore a substantial relationship to that purpose.[182]

The court also expressed concern that permitting assisted suicide in cases involving competent, terminally ill patients would put courts in difficult positions in terms of determining competency and terminal condition.[183] Finally, the court seemed concerned that permitting assisted suicide in the case of competent patients would open the door to assisted suicide by advance directive.[184]

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[176] *McIver*, 697 So. 2d at 103.

[177] *Id.* (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990)).

[178] *Id.* ("[L]egal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.").

[179] *Id.* at 104.

[180] Sampson v. State, 31 P.3d 88, 98 (Alaska Sept. 21, 2001).

[181] *Id.* at 95.

[182] *Id.* at 95–96.

[183] *Id.* at 97–98.

[184] *Id.* at 97.

4. Baxter v. State *(Mont. 2009)*

In December 2008, a Montana trial court ruled that the Montana Constitution protected MAID.[185] While the trial court rejected the equal protection argument, it accepted the privacy and dignity argument. The court also found there were no compelling state interests requiring the state to treat MAID as homicide. As discussed below, the Montana Supreme Court resolved the right to MAID at the statutory level, obviating the need to resolve the constitutional question.[186]

5. Morris v. Brandenburg *(N.M. 2016)*

In early 2014, a trial court in New Mexico invalidated that state's statutory prohibition on MAID, ruling that it violated the provision of the New Mexico constitution guaranteeing not only "the rights of enjoying life and liberty" but also "the right to seek and obtain happiness."[187]

In 2015, the intermediate court of appeals reversed that judgment.[188] In 2016, the New Mexico Supreme Court affirmed the appellate court's reversal of the trial court ruling.[189] While agreeing that New Mexico could grant its citizens more constitutional rights than those guaranteed by the federal Constitution, the court followed the reasoning of *Glucksberg*. The court held there was no "special characteristic of New Mexico law that makes physician aid in dying a fundamental right in this state."[190] In doing so, it refused to hold that United States Supreme Court jurisprudence had moved beyond "the careful substantive due process approach announced in *Glucksberg*, effectively overruling it."[191]

Finally, the court interpreted Article II, Section 4 (the Inherent Rights Clause) of the New Mexico Constitution as creating no judicially enforceable rights but instead guaranteeing New Mexicans an expansive view of rights otherwise existing in its constitution. While the portion of New Mexico's Constitution that refers to "seeking and obtaining . . . happiness" might, under other circumstances, ensure greater due process protections that those of the federal government, "the Inherent Rights Clause has never been interpreted to be the exclusive source for a fundamental or important constitutional right, and on its own has always been subject to reasonable regulation."[192]

The court ruled that the New Mexico statute bore a rational relationship to the legitimate governmental interest in "providing positive protection to ensure that a terminally ill patient's end-of-life decision is informed, independent, and procedurally safe." Setting forth such procedures is a job for the legislature, not the judiciary. The New Mexico legislature can and should draw the line between the

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[185] Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009).

[186] Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009).

[187] Morris v. Brandenburg, No. D-202-CV 2012-02909, 2014 WL 10672986, at *6–7 (2d Jud. D. Ct. N.M., Jan. 13, 2014) (citing to N.M. CONST. art. II, §4) *rev'd* Morris v. Brandenburg, 2015-NMCA-100, 356 P.3d 564, *aff'd*, Morris v. Brandenburg, 2016-NMSC-027, 376 P.3d 836.

[188] *See Morris*, 2015-NMCA-100 (decided Aug. 11, 2015).

[189] *See Morris*, 2016-NMSC-027 (decided June 30, 2016).

[190] *Id.* ¶ 36.

[191] *Id.* ¶ 23 (citing Obergefell v. Hodges, 135 S.Ct. 2584, 2620–21 (2015) (Roberts, C.J., dissenting).

[192] *Id.* ¶ 51.

state's legitimate interest and the state's conceded lack of "interest in preserving a painful and debilitating life that will end imminently."[193]

6. Myers v. Schneiderman *(N.Y. 2017)*

Constitutional litigation in New York turned out no better than in New Mexico. The Appellate Division dismissed plaintiffs' state equal protection claim quickly, saying that the right to equal protection under the New York Constitution was coextensive with the right under the United States Constitution, and the Supreme Court in *Vacco v. Quill* had already decided that issue. The Appellate Division also rejected arguments that a strong liberty interest existed for due process purposes. The court refused to alter its constitutional analysis based on evidence amassed over the two decades since *Vacco* and *Glucksberg*. "We are not persuaded . . . aid-in-dying is an issue where a legitimate consensus has formed. . . . we defer to the political branches of government. . . . "[194]

The Court of Appeals affirmed, holding that applying New York's statutes criminalizing assisted suicide to MAID violated neither due process nor equal protection rights under the New York state constitution. "Although New York has long recognized a competent adult's right to forgo life-saving medical care, we reject plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as they define it. We also reject plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests."[195]

B. *Baxter v. Montana* (1st Jud. Dist. Ct. 2008)

As with lower courts in Florida and New Mexico, Montana plaintiffs were able to obtain a trial court judgment that Montana's prohibition of MAID violated patients' privacy, and dignity rights under the state constitution.[196] In December 2008, the Montana First Judicial District Court ruled that the state constitution protected MAID.[197] Yet, as discussed below, the Montana Supreme Court vacated the judgment.[198] That court found a right to MAID at the statutory level, obviating the need to resolve the constitutional question.[199]

The plaintiff argued that the statute was unconstitutional under the Montana Constitution's equal protection clause, individual dignity clause, and express right of privacy. The trial court ruled that the statute did not violate the state constitution's equal protection clause for the same reasons the United States Supreme Court had ruled to that effect with respect to the U.S. Constitution's Equal Protection Clause.

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[193] *Id.*

[194] Myers v. Schneiderman, 140 A.D. 3d 51, 65 (N.Y. App. Div. 2016).

[195] Myers v. Schneiderman, 85 N.E.3d 57, 65 (N.Y. Ct. App. 2017) (decided Sept. 7, 2017).

[196] *See* Baxter v. State, No. ADV-2007-787, 2008 Mont. Dist. LEXIS 482 (Mont. Dist. Ct. Dec. 5, 2008), *aff'd in part, rev'd in part*, 224 P.3d 1211 (Mont. 2009) (holding that the prohibition violated MONT. CONST. art. II, §§ 4, 10).

[197] *Id.*

[198] *See infra* Section VII.A.

[199] Baxter v. State, 224 P.3d 1211, 1220 (Mont. 2009). One Justice wrote separately to express agreement with the trial court's reasoning on the constitutional issue. *Id.* at 1223.

Nevertheless, the trial court ruled that the statute was unconstitutional, holding that the state constitution's individual dignity clause and right of privacy combined to "mandate that a competent terminally ill person has the right to choose to end his or her life."[200]

Moreover, the right necessarily includes a right to have the assistance of a physician, for if a patient were forced to proceed without physician assistance he might end his life "sooner rather than later . . . and the manner of the patient's death would more likely occur in a manner that violates his dignity and peace of mind."[201]

The trial court then considered the state interests that Montana had advanced to convince the court that the statute was constitutional. The state asserted an interest in the preservation of life. The court ruled that such an interest is compelling in general, but "diminishes in the delicate balance against the individual's constitutional rights of privacy and individual dignity" when a patient is terminally ill.[202]

The court ruled that the state did have compelling state interests in "protecting vulnerable groups from potential abuses" and "protecting the integrity and ethics of the medical profession." Yet the court held the statute unconstitutional despite the existence of these compelling state interests because it was overbroad. The court suggested that the state of Montana should seek to serve these compelling state interests by enacting statutory protections such as those contained within Oregon's Death with Dignity Act rather than by prohibiting suicide assistance as a blanket matter, sweeping within the reach of its statutes decisions of competent, terminally ill patients choosing to end their own lives with the assistance of physicians.[203]

C. Other Court Rulings

While only six state supreme courts have analyzed the constitutionality of MAID under state constitutions, seven other trial and intermediate appellate have also adjudicated state constitutional claims. Trial courts in Florida, Montana, and New Mexico ruled that prohibition of MAID violated state constitutional rights. Yet, no appellate court sustained those judgments. Nearly fifteen other trial and appellate courts to reach the issue all found that there was no state constitutional right to MAID.

Two California cases asserted both federal and state constitutional claims. The adjudication of the federal claims is discussed above.[204] The state claims fared no better. First, Thomas Donaldson brought claims under both the U.S. Constitution and the California Constitution. Both the Superior Court and the Court of Appeal denied the states claims just as they denied the federal claims.[205] Second, Jack Kevorkian brought claims under both the U.S. Constitution and the California

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[200] *Baxter,* 2008 Mont. Dist. LEXIS 482, at *26. The court recognized that the state may want to erect some safeguards but could do so afterwards. *Id.* at *29.

[201] *Id*. at *29.

[202] *Id*. at *30.

[203] *See id.* at *15.

[204] *See supra* Section V.A.

[205] *See* Donaldson v. Lungren, 4 Cal.Rptr.2d 59, 60 (Cal. Ct. App. Jan. 29, 1992).

Constitution. The U.S. District Court denied the states claims just as it denied the federal claims.[206]

1. Sanderson v. Colorado *(Colo. App. 2000)*

The MAID issue in Sanderson differed significantly from that in other cases. Robert Sanderson was an 81-year-old former judge. Although in good health, Sanderson wanted to execute an advance directive authorizing his wife "to end his life by euthanasia, provided that two physicians agree his medical condition is hopeless."[207] He sought a declaratory judgment to assure himself that neither his wife nor the physician who actually engaged in the euthanasia would be subject to criminal liability.

Sanderson asserted claims under several federal constitutional provisions, but on appeal after dismissal of the complaint, he pursued only a claim under the free exercise clause of the First Amendment. Sanderson described his personal religious beliefs as including beliefs that the free will of man included an ability to direct euthanasia, and that man could delegate to another to authorize euthanasia.

The Colorado Court of Appeals ruled that the free exercise clause did not exempt the plaintiffs from the state law criminalizing their conduct, in large part because the law was an "'across-the-board' criminal prohibition on a particular form of conduct." Because Colorado's prohibition of assisted suicide fell into this category, the court ruled, it constituted a "valid, religiously-neutral, and generally-applicable criminal statute that prohibits conduct a state is free to regulate."[208]

In addition to its unique First Amendment argument, *Sanderson* is interesting, and differs from the other cases, in that the plaintiff was asserting a right to choose death through an advance directive rather than a right to commit suicide with assistance. Thus, the plaintiff was arguing that, while competent, he could direct others to euthanize him later, when he was incompetent. Rather than asserting his own right to take action, Sanderson sought to authorize others to take action, and he wanted to ensure that the state would not prosecute those who acted at his request.

The court noted the incongruity by describing his claim as weak, because he does not just seek a limited exemption from the assisted suicide statute for himself so that he may freely practice his religion without fear of criminal prosecution. He also seeks exemptions for third parties—his wife and his physician—based on his personal religious beliefs, which they may not share. Even assuming Sanderson had standing to raise such claims on behalf of third persons, the court found "no precedent for such a broad application of the Free Exercise Clause in First

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[206] *See* Kevorkian v. Arnett, 939 F. Supp. 725, 731–32 (C.D. Cal. 1996), *vacated, appeal dismissed*, Kevorkian v. Arnett, 136 F.3d 1360 (9th Cir. 1998).

[207] *See* Sanderson v. People, 12 P.3d 851 (Colo. App. June 8, 2000); *see also* Allison Sherry, *Ex-Judge Seeks Right to Die,* DENVER POST (June 9, 2000), www.extras.denverpost.com/news/news0609.htm (explaining that Sanderson was in good health despite his interest in the medical aid in dying cause).

[208] *Sanderson*, 12 P.3d at 854.

Amendment jurisprudence."[209] The Colorado Supreme Court declined to hear the case.[210]

2. People v. Kevorkian *(Mich. App. 2001)*

In 1999, a Michigan jury convicted Jack Kevorkian of second-degree murder and unlawful delivery of a controlled substance.[211] Kevorkian appealed.[212] He contended that his conviction was unlawful under the Ninth and the Fourteenth Amendments of the U.S. Constitution, as well as under their counterparts in the Michigan Constitution.[213]

The Ninth Amendment provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."[214] Dr. Kevorkian claimed that the "right to be free from inexorable pain and suffering must be among" the rights so protected.[215] The court summarily rejected this argument because of Kevorkian's failure to pursue it beyond its mere assertion.

The court dealt far more extensively, however, with Dr. Kevorkian's Fourteenth Amendment liberty interests argument. Using the U.S. Supreme Court's assisted-suicide jurisprudence as a base, Kevorkian argued that the "necessary and direct corollary" of the concern expressed in *Quill* about patients dying in pain was "that a person should not be forced to suffer unbearably."[216] While acknowledging the Supreme Court's concerns about pain, the court refused to rule that it was unconstitutional to apply Michigan's murder statute to active euthanasia based on those concerns.

The court articulated three bases for its ruling. First, the court expressed a concern that "expanding the right to privacy would begin, as the steps in the progression of defendant's argument supporting voluntary euthanasia clearly indicate, the slide down the slippery slope toward euthanasia."[217] Second, the court hesitated to take such a step because it believed that "[i]f society is to recognize a right to be free from intolerable and irremediable suffering, it should do so through the action of the majority of the legislature, whose role it is to set social policy, or by action of the people through ballot initiative."[218]

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[209] *Id.*

[210] *See id.* (indicating that certiorari was denied on October 23, 2000 due to an unsuccessful attempt at making a first amendment challenge); *cf.* Final Exit Network, Inc. v. Georgia, 722 S.E. 2d 722, 725 (Ga. 2012) (making a successful first amendment challenge); *see also* State v. Melchert-Dinkel, 844 N.W.2d 13, 18 (Minn. 2014), rev'g 816 N.W.2d 703 (Minn. Ct. App. 2012) (succeeding on first amendment grounds).

[211] *See* Dirk Johnson, *Kevorkian Sentenced to 10 to 25 Years in Prison*, N.Y. Times, (Apr. 14, 1999) http://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html.

[212] People v. Kevorkian, 639 N.W.2d 291, 296 (Mich. App. 2001).

[213] *See id.* at 300–303; *see also* Monica Davey, *Kevorkian Speaks After His Release From Prison*, N.Y. TIMES, (June 4, 2007), http://www.nytimes.com/2007/06/04/us/04kevorkian.html (indicating that even after eight years of imprisonment, Dr. Kevorkian still felt strongly about MAID).

[214] U.S. CONST. amend. IX.

[215] *Kevorkian*, 639 N.W.2d at 303.

[216] *Id.* at 304 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

[217] *Id.* at 306.

[218] *Id.*

Finally, the court expressed concern about judging quality of life. "Expanding the right of privacy to include a right to commit euthanasia . . . to end intolerable and irremediable suffering we would inevitably involve the judiciary in deciding questions that are simply beyond its capacity."[219]

3. Hooker v. Slattery *(Davidson County, Tenn. 2016)*

In May 2015, John Jay Hooker filed a lawsuit asserting a right to MAID under the Tennessee Constitution. In September 2015, the trial court held that Hooker had no right to MAID under the Tennessee Constitution.[220] In any case, the state had compelling state interests to prohibit MAID. Hooker unsuccessfully sought review directly from Supreme Court of Tennessee.[221] Hooker then voluntarily dismissed the appeal before a ruling from the intermediate appellate court.[222]

4. Donorovich-O'Donnell v. Harris *(Cal. App. 2015)*

Before California enacted the End of Life Options Act in October 2015, two separate sets of plaintiffs filed separate lawsuits seeking to establish a state constitutional right to MAID. In May 2015, Christy Lynne Donorovich-O'Donnell with other terminally ill patients and a physician filed in San Diego Superior Court.[223] In July 2015, the court sustained the defendants' demurrers, holding that no state constitutional right to privacy, free speech, or equal protection extended to MAID.[224]

By the time the California Court of Appeal issued its opinion, the legislature had already enacted the End of Life Options Act. Yet, that did not moot the case because the law was not yet in effect.[225] In October 2015, the Court of Appeal affirmed the Superior Court.[226] The California Supreme Court declined to hear the case.[227]

The plaintiffs in *Donorovich-Odonnell* argued that, as applied to competent, terminally ill persons seeking lethal medication to end their lives, the application of the criminal assisted suicide law to MAID deprived citizens of "autonomy privacy."[228] The California Constitution's explicit grant of a right to privacy could indeed protect more than the federal Constitution does, but the court in refused to so hold because the plaintiffs had not "parse[d] out why the reasoning of *Glucksberg* or *Vacco* is ostensibly inapplicable."[229] It also cited *Donaldson* as holding that the state

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[219] *Id.* at 307 (emphasis in original).

[220] *See* Hooker v. Slatery, No. 15061511 (Davidson Cty. Ch. Ct., Tenn. Sept. 29, 2015).

[221] *See* Hooker v. Slatery, No. M2015-01982-SC-RDM-CV (Tenn. Nov. 9, 2015).

[222] *See* Hooker v. Slatery, No. M2015-01982-COA-R3-CV (Tenn. Ct. App. May 20, 2016).

[223] *See* Complaint at 1, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. May 15, 2015).

[224] *See* Ruling on Demurrer, Donorovich-O'Donnell v. Harris, No. 37-2015-00016404-CU-CR-CTL (San Diego Sup. Ct. July 24, 2015).

[225] In addition, it is worth ruling on the constitutionality of MAID, because the California End of Life Options Act is scheduled to sunset in 2026.

[226] *See* Donorovich-O'Donnell v. Harris, 194 Cal. Rptr. 3d 579, 582 (Ct. App. Oct 29, 2015).

[227] *Donorovich-Odonnell v. Harris*, No. S230918, 2016 Cal. LEXIS 646 (Feb. 3, 2016).

[228] *See Donorovich-O'Donnell*, 194 Cal. Rptr. 3d at 590.

[229] *Id.* at 594.

constitution could not shield a third person from criminal liability for assisting a person in committing suicide.[230]

In sum, the court ruled that the plaintiff's asserted right to obtain "assistance of a third party in committing suicide" was not fundamental. Even if it were, the state had compelling interests in enforcing its statutory prohibition of suicide assistance in cases of MAID. Specifically, the state has an interest in ensuring that people are not influenced to kill themselves, and interests in preserving life, maintaining the ethics of the medical profession, protecting vulnerable groups, and guarding against a slippery slope toward involuntary euthanasia.

Overridingly, however, the court opined that the matter was one for the legislature rather than the courts. In doing so, it focused on the legislative imposition of many safeguards on the process of MAID in California's End of Life Options Act. "If the law were changed by judicial opinion, these extensive safeguards would not be in place."[231]

5. Brody v. Harris *(San Francisco Sup. Ct. 2016)*

In February 2015, another set of California plaintiffs filed in San Francisco Superior Court. They also made state constitutional claims. In February 2016, the court sustained the defendants' demurrers.[232] The trial court ruled that the right to privacy did not include MAID.[233] It also ruled that disallowing MAID did not violate equal protection.[234] Moreover, the court observed that the legislature had recently acted. The plaintiffs appealed but later voluntarily dismissed.[235]

D. Ongoing Litigation in 2018

While plaintiffs have been unable to establish a state constitutional right to MAID in any jurisdiction, they keep trying. There are two active cases: one in Hawaii and one in Massachusetts.

1. Radcliffe v. Hawaii *(1st Cir. Ct., Haw. 2016)*

In January 2017, John Radcliffe filed a lawsuit seeking declaratory and injunctive relief. But in July 2017, the trial court refused to address the merits of Radcliffe's challenge to the Hawaii assisted suicide statute, deferring the questions to the political branches of government.[236] First, the court held that plaintiffs cannot challenge a criminal statute through declaratory judgment. Second, the court held that it would not interfere with the state medical board and declare that MAID was

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[230] *See id.* at 592–93 (citing Donaldson v. Lungren, 4 Cal. Rptr. 2d 59 (Ct. App. 1992)).

[231] *Id.* at 595.

[232] Order Sustaining Demurrers at *4–5, Brody v. Harris, 2016 Cal. Super. LEXIS 1564 (No. CGC-15-544086) (San Francisco Sup. Ct. Feb. 16, 2016).

[233] *See id.* at 3 (citing *Donorovich-O'Donnell*, 194 Cal. Rptr. 3d 579 and *Donaldson*, 4 Cal. Rptr. 2d 59).

[234] *See id.* at 3–4 (citing Vacco v. Quill, 521 U.S. 793 (1997)).

[235] Brody v. Harris, No. A148572 (Cal. Ct. App. Oct. 14, 2016).

[236] Radcliffe v. Hawai'i, No. 17-1-0053-1-KKH, slip op. at 12–13 (1st Cir., Haw. July 14, 2017).

legitimate medical practice. Third, the court refused to issue an injunction, because the statute was presumed valid. The case is now on appeal.[237]

2. Kligler v. Healy *(Suffolk County Sup. Ct., Mass. 2017)*

In October 2016, two physicians filed a lawsuit in Suffolk County, Massachusetts court seeking a declaration that the state attorney general and a district attorney could not prosecute them for engaging in MAID.[238] One of the plaintiff physicians was terminally ill and seeking the option, while the other was willing to write the prescription if he would not be criminally punished for doing so. The plaintiffs asserted that the state's prohibition of MAID violated the Massachusetts constitution. Specifically, the plaintiffs alleged that MAID was protected by the state constitutional rights to privacy, liberty, free speech, and equal protection.

In May 2017, the trial court denied the defendants' motions to dismiss.[239] The court ruled that the case could proceed in the face of arguments that the court lacked jurisdiction over it and that the court should dismiss it either because any judicial decision would not completely resolve the dispute or because the matter of MAID is best left to the legislature. The court noted several times that it was not opining on the merits of the case, merely ruling that it had jurisdiction and would retain the case on the docket.

VII. LEGALIZING MAID THROUGH STATUTORY LITIGATION

In addition to making claims under the U.S. Constitution and under state constitutions, advocates have also brought statutory interpretation claims. They argue that MAID is not encompassed within the criminal prohibition of "assisted suicide." Advocates maintain that MAID and assisted suicide are such different acts that the prohibition of one does not entail the prohibition of the other.

The argument maintains that the choice of a competent dying patient for a peaceful death through MAID is not "suicide." MAID involves the rational choice of a competent, terminally ill patient who finds herself trapped in an unbearable dying process to precipitate death in order to avoid further suffering and preserve her personal dignity. Suicide, by contrast, is a person's choice to prematurely cut short a viable life, usually for reasons of a transient nature and often involving depression or other mental health impairments, recovery from which may be possible with counseling, support, and/or medication. Because MAID is not suicide, it is not covered by the assisted suicide statutes.

Indeed, a growing consensus of medical, mental health and health policy professionals recognize that the choice of a dying patient for a peaceful death through aid in dying is not "suicide." For example, the American Psychological Association

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[237] *See* Radcliffe v. State, No. CAAP-17-000594, ECOURT KŌKUA, http://www.courts.state.hi.us/legal_references/records/jims_system_availability (follow "Click Here to Enter eCourt* Kokua"; then follow "Search for case details by case ID or citation number," and search with case ID: "CAAP-17-0000594") (last visited Jan. 31, 2018).

[238] *See* Kligler v. Healy, 34 Mass. L. Rptr. 239 (Super. Ct. 2017). *See generally* Roger Kligler, *The Death I Want,* BOS. MAG. (Jan. 15, 2017, 6:05 am), http://www.bostonmagazine.com/health/2017/01/15/the-death-i-want-roger-kligler/.

[239] *See id.*

recognizes that "the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."[240] Even more recently, the American Association of Suicidology concluded that "suicide and physician aid in dying are conceptually, medically, and legally different phenomena."[241]

Yet, despite the semantic and logical cogency of the argument differentiating "suicide" and "MAID," no court has ever accepted it. On the other hand, the Supreme Court of Montana did accept a statutory interpretation argument based on the unique consent defense in its statute.

A. *Baxter v. Montana* (Mont. 2009)

As discussed above, the Montana trial court in Baxter found a state constitutional right to MAID.[242] The Montana Supreme Court neither affirmed nor reversed that holding, but vacated it. Because the court found a statutory ground for MAID, it did not need to reach the constitutional issue. The Montana Supreme Court ruled that physicians may legally assist competent, terminally ill patients in dying by writing prescriptions for lethal medications at their request.[243]

Suicide is not a crime in Montana, and aiding or soliciting a suicide is only a crime if the victim does not die. Instead, the crime that applies to aiding or soliciting a successful suicide is homicide.[244] Yet, the Montana legislature provides that consent is generally a defense to criminal charges, except in four enumerated situations.

The issue for the Montana Supreme Court was whether the consent that a competent, terminally ill patient would be giving for MAID was against public policy.[245] The court ruled that it was not, in part based on statutory interpretation and in part based on the "legislative respect for the wishes of a patient facing incurable illness" that appeared throughout Montana's statutes authorizing withholding and withdrawal of treatment.[246] Significantly, the Montana Supreme Court noted: "In light of the long-standing, evolving and unequivocal recognition of the terminally ill patient's right to self-determination at the end of life in [the Montana statutes], it would be incongruous to conclude that a physician's indirect aid in dying is contrary to public policy."[247]

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[240] *Patients' Rights to Self-Determination at the End of Life*, AM. PSYCHOL. ASS'N (Oct. 28 2008), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life.

[241] AM. ASS'N OF SUICIDOLOGY, STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: "SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING" 4 (2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf.

[242] *See supra* Section VI.B.

[243] *See* Baxter v. State, 2009 MT 449, ¶ 50, 224 P.3d 1211 (2009).

[244] *See id.* ¶ 11.

[245] *See id.* ¶ 13 ("Consent is ineffective if: . . . it is against public policy to permit the conduct or the resulting harm, even though consented to.") (quoting MONT. CODE ANN. § 45-2-211(2)).

[246] *Id.* ¶ 38.

[247] *Id.*

Unlike the six states that enacted MAID statutes, Montana has no legal requirements concerning eligibility criteria or request and prescription procedures. Consequently, the practice of MAID in Montana is presumably governed by the professional standard of care and regulatory process.[248]

B. *Blick v. Connecticut* (Hartford Jud. Dist., Conn. 2010)

In October 2009, Gary Blick brought a lawsuit seeking a declaratory judgment that the Connecticut assisted suicide statute did not cover MAID. The court rejected the argument, observing that the statute's application to MAID is amply demonstrated by multiple legislative attempts to amend the assisted suicide law to permit MAID.[249] The court declined to usurp a legislative function. Furthermore, because the attorney general would not exceed its authority by prosecuting MAID, the lawsuit was barred by sovereign immunity.[250]

C. Other Cases

Almost every recent case asserting state constitutional claims has also made statutory interpretation claims.[251] Yet, not a single court has accepted the statutory interpretation argument. As in *Blick*, every court agreed that MAID was encompassed within the state's prohibition of suicide assistance, as a matter of statutory interpretation.

For example, in *Morris*, the New Mexico Supreme Court found that MAID constitutes "deliberately aiding another in the taking of his own life," and thus constitutes suicide assistance under the statute.[252] The court found "compelling" evidence indicating that medical and psychological professionals do not consider MAID to be suicide and that the deaths in cases of MAID are considered to result from the underlying disease, not the taking of the medication. Nevertheless, the legislature had explicitly distinguished "assisted suicide" from withholding and withdrawal elsewhere in New Mexico's statutory scheme. The court held that the practice came within the statutory definition of suicide assistance.[253]

VIII. OTHER MEANS OF LEGALIZING MAID

While only a statute or appellate judgment provides patients and clinicians with clear sufficient ex ante permission to engage in MAID, there are two other means of "legalizing" the practice. First, lawmakers can limit prosecutorial discretion, thus making it unlikely that MAID participants will be arrested or

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[248] *Cf.* Kathryn L. Tucker, *Aid in Dying*, 142 CHEST. 218, 220 (2012) (noting that MAID is protected in Montana and that "absent a prohibition, the practice . . . can proceed subject to the best practices and an emerging standard of care").

[249] *See* Blick v. Office of the Div. of Criminal Justice, No. CV095033392, 2010 Conn. Super. LEXIS 1412, at *21 (2010).

[250] *See id.* at *42.

[251] *See supra* Sections VI.A & VI.C (including *Morris, Myers, O'Donnell,* and *Brody*).

[252] Morris v. Brandenburg, 2016-NMSC-027, ¶ 15, 376 P.3d 836 (2016) (quoting N.M. STAT. ANN. § 30-2-4).

[253] *See id.*

prosecuted. Second, even if MAID participants are prosecuted, juries can refuse to convict.

A. Prosecutorial Discretion

The eminent Canadian health law scholar Jocelyn Downie observes that "guidelines for how prosecutorial discretion should be exercised . . . may also be a pathway to a more permissive legal regime."[254] Prosecutors already exercise significant discretion as to which cases to pursue.[255] Downie argues that while MAID would remain illegal, prosecutors could publish guidelines indicating the factors and circumstances under which they would prosecute.

There is substantial track record for this approach outside the United States. For example, before affirmative legalization in 2002, MAID was tolerated for decades in the Netherlands.[256] In Switzerland, MAID is widely practiced, yet still not affirmatively regulated.[257] In the UK, MAID is clearly prohibited by the Suicide Act of 1961.[258] Nevertheless, in 2010, the Crown Prosecution Service introduced guidelines.[259] At least one U.S. jurisdiction has taken a similar approach.[260]

Surprisingly, physicians provide MAID with significant frequency even in those jurisdictions where it remains illegal. Still, there have been few prosecutions. The paucity of reported legal cases is probably attributable primarily to the failure by law enforcement authorities to detect their occurrence. Yet, even when these cases "come to the attention of the authorities, by dint of pervasive discretion in the criminal justice system," prosecutors do not bring indictments.[261] If prosecutors

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[254] Jocelyn Downie, *Permitting Voluntary Euthanasia and Assisted Suicide: Law Reform Pathways for Common Law Jurisdictions,* 16 QUT L. REV. 84, 91 (2016); *see also* Ben White & Jocelyn Downie, *Prosecutorial Guidelines for Voluntary Euthanasia and Assisted Suicide: Autonomy, Public Confidence and High Quality Decision-Making,* 36 MELB. U. L. REV. 656 (2012).

[255] *See generally* ANGELA J. DAVIS, ARBITRARY JUSTICE (2007).

[256] *See* Agnes van der Heide et al., *End-of-Life Decisions in the Netherlands over 25 Years*, 377 NEW ENG. J. MED. 492 (2017).

[257] *See* Samia A. Hurst & Alex Mauron, *Assisted Suicide in Switzerland: Clarifying Liberties and Claims*, 31 BIOETHICS 199, 199 (2017).

[258] *See* R (*In re* Purdy) v. Dir. of Pub. Prosecutions [2009] UKHL 45, [2010] 1 AC (HL) 345 (appeal taken from Eng.).

[259] THE DIR. OF PUB. PROSECUTIONS, POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ENCOURAGING OR ASSISTING SUICIDE (2010); *see also* R (Nicklinson) v. Ministry of Justice [2013] EWCA (Civ) 961, [2015] AC 657 (Eng.) (involving prosecution after the guidelines were created), *rev'd*, [2014] UKSC 38; Alexandra Mullock, *Compromising on Assisted Suicide: is 'Turning a Blind Eye' Ethical?,* 7 CLINICAL ETHICS 17 (2012) (discussing the effects of the guidelines); *Assisted Suicide*, CROWN PROSECUTION SERV. (Jan. 31, 2018), https://www.cps.gov.uk/publication/assisted-suicide (providing the latest assisted suicide figures).

[260] *See Bisbee Taking a Stance on Assisted Suicide*, KVOA.COM (Sept. 4, 2015), http://www.kvoa.com/story/29964343/bisbee-taking-a-stance-on-assisted-suicide (reporting a city council resolution asking the Cochise County Attorney to "deprioritize" prosecuting anyone involved in MAID).

[261] *See* THE RIGHT TO DIE, *supra* note 21, § 12.04[D]; *see also* Kenneth A. De Ville, *Physician Assisted Suicide and the States: Short, Medium, and Long Term*, *in* PHYSICIAN ASSISTED SUICIDE: WHAT ARE THE ISSUES? 171, 173–75 (Loretta M. Kopelman & Kenneth A. De Ville eds., 2001). For example, Dr. Rodney Syme was never prosecuted after admitting to assisting the suicide of Steve Guest. *See* Jeff Turnbull, *'Benign Conspiracy' over a Death*, SYDNEY MORNING HERALD (April 21, 2009),

provide ex ante guidance in when they will bring charges, then patients and physicians might have sufficient comfort and clarity to engage in MAID despite its illegality.

B. Jury Nullification

Closely related to prosecutorial discretion is jury nullification. Just as prosecutors can decline to prosecute illegal activity, jurors can decline to convict when there is prosecution. Even when evidence of factual guilt is clear, and the jury believes beyond a reasonable doubt that the defendant engaged in MAID, the jury can still vote the defendant "not guilty."[262] Juries can and do refuse to convict when they think the underlying law is unjust.

Jury nullification is common in MAID cases.[263] For example, Tim Quill wrote in the New England Journal of Medicine that he participated in MAID.[264] This was a very public confession. And MAID is criminally prohibited in New York.[265] Nevertheless, a Rochester grand jury refused to indict Dr. Quill.[266] Similarly, Michigan juries repeatedly refused to convict Jack Kevorkian despite his clear violation of laws in that state.[267] In short, while not the same as decriminalization, jury nullification, like prosecutorial discretion, could help pave a pathway to MAID.[268]

IX. CONCLUSION

The legalization is MAID in the United States is a train that has left the station. It will eventually reach most of the other forty-nine U.S. jurisdictions where it is not yet legal. Yet, policymakers must then grapple with next-generation issues such as the appropriate eligibility criteria and process requirements. The safeguards built into the existing six statutes may unduly restrict access to MAID.[269]

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http://www.smh.com.au//breaking-news-national/benign-conspiracy-over-assisted-death-20090421-adie.html.

[262] *See* Morissette v. United States, 342 U.S. 246, 276 (1952) ("[J]uries are not bound by what seems inescapable logic to judges."). *See generally* JEFFREY ABRAMSON, WE, THE JURY 57–97 (1994); CLAY S. CONRAD, JURY NULLIFICATION (Cato Inst. Press 2014).

[263] *See generally* Liana C Peter-Hagene & Bette L Bottoms, *Attitudes, Anger, and Nullification Instructions Influence Jurors' Verdicts in Euthanasia Cases*, 23 PSYCHOL., CRIME & L. 983 (2017) (researching the potential for nullification due to MAID attitudes).

[264] *See* De Ville, *supra* note 261, at 173.

[265] *See* Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. Ct. App. 2017).

[266] *See* Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES (July 27, 1991), http://www.nytimes.com/1991/07/27/nyregion/jury-declines-to-indict-a-doctor-who-said-he-aided-in-a-suicide.html.

[267] Michigan juries repeatedly acquitted Jack Kevorkian, in trials over the suicide of: Thomas Hyde (May 1994), Ali Khalil and Merian Frederick (March 1996), and Sherry Miller and Marjorie Wantz (May 1996). *See* NEAL NICOL & HARRY WYLIE, BETWEEN THE DYING AND THE DEAD 185–187 (Univ. of Wis. 2006) (2006). Only when Kevorkian moved from assisted suicide to active euthanasia was he convicted of second degree murder in the killing of Thomas Youk. *See Jail Time for Dr. Kevorkian,* N.Y. TIMES (April 15, 1999), http://www.nytimes.com/1999/04/15/opinion/jail-time-for-dr-kevorkian.html.

[268] In addition, even when there are convictions, the sentences are often very light.

[269] *See* Pope, *supra* note 20.

Testimony - Victor Thuronyi 2024.pdf
Uploaded by: Victor Thuronyi
Position: FAV

Testimony of Victor Thuronyi
Support for HB0403 and SB0443
The End-of-Life Option Act
Feb. 8, 2024

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 and 26,328 in 2021.[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.

Cessation of eating and drinking

Opponents of aid in dying legislation sometimes point out that patients are free to end their life by stopping eating and drinking. That is certainly an option I would consider when the time comes, but it has the disadvantage of being a prolonged process and involving delirium or a long period of unconsciousness towards the end. Whether this is a better method as compared with taking a prescription under the end-of-life options act is a decision that should be made by patients and their doctors, not by legislators. Experience with legislation in other areas of medical care (banning abortions where the health of the mother is in danger; banning certain forms of care for transgender persons) shows us that difficult medical decisions are better made by the patients concerned and their doctors than by legislators.

Encouraging honest 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-

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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/.

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 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 becomes 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

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

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 always 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.

SB443End.pdf

Uploaded by: WENDEL THOMPSON

Position: FAV

SB443 End–of–Life Option Act

FAVorable

Wendel Thompson
Charlestown Senior Living
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443-602-1942
wendelth@yahoo.com

My wife, Carolyn, died a year ago. She was 86. We were married for 60 years. The spirit had left her; she had pain from lumbar stenosis; she wanted to die before me. And she did so by not taking any food or drink. That was her terminal illness. Hospice Care in the last week of her life meant we had morphine available which put her to sleep. Her last days in our own home were days of silence. As she took her final breath, my granddaughter, on one side of the bed, whispered the names of those who loved her. I, on the other side, held her hand and whispered, “I love you.”

Could our last time with Carolyn have been different if this law had been in place? Carolyn could have been awake and present to us, not silent. We would sing our family goodbye hymn, “Bless Be the Tie that Binds.” We would read some scripture selected by each one or tell a favorite story. We could play one of the songs Carolyn used to sing—maybe “For God So Loved the World”. We would have moments of silence and prayer. We might listen to “Pomp and Circumstance,” her one request for her memorial service. Would Carolyn have chosen this? Who knows? I think she would have. Our son disagrees. But it was not an option Carolyn had.

The comforting scene I just laid out might have been interrupted by some trouble. But haven’t we learned to deal with trouble as a normal part of our life here on earth?

A favorable vote on this legislation would give folks another option for end of life.

SB 443 - JPR - MDH - SWA (1) (1).docx.pdf

Uploaded by: Jason Caplan
Position: FWA

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 8, 2024

The Honorable William C. Smith, Jr.
Chair, Senate Judicial Proceedings Committee
Room 2 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: Senate Bill 443 - The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act - Support with Amendments

Dear Chair Smith and Committee Members:

The Maryland Department of Health (Department) respectfully submits this letter of support with amendments for Senate Bill (SB) 443 – *The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act*. The bill would establish a process for an individual suffering from a terminal illness to request aid in dying with protections to ensure that the individual has the capacity to make the decision. The bill also requires the Department to establish regulations regarding the collection of data around the option and to publish an annual statistical report surrounding the process.

The Department supports this important legislation. In recent years, more states have adopted this option in recognition of individuals' right to bodily autonomy. The legislation, as noted above, contains numerous protections to ensure that individuals suffering from a terminal illness electing an end of life option have the capacity to make the decision.

The Department will submit proposed amendments around the reporting language to ensure that the reporting complies with best practices.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron at sarah.case-herron@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

SB443 - OPPOSE.pdf

Uploaded by: Alexandra Rak

Position: UNF

OPPOSED - SB443 - End of Life Option Act

Dear Members of the Senate Judicial Proceedings Committee,

I am writing to express my strong opposition to SB443, The End of Life Option Act.

While recognizing the intention to address pain and suffering, I urge you to consider the following concerns regarding assisted suicide:

1. **Reasons for Choosing Assisted Suicide**: The primary motivations for seeking assisted suicide, as observed in states where it is legal, go beyond pain and often include loss of autonomy, loss of bodily function, and feelings of being a burden on family members.
2. **Financial Incentives for Insurance Companies**: Legalizing aid in dying may create financial incentives for insurance companies and state health plans to save money by not providing costly treatments for late-stage cancer sufferers or those with degenerative conditions.
3. **Redefined "Death by Natural Causes**: The bill seeks to redefine "death by natural causes" to include assisted suicide, which has broader implications for our understanding of end-of-life care.
4. **Impact on Healthcare Providers**: Passage of this bill could change professional expectations for healthcare providers and potentially diminish the established medical standard of care.
5. **Financial Incentives for Surviving Relatives**: The legislation may create a financial incentive for surviving relatives, potentially influencing decision-making surrounding a relative's assisted suicide.

Moreover, SB443 replicates past legislation that has been viewed unfavorably by Marylanders and committees. Concerns include:

- Lack of Safeguards: There are insufficient safeguards to protect vulnerable populations from coercion and abuse.
- Inaccuracy of Terminal Diagnoses: Doctors cannot accurately predict a 6-month terminal diagnosis, leading to potential errors in eligibility.
- Reasons for Requesting Lethal Drugs: Patients in states with similar laws have requested lethal drugs due to feeling like a burden on their family, rather than solely due to pain.
- Risk of Drug Diversion: Unused barbiturates may enter the illicit drug market, exacerbating the opioid crisis.

Additionally, considering that this year is the Year of the Military Family in Maryland, addressing the mental health crisis among veterans is crucial. Veterans, along with the elderly, ill, and disabled, deserve dignity and compassion, not assisted suicide. I fear legalizing suicide sends the exact opposite message to our veterans struggling with mental health since we know that those seeking "aid in dying" do so at a higher rate because they fear being a burden to their loved ones than they fear pain and suffering.

I am deeply concerned that the bill's proponents find the existing safeguards burdensome, raising the potential for future General Assemblies to eliminate these crucial protections.

As a citizen, I fear becoming a victim of this legislation, pressured into ending my life rather than receiving proper treatment during a vulnerable moment in my old age or following a life-limiting diagnosis.

Thank you for considering my perspective, and I urge you to issue an unfavorable report on SB443.

Sincerely,
Alexandra Rak
Port Tobacco, MD
Email: alexandra.petti@gmail.com

SB 443 Physician Assisted Suicide Written Testimon

Uploaded by: Amy Waychoff

Position: UNF

SB 443
Amy Waychoff
LD 18
Unfavorable

My name is Amy Waychoff, and I have been a Maryland resident since 1987. I am writing in opposition to SB 443, End of Life Options Act. Many in the medical profession have come out strongly against physician-assisted suicide. Here are just a few of the medical groups:

- American Medical Association
- American College of Physicians
- Maryland Chapter of the American College of Physicians
- Maryland Psychiatric Society

To quote from the Maryland Chapter of the American College of Physicians:

“We all have fears about death. But for a doctor to prescribe a bottle of poison is neither compassion nor treatment. The physician’s role is as healer and comforter. The compassionate choice for Maryland is to promote access to high quality palliative and hospice care.”

When someone receives a “terminal” diagnosis, it is no longer a death sentence, thanks to advances in medical science. I know several people who are continuing to live productive lives despite their diagnoses.

Assisted suicide is a danger to Maryland citizens. Allowing doctors to prescribe large and lethal doses of drugs with no protection to make sure those drugs do not end up in the wrong hands or on our streets puts us all at risk. Doctors might be bribed to make this decision for financial gain. Indeed, some advocates for physician-assisted suicide grossly point to the potential “cost-savings” for taxpayers.

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.

If this bill passes, there would be terrible unintended consequences for people with disabilities. They would become victims of government overreach. The poor, who could not afford to pay for treatments, would be encouraged to commit suicide.

I know that you want to do the right thing, but you must be very careful because your decision will affect all of the people in our state, and it will resonate throughout our country.

Your laws have consequences.

0_Campbell Testimony .pdf

Uploaded by: Andrea Campbell

Position: UNF

SB0443 Testimony

SB443 -written testimony 2/7/24
Andrea Campbell
Position- Unfavorable
Arnold, MD

There is the view that an individual who is not mobile (permanently wheelchair or in bed) has a fate worse than death.
I have visited Future Care for over a decade on monthly basis. There are many many persons who are permanently in a bed and without visitors. However, their lives have worth and Dignity.
With this Bill, will staff or family easily persuade them that it's compassion to help them die?
A disability should not be considered a suffering that requires suicide.
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.
They feel that they are a burden to their family anyway. The family may hint at this. They may believe they have a Responsiblity to die. They may be in some stage of dementia. Individually, without their families, they make a decision that is not " truly informed.
Individuals will have the “option” to go to the pharmacy by themself, go home alone and take 100 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 in pain ?
You may believe you should not inform your family. They 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.
Too many teenagers have committed suicide.
" 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 word compassion means to " Suffer Together or Suffer With" - not just give you the means to kill yourself alone.

Anita Cameron testimony against Maryland SB 0443.p

Uploaded by: Anita Cameron

Position: UNF

February 7, 2024

SB0443
End of Life Option Act
Senate Judicial Proceedings
Position: Oppose

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 0443 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 0443 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 Pew Research Center 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 0443

Anita Cameron testimony against Maryland SB 0443.p

Uploaded by: Anita Cameron

Position: UNF

February 7, 2024

SB0443
End of Life Option Act
Senate Judicial Proceedings
Position: Oppose

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Kelly Testimony opposing MD SB0443 End of life op

Uploaded by: Anita Cameron

Position: UNF

February 07 2024

John B. Kelly
Not Dead Yet
Communications Director
Boston, Massachusetts

SB 0443
End of life Option Act
Senate Judicial Proceedings

My name is John B. Kelly. I am Communications Director for Not Dead Yet, the leading national disability rights group opposing assisted suicide, futility judgments, and "better dead than disabled" policies. We organized in 1996 to help stop Kevorkian, whose client victims were presented in the media as terminally ill. Two thirds of them were later found by the New England Journal of Medicine to be NOT terminally ill but disabled.

I keep thinking about Canada, where people like me – I'm a quadriplegic paralyzed below my shoulders, but I am not terminally ill – have become eligible for its version of an "aid in dying" program – and by aid in dying Canada means euthanasia 99% of the time.

At first, Canada legalized euthanasia/assisted suicide for people diagnosed as terminally ill, which it defined as people whose deaths were "reasonably foreseeable." The courts soon stretched that definition to include non-dying disabled people. Now, anyone with a "grievous irremediable medical condition" can qualify for euthanasia. Disabled people have "chosen" euthanasia when denied services (Sean Tagert) or accessible housing ("Sophia").

In Maryland and other states, proponents insist that "aid in dying" hinges on a definition of terminal illness that limits the population to people expected, "within reasonable medical certainty," to die within the following six months. There have already been calls to expand eligibility beyond six months and beyond people diagnosed terminally ill. For example, New Mexico's HB 90, the Elizabeth Whitefield End Of Life Options Act, was first submitted in 2019 with a definition of terminal illness encompassing all incurable and irreversible conditions that "will result in death within the foreseeable future." The bill passed in 2021 after switching back to the six-month standard used in other states. When proponents testify before committees such as yours, they often emphasize "safeguards." When bills get passed, they return in following sessions to complain about these same safeguards as "barriers" to care.

From the first Oregon report in 1998 regarding its "Death with Dignity Act," it's been clear that use of assisted suicide has been most associated with perceptions of individual control and autonomy, not the experience or fear of physical pain. The reported "end of life concerns" in Oregon largely reflect people's "existential distress," as one study termed it, in reaction to the disabling features of their illness: "losing autonomy" (over all years, 90%), "less able to engage

in activities" (90%), "loss of dignity" (72%), "burden on others" (48%) and "losing control of bodily functions" (44%). These are all disability-related concerns.

The best article on this issue is by Washington Post reporter Liz Szabo. In 2016, she reported that where assisted suicide has been legalized, proponents have succeeded in "convincing voters, lawmakers and courts that terminally ill patients have the right to die without suffering intractable pain in their final days or week."

> Yet the latest research shows that terminally ill patients who seek aid in dying aren't primarily concerned about pain. Those who have actually used these laws have been far more concerned about controlling the way they exit the world than about controlling pain.

No less an authority than Lonny Shavelson, now the Chair of the American Clinicians Academy on Medical Aid In Dying, told Szabo, "It's almost never about pain, it's about dignity and control."

Szabo also quotes ethicist Ezekiel Emanuel on the social factors that motivate usage of the suicide drugs.

> "The dominant reasons for wanting euthanasia or assisted suicide are psychological and involve control factors," said Ezekiel Emanuel, chair of medical ethics and health policy at the University of Pennsylvania's medical school. He noted that most of those who have used aid-in-dying laws are white, well insured and college-educated. "These are people who are used to controlling every aspect of their lives, and they want to control this aspect of their lives."

Szabo reports on a 2009 study on 56 Oregon patients, who were found not to be concerned about pain, but "quality-of-life" issues such as loss of autonomy and dependence on others.

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> "It's a bait-and-switch. We're actually helping people hasten their deaths because of existential suffering. That's chilling to me."
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Szabo interviewed Barbara Coombs Lee, co-author of the Oregon bill and former director of Compassion & Choices, who admitted that there are many kinds of suffering. In her book, Lee describes one person with incontinence saying that "I like doing things for myself, and the idea of having somebody take care of me like I am a little 2-month-old baby is just absolutely repulsive. It's more painful than any of the pain from the cancer."

Advocate Dan Diaz, widower of Brittany Maynard, stressed as a point of pride the ableist prejudice fuels the movement.

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> "If I find myself in a situation where I can't go to the bathroom on my own, where someone has to change my diapers, where I can't feed myself, where I can't care for the people around me, where other people have to move me around to keep me from having bedsores, I would then submit, 'Is that really living?' " Diaz said.

We disability rights advocates view the assisted suicide movement as a reaction to disability, especially dependence on other people. In September 2020, I debated bioethicist Thaddeus Pope, who conceded that "Everybody who's using medical aid in dying is disabled. And probably you could go to the next step and say the reason they want medical aid in dying is because of their disability."

In February 2021, Pope said that the US is alone in limiting eligibility for assisted suicide to people diagnosed as terminal. He predicted that eligibility will be extended to non-terminal disabled people. Last October, Pope published "Top 10 New and Needed Expansions of US Medical Aid In Dying Laws." in which he called for the elimination of any time frame for predicted death. He wrote that "many seriously and irreversibly ill individuals not within six months of dying may still suffer greatly every day from their disease."

There is no way to contain eligibility to a narrow set of people. Especially when thousands of disabled Americans now live with conditions that in some states are seen as "worse than death." Anorexia nervosa and diabetes can now qualify as terminal conditions. Once death is accepted as a positive outcome of medical care, it inevitably gets offered to more and more people.

The problem for us disabled people is that we are already treated badly in the medical system. As medicine has focused increasingly on patient "quality-of-life" as a barometer of life-worthiness, death has been recharacterized as a benefit to an ill or disabled individual. Most physicians (82%, a 2020 Harvard study found) view our "quality-of-life" as worse than nondisabled people.

Disability advocates have raised concerns about the fate of disabled people like nonverbal Oregonian Sarah McSweeney and Black Texan quadriplegic Michael Hickson. Both wanted to live, both were loved by family and caregivers, but they died after hospital personnel denied them treatment based on their supposed low quality-of-life.

The 2012 Massachusetts ballot results and the patient demographics in states like California show there is a social class, race, and ethnicity component in the use of and support for assisted suicide. A 2013 Pew Research Center study showed that Blacks oppose assisted suicide by 65%-29%, and Latinos by 65%-32%. Majority Latino Lawrence, Massachusetts, voted 69% against the 2012 ballot question, while white working class towns like Taunton and Gardner

also opposed. Wealthier Massachusetts towns voted heavily in favor. In California, 88% of reported assisted suicides have been by non-Hispanic whites, more than twice the group's share of the state population. Virtually no Black people have used the program.

Black patients under legalized assisted suicide will be more likely to be "written off' as better off dead, just as has happened with medical responses to COVID-19.

Meanwhile, terminal diagnoses are often wrong. Jeanette Hall wrote the Boston Globe in 2011 that she voted for Oregon's Death with Dignity bill, and when she received a terminal diagnosis, sought assisted suicide from her doctor. He persuaded her to try more treatment, and she is still alive more than 20 years later! The late actor Valerie Harper reported in 2013 that she had been given three months to live. She lived *six years*, and in that time appeared in a movie and starred in a play.

A few years ago, Oregon revealed that 4% of people who entered the assisted suicide program were still alive after six months. But NPR reported in 2017 that nearly 20% of people who enter hospice outlive their six month prognosis. The difference between 4% and nearly 20% is the percentage of people and their families who may have lost months, years, and in some cases decades of meaningful life.

That 4% survival rate in Oregon happens to match the percentage of people sentenced to death row who are estimated to be innocent. Many people, especially progressives, base their opposition to capital punishment at least in part on this unavoidable fact. We believe that people with serious illnesses and disabilities deserve the same level of concern.

In this and other ways, we are making social justice arguments against systemic discrimination against vulnerable communities. Indeed, Not Dead Yet joined a federal lawsuit against the state of California, arguing that its assisted suicide program violates the Americans with Disabilities Act and the Constitution by discriminating against disabled people. While younger, more able people receive suicide prevention services, old, ill, and disabled people all too often experience support for our deaths over support for our lives.

Maryland must not sponsor people's suicides because other people consider them a burden, because they believe they are dying when they are not, and because they have been denied the treatment and support services that would keep them alive.

Please protect disability rights, reject this bill and the discrimination it promotes.

Kelly Testimony opposing MD SB0443 End of life op

Uploaded by: Anita Cameron

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February 07 2024

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Please protect disability rights, reject this bill and the discrimination it promotes.

2024^J Testimony.pdf

Uploaded by: Ann Dowling

Position: UNF

Oppose SB0443 End-of-Life Option Act
Ann Dowling
410-956-3621

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 the potential to do just that.

Furthermore, what if the coercion to make a drastic end-of-life decision comes from the physician himself? Eleven 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

HB443 -- 2024 MPS Testimony.pdf

Uploaded by: Anne Hanson
Position: UNF

MARYLAND PSYCHIATRIC SOCIETY

February 8, 2024

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

RE: Oppose - Senate Bill 443: 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) is a state medical organization 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, this organization works to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As a district branch of the American Psychiatric Association covering the state of Maryland, MPS represents more than 700 psychiatrists and physicians currently in psychiatric training.

The MPS recognizes 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 opposes Senate Bill 443 (HB 403): 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 audits of the prescribing physician's records to ensure adherence with the law. **We strongly recommend a review of all cases by the Suicide Mortality Review Board.** We realize that some do not consider the ingestion of a legally prescribed medication to be Physician Assisted Suicide (PAS) and prefer the terminology Medical Assistance in Dying (MAID); however, we believe that the intentional ingestion of a substance that causes death would meet the definition of suicide and thus could be reviewed by the Suicide Mortality Review Board.

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. Only a trained clinician expert in diagnosing mental health disorders could discern if these are clinical symptoms requiring treatment by conducting a comprehensive psychiatric evaluation.

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 requested 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. Under this bill there would be no way to stop the process if a patient obtains lethal medication through deception or by concealing their current psychiatric care. There should be a process analogous to our extreme risk protection order law to confiscate the medication.

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.

SB443/HB403 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.

Furthermore, doctors working in state psychiatric hospitals may be forced to participate due to legislation passed in the 2023 session. House Bill 121, "Mental Health - Treatment Plans for Individuals in Facilities and Resident Grievance System" modified Health-General 10-706 to allow patients to seek a treatment mandate from an administrative law judge. If the patient is found to be qualified under HB433, the judge could order a treating psychiatrist to write a lethal prescription for their patient.

For the safety of the patient and the welfare of others present, lethal medication should be consumed in a controlled or monitored setting. Prescription of lethal drugs puts another means to accidental and intentional injuries in homes where there may not be close monitoring of the prescribed medication. This has happened in another jurisdiction. Through regulation, we encourage the Maryland Department of Health to develop standards to provide the necessary protections.

While there are academic arguments against "slippery slope" fears in certain situations, when it comes to legally prescribed lethal medications in certain countries and jurisdictions, there has been an extension of this practice to include clinical situations that are not imminently life threatening. There are examples in some jurisdictions of this practice extending to those with mental health issues and without life threatening medical conditions. We are very concerned that this legislation could increase the number of people choosing to die rather than continuing to seek treatment for their treatable psychiatric and medical conditions. If this legislation were to be passed, it would be important to specify clearly that this law should never be extended to include clinical situations that are not clearly documented to reflect a medical condition expected to imminently cause death.

To conclude, MPS recognizes 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 asks this committee for an unfavorable report on SB443/HB 403.

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

HB403 - SB443 assisted suicide 2024.pdf

Uploaded by: Barbara Cantilena
Position: UNF

I OPPOSE Assisted Suicide. It creates a bad policy for the citizens of Maryland. It has dangerous and careless provisions with a strong economic incentive to deny treatment to patients in crisis. No legislation can ever be a solution when doctors cannot accurately predict a terminal diagnosis.

I am amazed at your supposed empathy for patients when, in fact, the opposition against family notification is required. Where is your empathy when no doctor or nurse is required to be present when the patient ingests the lethal dose and something goes wrong?

Legalizing Assisted Suicide enables health insurance and medical providers to deny life sustaining care to patients and evade liability for the death of patients - as if they need more incentive to deny benefits! There are no standard requirements that each patient receive mental health screening and counseling and a screening from a doctor untrained in mental health is not sufficient to assess a patient's true needs. 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.

To the most vulnerable, including the poor and those with disabilities, a right to die may become a responsibility to die.

Determining your action to make suicide socially acceptable thus increasing suicide rates, your action against patients in crisis, their family, their child(ren), and the overall lack of true informed consent, I and countless other Maryland residents, respected physicians, the faith community, and leading advocacy from all corners of the state, I OPPOSE this legislation.

SB 443 Opposition Testimony.pdf

Uploaded by: Becky Ford
Position: UNF

Testimony Opposing SB443

Thank you, Mr. Chairman and members of the Committee. My name is Becky Ford and I strongly oppose Senate Bill 443. Last year, I gave testimony to both this committee and the House Health and Human Services Committee, sharing that I have had chronic major depression, anxiety, and PTSD. It took all the strength I had to try and explain how I understand what it's like to want to die, as I'm a multiple suicide survivor.

I've spent the past, almost year, thinking about that night. Because as I often say, you never know when you will be drug into that black hole, again, I felt like I needed to speak up for those who couldn't. But it was after reading a book by a gentleman my age, who was for Medical Aide in Dying, was signed up for it in Canada, but is now a popular opponent, who has Schizophrenia, Bipolar Disorder, PTSD, is a recovering alcoholic, and spent years as a homeless person. It was his book released in December 2023, Therefore Choose Life, where he wrote, "Some people are embarrassed to talk about their mental illness. I am not. What's there to be embarrassed about...we're all "damaged goods". We've been broken in one way or another" (Dunlop, 81). While it wasn't like me to openly say that, I always knew I had a purpose in mental health advocacy because of what I've been through, would in some small way help someone else.

To say that life has been a walk in the park since last March, would really be pushing the limits. Because the thing about last year is I testified right in the middle of being handed off from specialist to specialist to find help with a 2022 diagnosis of fibromyalgia, or chronic pain. I spent the long day waiting to testify taking any OTC medication that I thought would give even just minutes of pain relief to my back. You wouldn't see me doing my own hair, I couldn't reach my hands that far up. Thankfully, I did finally find a genius of a specialist that wasn't dismissive and who actually listened, and who I absolutely adore. And despite his own inventions, or surgical procedures that brought relief I never believed could be done, along with extensive physical therapy, things just kept getting worse. My left side would go numb, then my once admired and perfect memory started losing its ability to handle things short term. I could no longer do the things I enjoy the most, writing something that made sense regardless of the length (I'm known for dissertation texts), to reading as intensely and passionately as I always have, or being able to read a book in a day, or a few, as I always did. My speech became increasingly slow, nothing I noticed, but the first thing numerous neurologists did, as well as those who knew me best. I was finally also diagnosed with a neurological disorder this past fall. A disorder that 4 to 12 people per thousand receive (NIH, 2024).

Between not being able to continue my goal of running a full marathon, messing up recipes to simple instructions, making the wrong turn on a route I drove every day, to not being able to think of the word I needed when talking, I felt like a burden. There were days when I didn't want to get out of bed. When my dream Italy trip fell through this past July, one marked on my calendar since 2022, one I was prepped for, that's when there didn't seem like a point to dreaming.

I'm familiar with feeling like a burden. Right now, every illness I have is invisible. But the pain I experience is so real.

I'm fortunate, I come from a loving family that will do anything for me. But not everyone has that. I wouldn't be able to cook without help lifting a heavy pot. That's when the voice of depression is it's loudest, when others must do things for you, or you have to turn down invites due to sensory issues. That voice that tells you the people you love don't deserve to put up with this and you want to do everything you can to not be a burden…that is the beginning of suicidal ideation.

While I have a tremendous medical team that believes in the same values I do, before I ever started voicing an opinion on this bill, I was familiar with it. Because in 2016, I was handed a pamphlet by a therapist I was seeing at the time. I was not in a dark state, I didn't even have suicidal ideation going on at the time. But because he knew my diagnosis was "chronic," he briefly explained I'd never get better. And then I was handed a pamphlet, one that had the face of Brittany Maynard, a young woman with a terminal illness who the press followed as she went to Oregon and chose physician assisted suicide. An expert handed me a pamphlet and told me that's what I should choose. My first thoughts were not knowing what I do now, but rather, why should I pay to die? It's done for free each day. But I knew I couldn't go back to him as a patient, he didn't see me as anyone valuable. When you already don't see yourself as having value, even on a "good day," you need to be able to have medical professionals who see value in your life, too.

I've been informed of the research. Some days, this bill didn't allow me to get out of bed. The message of opposition from someone like me, who has 3 chronic invisible illnesses now, is not simply that every life is important regardless of what their physically, or mentally facing, but that what makes my life important, in the long view, in the providential view, is almost always what the world considers now considers silly, trivial—a burden. This bill labels me and anyone else who carries a chronic diagnosis, to a mere challenge, as a burden. So many great bills are being introduced to help with veteran suicide, to expand mental healthcare access to the youth, or to provide better insurance and drug coverage. But this bill doesn't fit. If you allow for this, for doctors to dictate to vulnerable populations that they have no worth, as the mere suggestion does just that, how will any of us, facing any challenge, any illness, terminal, or otherwise, help pave the way for someone else given the same diagnosis in the future for their lives to be just a little better? That's what keeps me sticking around.

But I believe those who hold an office should be standing up for vulnerable patients and sending out a message of resiliency and hope, not one of burden shaming and death. Please do not pass this bill.

Thank you.

Sources

Dunlop, Tyler James, *Therefore Choose Life, My Journey from Hopelessness to Hope*. Independently Published, 2023.

www.ninds.nih.gov/health-information/disorders/functional-neurologic-disorder#:~:text=Anyone%20can%20develop%20FND.,per%20100%2C000%20will%20develop%

SB443_Opposition_Cassilly.pdf

Uploaded by: Bob Cassilly

Position: UNF

ROBERT G. CASSILLY
Harford County Executive

ROBERT S. MCCORD
Director of Administration

February 8, 2024

Senator William Smith, Chair
Judicial Proceedings Committee
2 East Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

Re: Letter of Opposition to Senate Bill 443 – End-of-Life Option Act

Dear Chairman Smith and Committee Members,

You are about to vote on whether Maryland should encourage suicide by the aged and poor to reduce our medical costs. Advocates for Senate Bill 443 misleadingly proclaim the bill is all about allowing the terminally ill to die without pain. But the truth behind this misguided effort is clearly exposed by the provisions of the bill and the current law.

Maryland already allows health care providers to prescribe pain medication for the terminally ill in amounts that will cause death, so there is no reason under the current law for the terminally ill to forgo ample pain medication. The primary difference between Bill 443 and current law is that Bill 443 encourages suicide by those who are not in any pain and, whose death might be years away, but whose continued care will negatively impact medical providers' bottom line.

This sad tale begins with Maryland's unique Total Cost of Care Model in which the federal government pays hospitals a set budget for medical care. Under this model, repeat patients of limited financial means with prolonged illnesses present a financial burden on the hospital's fixed resources, reducing profits. This dynamic creates a perverse incentive for the medical industry to encourage these folks, typically the aged and poor, to end their lives quickly to reduce medical expenses.

Bill 443 achieves its purpose by creating an atmosphere that allows medical providers to pressure targeted populations to terminate their lives without pesky oversight by families and friends who might otherwise intervene. Consider the following provisions of this legislation: While a doctor treating your little toe is held to the highest standard of care of a medical professional, under Bill 443 a doctor advising or enabling suicide is simply held to a minimal standard of "good faith". Medical records of a loved one who dies during medical treatment are usually reviewable by the family so they can have their own experts determine whether the treating physician's negligence was the cause of death. By contrast, in the case of doctor assisted suicide, the victim's family is not allowed access to any of the records by which they can evaluate whether their loved one's death was a result of undue pressure by the medical industry. In fact, the SB443 death certificate is even altered to hide from the family the fact that their loved one's death was a result of doctor assisted suicide.

Our medical care system is flawed and needs change. Killing our aged and poor neighbors is not an acceptable solution.

Thank you.

Yours truly,

Robert G. Cassilly

Against Assisted Suicide SB 0443.pdf

Uploaded by: Brent Macdonald

Position: UNF

Senate Bill “End of Life Options Act” (SB 443) Physician Assisted Suicide is NEVER medical care.

Physicians are not mere “providers”. I oppose this bill legalizing assisted suicide also called “aid in dying” or a “compassionate choice”. There is nothing compassionate about a physician intending to end a patient’s life abruptly by providing the means of death by prescribing a known lethal dose of pills. What we are talking about is suicide not medical care. Patients don’t trust physicians that prescribe death. Due to the Coronavirus pandemic patients have lost trust in healthcare system “providers”. Proponents of physician assisted suicide (PAS) are back again trying to change Maryland law rendering physicians engage in patient suicide by prescribing a non-FDA lethal dose of pills and forever change the role of physicians as healers. This bill conflates a physician as a “provider” causing death.

As a clinician and medical educator, I have nearly 33 years of experience practicing inpatient, outpatient, urgent care, transitional, as well as 14 years of hospice medicine in Baltimore City. I have treated tens of thousands of patients and there is no place in medical tradition or medical residency training programs for assisted suicide. I can think of no situation in medical practice including hospice or palliative care that requires ending life abruptly. Maryland currently has world class medical institutions of care. This bill does not address futility or futile medical care. I continue to see numerous patients living normal lives over many years with medical diseases including cancers that are classified as terminal illnesses including terminal brain cancer and widespread metastatic cancers. I have seen Glioblastoma Multiforme (End Stage 4 brain cancer) patients live 7 years, get married, and become employed in the delivery of medical care, and lead normal lives. I see patients survive hospice for leukemia only to later have their leukemia treated one year later. We need better supports for patients in hospice and palliative care, not changing the role of physician as healer to be involved in suicide.

To expose the illusory logic: “aid in dying” maligns the term “terminal illness”. Proponents use “terminal illness” as a sufficient and necessary reason for ending life by suicide rather than allowing the course of natural death. In contrast historically, physicians as healers use the good faith designation of a “terminal illness” to provide good medical care such as palliative or hospice care to aid in living life, improving quality of life, and reducing human suffering. These resources may include narcotics, other medications, and family support, but never intending to end life abruptly through a lethal dose of pills as a means for death prescribed by a physician. Pills will be used with the intent to kill if this Senate Bill passes. Yes, pills can kill with the wrong physician intent. The intent of physicians is that of healing.

Proponents of aid in dying also want to malign the death certificate to read that a medical disease process caused death. Patients should remember that proponents of physician assisted suicide are in fact telling us how a non-FDA approved lethal overdose of pills, that is not part of medical care, can cause death abruptly. Proponents argue that it is “relative” when the patient dies but they want the patient “absolutely” dead by swallowing a lethal dose of pills. Let’s call them out by their abject lie about the “relative” time of the patient’s death. There is nothing “relative” about “absolutely” and “abruptly” ending a patient’s life with pills. Assisted suicide involves a premeditated intent to end life.

Let’s continue to be factual on the death certificate, the pills cause death. Help the Maryland Senate put to death the “End of Life Options Act” (SB 443) by opposing physician assisted suicide, rather than patients swallowing a lethal dose of non-FDA approved pills and changing the physician role.

Brent Bruce Macdonald, MD, FACP is an Instructor of Medicine and Medical Educator at Johns Hopkins University School of Medicine, a Fellow of the American College of Physicians and practices through Johns Hopkins Medicine affiliates. The opinions therein are not those of Johns Hopkins entities but support the position statement of the American College of Physicians opposing the legalization of physician assisted suicide since 2001 and reaffirmed opposition in 2017.

HB443 -- 2024 MPS Testimony.pdf

Uploaded by: Brian Zimnitzky

Position: UNF

MARYLAND PSYCHIATRIC SOCIETY

February 8, 2024

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

RE: Oppose - Senate Bill 443: 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) is a state medical organization 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, this organization works to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As a district branch of the American Psychiatric Association covering the state of Maryland, MPS represents more than 700 psychiatrists and physicians currently in psychiatric training.

The MPS recognizes 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 opposes Senate Bill 443 (HB 403): 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 audits of the prescribing physician's records to ensure adherence with the law. **We strongly recommend a review of all cases by the Suicide Mortality Review Board.** We realize that some do not consider the ingestion of a legally prescribed medication to be Physician Assisted Suicide (PAS) and prefer the terminology Medical Assistance in Dying (MAID); however, we believe that the intentional ingestion of a substance that causes death would meet the definition of suicide and thus could be reviewed by the Suicide Mortality Review Board.

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. Only a trained clinician expert in diagnosing mental health disorders could discern if these are clinical symptoms requiring treatment by conducting a comprehensive psychiatric evaluation.

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 requested 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. Under this bill there would be no way to stop the process if a patient obtains lethal medication through deception or by concealing their current psychiatric care. There should be a process analogous to our extreme risk protection order law to confiscate the medication.

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.

SB443/HB403 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.

Furthermore, doctors working in state psychiatric hospitals may be forced to participate due to legislation passed in the 2023 session. House Bill 121, "Mental Health - Treatment Plans for Individuals in Facilities and Resident Grievance System" modified Health-General 10-706 to allow patients to seek a treatment mandate from an administrative law judge. If the patient is found to be qualified under HB433, the judge could order a treating psychiatrist to write a lethal prescription for their patient.

For the safety of the patient and the welfare of others present, lethal medication should be consumed in a controlled or monitored setting. Prescription of lethal drugs puts another means to accidental and intentional injuries in homes where there may not be close monitoring of the prescribed medication. This has happened in another jurisdiction. Through regulation, we encourage the Maryland Department of Health to develop standards to provide the necessary protections.

While there are academic arguments against "slippery slope" fears in certain situations, when it comes to legally prescribed lethal medications in certain countries and jurisdictions, there has been an extension of this practice to include clinical situations that are not imminently life threatening. There are examples in some jurisdictions of this practice extending to those with mental health issues and without life threatening medical conditions. We are very concerned that this legislation could increase the number of people choosing to die rather than continuing to seek treatment for their treatable psychiatric and medical conditions. If this legislation were to be passed, it would be important to specify clearly that this law should never be extended to include clinical situations that are not clearly documented to reflect a medical condition expected to imminently cause death.

To conclude, MPS recognizes 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 asks this committee for an unfavorable report on SB443/HB 403.

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

SB 443 - End of Life Options Act 2024 .pdf

Uploaded by: Brigitta MULLICAN

Position: UNF

Brigitta Mullican
1947 Lewis Ave.
Rockville, MD 20851 LD-17 (Montgomery County)

February 6, 2024

OPPOSE SB 443 - End of Life Options 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 this - End of Life Options Act Bill. How can helping someone die by drugs be considered "died by natural causes or dignity?" 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 443 - End of Life Options 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 do not end up in the wrong hands or on our streets puts us all at risk. Doctors might be bribed to make this decision for financial gain.

I am concerned about the elderly, our veterans, people with disabilities, and those diagnosed with 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.

Please protect all Marylanders from this extreme legislation SB 443 - End of Life Options Act. Be compassionate and respect life.

Testimony end of life.pdf

Uploaded by: Carol Frazier

Position: UNF

To: Members of the Senate Committee on Judicial Proceedings

From: Carol M. Frazier
64 Bramblewood Drive
Ocean Pines, MD 21811
410-430-4456
carol.frazier54@gmail.com

Date: February 7, 2024

Re: SB0443 -End of Life Options Act

I am writing in strong disagreement with this legislation and requesting an unfavorable report out of committee.

There are many, many reasons to disapprove of this bill, and to fear its “unintended consequences”. I am sure you have heard from many Marylanders regarding these issues.

One issue I have not seen covered, and which concerns me greatly, is the integrity of the doctors and pharmacists who will be needed to prescribe the lethal medications, and then to fill the prescriptions. Many doctors and pharmacists   are very opposed to this legislation, and fear being forced to participate in procedures which violate their consciences and Hippocratic Oath. I also wonder how long before these providers are REQUIRED to prescribe and fill, no matter whether they have a conscientious objection? After all, we know that history shows that once something becomes a “right” then it becomes illegal to interfere with that “right”.

It is simply wrong to put doctors and pharmacists in this untenable position.

Please think long and hard about this issue before casting your votes. It is important to be fair to all of the parties involved.

Thank you for your consideration.

Testimony against SB0443.pdf

Uploaded by: Catherine King

Position: UNF

Oppose SB0443/HB0403
End-of-Life Option Act
Catherine King
410-340-2842

I am writing to you as a retired hospice nurse regarding the Physician Assisted Suicide Bill (SB0443) that is before you. The passing of this bill would be a grave mistake for our great state of Maryland. By definition, suicide is the act of intentionally causing one's own death. There is a better and humane option.

'Death with dignity' is not death by physician assisted suicide. 'Death with dignity' is hospice care. Hospice is not a death sentence but rather a way to truly live each and every remaining moment to its fullest.

I have worked with hospice patients and families in Maryland for nearly five years. They always admit that they wish they had come into hospice care sooner. They had a misconception of what the purpose of hospice really is. They also often believed there is financial burden to be borne when in actuality hospice care is covered by Medicare, Medicaid and private insurance. They had preconceived notions that hospice means there is no more hope or purpose in living. The medical community has given up on them. The job of the physician in general is to cure their patient. Some physicians will go to great lengths trying to accomplish a cure and will never give up. Patients are put thorough endless tests, surgeries and treatments that are painful; and frankly, will make no difference to their outcome. At some point though there needs to be a shift from cure to comfort. In the end when everything possible has been tried the word 'hospice' comes up. Patients and families are devastated at this suggestion with no clear understanding of what hospice care actually is. With no other options they reluctantly accept this last option they have been given.

I have personally seen patients, in distress and feeling helpless, improve in their quality of life in hospice. Once their symptoms of pain, nausea, shortness of breath, anxiety, etc. are well-managed they feel better, are happier, and are able to spend quality time with families and love-ones. I have also had patients whose symptoms improved enough that they were discharged from hospice into palliative care.

The medical community are often reticent to use pain medications for fear of overdosing their patients. Palliative and hospice physicians are much better at symptom management. They are proficient at using a variety of medications to achieve the desired goal of elimination of symptoms secondary to their admitting diagnoses. Each patient is different. My medical director, Dr. Eric Bush, always told us "The patient is driving the bus. We are just along for the ride". We let them take the lead and continually adjust their plan of care as needed.

We do not need a law for physician assisted suicide. We do need more education for our medical community and the community at large of what palliative care and hospice care are…. true compassion for the seriously ill and dying.

Physician Assisted Suicide- Against- Catherine Sim

Uploaded by: Catherine Simmons

Position: UNF

Catherine Simmons
310 Sandy Spring Road
Laurel, MD 20707
240-529-8173

February 8, 2024

Esteemed Senators:

I thank you for your time and careful consideration of this matter. My name is Catherine Simmons, and I am coming to you as a concerned citizen.

Like everyone in this room, I too have my story. That's the thing-the unfortunate thing- that this issue unites us as humans far more than it divides us. How we deal with suffering and death shapes our lives in every action. The question you must decide- for yourselves, and for the people for whom you make decisions- is this: Is life always worthwhile, or is there a point at which it's ok to give up?

We live in a society in despair. Mental health is frighteningly low; relationships are fractured; people turn to drugs to escape. If you pass this bill to allow people to leave when life is at its most difficult, what message does that send to those who are already low? It is well known that in states where Assisted Suicide is legal, there has been a 6.3% increase in the general suicide rate, due solely to this new acceptance of suicide. In Maryland, that would equate to more than 50 additional persons taking their own lives, on top of the nearly 700 who already do yearly. Please do not add to the despair.

We humans do not live only for ourselves but are part of something bigger, greater than us, and every minute of our lives has a meaning that ripples out to affect everyone. Every minute, even- and perhaps especially- the impossibly difficult ones. Do not give up in your own lives, and do not allow the people you serve to give up. Please vote no to SB 443.

Thank you for your time.

Sincerely,

Catherine Simmons

OPPOSE SB443 GOTTLIEB.pdf

Uploaded by: Cheryl Gottlieb
Position: UNF

Written Testimony in OPPOSITION of SB443

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I write to you today as a disability rights activist with strong ties to the wider disability community throughout Maryland, as the daughter of someone who has lived over 24 years with a "terminal illness," and as the dear friend of someone who died from lymphoma in 2022. These views do not represent those of any current or former employer. I write to you in opposition of the End-of-Life Option Act for several reasons which I will outline below.

1. On page 6 line 5 the bill states that "TERMINAL ILLNESS" MEANS A MEDICAL CONDITION THAT, WITHIN REASONABLE MEDICAL JUDGMENT, INVOLVES A PROGNOSIS FOR AN INDIVIDUAL THAT LIKELY WILL RESULT IN THE INDIVIDUAL'S DEATH WITHIN 6 MONTHS.

   My mom was diagnosed with Chronic Myelogenous Leukemia (CML) in 2000 at the age of 42. At the time, the five year survival rate of someone with CML was 20%. Years later, my mom's oncologist told her that he had never seen someone as sick as she was who survived. Today, my mom is still alive, and is currently in California celebrating her 66th birthday with her 10 year old grandson. This is something that 24 years ago, no one believed would be possible. But with advances in medical science, although most patients with CML will never go into remission, the 10 year survival rate is 85%[1], and most patients will die from something other than Leukemia. When the medication my mom went on first went on the market, no one had any idea how revolutionary it would be. Now, it is more and more common to see patients (including Elijah Cummings, for whom this bill is named) live decades with a cancer diagnosis.

   I can also list several other people I've known who were believed to be terminal, but exceeded their life expectancy. These include 1) my grandma's best friend who was diagnosed with pancreatic cancer and given 6 months to live, and who lived for 2 years, 2) my former mentor who was diagnosed with Juvenile Rheumatoid Arthritis in the 1950s, whose parents were told not to expect her to live past the age of 5, but who died at the age of 60 in 2014, and 3) my very dear friend Sheryl Grossman, who's 2017 testimony opposing this bill I have included at the end of my own. I'm writing this on behalf of Sheryl, who died in 2022, 5 years, and at least 4 cancer diagnoses after she gave that testimony. Sheryl deserved to have all the years she could, without having doctors try to coerce her into making decisions that she didn't want.

   Determining how long someone has to live is not something that any human or computer algorithm is capable of accurately predicting.

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[1] https://www.lls.org/research/chronic-myeloid-leukemia-cml retrieved Feburary 6, 2024

2. On page 6 line 24 the bill states that AT LEAST ONE OF THE ORAL REQUESTS MADE UNDER SUBSECTION (A) 25 OF THIS SECTION SHALL BE MADE WHILE THE INDIVIDUAL IS ALONE WITH THE ATTENDING PHYSICIAN. As well, page 12 line 29 states that THE ATTENDING PHYSICIAN SHALL … CONFIRM THAT THE QUALIFIED INDIVIDUAL'S REQUEST DOES NOT ARISE FROM COERCION OR UNDUE INFLUENCE BY ANOTHER INDIVIDUAL BY DISCUSSING WITH THE QUALIFIED INDIVIDUAL, OUTSIDE THE PRESENCE OF ANY OTHER INDIVIDUAL EXCEPT FOR AN INTERPRETER, WHETHER THE QUALIFIED INDIVIDUAL IS FEELING COERCED OR UNDULY INFLUENCED BY ANOTHER INDIVIDUAL

   While I can understand that the intent of these sections are to ensure that the patient is not being coerced by anyone into making this decision, they do no such thing. There is no possible way to ensure that patients aren't being coerced by people in their life prior to coming to the appointment, or by the doctor during the appointment. An example of this can be seen in Sheryl Grossman's previous testimony, which I've attached.

3. Page 10 section C states that AN ATTENDING PHYSICIAN SHALL ENSURE THAT AN INDIVIDUAL MAKES AN INFORMED DECISION BY INFORMING THE INDIVIDUAL OF: … (5) ANY FEASIBLE ALTERNATIVES AND HEALTH CARE TREATMENT OPTIONS, INCLUDING PALLIATIVE CARE AND HOSPICE.

   As someone who has been disabled close to 40 years with a combination of disabilities that require me to have assistance with activities of daily living, such as laundry and cooking, which is similar to the type of assistance that someone with a terminal diagnosis might need, I can assure you that not a single practitioner I have seen throughout my life (from my PCP, to mental health practitioners, to ones highly specialized in my diagnoses) has had the faintest clue as to what was and is available to me. This resulted in a delay of 16 years from when I should have been receiving waiver services to when I actually started receiving them. Even now, when I go to appointments and talk about the services I'm receiving, my practitioners look at me either blankly or in shock. It's clear that their discussion with me is the first time they had anyone talk to them about the home and community based services (HCBS) that are available to anyone in Maryland who needs assistance with activities of daily living, regardless of type or age of onset of diagnosis.

   If attending physicians aren't aware that HCBS exist, how can they counsel their patients on how to access them? The application process is onerous. It took me 3 years to get through the process, and that was after spending 8 years mistakenly trusting multiple professionals who wrongly told me that I wasn't disabled enough in the right way, wasn't the right age, to qualify. How is the state going to ensure that attending physicians are accurately educated on the eligibility criteria, application processes, and breadth of options for support available for sometimes little, or often no cost to patients? Are we going to institute mandatory training from MDH about the programs that they oversee?

4. Page 11 Line 22 states that 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, THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT.

As written, the bill does not require all individuals requesting aid in dying to undergo a mental health evaluation. This is left up to the subjective opinion of attending physicians, who have not been trained on how to recognize the symptoms of mental illness[2]. Additionally, it is well known within the chronic illness, physical, and developmental disability communities that there is a lot of prejudice against individuals living with disabilities throughout society. Often we're believed to be less deserving of respect, equal treatment, and equality before the law.[3] This leads physicians to be less likely to refer someone with a presumed life limiting diagnosis for an assessment, since they're less likely to view their patient's depression as concerning.

Individuals with disabilities experience the effects of this prejudice (called ableism) daily, and one of the places that we experience often the most damaging ableism, is a physician's office.[4] Even to this day, clinicians still aren't educated about the impact of long-term disabilities on individuals while in graduate school.[2,5] When individuals are continuously on the receiving end of ableism, they begin to believe that these negative assumptions about our lives are true. This is called "internalized ableism,"[3] and it can take years of difficult work to unlearn these assumptions and realize that they are NOT true. When doctors tell us and our families at diagnosis that we will be a burden[4] it may lead individuals or their families to believe that they're better off dead than disabled.[6]

At the same time, the lack of training that mental health professionals receive on the effects of living with disabilities[2,5], combined with this stigma, leaves a lack of mental health parity throughout the state. It can often take months or years for individuals with co-occurring diagnoses to obtain appropriate inpatient or outpatient mental health care (in my personal experience, it just took me two years of sitting on a waitlist to be able to see the one adult neuropsychiatrist with experience with my diagnosis in the entire state), whereas individuals with a singular diagnosis of a serious mental illness can usually obtain services within a few weeks for outpatient services, or possibly hours through an ER or crisis walk in clinic.

I urge you to vote NO on SB 443.

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[2] Werges, D. (2007). The Other Dual Diagnosis: Intellectual Disability & Mental Illness. Retrieved February 6, 2024, from https://web.archive.org/web/20190930204727/http://thenadd.org/modal/bulletins/v10n5a2~.htm

[3] Johnson, M. (2006). *Disability awareness--do it right!* Louisville, KY: Advocado Press.

[4] Seidman, E. (2016, July 12). How wrong were the doctors about your child? Retrieved February 6, 2024, from https://www.lovethatmax.com/2016/07/how-wrong-were-doctors-about-your-child.html

[5] Quintero, M., PhD, & Flick, S., MD. (2010). Co-Occurring Mental Illness and Developmental Disabilities. *Social Work Today, 10*(5), 6. Retrieved February 6, 2024, from https://www.socialworktoday.com/archive/092310p6.shtml

[6] Autistic Self Advocacy Network. (n.d.). 2024 Anti-Filicide Toolkit. Retrieved February 6, 2024, from https://autisticadvocacy.org/projects/community/mourning/anti-filicide/

Oral Testimony from Sheryl Grossman
originally delivered February 2017

retrieved from
https://notdeadyet.org/2017/02/disability-advocate-sheryl-grossman-gives-moving-testimony-against-maryland-assisted-suicide-bill.html

My name is Sheryl Grossman. I have a very rare genetic condition called Bloom's Syndrome, so rare in fact that I am the 72nd case ever recorded worldwide, historywide.

Back in the olden days when I was diagnosed doctors didn't know much and they advised my parents that I wouldn't live past 2, maybe 4 (it got longer every yr—I'm 41 now and they just throw up their hands and shake their heads). My parents were told I wouldn't walk, talk, or amount to much. They were told they should just put me away as they were young and could have other children. Clearly, doctors don't know everything.

This bill before you depends on doctors stating that someone has 6 months, or less to live, a prognosis that pretty much everyone agrees is impossibly hard to accurately predict. As a disabled person, this bill scares me even more because I know the societal barriers (stigma and discrimination) that we face. Our lives are often seen as being worse quality of life and less worthy than others. doctor's whole profession sees us as broken and something to be fixed, but often we can't be (and don't want to) be fixed.

Why does this bill scare me given this statement, let me give you a personal example. Bloom's Syndrome results in my being prone to multiple cancers. During my 7th cancer, a stage IV lymphoma that had metastasized to form a solid tumor in my liver, the head of Johns Hopkins Cancer Psychiatric Department entered my room during treatment, when I was barely conscious, barely able to speak. She said, "you know, you don't have to do this anymore. You have been through so much. You can stop at any time you know, it is ok. We can simply turn off the machines, or we can increase your pain meds—you're 37 lbs, it won't take long". I gave the last of my conscious energy to screaming NO and trying to get her out of my room. On her way out she said "I don't understand why you want to live like this, in and out of hospitals for years."

The answer is because I love my life. Sure, there have been plenty of times I have been bent over an emesis bowl when I didn't feel that way, but this is my life and I am worthy of it! It has been 3 ½ years and 2 cancers and 1 chemotherapy regimen since then and here I am before you, a happy 41 year old.

Ladies and gentlemen, I fear that if this law were on the books then, I wouldn't still be here today. It is far too easy to coerce someone into thinking themselves a burden to medical care staff, or family members. It is far too easy to make us think that our care is costing too much and draining those around us. This bill does not provide for a mental health evaluation before the prescription of lethal medications which takes away the only protection against this thinking.

When others in society say they want to harm themselves, crisis intervention services are provided. As a former certified crisis worker, I can tell you that many call back months and even years later to thank us for the intervention.

Why should people with disabilities and medical conditions with less than 6 months to live be treated any differently? I fear that even with a psychiatric evaluation, if one gets a psychiatrist like I did, who doesn't believe in the quality of our lives, people will still be encouraged to choose an early exit. We should be providing long term care services to help these individuals and their support networks, not methods to die.

Please, vote no.

IL Written Testimony SB 443 of 2024.pdf

Uploaded by: Chris Kelter

Position: UNF

Maryland
Independent Living
Network

SB 443: End–of–Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Testimony of Maryland Centers for Independent Living

OPPOSE

Senate Judicial Proceedings, February 8, 2024

The seven Centers for Independent Living (CILs) in Maryland 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. HB 403, if enacted, would endanger all vulnerable populations, such as the elderly and people with intellectual and developmental disabilities, opening the door for abuse and coercion.

SB 443, if enacted, 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 of negative possible outcomes makes this bill dangerous rather than compassionate, and it destroys dignity rather than preserving it.

If enacted, SB 443 has the potential to exploit disparities within the health care system in the most heinous way possible. Vulnerable, ill people would have the option to choose death because of feeling like a burden on family and friends rather than basing that choice on their dignity and value.

Furthermore, doctors' terminal diagnoses are speculative 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 enacted.

The Maryland Centers for Independent Living strongly oppose SB 443 because it fails to consider the impact it would have on vulnerable populations and those living with significant illnesses.

The Maryland Centers for Independent Living strongly **opposes** SB 443 and urges an **unfavorable** report.

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Testimony_Written_SB0443_2024.pdf

Uploaded by: Christine Sybert

Position: UNF

Oppose SB0443 – "End-of-Life Option Act"
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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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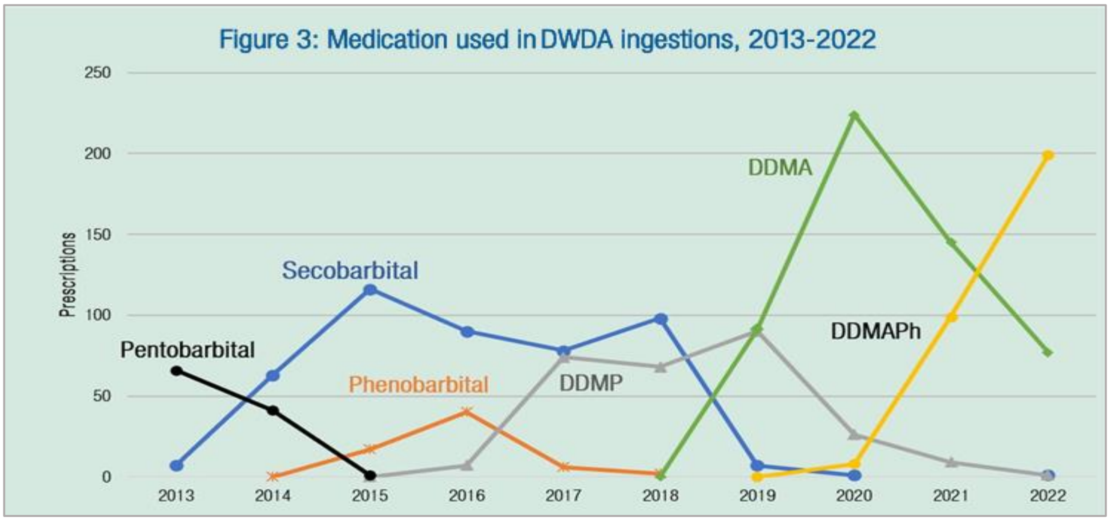
[1] https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

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

- Oregon 2022 – 43% of the prescriptions were not used or unknown (up from 38% in 2021).[2]
- Washington 2022 – 20% were not used or had an unknown status (down from 27% in 2021).[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, seizures, 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.



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

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[2] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year25.pdf

[3] https://doh.wa.gov/sites/default/files/2023-10/422-109-DeathWithDignityAct2022.pdf

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 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…

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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

Increased nonassisted suicide rates

This legislation will serve to increase the suicide rate. The latest CDC data indicates that there were 620 suicides in Maryland in 2021 (up from 585 in 2020), for an age-adjusted rate of 9.7 per 100,000.[7] While this is less than the national average, 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 39 all-cause suicides (excluding assisted ones, however, due to falsified death certificates) will occur with a new total of 659 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 passed legislation to remove "barriers." [9]

- Oregon (legalized in 1998) – first change took 21 years: 2019 - waiver of waiting periods allowed; 2023 - removed 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 - removed residency requirements
- California (2016) – after only 6 years, first change: 2022 - reduced waiting period to 48 hours
- Washington (2009) – took 14 years for first attempt to change: 2023 - allow NPs and PAs to be prescribers, reduce waiting period to 7 days, and mailing of lethal prescriptions
- Hawai'i (2019) – just four years to first change: 2023 - added Advance Practice RNs and NPs as prescribers, reduced waiting period to 5 days or waived altogether for some patients

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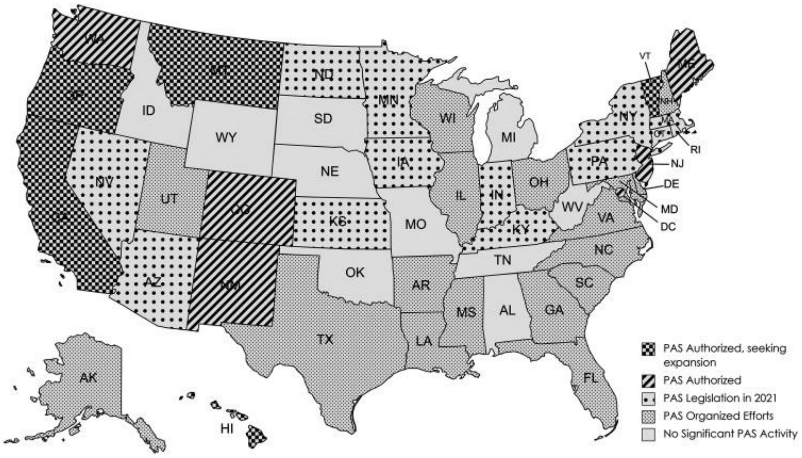
[7] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[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/

[9] https://www.compassionandchoices.org/in-your-state/

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.

Status of Assisted Suicide (2021)[10]



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
- 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 2023, in Maryland this legislation died in committee. [There was a hiatus of pushing this legislation from 2020-2022 due to

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[10] https://doi.org/10.1177%2F00243639211058966

trying to save lives during the COVID pandemic.] In 2019, 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 (> 70%) of the tiny number of people who killed themselves in 2022 (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. And, eventually, autonomy and choices will be denied to those who do not agree with this "option," and it will become an automatic expectation for them to terminate their own life.

Summary

Please don't fall for the euphemisms of "end-of-life options," "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 oppose this bill. Thank you.

2024 SB0443 - Kijesky-OPPOSED.pdf

Uploaded by: CRYSTAL KIJESKY

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SB0443– OPPOSED

“End-of-Life Options” already exists. Aid in dying is not a “compassionate choice.” Compassion does not include the intentional killing of human beings.

I have loved ones who have passed since 2021. In their lives, they were given a choice in how they died. This bill, SB0443, is not needed and is in fact, **harmful**.

My mother-in-law passed away in December 2021 after a lengthy battle with cancer. Finally, what took her life was unexplained bleeding and sepsis. She was loved beyond measure and we are grateful for the “extra” sixteen years after her cancer diagnosis. Treatments of chemotherapy and radiation as well as life-saving procedures by surgeons at George Washington Hospital in 2017 helped to extend her life. A bill like this has been shown to have detrimental effects for people who want to live receive life-extending care.

My father was living pretty well with run-of-the-mill health issues from his 50s through his early 60s plus a rare lung condition from his time in the military. Finally, what took his life was aggressive (turbo) pancreatic cancer. My mom and I were with him until the end in May 2022. My mother, who he was a primary care-giver to for the last 40 years, held his hand as he took his last breath. She continues to cherish the time they had together, as she says, “ till the end.” I have attached a photo so you can see what love and “end-of-life options” looks like.

Another personal story is about my mom, Rosa. She was diagnosed with Multiple Sclerosis in 1982. She was 24 years old; I was three years old. Thankfully, “aid in dying” was not available to her through coercion and she participated in early trial drugs at the National Institutes of Health (NIH). Receiving the first doses of interferon Alpha and Beta. She helped forge the way for new and groundbreaking methods to treat MS. Many in her support group from the 1980s did not live past a few years of their diagnosis; dying from complications of MS.

She went from wheel-chair bound to walking after the early treatments. She then lost her eyesight to MS, becoming legally blind by the mid-1990s. Thankfully, she participated in laser surgery trials at the NIH. She regained enough sight to continue to work in accounting through the late 1990s and read and enjoy every day as a gift.

My mom’s health has ebbed and flowed with highs and lows. She is an absolute inspiration showing my family, including her three grandchildren, that living each day is worth it.

She suffers daily with chronic pain in her arms and legs. She is now in a wheelchair for longer distances and lives in a nursing home after my dad’s passing. She takes advantage of many activities- from concerts to bingo. She brings joy to the nursing staff where she lives and has a group of friends who all look forward to the little joys of the day like sunshine and a warm breeze. She reads large print books on her kindle and printed books from the library. It takes her a while, but she enjoys what she can do.

Aid in dying would risk the lives of people, such as my mom, who may seem disabled to the able bodied person.

Cost for chronic illness care and treatment have a vast range. The cost for MS interferon dosing is over $10,000 for each injection.

Rebif Prices, Coupons, Copay & Patient Assistance - Drugs.com

Also, insurance has stopped paying for life-extending treatments in states like Oregon, were assisted suicide laws have been effect for years. We have data.
Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care | Fox News
Death Drugs Cause Uproar in Oregon - ABC News
Nevada's disability right group compiled a list of confirmed awful cases which should give great pause when hearing and voting on HB933.
OpenExhibitDocument (state.nv.us)

One that struck me is below. Imagine how awful it would be for a family member after two and a half days thinking your loved one is gone, then having them back, with all the ramifications of whatever the pills have done to further decline their mental state.

"• David Prueitt29 took his prescribed lethal overdose in the presence of his family and members of the assisted-suicide advocacy group Compassion & Choices. After being unconscious for 65 hours, he awoke. His family leaked the failed assisted suicide to the media. Oregon OHS issued a release saying it "has no authority to investigate individual Death with Dignity cases." 30"

Maryland does not need to create risk for the well-being of all Marylanders in the name of "choice."

For all of these reasons, I urge you to please issue an unfavorable report on **SB0443**.

Sincerely,
Crystal Kijesky
LaPlata, MD

Rosa and Harry - Mom and Dad – together until the end. Nov. 25, 1977-May 16, 2022

Assisted Suicide.pdf

Uploaded by: Dan Cox
Position: UNF

From the Desk of Dan Cox

Candidate for U.S. House of Representatives (MD-6) ‘24;
Maryland State Delegate, 2019-2023

7 February 2024

Senator William C. Smith, Jr., Chairman
Judicial Proceedings Committee
11 Bladen Street
Annapolis, MD 21401

Re: Oppose Big Corporate Killing of Vulnerable Marylanders – UNFAVORABLE - SB 443

Honorable Chairman Smith and members of the Committee:

Greetings former colleagues and friends and thank you for your service to our State. **Martin Luther King, Jr.** uplifted America when he said, **“Our lives begin to end the day we become silent about things that matter.”** Defending the vulnerable is our important duty to humanity.

I am asking you to report unfavorable SB 443 – Assisted Suicide (End of Life Option Act). At no point in world history has state-sanctioned support for killing innocent and vulnerable people resulted in peace and happiness for those who do such evil. Instead, it incurs the wrath of God.

Assisted Suicide is deadly to civilization, and must be opposed at least because of the following:

- Legalizing Assisted Suicide enables powerful health insurance and medical providers to deny life sustaining care to patients and evade liability for the death of patients. **This preys upon the poor and vulnerable.** 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.
- **No family notification is required. This is in direct contradiction with Estate Law.**
- One in three patients who fill the lethal prescription-typically 100 pills, decide against taking it. There are no safeguards to protect children.
- 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. **This is especially dangerous since without licensed third-party witnesses, there would be no verification of the patient’s wishes – opening the door for murder without ability to prove otherwise.**
- Taxpayers foot the bill to pay for the lethal drugs and doctor visits.

In the name of God and everything good I appeal to you to vote UNFAVORABLE on SB 443.

Respectfully submitted,

Dan Cox for Congress
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Paid for by Dan Cox for Congress, Inc.

Sulmasy-Testimony-Maryland-2024.pdf

Uploaded by: Daniel Sulmasy

Position: UNF

Testimony regarding SB-0443

“End of Life Option Act”

Daniel P. Sulmasy, MD, PhD, MACP

Director, Kennedy Institute of Ethics

Georgetown University, Washington, DC

February 8, 2024

Address inquiries to:

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My name is Dr. Daniel Sulmasy. I am a general internist and a philosopher, the André Hellegers Professor of Biomedical Ethics and Director of Georgetown University's Kennedy Institute of Ethics. I have served on New York State Task Force on Life and the Law under Governor Pataki and on the Presidential Commission for the Study of Bioethical Issues under President Obama. I am currently a member of the Council on Ethical and Judicial Affairs of the American Medical Association. I am here today to express my strong opposition to SB-0443, the "End of Life Option Act." This law represents bad medicine, bad ethics, and bad public policy and should not be permitted to obtain the force of law.

First, a word on language. This bill legalizes a form of suicide with the assistance of a physician. Proponents call it "aid in dying," but that is merely a euphemism concocted to gain support. I aid lots of dying patients. It is my job to accompany them, care for them, treat their symptoms, and ease their dying. This bill does something different. In plain speech, it would enable patients to kill themselves by overdosing on medication prescribed by a physician. In more honest language, that means it legalizes physician assisted suicide. This dishonesty is compounded when physicians are forced to lie on death certificates, as other states have done, making them state the cause of death as the underlying illness, not an intentional overdose.

Physician assisted suicide (PAS) is bad medicine. It subverts the meaning of healing to which medicine is dedicated. No patient is healed by being made dead. PAS runs roughshod over the Hippocratic Oath which states, with good reason, "I will not give a deadly drug to any patient, even if asked, nor will I make such a suggestion." It has been recognized since ancient times that profound trust is required to enable vulnerable patients to bare their bodies and their secrets to doctors. The bare minimum of the Oath assures patients that their doctors will not disclose their secrets will not have sex with them, and will not kill them. Everyone is a potential patient, and no one should ever fear that the doctor secretly wants to do her in.

PAS is also bad medicine since it should not be necessary. We can do more than has ever been possible in the history of humankind to heal the physical suffering of patients—drugs, electrical stimulation, complementary therapies. Studies from Oregon and Europe bear this out. The chief reason patients opt for PAS and euthanasia is not pain (which can be treated) but loss of control. They say they feel like burdens. Should we say yes, you are a burden? They say they are tired of life or lonely. Is the answer enlisting doctors to help them kill themselves? DO NOT be deceived into believing the false dilemma that patients have a choice of either being strapped to machines, poked with needles, and racked with pain, or they can seek assisted suicide. Hospice and palliative care can treat physical symptoms, even, if necessary, to the point of rendering a patient unconscious through invoking the rule of double effect and the careful practice of palliative sedation. Even shortness of breath can be treated (with lower doses of morphine than it takes to treat pain). This whole movement is about something else—a very small but vocal, forceful, and powerful group of people who want to have the freedom to kill themselves rather than depend upon other people to help them. They often enroll in hospice, but refuse its routine services, demanding that they be given the drugs with which to end their lives. Most patients, however, when they learn what palliative are and hospice are about, want these services and take advantage of them.

And if the health care system is not delivering such good, state of the art hospice and palliative care to the citizens of Maryland, then fix your health care system, don't legalize medical aid in suicide.

PAS is bad ethics. Not only does it undermine the trust that ought to undergird the patient-physician relationship, it gives state sanction (and medical sanction) to the notion that being dependent upon others is so awful a state that it makes life no longer worth living. That is why the disabled are so fearful of these laws. They do not expect to have their wheelchairs lined up so that they can be forcibly injected (at least not yet). What sends shivers down their spines is that the state has said that lives like theirs are so bad that they are not worth living. They know that once it is permissible for an individual to declare his *own* life is not worth living, it is a very short step to third party determinations that the lives of *others* are not worth living—the physically disabled, the cognitively and intellectually challenged, and so many other vulnerable groups that we physicians treat. The state has an interest in cultivating a medical profession that sees the sick and disabled as worthy of service.

You see, PAS flips the default switch. At present, patients are presumed to want to live until treatments become more burdensome than beneficial, and then we stop. Once PAS is on the table, however, the question becomes, "Why haven't you done it yet? Why are you still burdening yourself and us by continuing? Here's your prescription, just in case you want to use it." That poisons medical ethics.

Personal autonomy is not absolute, and there is a difference between the negative right to be free of unwanted therapy and the positive right to receive whatever treatment one wishes, including suicidal medication. As Wittgenstein once observed, if suicide is allowed, anything is allowed. If we are to have ethics and the rule of law it must be based on the idea that all lives are worthy of respect and that no one, not the state, not the doctor, not the patient, should have the power to end lives deemed unworthy of living.

PAS is also bad public policy. PAS cannot be controlled by regulations and additional amendments. Maryland should not let this genie out of the bottle. Abuse happens, and will happen. But the regulatory structures in this bill, modeled on Oregon, make it nearly impossible to detect abuse. The data collected are really bare bones. Everything depends on self reporting by physicians, who are really smart. They know how to say what will keep them out of trouble, and they don't want a lot of bureaucratic hassle. Only state officials have access to the data, and we can't know what we don't observe. We do know, however, that while, on average, about 40% of terminally ill patients can be expected to be depressed, in Oregon less than 5% of PAS patients (in some years no one) is referred for psychiatric assessment. Anorexia nervosa has been deemed a terminal, qualifying condition. Diabetes has been called terminal if you decide not to take your insulin. Demented patients have used the law, even though patients are supposed to have decisional capacity. Family members have assisted patients who are too weak to self-administer, even though that constitutes euthanasia which is not permitted by the law. There are disturbing anecdotes.

Moreover, suicide of any form has a social contagion effect. We have an epidemic of suicide in this country, and data suggest that legalized PAS leads to more suicide in the general population. That's misguided policy.

The cost-constrained environment of contemporary medical care is a really unsuitable atmosphere into which to release PAS. There are a number of anecdotes describing patients who have been offered PAS by insurers who simultaneously denied overage for life-extending therapies. My colleagues and I have shown that there is a strong correlation between a cost-saving attitude and a pro-PAS attitude among physicians. And the Canadians have been bold enough to publish a recent cost-effectiveness analysis on how much their law will save for the health care budget.

Most importantly, assisted suicide is just the beginning. You see, once PAS is legalized, logic and law lead inexorably to euthanasia. Every proposed safeguard will be re-interpreted as a barrier. Waiting times will be shortened. Nurses will be permitted to prescribe. Residency requirements will be dropped. It will be declared discriminatory to prevent patients who are paralyzed from equal access, and that requires active euthanasia for a person can't take the pills. And what about the demented? Can't one claim that grandma would have wanted to be made dead quickly if she knew she had become demented? That will require euthanasia by third party consent. In Canada and Belgium, 5% of all deaths are by euthanasia. The indications for euthanasia in Belgium and the Netherlands include psychiatric illness since psychiatric suffering is as great as physical suffering. Canada is poised to follow them. In Belgium and the Netherlands, euthanasia is prescribed for children and for infants born with genetic disorders. Pass this bill and you'll end up in Brussels, not Portland.

Why has this not happened in yet in the US? Proponents have been very disciplined in not expanding their campaigns beyond asking for PAS until they have enough states on board. Maryland could be their tipping point. With a large mid-Atlantic state legalizing PAS, proponents will be able to claim enough momentum to carry a few more states and then the calls will start. Actually, a few such bills have already been passed in Oregon, Vermont, New Mexico, Hawaii, and California. Waiting periods are being shortened. Nurses empowered to prescribe. Residency requirements dropped. You know the real zealots don't quit. How many PAS bills have already been introduced in Maryland? They will not stop with PAS. I have attached a recent article by law professor and advocate Thaddeus Pope, who has been frank in admitting that the law you are thinking about passing is only the beginning of where advocates want to go.

So be courageous leaders for Maryland, and be careful. Bear in mind that a recent well-intentioned venture in bad medicine, bad ethics, and bad public policy led us to the present opioid epidemic. Policymakers just a few years ago were urging physicians to prescribe more pain medication and not cruelly leave patients in pain. That policy shift took on a life of its own and led to our current opioid crisis.

I care deeply about compassionate care for the dying and have worked hard over my whole career to make that care better. Physicians and legislators can work together to do improve the care of the dying through expanding access to hospice and palliative care, expanding social work and chaplaincy services, and educating physicians to do a better job in care at the end of life. That's what the vast majority of patients want and deserve. Assisted suicide plays no role in that care.

Don't pass this bill, which will do far more harm than good.

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World Medical Association. Declaration on Euthanasia and Physician-Assisted Suicide. 2019. https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/

The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide.

For the purpose of this declaration, euthanasia is defined as a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request. Physician-assisted suicide refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death.

No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.

Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient.

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5.7 Physician-Assisted Suicide Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. 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. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at *the end of life. Physicians: (a) Should not abandon a patient once it is determined that cure is impossible. (b) Must respect patient autonomy. (c) Must provide good communication and emotional support. (d) Must provide appropriate comfort care and adequate pain control.*

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Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws

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OPEN PEER COMMENTARIES

Top Ten New and Needed Expansions of U.S. Medical Aid in Dying Laws

Thaddeus Mason Pope

Mitchell Hamline School of Law

Pullman argues that when it comes to medical aid in dying (MAID), "Canada … has much to learn from California" (Pullman 2023). Canada and California have similar populations: each about 40 million citizens. But, each year, while fewer than 1,000 Californians take MAID medications, more than 10,000 Canadians use MAID. This ten-fold difference is astonishing and merits attention. But how should we interpret it?

Pullman describes the Canadian numbers as "disturbingly high." I take the opposite approach and contend the California numbers are disturbingly low. Pullman rightly notes that MAID in California is subject to "strict eligibility criteria" and that we take a "more cautious approach in the United States" (Pullman 2023). But even Pullman concedes ingenuousness in how best to strike the balance between safety and access. He does not know whether the Californian "criteria are too restrictive" or the "Canadian criteria are too liberal" (Pullman 2023).

But we already have the evidence. Significant data and testimony gathered by researchers and state legislatures show that U.S. criteria for MAID are too restrictive and impede access to individuals who want to relieve suffering at the end of life (Kusmaul et al. 2023). Similar evidence is emerging in other restrictive MAID jurisdictions like Australia and New Zealand. In this Open Peer Commentary, I describe the top ten new and needed expansions of U.S. MAID laws. These are not the only indicated reforms. We need better data to identify other barriers and disparities (Riley 2023).

PERMIT NON-PHYSICIAN PROFESSIONALS

For decades, only physicians could provide MAID in the United States. But it became increasingly obvious that this limited access (Pope 2020). Especially in rural areas, physicians weren't always available. So, when New Mexico enacted its MAID statute in 2021, it also authorized advanced practice registered nurses and physician assistants to provide MAID. In 2023, Hawaii and Washington followed suit. Today, both current and prospective MAID states are considering legislation that would authorize not only physicians but also APRNs and PAs. Furthermore, the states are also expanding the types of clinicians authorized to conduct the mental health exams always required in Hawaii and required in other states when the attending or consulting clinician is uncertain of the patient's capacity.

SHORTEN OR WAIVE WAITING PERIODS

Another way states are already expanding access to MAID is by reducing or waiving waiting periods. For decades, one of the standard safeguards in U.S. MAID statutes required that the patient make two separate oral requests, the second after a waiting period of at least 15 days. The rationale was to permit patients to calmly reflect and deliberate about their decision. But over two decades of experience with MAID shows that many patients cannot wait that long. Since many patients don't seriously consider MAID until the late stages of their illness, they either die or lose decision-making capacity before the end of the 15-day period. In

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short, the waiting period frequently constitutes an undue burden.

In response, several states have either shortened or waived the waiting period. Both California and New Mexico reduced their waiting periods from 15 days to 48 h. Hawaii, Vermont, and Washington also reduced their waiting periods (Meisel, Cerminara, and Pope 2023). Today, bills in both current and prospective MAID states propose similar reductions. In addition to, or instead of, shortening the waiting period, some states exempt patients from having to satisfy the waiting period, however long it is, when the patient isn't expected to survive that period. New Mexico and Oregon, have already enacted such waiver laws. Bills in both current and prospective MAID states propose the same.

DROP RESIDENCY REQUIREMENTS

Traditionally, states limited MAID to their own residents (Pope 2020). Many patients have been able to satisfy these residency requirements by, for example, briefly renting an apartment in the MAID jurisdiction. But while surmountable, residency requirements still pose an obstacle. Consequently, physicians and patients brought federal lawsuits challenging residency requirements in Oregon and Vermont as violating the privileges and immunities clause of the U.S. Constitution. After settling the lawsuits, those states removed the residency requirement. That opened the door to patients traveling to Oregon and Vermont for MAID from other states. Now, bills in other states similarly propose authorizing MAID without a residency requirement. States appear to recognize that they can't constitutionally limit healthcare services to their own residents. A new lawsuit is proceeding in New Jersey.

ENFORCE TRANSPARENCY LAWS

All U.S. MAID laws include broad conscience clauses for both institutions and individual clinicians. Invoking these rights, many religiously affiliated institutions have opted out of participating in MAID. But to help patients make informed decisions about where to seek treatment, California and Washington require facilities to publicly post their MAID policies. That way, patients seeking MAID can make informed choices, for example to avoid enrolling in a nonparticipating hospice. Unfortunately, compliance is poor and states have not enforced the transparency requirements. Colorado now seems poised to do a better job.

PERMIT ASSISTED SELF-ADMINISTRATION

Some individuals otherwise currently eligible for MAID are unable to self-administer their medications because of neurological conditions like ALS. A recent debate in this Journal discussed whether the Americans with Disabilities Act permits, or even requires, clinicians or others to assist these patients in self-administering MAID medications when their physical disability prevents them from completing administration by themselves (Shavelson et al. 2023). Even Pullman admits that California should permit this much (Pullman 2023).

DROP THE SIX-MONTH REQUIREMENT

All U.S. MAID jurisdictions require that the patient have a prognosis of six months or less to live. This strict temporal requirement is unusual compared to other countries, such as Canada, which require only that the patient have a "grievous and irremediable medical condition." Indeed, many seriously and irreversibly ill individuals not within six months of dying may still suffer greatly every day from their disease. A growing number of advocates (including within Pullman's target jurisdiction, California) want U.S. laws to be more like broader laws in Australia, Belgium, Canada, Luxembourg, Netherlands, Spain, and Switzerland (www.abetterexit.org).

PERMIT INTRAVENOUS ADMINISTRATION

Under U.S. MAID laws, medications can be self-administered orally, rectally, or through a feeding tube. All three methods require ingestion (through the stomach and intestines). But evidence from other countries shows that intravenous infusion is more reliable and faster than ingestion (Pope 2020). Unfortunately, IV administration is unavailable in the United States because MAID laws specifically prohibit ending a patient's life "by lethal injection." To allow safer and more effective IV administration, state legislatures should repeal that prohibition. This would not cross the line from MAID to euthanasia. While clinicians would set up the IV, the patient would take the final step of opening the valve to let the medication into their body.

REQUIRE PATIENT DECISION AIDS

All MAID laws have multiple safeguards that help assure the patient's voluntary and informed consent. But because the stakes are so high, we should use the best means available. Patient decision aids are evidence-based educational tools that dramatically improve patient understanding of their options compared to clinician discussion alone (Pope 2022). Other end-of-life decisions are already supported by decision aids. We must develop a PDA for MAID. And we must get it certified by the Washington State Health Care Authority (Pope 2017).

PERMIT ADVANCE REQUESTS

Many older Americans fear living with late-stage dementia. But MAID isn't an option for these individuals. By the time they're terminally ill, they no longer have capacity. And when they still have capacity (for example, in early stages of Alzheimer's), they're not yet terminally ill. In response, some advocates are pushing to permit individuals to arrange MAID through an advance directive. This is already permitted in some European countries and is being actively considered in Canada. In the meantime, there has been a significant interest in VSED advance directives which direct caregivers to stop providing food and fluid by mouth (Pope 2021; Quill et al. 2021).

REPEAL ASFRA

While MAID is primarily a state matter, many terminally ill patients are on Medicare. That impedes access because the Assisted Suicide Funding Restriction Act of 1997 prohibits federal money from being spent on MAID. Consequently, patients must find another way to pay roughly $750 for the medications. Furthermore, ASFRA deters many hospices and other providers from offering MAID because they worry about inadvertently billing Medicare for it. For these reasons, while most advocacy has been at the state level, some advocates seek to repeal ASFRA.

CONCLUSION

The Dubai World Cup is often referred to as the "world's richest horse race." In 2017, one of the favorites was Highland Reel, an Irish thoroughbred racehorse. He took an early lead and kept it for most of the race. But Highland Reel lost his lead 400 meters from the finish line. Worse, he was then passed by the entire field and relegated to a dead last finish. Analogously, the United States took an early worldwide lead with MAID when Oregon enacted its Death with Dignity Act in 1994. But like Highland Reel, the United States has lost its lead. And it is quickly falling to the back of the pack in terms of MAID safety and access.

DISCLOSURE STATEMENT

Professor Pope is a regular consultant to the American Clinicians Academy on Medical Aid in Dying (ACAMAID) and has served as an expert witness in federal litigation challenging the California End of Life Option Act.

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Americans
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for Life

Written Testimony of Danielle Pimentel
Policy Counsel, Americans United for Life
In Opposition to Senate Bill 443
Submitted to Senate Judicial Proceedings Committee
February 8, 2024

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

My name is Danielle Pimentel, and I serve as Policy Counsel 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,[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] 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 443 ("S.B. 443"). It is my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 7, 2024). AUL is the original drafter of many of the hundreds of pro-life bills enacted in the States in recent years. *See* Olga Khazan, *Planning the End of Abortion*, ATLANTIC (July 16, 2020), www.theatlantic.com/politics/archive/2015/07/what-pro-life-activists-really-want/398297/ ("State legislatures have enacted a slew of abortion restrictions in recent years. Americans United for Life wrote most of them."); *see also* Anne Ryman & Matt Wynn, *For Anti-Abortion Activists, Success of 'Heartbeat' Bills was 10 Years in the Making*, CTR. PUB. INTEGRITY (Jun. 20, 2019), https://publicintegrity.org/politics/state-politics/copy-paste-legislate/for-anti-abortion-activists-success-of-heartbeat-bills-was-10-years-in-the-making/ ("The *USA TODAY/Arizona Republic* analysis found Americans United for Life was behind the bulk of the more than 400 copycat [anti-]abortion bills introduced in 41 states.").

[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 6, 2024).

[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).

coercion, the bill's "safeguards" fail to adequately protect 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 additional abuse under S.B. 443. If enacted, not only would the bill perpetuate false narratives about assisted suicide and its impact on vulnerable persons, but it would also promote both ableism and ageism.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management reasons. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control" or just *concern* about inadequate pain control as a reason for choosing suicide by physician.[6] Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington).
- Losing autonomy (86.3% in Oregon, 83.0% in Washington).
- Loss of dignity (61.9% in Oregon, 69.0% in Washington).
- Burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington).
- Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[7]

Physicians should ensure that their patients receive the best palliative care and help them cope with feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, in states that have legalized assisted suicide, vulnerable patients are being encouraged to take their own lives, which opens the door to real abuse, especially for the elderly and those with disabilities.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states which have decriminalized suicide by physician. These include a lack of reporting and accountability, coercion, and failure to ensure the competency of the requesting patient.[8] In Oregon and Washington, individuals have died by assisted suicide even though they were not terminally ill and did not have the capacity to

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[6] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9, 14 (Mar. 8, 2023); WASH. DISEASE CONTROL & HEALTH STATS., 2022 DEATH WITH DIGNITY ACT REPORT 7 (June 2, 2023).

[7] *Id*.

[8] 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.).

consent.[9] Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.[10] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[11] These examples from Oregon and Washington evidence the wide-spread abuse vulnerable end-of-life patients face when considering to engage in assisted suicide.

Notably, in November 2023, the American Medical Association (AMA) affirmed its opposition to assisted suicide and euthanasia.[12] The current policy will remain in place, which states,

> [e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.[13]

The AMA also refused to change the term "assisted suicide" to the misleading and inaccurate euphemism, "medical aid in dying."[14]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, advocacy groups continue to promote its legalization. This has led to a "suicide contagion," or the Werther Effect.[15] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[16] One study demonstrates that legalizing suicide by physician in certain states has

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[9] *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 Feb. 7, 2024).

[10] *See Id*.

[11] 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/.

[12] Wesley J. Smith, *AMA Retains Policy Against Assisted Suicide*, NAT'L REV. (Nov. 13, 2023), https://www.nationalreview.com/corner/ama-retains-policy-against-assisted-suicide/.

[13] American Medical Association, *CEJA Report B – A-91 Decisions Near the End of Life*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/5.8%20Euthanasia%20--%20background%20reports.pdf (last visited Feb. 6, 2024).

[14] Smith, *supra* note 12.

[15] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOV'T (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/.

[16] *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 RSCH. 137 (2004).

led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[17] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[18] 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.[19] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[20]

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. 443 targets these vulnerable individuals and communicates the message that their lives are not worth living simply because of their physical or mental disability, illness, or age. However, these individuals are worthy of life and are entitled to equal protection under the law, which is why this Committee should reject this bill.

II. *S.B. 443's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although the bill includes so-called "safeguards," in effect, these provisions cannot adequately protect vulnerable end-of-life patients. For example, under § 5–6A–06, a physician is only required to refer a patient to a mental health professional, if the physician believes the "individual may be suffering from a condition that is causing impaired judgement or otherwise does not have the capacity to make medical decisions." Yet, counseling referrals for patients considering assisted suicide are astonishingly rare.[21] In Oregon in 2022, for example, assisted suicide physicians prescribed lethal drugs to 431 patients yet only referred three of these patients for counseling—*approximately 0.7% of patients*.[22]

Additionally, although the bill requires the attending physician to have "primary responsibility for the medical care" of the patient, the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[23] The short duration of these relationships raises serious concerns as to whether a physician can accurately determine the capacity of the patient. Accordingly, if the bill is passed, the

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[17] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (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.

[18] Jones & Paton, *supra* note 17, at 601.

[19] *Id*. at 603.

[20] *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").

[21] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 6, at 14.

[22] *Id*. at 9.

[23] *Id.* at 14.

likelihood of a Maryland physician referring an end-of life patient for an evaluation is extremely low, especially when the physician may have only known the patient for less than five weeks.

The lack of counseling referrals for vulnerable end-of-life patients is gravely concerning. Scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[24] "[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."[25] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[26] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[27]

Moreover, on the off chance that a Maryland physician refers a patient to a mental health professional for an assessment, the bill has no requirement that the patient and mental health professional meet more than once. In § 5–6A–01 (M), the bill defines "mental health professional assessment" as "one or more consultations between an individual and a licensed mental health professional." This means that a psychologist or psychiatrist just needs to meet with the patient once before that patient can be deemed competent to end their own life. This raises serious informed consent issues because healthcare professionals have limited abilities to diagnose mental health issues when evaluating referred patients considering assisted suicide. As 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."[28] Nevertheless, under the bill, an individual suffering from depression can be deemed competent to take their own life after one meeting with a mental health professional. For these reasons, it is difficult to argue that any of these alleged "safeguards" will allow medical providers, or mental health professionals to accurately assess an individual's mental health and whether they have the requisite "capacity."

Lastly, the bill assumes that physicians can correctly diagnose a patient with a "terminal condition." Under § 5–6A–04, the bill requires the attending physician to determine if the patient is a "qualified individual," *i.e.*, the individual has a terminal illness that will result in the 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 the life expectancy of a terminally ill patient. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed

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[24] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).

[25] *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").

[26] *Id*.

[27] *Id*.

[28] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996) (emphasis added).

as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[29] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[30]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[31] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[32] 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 prognosis.[33] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[34] In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness or would have outlived a six months life expectancy.

In sum, these purported "safeguards" fail to protect vulnerable end-of-life patients. The bill leaves patients susceptible to coercion and abuse by family members and caregivers, and does not—and cannot—ensure patients have given their informed consent to die through medicalized suicide. S.B. 443 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 unfettered ability to prematurely end their patients' lives in direct violation of their Hippocratic Oath "to do no harm."

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession*

Prohibitions on physician-assisted suicide 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."[35] 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. "[T]here is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[36] 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

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[29] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).

[30] *Id*. at 22.

[31] 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.

[32] *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).

[33] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

[34] *See id.*

[35] 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).

[36] 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).

demonstrated in order to approve the drug for distribution and marketing to the public."[37] Assisted suicide medication could never meet the safety or efficacy requirements for treating mental or physical ailments, because it is treating an individual's health condition with a lethal drug overdose.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[38] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[39] 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*."[40] Consequently, 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."[41]

Under § 5–6A–04 (C), the bill only requires the attending physician to inform the patient of the risks with taking the lethal drugs and the "probable result of self-administering the medication to be prescribed for aid in dying." However, the bill does not require that the physician inform the patient that such medication is *experimental* and not approved by the FDA. Furthermore, the bill is silent as to what drugs doctors must use and there are absolutely no safeguards preventing doctors from using experimental lethal drug compounds directly on patients. This is one of the many informed consent issues in the bill because the patient may not understand that she is agreeing to an experimental overdose that is not FDA approved, has not undergone clinical drug trials, and has virtually no oversight from the government or medical institutions.

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."[42] 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: "[v]irtually 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.'"[43] The bill directly

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[37] *Id*. at 340.

[38] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).

[39] *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).

[40] *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).

[41] 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/.

[42] Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

[43] Gonzales v. Oregon, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

contradicts Maryland's legitimate interest in protecting the integrity and ethics of the medical profession. Instead, the bill allows physicians to freely violate their ethical obligations and cause lethal harm to their patients through experimental drugs.

Consequently, S.B. 443 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. The bill opens the door for physicians to be forced to violate 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.

IV. *Conclusion*

Physician-assisted suicide is not healthcare. Instead, it acts as a limited exception to homicide liability under state law and allows physicians to use experimental drugs directly upon patients without FDA approval nor clinical trials. Accordingly, 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 more than "200 assisted-suicide bill have failed in more than half the states."[44] Likewise, this Committee should reject S.B. 443 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,

Danielle Pimentel
Policy Counsel
AMERICANS UNITED FOR LIFE

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[44] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 53 (2018).

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2024 PAS testimony

Nursing Implications of Physician Assisted Suicide

In meeting with a few legislators leading up to this testimony, one stated, “I fail to see how this legislation affects nurses. It is between the physician and his or her patient.”

Let me address that statement.

The nurse encounters each patient on a number of occasions as the patient journeys through the health care system. Nurse navigators guide patients through the system for the varied testing and treatments. In the course of a hospital stay, a nurse brings medication, administers long-term infusions, and makes follow-up phone calls to patients. In each of these encounters as well as countless others, the nurse develops a very close relationship with each patient.

- In my first job as a nurse, I got to know several of the patients at the VA Medical Center as they returned every 3 weeks for their chemotherapy doses.

- I can remember speaking with my own mother after her 4-hour chemotherapy infusions and hearing, “I want you to meet my nurse…she’s from Pennsylvania, she has 3 kids, and she’s really neat.” When I met the nurse, she asked me how nursing school was going and how my brothers were doing.

Within these relationships, the nurse gains the trust of the patient, and the patient feels comfortable enough to ask questions about their care, such as “What would you do if you were me?,” “Should I try this treatment/medication, etc?”

If a patient asks me about Assisted Suicide, I will try to talk him or her out of it. But, in doing so, I put my career at risk, because this Bill offers me and other nurses no conscience protections.

I am either forced to honor the patient’s wishes against my personal moral objections or risk a claim of patient abandonment.

There are no conscience protections for nurses. In fact, nurses are not mentioned in this Bill at all.

In its 2019 statement, The American Nurses Association has a clear advice for states where this is legal: there must be conscience protections.

They state:
Conscience-Based Refusals
“Respect for patient decisions does not require that the nurse agree with or support all patient choices,” thus the nurse is not required to compromise his or her integrity in the provision of

such care. Such situations may result in the nurse experiencing moral distress. “When a particular decision or action is morally objectionable to the nurse…the nurse is justified in refusing to participate on moral grounds. Conscience-based refusals to participate exclude personal preference, prejudice, bias, convenience, or arbitrariness” (ANA, 2015a, p.21). A well-established ethical commitment when declining to provide care on moral grounds is the primacy of patient care. “Nurses are obliged to provide for patient safety, to avoid patient abandonment, and to withdraw only when assured that nursing care is available to the patient” (ANA, 2015a, p. 21)
https://www.nursingworld.org/~49e869/globalassets/practiceandpolicy/nursing-excellence/ana-position-statements/social-causes-and-health-care/the-nurses-role-when-a-patient-requests-medical-aid-in-dying-web-format.pdf

Being a nurse is a call to healing, and this practice is the antithesis of healing. No nurse enters the workforce just to sit idly by while someone take his or her own life. And, no matter how you state it in the Bill, self-administration of a substance known to be lethal is still suicide.

Quite frankly, Assisted Suicide represents a failure of health care, failure to identify a patient’s depression, failure to unload the burden of the patient’s illness, and even failure to adequately treat pain.

Other points to consider:

1. Assisted Suicide laws exist in direct conflict with the DEA.

   This Bill puts lethal doses of multiple controlled substances into the community. In the 2022 Oregon Report, it states that 32 people died from prescriptions written in previous years, leading one to wonder where those prescriptions were kept while the patient waited to take them. Of the 431 individuals who had prescriptions written in 2022, 84 died of other causes, and ingestion status was unknown for 101 individuals who also had prescriptions. So, what happened to those unused prescriptions? They are likely still in the community, but that statistic is not known.
   Source: Oregon Death with Dignity Act: 2022 Data Summary

   Contrast that with Drug Enforcement Administration (DEA) Diversion Control Division which serves the purpose of keeping controlled substances out of the community. This law puts lethal doses of multiple controlled substances *into* the community.

2. Instead of receiving an adequate psychiatric evaluation, individuals that qualify for Assisted Suicide are given the very weapon with which to carry out the suicide.

The government should not be in the business of deciding which citizens receive life-saving psychiatric care, and which patients do not.
Otherwise healthy individuals with suicidal ideation or a suicide attempt are admitted for in-patient psychiatric care and treatment of their underlying mental condition. However, those with less than 6 months to live would not receive this care; the Bill sends the message that these individuals do not deserve to be saved.

3. In this version of the Bill, even if the physician finds this practice morally objectionable, he or she is forced to comply, starting the process by forwarding records to someone who will participate.
   Thus, even the conscience protection for physicians is weak. On page 19 of SB 443, it states, "If the physician does not wish to participate…the attending physician expeditiously shall transfer the relevant medical records to another physician." In short, the physician is forced to comply.

Debbie Ryan, BSN, RN, MS, NNP

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TESTIMONY AGAINST SB443 – END OF LIFE OPTION ACT

February 8, 2024
Judicial Proceedings Committee

DEBBIE YATSUK
District 30A, ANNAPOLIS
#410-507-4543

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. Yet we wonder why killers don't value life. **Life is not a partisan issue but the whole issue.** It should be cherished from conception to death.

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 God created life, and our value and purpose come from God. Maybe it is more necessary to live.

Our middle-age and young people have grown up with easy access to and use of abortion which casually kills a beating heartbeat and growing human. Now this bill encourages killing by allowing someone to take their own life when they may be in a vulnerable position.

Kill pain not the person. Death is too final to allow it so much latitude.

We know that Hospice and Palliative Care are wonderful options to provide medicines, comfort and support for the patient and the family. We know that other countries and states that have allowed assisted suicide show that pain is not the main reason, more the loss of enjoying activities and autonomy. We know that assisted suicide inevitably expands where it has been decriminalized to include chronic conditions, psychological distress and disabilities. Where is the dignity in that?

We are not asked to be born, and we should not have to ask to die. Let us care for each other whatever our circle of life encompasses. **Dignity depends on one's character, not circumstances.** Life with grace delivers more blessings than an untimely death. **Let's focus on the worth of treatment and not the worth of a person.** Unnatural death is not our friend.

Just as it takes courage to live out your life with dignity and grace, I ask for your courage to protect life. Thank you for your consideration, and I urge an UNF on SB443.

Debbie Yatsuk
Annapolis
410-507-4543

2024 SB443 PAS Opposition personal.pdf

Uploaded by: Deborah Brocato

Position: UNF

Opposition Statement SB443
End-of-Life Option Act

Deborah Brocato
3206 Glouchester Dr, Fallston MD 21047
410.440.6348

My name is Deborah Brocato and I urge you to oppose this suicide bill known as the End-of-Life Option Act or Senate Bill 443.

I know something about suicide. My father suffered from depression and alcoholism as a result of physical and emotional abuse at the hands of his father. My father was violent and struggled to hold down a job. Several stints in alcohol rehabilitation failed. After years of struggling and failing to overcome his afflictions, he decided his family would be better off without him. He hung himself.
My father's suicide left our family broken and in shock. We wanted him to get well, not die. Years later, my siblings and I admitted to each other that we had each thought about suicide. We just wanted to stop the pain. Suicide almost became a family legacy. One person kills himself and others start thinking that might work for them. Thankfully, none of us ever took action on those thoughts.
Suicide is the result of despair. 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. Suicide is not healthcare.

If you want more suicide, then pass this bill. According to the National Institute of Health (NIH), "Legalizing PAS has been associated with and increased rate of total suicides relative to other states and no decrease in nonassisted suicides." (https://pubmed.ncbi.nlm.nih.gov/26437189/)

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 healthcare professionals into executioners.

In contrast, I cared for both my mother and, more recently, my brother during their battles with cancer. Both received chemotherapy treatments until they realized the cancer was winning. The treatments didn't save them but they did gain extra time with their families. If this legislation was in effect, the insurance companies would be incentivized to offer the cheaper prescription of suicide drugs over the life-extending chemotherapy. They might not have been given a choice. People with fatal diseases do have choices but suicide should never be put into the healthcare codes as a legitimate medical treatment.
Suicide is not compassionate. Putting physician in front of it does not make it healthcare. The American Medical Association (AMA) has reaffirmed it's position that suicide is against their medical ethics. Their statement says, "Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could be extended to incompetent patients and other vulnerable populations."

Opposition Statement SB443
End-of-Life Option Act

Deborah Brocato
3206 Glouchester Dr, Fallston MD 21047
410.440.6348

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. When our fellow human beings are suffering, they need appropriate treatment. They need true compassionate care.

If you want less compassion, then pass this bill. If you want more suffering, then pass this bill.

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.

What a suffering person needs is to know they are worth the effort for them to receive true, compassionate care including effective pain management, psychological and emotional care and physical care.

Do not normalize suicide. Do not turn healthcare into deathcare. Do not make Maryland a haven for death.

I urge you to promote compassion and appropriate treatment for those who suffer. Reject this inhumane bill. Please give an unfavorable report on **SB443**.

Mrs. Diane M. Alvarez
1109 Revolution Street
Havre de Grace, MD 21078

alvarezboe@gmail.com
(443) 502-2044

Saturday, January 20, 2024

Honorable Legislator,

Thank you for serving the state of Maryland, your decisions form the culture we live in. I ask you to support a culture of life by not supporting any legislation that devalues life. For many, laws form their moral compass. If laws do not support life in all forms and conditions, then individuals may not value life as well. Medical professionals at one time took an oath to do no harm, most doctors believe that means to save lives not to take them. I would like to share with you a few of my experiences.

When my aunt's cancer returned in her 60's she knew the end was near, was afraid, and alone. She was so afraid of the pain that she might endure that she attempted to take her own life. Fortunately her sister found her and rescued her. From that day forward the family surrounded her with love and made sure she never felt alone. When I visited her, she would say with a smile I am not in any pain. She was so grateful that her worst fear was not true, and she loved being surrounded by a family that cherished her. She lived out her final days surrounded by love, and we got to say goodbye and we love you. A vote to approve assisted suicide would have taken away an opportunity for our family to bond and my aunt would have died not knowing how much we valued and loved her. She would not have included the family and would have died all alone.

My mother was diagnosed with cancer in 2018, she was given 6 months to live. She lived 18 months, 12 months longer than the doctor's predicted. Although, my mother was bedridden the last two months of her life, she smiled often, and she died peacefully. There are other cases that patients have lived for years beyond the diagnosis. My cousin was diagnosed with a rare brain illness at 11 years old he was not thriving and was not expected to live long. His illness went into remission, and he is still alive 40 years later. I am so grateful for the extra time that I was able to spend with my mother, my cousin is still with us today. The truth is doctors cannot determine how much longer anyone will live and predictions are often wrong.

Physician assisted suicide sends a message to society that suicide is acceptable, and you should control your own death, and that death by lethal drugs is a better death more dignified death than natural death. With all the issues with suicide is that message we want to send? This bill is a measure of how spoiled and selfish some in our society have become. Your decision is important, support life, vote no to physician assisted suicide.

Respectfully,

Diane M. Alvarez
Maryland Voter

Maryland Catholic Conference_UNF_SB443.pdf

Uploaded by: Diane Arias

Position: UNF

MARYLAND
CATHOLIC
CONFERENCE

February 7, 2024

Senate Bill 443
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 (MCC) 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 443 would allow licensed physicians to legally prescribe lethal 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.

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. The 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. The MCC 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.

For these reasons, the MCC asks for an unfavorable report on **SB 443.**

Thank you for your consideration.

Not Dead Yet Testimony Opposing MD Assisted Suicid

Uploaded by: Diane Coleman

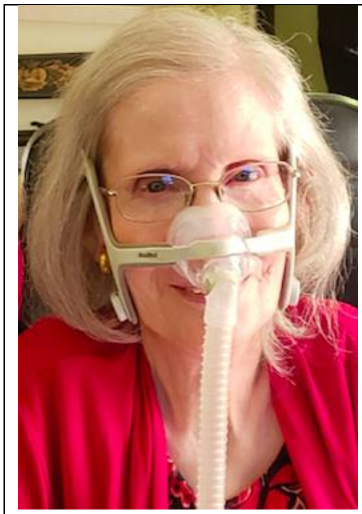
Position: UNF

NOT DEAD YET
The Resistance

Testimony Opposing Maryland "End-of-Life Option" Bill HB403/SB443

Diane Coleman, JD, President & CEO, Not Dead Yet (708-420-0539)

February 8, 2024



I am a two-time cancer survivor who depends on full-time breathing support. This testimony is filed on behalf of Not Dead Yet, a national disability organization headquartered in New York with members in Maryland. Not Dead Yet is among 17 major national disability organizations that oppose assisted suicide laws. Not Dead Yet is also a plaintiff in a major lawsuit filed under the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and the U.S. Constitution to challenge the California assisted suicide law as discriminatory based on disability.

One of the most frequently repeated claims by proponents of assisted suicide laws is that there has not been "a single documented case of abuse or misuse." To the contrary, I refer you to two resources describing problem cases. The first is from the Disability Rights Education and Defense Fund, Oregon and Washington State Abuses and Complications. The second is a journal article by two New York medical doctors, Drs. Herbert Hendin and Kathleen Foley, Physician-Assisted Suicide in Oregon: A Medical Perspective (2008).

Data from states where assisted suicide is legal show that all people who request assisted suicide have disabilities, even if some don't think of their impairments that way, and that unmet disability related needs are their reasons for wanting to die. The top five reasons Oregon doctors give for their patients' assisted suicide requests over all reported years are not pain or fear of future pain, but psycho-social issues that pertain to disability. Three of these (losing autonomy, losing dignity, burden on family) could be addressed by consumer-directed in-home personal care services, but the law operates as though the person's reasons don't matter, and nothing need be done to address them.

Moreover, eligibility is far broader than most people imagine. Oregon reports that the types of non-cancer conditions found eligible for assisted suicide have grown over the years, to include: neurological disease, respiratory disease, heart/circulatory disease, infectious disease, gastrointestinal disease, endocrine/ metabolic disease (e.g. diabetes), and, in the category labeled “other”, arthritis, arteritis, sclerosis, stenosis, kidney failure, musculoskeletal systems disorders and, most recently, **anorexia** (reported for 2021).

Doctors are also supposed to detect coercion, but how could they do so when, for example, Oregon’s state reports say that the median duration of the prescribing physician patient relationship was only 5 weeks in 2021 and 2022. Over all the years, a supposed lack of coercion is not usually determined by a physician with a longstanding relationship with the patient. This is significant in light of well-documented elder abuse-identification and reporting problems among professionals in a society where an estimated one in ten elders is abused, mostly by family and caregivers. (Lachs, et al., New England Journal of Medicine, Elder Abuse.)

In about half the reported Oregon cases, there is also no independent witness to consent or self-administration at the time of ingestion of the lethal drugs. If the drugs were, in some cases, administered by others without consent, no one would know.

Research on healthcare disparities has also shown that medical providers are not immune to prevailing social biases. Making assisted suicide part of “end-of-life care” and designating doctors as its gatekeepers and administrators could only further undermine patient safety, particularly for older adults, disabled people, Black, indigenous, communities of color and other multiply marginalized people who already experience life threatening healthcare discrimination.

Legislators should also be concerned about the pressures toward expansion in the broader euthanasia movement. Expansions already adopted by a few states allow non-physician prescribers of lethal drugs and allow waiting periods to be waived.

To further consider the risks of expansion, it would be appropriate to look at Canada. Only five years after Canada passed its national law for people with terminal illnesses, Bill C-7 was passed making assisted suicide and active euthanasia available to healthy people with disabilities. Canadian press has since reported on disabled individuals getting euthanasia by lethal injection when they want to die because they can’t get housing or otherwise can’t afford to live on government payments. Next year, Canadians whose sole illness is psychiatric are scheduled to become eligible for euthanasia. See Coelho R, Maher J, Gaind KS, Lemmens T (2023). The realities of Medical Assistance in Dying in Canada. *Palliative and Supportive Care*. https://doi.org/10.1017/S1478951523001025

Equal rights include equal suicide prevention, not suicide agreement and assistance for people who are too often devalued. Maryland should firmly reject the dangerous discrimination of assisted suicide.

Diane Coleman, JD, President/CEO, Not Dead Yet, dcoleman@notdeadyet.org

708-420-0539

AAPS Association of American Physicians and Surgeons

Testimony is respectfully submitted on behalf of the nationwide Association of American Physicians and Surgeons - to the Maryland General Assembly in opposition to SB 443/HB 403 in March 2024 by Dr. James Kelly- a Maryland physician and adult, child, adolescent and forensic psychiatrist for 37 years.

Research has proven that most people seeking legal assisted suicide do so for **emotional**, **social and financial reasons** such as depression, feeling unwanted and a burden and **NOT** due to physical illness terminal illnesses, or unbearable pain. People suffering from unbearable pain or terminal illnesses want to live and do not want to kill themselves generally, until they become depressed, feel unloved and a burden to their family. Research has shown that suicides tend to be a “contagious” and that children of parents who suicide have a 300% increase of suicide.

This bill is asking you legislators to personally decide if you vote that **Suicide** a good thing -that the government should legalize, legitimize and promote or is suicide a tragedy!!!

What is the point of all of the funding of suicide prevention programs if now the Maryland legislature is going to say that the M.G.A. is against suicide -- except when someone is actually suicidal and wants to kill themselves????

Please do not be deceived this bill is **NOT** about providing compassionate care options or providing autonomy to suffering people. Every year there are over 800,000 suicides in America -that means every 40 seconds someone kills themselves. The choice, methods, time and place of suicide have always been tragically available and under the control of each individual - this is proven by a suicide every 40 seconds. This bill is about replacing helpful treatments with legitimizing and promoting suicides.

Promoters of suicide claim that all people suffering from depression or any mental illness will be referred to a “mental health care provider” for a “mental health assessment”. But the truth is far different from their claims.

Research has shown that such claims are never true. Recent research has shown that the majority of people requesting assisted suicide have symptoms of depression illness by that only 1%- 3% of patients in Oregon actually have a mental health assessments- and such assessments are rarely comprehensive psychiatric evaluations done by experts psychiatrists. Proponents of the bill claim that many well-documented continual neglectful circumstances and abuses of physician assisted suicide observed in other countries and other states will never of course occur in Maryland --as it has occurred everywhere else in the world and in other states that have legalized physician assisted suicide. Proponents of this bill -in an effort to gain your approval -claim that this bill provides plenty of adequate safeguards- but they know very well that those hypothetical safeguards will be reinterpreted, challenged in court, changed and eliminated and will be at best only temporary .

This bill gives doctors legal protection and justification, and the means and power to prescribe deadly experimental unproven poisons to the most vulnerable people in our communities. This bill demands that physicians become liars. It demands that physicians lie by documenting that the patient died from some potential future natural cause instead of reporting the truth- that they were killed from prescription poisons. This bill gives doctors the power and authorization to arrange the deaths of vulnerable desperate people. It legitimizes abandoning the physicians' Hippocratic oath and promise- to never abuse or harm their patients, and to become liars. Once this **permanent damage** is made to the doctor-patient relationship how can we ever **trust our physicians again**?

Please do not be fooled by the professional suicide promoters who are claiming that this bill will actually help a few people. They may have solicited some supporters who may actually believe that this will help some people -- but the real net result will be **promoting, legitimizing and increasing death and suicide** and establishing new Maryland-based **for-profit government- approved suicide industries**. It will also legitimize **denying care** to people and **encouraging suicides** in an effort to **save money and increase profits.**

The Association of American Physicians and Surgeons respectfully requests that you **DO NOT** give doctors or the healthcare industry approval to **prescribe deadly poisons**. Please vote **NO** on **SB 443/HB 403**

End of Life Option Act 2024.pdf

Uploaded by: Dr. Marie-Alberte Boursiquot
Position: UNF

Marie-Alberte Boursiquot, MD, FACP

RE: Senate Bill 443/House Bill 403:-"End of Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Oppose

Dear Honored Senate and House 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.

I maintain 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 as defined, in the Merriam-Webster dictionary, is *"The act or an instance of taking one's own life voluntarily and intentionally".*[3]

Suicide is not medical care nor an "option" in medical care. It has now become a public health crisis, it is the tenth leading cause of death in this country, and its' rates are rising.[4] In a civilized society suicide should not be promoted.

Assisting a patient in doing harm to themselves is never part of the medical training of a physician. This Bill supports exactly that. It is natural that a patient and their families may experience fear and anxiety at the end of life and/or as a serious illness progresses. 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:

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[1] American College of Physicians Ethics Manual: (online) www.acpjournals.org/doi/pdf/10.7326/M17-0938

[2] Code of Medical Ethics of the American Medical Association: (online) code-medical-ethics.ama-assn.org. See Opinion 5.7 and 5.8.

[3] www.merriam-webster.com

[4] American Foundation for Suicide Prevention: www.afsp.org

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.
4. It is not clear that a Physician can refuse to participate in this act whether the patient makes this request orally and/or in writing.
5. The determination of a "terminal illness" resulting in the individuals death within six months is seldom accurately predicted.

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 intended to be misused or abused to harm patients. Drug overdose is the leading cause of unintentional death in the United States. Opioid addiction is driving this epidemic. These are the same drugs that are often found in the drug cocktails prescribed to patients involved in assisted suicide.

In the event that the patient succeeds in committing suicide, the "attending physician" is then selectively protected by law to falsify the death certificate by listing an underlying medical condition as the 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 undermines the integrity of the medical profession.

The legalization of Physician Assisted Suicide will eventually lead to the more disturbing practice of Euthanasia. In this instance it's the physician who decides that the patients' life is no longer worth living and ends the life of the patient.

We need only look north to our neighbors in Canada to see the disastrous effects of this practice.[5]Safeguards such as waiting periods, terminal illness restrictions and residency requirements which were originally assured as Physician Assisted Suicide was accepted were rescinded. Particularly disturbing is what happens with the expansion of Euthanasia to include patients suffering with mental illness.[6]

There are already "end of life" options available to suffering patients. Palliative Care[7] for instance is designed to prevent and alleviate the suffering associated with a chronic or advanced medical condition. This includes such conditions as:

- Lung Disease (i.e COPD)
- Heart Disease
- Liver or Kidney Disease
- Cancer
- Dementia, ALS, or other neurologic conditions.

It can and should 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, manage, and refer to subspecialists those who suffer from these conditions.

Physical suffering at the end of life can already be effectively managed with palliative sedation and narcotics. Patients already have a right to discontinue medical care when such management has become futile.

Hospice Care[8] 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.

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[5] (2022)70(3) World Medical Journal 27-25. (online) www.wma.net/wp-content/uploads/2022/11/WMJ_2022_03_final-1.pdf

[6] (2022)71(4) World Medical Journal 72-82.

[7] www.nhpco.org/palliative care/explanation-of-palliative care

[8] Nia.nih.gov/health/frequently-asked-questions-about-hospice-care

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 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: “Physician Assisted Suicide is fundamentally incompatible with a Physicians role as healer”.[9]

Physician Assisted Suicide under any name (i.e “End of Life Option”, “Medical Aid in Dying”, “Aid in Dying”, etc.): is unnecessary, is dangerous, and is not medical care. Thankfully the majority of physicians will not participate in this act.

Thank you

Marie-Alberte Boursiquot, MD, FACP
Columbia, MD 21046
Mariealberte1115@gmail.com

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[9] Code of Medical Ethics of the American Medical Association. (online)code-medical-ethics.ama-assn.org. See opinion 5.7

SB 0443 End of Life Options Act-2024.pdf
Uploaded by: Ella Ennis
Position: UNF

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
Maryland Senate
Annapolis, Maryland

RE: **SB 0443** *End of Life Options Act* – **UNFAVORABLE**

Dear Chairmen Smith and Members,

For the following reasons, the Maryland Federation of Republican Women strongly opposes SB 0443 – *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.
- Patients with serious illness can be denied treatment as “not appropriate”.
- Lethal drugs prescribed for an individual may instead kill someone else by error or intent.
- 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 “Obligation 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.

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 0443** 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

2024.SB0443.Arlinghaus.pdf

Uploaded by: Francis Arlinghaus

Position: UNF

SB0443

Dr. Frank Arlinghaus

Opposed

I ask the committee to oppose Senate Bill 443, The End of Life Option Act. I join both the National Council on Disability and the American Medical Association in opposition to this bill (as well as numerous other disability rights and medical groups). I believe there are many good reasons for such 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, particularly the insufficient protections for many vulnerable groups. I outline a few of these reasons below.

The National Council on Disability opposed Physician Assisted Suicide in a comprehensive 2019 report.

Please note that if you were to refer to one resource for information, I would ask that you look at the National Council on Disability report from October 2019 (at https://beta.ncd.gov or by searching on "The Danger of Assisted Suicide Laws") "The Danger of Assisted Suicide Laws: Part of the Bioethics and Disability Series", which documents a number of issues which contradict the narrative from Compassion and Choices. Importantly, this 70 page paper analyzes the law and examines whether the previous predictions by the NCD about these laws was correct (for example, their prediction on the ineffectiveness of claimed safeguards). For a shorter read, I recommend the 4 page executive summary on pages 11-14 of the report. However, I mention a few quotes from that summary:

"Many national disability organizations have taken positions opposing these laws due to concerns regarding their impact on people with disabilities" (p.11)

"Insurers have denied expensive, life-sustaining treatment but offered to subsidize lethal drugs" (p.11)

"People with the disability of depression are subject to harm where assisted suicide is legal" (p.11)

"Assisted Suicide laws apply the lowest culpability standard possible to doctors…which creates the potential for abuse" (p.12)

“Evidence of suicide contagion in states where assisted suicide is legal has been found in several studies” (p.13)

“States should not legalize any form of assisted suicide” (p.14)

The NCD is not the only organization to oppose PAS. However, in their bioethics report on PAS, they document evidence for these and other claims made in that executive summary. Other groups opposed range from the Disability Rights Education and Defense Fund or the Patients Rights Council to Not Dead Yet. All of these groups are concerned that patients with disabilities are put at even greater risk by these laws. Proponents of the law cite the number of safeguards and assert the strength of those safeguards; however, the NCD report addresses the problems with those safeguards by providing specific examples, many from the state of Oregon.

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**. Two such examples are the 2008 case of Barbara Wagner in Oregon (whose lack of treatment by the Oregon Health Plan can be compared to the Randy Stroup case, and which is described on page 20 of the NCD report referenced above with further details in the article “Oregon Rationing Cancer Treatment But Offering Assisted Suicide to Cancer Patients–Paying to Die but not to Live”) and the 2016 case of Stephanie Packer in California (referenced on page 16 of the NCD report and both the Center for Bioethics and Culture Network and Patient Rights Action Fund). 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, and is moving toward euthanasia, and each year gets progressively worse for those in vulnerable groups.

-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. You have heard many of these stories over the past eight years, and you see that society lacks respect for those vulnerable groups–the physically or mentally challenged, the elderly, the poor, the depressed.

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, and these numbers declined in 2020-2022 despite the number of deaths and prescriptions rising dramatically (cf Oregon 2022 report); that doctors are only required to refer if they believe the depression rises to the level of impairing the patient's judgment; 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. The case of Michael Freeland presented on pages 23-24 of the 2019 NCD report involves a man with a 43 year history of depression whose history was ignored by a C&C-associated doctor, and who was rescued by Physicians for Compassionate Care, who treated his depression instead. In fact, a British Medical Journal study of 58 patients in Oregon receiving lethal prescriptions showed that 26% presented for depressive disorder and 22% for anxiety disorder. We're seeing suicide rates increasing dramatically as well as significant amount of depression, but we rarely see the doctors involved referring for depression (perhaps this is because the median length of time of the doctor-patient relationship in the Orgon cases is only 5 weeks).

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.**

As **the parent of a teenager who considered suicide,** I have had to deal with responding to her concerns that society allows people to kill themselves, so why shouldn't she be permitted to do so. I have another child who dealt for multiple years with depression, and who was at similar risk. Both of them have heard the message we're sending, and it makes it more challenging for me (and for them).

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. If we just look at Oregon, between 1999 and 2010, the suicide rate among the age group 35-64 rose 49% compared to a 28% increase nationally, and the overall suicide rate in Oregon went from near average levels to 41% above the national average. Between 2011 and 2019, the number of suicides (excluding those which were physician assisted by lethal prescription) rose from 685 to 906 (an increase of 32%). During that same time period, the number covered by Oregon's version of this bill rose by more than 100 additional deaths, and in 2020 would result in over 250 additional deaths.

Additionally, we are in a state of emergency concerning the mental health of minors, and a mental health crisis across all ages. Just **one adult category that is at even greater risk is that of our veteran population**. At the same time, the study of reasons in Oregon that people seek this treatment includes the top two warning signs for suicide listed by the US National Institute of Mental Health. Talking about wanting to die, feeling guilt or shame, or believing that one is a burden to others, and planning or researching ways to die are warning signs for other patients, and things which we seek to treat with counseling, not counseling those people to die.

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 (two examples cited above are the Wagner and Packer cases).

Within the Senate, during a previous year's committee hearing, the legal and medical standards were questioned by one of the senators, and the main sponsor did not have an answer for the weaker standards. One specific case of this is the unwarrantedly weak standard for physicians that replaces the standard negligence model (used for virtually all other physician duties) to the weaker "good faith" model. 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. The good faith model is the **weakest standard** we would use, and is **lower than what we use for almost all other physician duties.** It is designed to protect the doctor and not the patient.

Furthermore, **the investigatory powers of the state are limited**, so protections from abuse are perfunctory at best. To quote the Oregon Department of Health and Human Services, " We are not given the resources to investigate and, not only do we not have the resources, but **we don't have the legal authority** to insert ourselves".

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. Additionally, polls which use the term "Medical Aid in Dying" gain broad support due to this confusion.

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. Proponents of the bill fail to consider the risk of those drugs being used on a patient who has changed their mind, or used on someone else.

In the most recent version of the Oregon report available (2022), 431 people were reported to have received lethal prescriptions, and of them, 246 had died by ingesting the medications (278 patients had died, but 32 had received the lethal drugs in 2021 or earlier). The past four years have seen an increasing number of prescriptions unused.

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. The cases cited above from the NCD report include evidence that denial of treatment of medical conditions in favor of PAS was based on estimated 5 year survival rate (which is a far different standard than the 6 month standard).

9. **Conscience protections should be extended further–to nurses, pharmacists, other health care workers, and facilities.**

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 80 years of legality to dismiss problems. We have not had 80 years of legality, we have had over 80 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 (the 2021 and 2022 reports show a big increase in death, consistent with 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 nine 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). Many of 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, and now a variety of drug mixtures is used.

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 2021, a single doctor wrote 47 prescriptions, while in 2022, a single doctor wrote 51 prescriptions. 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 protections for so many of the things mentioned here.

gayno_sb443.pdf
Uploaded by: George Gayno
Position: UNF

Senate Bill 443 - End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
February 8, 2024

George A. Gayno
Edgewater, MD

OPPOSE

I am writing to express my ***strong opposition to SB 443***.

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 443 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 443 makes suicide 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. This has already happened in Australia, where a man killed himself by ingesting the poison prescribed for his wife.

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 financially strained, people who struggle with mental illness will 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.

SB 443 2024 End of Life Option Act GMurray.pdf

Uploaded by: Gwenn Murray

Position: UNF

SB443/HB403 – End-of-Life Option Act - AGAINST

Submitted by:

Gwenn Murray

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Why Oppose Senate Bill 443 and House Bill 403

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. ***A niece of mine commented to my mother-in-law who had dementia that she 'should hurry up and die so that she did not waste her inheritance.'*** She actually spoke this to her. I am certain that if this legislation were in place, fellow Marylanders will fall victim to greedy family members.

- 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 SB443.

2024 Opposition to Physician Assisted Suicide.pdf

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

February 6, 2024

Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member:

My name is Dr. Holly Dahlman. I am the owner of and one of the physicians at Green Spring Internal Medicine, a small independent primary care practice in Lutherville. I am a graduate of the Johns Hopkins University School of Medicine and trained in medicine at the Johns Hopkins Hospital. Over my 25 year career, I have specialized in the care of adults, including at the end of life, often with home hospice in place. What is good, what is just, what avoids wrong, what is safe, and what is wise must be at the forefront of my every consideration as a doctor.

I am writing in opposition to SB0443 for the following reasons:

- Legalizing PAS would harm the trust between physicians and our patients, worsening health disparities and putting vulnerable populations at risk.
- PAS would threaten access to care in cost-conscious healthcare environments.
- PAS would create financial conflicts of interest for physician practices, hospitals and health systems due to healthcare models which incentivize cost-saving.
- This bill attempts to redefine “aid in dying” and “suicide” in ways which deceive the public.
- Amidst an opioid overdose epidemic, this is no time to release more dangerous drugs into Maryland communities.
- Amidst a suicide epidemic, this is no time to signal to Marylanders that ending one’s own life in the face of suffering is favorable.
- The bill requires physicians to falsify death certificates, which is unethical and makes PAS deaths impossible for officials to track and nefarious acts impossible to investigate.
- The largest physician organizations oppose PAS, and physicians will not participate in PAS.

My role as a physician is not to kill but to heal and when there is no remedy, to provide comfort. To relabel physician-assisted suicide by using a mild-sounding phrase like “Medical Aid in Dying” is deceptive. What is being debated, put plainly, is a prescription for death. “Medical Aid in Dying” deceives the public as a term. This bill also attempts to redefine “suicide” itself in a way which is untrue, confusing to the public and dangerous.

Trust in physicians is vital if we are ever going to reduce health disparities. The pandemic produced perilous and disparate health outcomes because of public distrust in healthcare. Legalizing PAS would worsen distrust in physicians. PAS puts vulnerable populations at risk. There are no safeguards in this legislation to protect them. Your own autonomy could come at the expense of many others. This should not be. Autonomy must be weighed against medical ethics of beneficence, non-malevolence, and social justice. If physician-assisted suicide were to be legalized in Maryland, the following individuals would be at greatest risk of harms: people unable to afford care, elders believing they are a burden or with weary caregivers, those wanting to avoid health costs in order to leave inheritances, the lonely, the chronically ill, and people living with disability.

There is no way to prevent a patient from being coerced by a family member or a healthcare provider, as this legislation creates opacity in its processes. An estate beneficiary would be allowed to serve as a witness on a written request for PAS. Somone other than the patient would be able to pick up the prescription at the pharmacy. There is no guarantee that the medication would be taken by the person for whom it was prescribed nor destroyed appropriately if not taken.

Life-saving care is often expensive for the individual and the insurer. 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. For example, insurance companies keep denying coverage for medications proven to be effective to treat obesity. This is no time for the low-cost death option!

Here in Maryland, the Total Cost of Care Model began in 2019 and carries through to 2026, a model which incentivizes hospitals and health systems to reduce healthcare costs. Accountable Care Organizations (or ACOs) throughout Maryland incentivize medical practices like mine to achieve shared savings in healthcare by lowering the cost-of-care across a population of patients. To permit medically-prescribed death would be to open the way to an entirely unmanageable set of financial conflicts of interests for insurance companies, hospitals, and medical practices.

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 worsening opioid overdose death and suicide epidemics. We should not allow dangerous medications to be released into our communities. The desire to end life is often a symptom of severe mental illness, suicidality often only transient, as I have seen with my own family members. Legalizing PAS would signal to young, healthier people that choosing to die is an acceptable way to alleviate suffering.

Finally, it is wrong to ask physicians to falsify death certificates. Ethically, we are bound to standards of truth. Could you imagine writing a cause of death as heart failure, for example, when the very medication you prescribed was what actually caused it? False information hamstrings the ability to use data to study the impact of PAS. It also shields information necessary for criminal investigations, opening the door wide for misuse. Physician liability limitations are written in!

I am a member of the American College of Physicians (ACP), representing 161,000 internal medicine specialists. The ACP opposes physician-assisted suicide as does the American Medical Association. The AMA Code of Ethics states, “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.” Most physicians would refuse to participate. Legalizing PAS would never be good for Maryland. I am asking for an unfavorable report!

Professional regards,

Holly Ryerson Dahlman, MD, FACP
CEO, Owner, Physician
Green Spring Internal Medicine, LLC

PAS statement - Dr Conway.pdf

Uploaded by: Janet Conway

Position: UNF

PAS statement

Dear Honorable state legislators,

I can't believe HB 0403 and SB 0443 "the end of life option act" 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's 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.

I know from personal experience as my mom died when I was 24 from stage 4 ovarian cancer. Every day we had with her was precious and as she was nearing the end of her life her exact words were "I feel like I'm leaving the party early." We did our best to make her every second with us count. There is no way she wanted to end her life.

As a physician, it is my job to protect my patients and their life. I was never taught to kill anyone in medical school. Everything we ever learned in medical school was for healing the sick and promoting wellbeing. No doctor or healthcare provider is a death expert. 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 who's job it is to ensure patient protection and physical well-being.

We should be extinguishing suffering and pain not life. I entreat you all to reject this bill and protect the patient. I am adamantly opposed to this bill.

Janet D Conway MD
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Oppose SB0443.pdf

Uploaded by: Jean Gaes

Position: UNF

My fear is that legislators may be so swayed by the premise that medically assisted dying is another “right” based on the principle of autonomy that they will refuse, on principle, to acknowledge the very real problems with SB 0443.

Firstly, far from being an individual choice, each “medically assisted death” will require the cooperation of medical professionals, pharmacists, and possibly hospice employees, relatives, friends, hospitals, nursing homes, and assisted living facilities. It will introduce dangerous drugs into our communities without follow-up or clear requirements for safe disposal.

Secondly, by affirming that actively seeking death when one is suffering is a sane and rational choice, the state is establishing two classes of people: those whose deaths should be prevented, and those whose deaths should be facilitated. Although the present regulations would limit this to those whose life expectancy is six months or less (if their illness is untreated), the experience of other jurisdictions is that “guardrails” come to be seen as “barriers” that need to be broken down. There is no shortage of suffering people with chronic illnesses, disabilities, limited resources, and mental health concerns. In 2022 6.6% of deaths in Quebec were “medically assisted.” Thus, the underlying issue is not one of autonomy, but of justice. A vastly disadvantaged class of people would be created by this legislation.

Thirdly, “medically assisted” dying is an elastic term. Although SB0443 refers to a physician who prescribes a lethal dose of drugs to be taken by the patient, the term also describes prescriptions by telehealth, written by another professional, and even active euthanasia. Some advocates claim that it is discriminatory not to allow medical professionals to administer the lethal dose if the patient finds it difficult. Others maintain that individuals should be able to authorize their deaths by euthanasia in advance in case they develop dementia.

“Assisted dying” has repeatedly been rejected in Maryland because of the grave dangers it poses to vulnerable citizens. Our present legislation permits effective pain control. Please fund more help for aged, ill, and disabled individuals in our state instead of giving them lethal prescriptions.

SB443 testimony.pdf

Uploaded by: JENNIFER PALMER
Position: UNF

Testimony in OPPOSITION to SB443 - Jennifer Palmer, M.D. for the Maryland Psychiatric Society

This bill raises serious questions for me as a private practice psychiatrist who treats patients with mood and eating disorders, including those suffering from anorexia who have SI despite weight restoration.

1. **If a patient asks me for a lethal Rx** and I refuse, am I obliged to refer them to a psychiatrist who will “treat” their condition with a lethal Rx?
2. **If another doctor asks me to evaluate a patient’s competence** for a lethal Rx and I refuse, am I obliged to find a psychiatrist who will?
3. **If a patient obtains a lethal Rx from another doctor,** but I believe their psychiatric condition is not fully treated, will I be able to communicate this with that doctor? What if the doctor doesn’t know they are being treated by a psychiatrist at all?
4. **If a patient has a lethal Rx and tells me they intend to take it**, can I petition to have the Rx taken away as if it were a firearm? Can I EP them for emergency evaluation of SI? Will they be retained? This would affect definitions of dangerousness. Are ALJs prepared for this?

The bill answers none of these questions and is therefore untenable. I ask for an UNFAVORABLE report.

John Dyer Oppose HB403 SB443 Assisted Suicide.pdf

Uploaded by: John Dyer

Position: UNF

Written Testimony of John J. Dyer IV

Oppose HB403/SB443 Assisted Suicide

February 7, 2024

My Name is John Dyer and I have been a lifelong resident of Maryland, even while serving on Active Duty in the Military. My family and I currently own a home at 11602 Hunters Run Drive Cockeysville MD.

The following reasons are my personal testimony as to why I request you also Oppose HB403/SB443 Assisted Suicide

First, in 2004, following the birth of our oldest daughter in 1998 and after 3 subsequent miscarriages in 1999, 2000 and 2001 we decided to pursue the adoption of a child.

Circumstances lead us to adopt a 1-year-old little girl from Russia on November 30, 2004. Our daughter like many of these children from Russia suffers from Fetal Alcohol Syndrome Disorder which has led to her being diagnosed with multiple mental disabilities. She also has learning disorders as well. She suffers from anxiety, very low self-esteem and makes statements that she wants to take her own life.

I Oppose HB403/SB443 in this instance because I have a disabled daughter with mental illness and *in* no way do I want the State of Maryland to make it easier to have a legal mechanism to end her own life at her own hand or by a medical providers hand once she becomes an adult in a few short years.

Second, my siblings and I have always provided care for our parents, and we would never consider them a burden**. It takes a sacrifice to care for a parent in their later years and Maryland should help by providing better tools for family to screen potential caregivers for credentials and criminal history and to provide tax breaks for those caring for their parents. Not an easier way to end their lives.**

I Oppose HB403/SB443 Assisted Suicide in this instance because I feel that if this law is passed, Maryland's medical providers will be more inclined to prescribe the poison pills to end an elderly person's suffering because it will be legal and there will be plenty of legal and political protection for their licenses to prescribe these pills in lieu of an adequate pain pill for citizens.

Additionally, I hear that this is a matter of the heart and so-called compassion for the suffering and that is why the poison pill needs to become legal in Maryland. I disagree I contest this is a matter of the head and I would rather use my brain instead of my heart to fight for the proper care of our family members then just to say it is somehow more compassionate to provide them the choice of a pill that will end their lives.

Our Nation's Veterans comprise nearly a quarter of the suicides in the US. Thousands each year. As a veteran like my father both of us serving over 30 years in the Maryland Air National Guard and the Air Force, I am very concerned about making it easier here in Maryland for a Veteran to take their own life. Instead of this I would rather our efforts be focused on legislation to help them save their lives.

In fact, I am personally involved as a volunteer in a local chapter of the Military officers of America here in Baltimore and for the 4th year we are hosting a fundraiser for an organization called "pws4vets". Organizations like this are making a real life saving difference in providing highly trained services dogs to our struggling combat Veterans with mental health problems. **I chose the Pooch over the Poison Pill.**

I Oppose HB403/SB443 Assisted Suicide in this instance because there are proven ways like paws4vets to help our Veterans and to protect them from the seductive call of Suicide. Why would we choose to fight against this great organizations by making it easier for our Veteran's to end their own liv her in Maryland.

Respectfully Submitted,

John J. Dyer IV

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410-610-7183

Kelly Testimony opposing MD SB0443 End of life op

Uploaded by: John Kelly

Position: UNF

February 07 2024

John B. Kelly
Not Dead Yet
Communications Director
Boston, Massachusetts

SB 0443
End of life Option Act
Senate Judicial Proceedings

My name is John B. Kelly. I am Communications Director for Not Dead Yet, the leading national disability rights group opposing assisted suicide, futility judgments, and "better dead than disabled" policies. We organized in 1996 to help stop Kevorkian, whose client victims were presented in the media as terminally ill. Two thirds of them were later found by the New England Journal of Medicine to be NOT terminally ill but disabled.

I keep thinking about Canada, where people like me – I'm a quadriplegic paralyzed below my shoulders, but I am not terminally ill – have become eligible for its version of an "aid in dying" program – and by aid in dying Canada means euthanasia 99% of the time.

At first, Canada legalized euthanasia/assisted suicide for people diagnosed as terminally ill, which it defined as people whose deaths were "reasonably foreseeable." The courts soon stretched that definition to include non-dying disabled people. Now, anyone with a "grievous irremediable medical condition" can qualify for euthanasia. Disabled people have "chosen" euthanasia when denied services (Sean Tagert) or accessible housing ("Sophia").

In Maryland and other states, proponents insist that "aid in dying" hinges on a definition of terminal illness that limits the population to people expected, "within reasonable medical certainty," to die within the following six months. There have already been calls to expand eligibility beyond six months and beyond people diagnosed terminally ill. For example, New Mexico's HB 90, the Elizabeth Whitefield End Of Life Options Act, was first submitted in 2019 with a definition of terminal illness encompassing all incurable and irreversible conditions that "will result in death within the foreseeable future." The bill passed in 2021 after switching back to the six-month standard used in other states. When proponents testify before committees such as yours, they often emphasize "safeguards." When bills get passed, they return in following sessions to complain about these same safeguards as "barriers" to care.

From the first Oregon report in 1998 regarding its "Death with Dignity Act," it's been clear that use of assisted suicide has been most associated with perceptions of individual control and autonomy, not the experience or fear of physical pain. The reported "end of life concerns" in Oregon largely reflect people's "existential distress," as one study termed it, in reaction to the disabling features of their illness: "losing autonomy" (over all years, 90%), "less able to engage

in activities" (90%), "loss of dignity" (72%), "burden on others" (48%) and "losing control of bodily functions" (44%). These are all disability-related concerns.

The best article on this issue is by Washington Post reporter Liz Szabo. In 2016, she reported that where assisted suicide has been legalized, proponents have succeeded in "convincing voters, lawmakers and courts that terminally ill patients have the right to die without suffering intractable pain in their final days or week."

> Yet the latest research shows that terminally ill patients who seek aid in dying aren't primarily concerned about pain. Those who have actually used these laws have been far more concerned about controlling the way they exit the world than about controlling pain.

No less an authority than Lonny Shavelson, now the Chair of the American Clinicians Academy on Medical Aid In Dying, told Szabo, "It's almost never about pain, it's about dignity and control."

Szabo also quotes ethicist Ezekiel Emanuel on the social factors that motivate usage of the suicide drugs.

> "The dominant reasons for wanting euthanasia or assisted suicide are psychological and involve control factors," said Ezekiel Emanuel, chair of medical ethics and health policy at the University of Pennsylvania's medical school. He noted that most of those who have used aid-in-dying laws are white, well insured and college-educated. "These are people who are used to controlling every aspect of their lives, and they want to control this aspect of their lives."

Szabo reports on a 2009 study on 56 Oregon patients, who were found not to be concerned about pain, but "quality-of-life" issues such as loss of autonomy and dependence on others.

Then she talked to leading opponent Dr. Ira Byock:

> "It's a bait-and-switch. We're actually helping people hasten their deaths because of existential suffering. That's chilling to me."
>
> Although right-to-die campaigns suggest that excruciating pain is often unavoidable, Byock said that "we can relieve the suffering of almost everyone that we care for if we have the time to prepare."

Szabo interviewed Barbara Coombs Lee, co-author of the Oregon bill and former director of Compassion & Choices, who admitted that there are many kinds of suffering. In her book, Lee describes one person with incontinence saying that "I like doing things for myself, and the idea of having somebody take care of me like I am a little 2-month-old baby is just absolutely repulsive. It's more painful than any of the pain from the cancer."

Advocate Dan Diaz, widower of Brittany Maynard, stressed as a point of pride the ableist prejudice fuels the movement.

> Diaz said people shouldn’t underestimate how devastating it can be to lose one’s autonomy.
>
> “If I find myself in a situation where I can’t go to the bathroom on my own, where someone has to change my diapers, where I can’t feed myself, where I can’t care for the people around me, where other people have to move me around to keep me from having bedsores, I would then submit, ‘Is that really living?’ ” Diaz said.

We disability rights advocates view the assisted suicide movement as a reaction to disability, especially dependence on other people. In September 2020, I debated bioethicist Thaddeus Pope, who conceded that “Everybody who's using medical aid in dying is disabled. And probably you could go to the next step and say the reason they want medical aid in dying is because of their disability.”

In February 2021, Pope said that the US is alone in limiting eligibility for assisted suicide to people diagnosed as terminal. He predicted that eligibility will be extended to non-terminal disabled people. Last October, Pope published “Top 10 New and Needed Expansions of US Medical Aid In Dying Laws.” in which he called for the elimination of any time frame for predicted death. He wrote that “many seriously and irreversibly ill individuals not within six months of dying may still suffer greatly every day from their disease.”

There is no way to contain eligibility to a narrow set of people. Especially when thousands of disabled Americans now live with conditions that in some states are seen as “worse than death.” Anorexia nervosa and diabetes can now qualify as terminal conditions. Once death is accepted as a positive outcome of medical care, it inevitably gets offered to more and more people.

The problem for us disabled people is that we are already treated badly in the medical system. As medicine has focused increasingly on patient “quality-of-life” as a barometer of life-worthiness, death has been recharacterized as a benefit to an ill or disabled individual. Most physicians (82%, a 2020 Harvard study found) view our “quality-of-life” as worse than nondisabled people.

Disability advocates have raised concerns about the fate of disabled people like nonverbal Oregonian Sarah McSweeney and Black Texan quadriplegic Michael Hickson. Both wanted to live, both were loved by family and caregivers, but they died after hospital personnel denied them treatment based on their supposed low quality-of-life.

The 2012 Massachusetts ballot results and the patient demographics in states like California show there is a social class, race, and ethnicity component in the use of and support for assisted suicide. A 2013 Pew Research Center study showed that Blacks oppose assisted suicide by 65%-29%, and Latinos by 65%-32%. Majority Latino Lawrence, Massachusetts, voted 69% against the 2012 ballot question, while white working class towns like Taunton and Gardner

also opposed. Wealthier Massachusetts towns voted heavily in favor. In California, 88% of reported assisted suicides have been by non-Hispanic whites, more than twice the group's share of the state population. Virtually no Black people have used the program.

Black patients under legalized assisted suicide will be more likely to be "written off' as better off dead, just as has happened with medical responses to COVID-19.

Meanwhile, terminal diagnoses are often wrong. Jeanette Hall wrote the Boston Globe in 2011 that she voted for Oregon's Death with Dignity bill, and when she received a terminal diagnosis, sought assisted suicide from her doctor. He persuaded her to try more treatment, and she is still alive more than 20 years later! The late actor Valerie Harper reported in 2013 that she had been given three months to live. She lived *six years*, and in that time appeared in a movie and starred in a play.

A few years ago, Oregon revealed that 4% of people who entered the assisted suicide program were still alive after six months. But NPR reported in 2017 that nearly 20% of people who enter hospice outlive their six month prognosis. The difference between 4% and nearly 20% is the percentage of people and their families who may have lost months, years, and in some cases decades of meaningful life.

That 4% survival rate in Oregon happens to match the percentage of people sentenced to death row who are estimated to be innocent. Many people, especially progressives, base their opposition to capital punishment at least in part on this unavoidable fact. We believe that people with serious illnesses and disabilities deserve the same level of concern.

In this and other ways, we are making social justice arguments against systemic discrimination against vulnerable communities. Indeed, Not Dead Yet joined a federal lawsuit against the state of California, arguing that its assisted suicide program violates the Americans with Disabilities Act and the Constitution by discriminating against disabled people. While younger, more able people receive suicide prevention services, old, ill, and disabled people all too often experience support for our deaths over support for our lives.

Maryland must not sponsor people's suicides because other people consider them a burden, because they believe they are dying when they are not, and because they have been denied the treatment and support services that would keep them alive.

Please protect disability rights, reject this bill and the discrimination it promotes.

End of Life Option - Assisted Suicide.pdf

Uploaded by: John Miller

Position: UNF

Please oppose End of Life Option - 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 six 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.

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.

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

For these reasons, please oppose legislation to legalize Assisted Suicide.

John Whitehead_Testimony against SB443.pdf

Uploaded by: John Whitehead

Position: UNF

Testimony against SB443: The End-of-Life Option Act (02-07-24)

I am writing today to express my strong opposition to SB443, the End-of-Life Option Act, which the Senate Judicial Proceedings Committee is considering.

I oppose this bill both because I am opposed in principle to medical assistance in dying and because this specific bill has significant practical flaws.

I oppose this bill because I believe society must protect human life and prevent suicide. The necessity of protecting human life in this way is generally recognized, as reflected in the many measures and resources currently in place to prevent suicidal people from harming themselves. For example, this is why Maryland has its Office of Suicide Prevention (https://health.maryland.gov/bha/suicideprevention/Pages/home.aspx).

Laws such as the proposed End-of-Life Option Act carve out exceptions to the general principle that suicide should be prevented and that suicidal people should be supported to help them continue with their lives. Such exceptions effectively devalue the lives of the people targeted by them.

The End-of-Life Option Act is essentially saying that while people should generally be protected from suicide, people with terminal illness diagnoses should not be protected from it. Such an attitude treats the lives of people with such diagnoses as worth less than other people's lives. It is saying "Suicide is generally bad, but in your case, suicide makes sense because your life is not as worth preserving as someone else's."

I reject this notion of making exceptions to suicide prevention. Such exceptions introduce inequality into suicide prevention and medical care. (They also open the door to further exceptions beyond terminal diagnoses, such as for people with disabilities or severe chronic illnesses.)

Even setting aside these objections to the proposed Act, SB443 is seriously flawed on practical grounds:

1. The bill has no minimum required time for the attending physician to have treated the individual requesting assistance in dying. This means the physician might lack important medical or social context for judging the individual's situation. It also allows for individuals seeking death to shop around for doctors who will agree to their requests.

2. The bill does not require a mental health evaluation, leaving open the possibility of people with depression or other cognitive impairments

(which may be quite subtle in some cases) being given assistance in dying.

3. The bill does not require informing the family of the person requesting assistance in dying. This omission cruelly ignores the wishes and concerns of family members for their loved ones and risks ignoring important medical or social context that doctors might wish to have.

4. The bill has no provisions for ensuring that prescribed medications are properly disposed of, either after someone has self-administered some of them or if they indefinitely delay doing so. It contains only a vague provision that “A person that, after a qualified individual’s death, is in possession of medication prescribed for aid in dying that has not been self–administered shall dispose of the medication in a lawful manner.” This omission risks dangerous medications being sold or circulated illegally.

Last, I would like to mention my own personal experiences in this matter. I have lost a relative to medical assistance in dying. I have other, aging relatives, some of whom may be suffering from subtle depression or cognitive issues. I have known many people who suffer from suicidal thoughts and feelings.

Experience has shown me the tragedy of these situations and the anxiety and pain of having people I care about being at risk of taking their own lives. Family experience has also shown me how elderly, lonely people can be manipulated into self-destructive behaviors by others. I fervently oppose legal changes that would increase the dangers to people in such situations.

We should not make it easier for people to end their lives. I strongly urge you to reject SB443, the End-of-Life Option Act.

Thank you,

John Whitehead
Gaithersburg, MD

Testimony opposing SB443.pdf

Uploaded by: Joseph Gillin

Position: UNF

This is my written testimony opposing SB443, the bill that would legalize and promote assisted suicide. I support the protection of human life at every stage and condition.

- 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.
- The American Medical Association (AMA) recently re-affirmed its opposition to assisted suicide because it is fundamentally incompatible with the physician’s role as healer.

Pushing an assisted suicide measure 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 devaluing the lives of the sick and the elderly, but by expanding the sphere of protection for all.

Again, please reject SB443, the Assisted Suicide Measure.

Joseph P. Gillin

21 Castle Cliff Court, Silver Spring, MD 20904

LD14

Joseph Marine -MD Senate JPR Committee Testimony 2

Uploaded by: Joseph Marine

Position: UNF

Joseph Marine, MD
Testimony to Senate Judicial Proceeding Committee
February 8, 2024
Re: Senate Bill 443 - "End of Life Option Act"
OPPOSE

Senator Smith and Honored Committee Members:

My name is Joseph Marine. I am a cardiologist practicing with Johns Hopkins Medicine in Baltimore with over 19 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 should also consider the fact the US and the State of Maryland are suffering from an explosion of drug overdose deaths, largely due to opioids, now at a record of >100.000 in the US this past year. What message does the State send when it legalizes and endorses this new form of drug overdose death? What message does it send to young people, who are already suffering from unprecedented levels of mental illness, anxiety, despair, and suicide? The effects of this message and introduction of more deadly drugs into our communities can only be harmful.

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 medical 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 – strong evidence 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.

We should also understand that this law will affect everyone. If this bill becomes law, it will undermine the ethics of the medical profession and alter how future doctors view patients with disabilities and advanced illnesses. It effectively changes the standard of care of vulnerable patients from suicide prevention to suicide promotion. At a time when public trust in the medical profession and the biomedical sciences is at an all-time low due to the many controversies created during the covid pandemic, further loss of trust, particularly in the African-American community, is something we can ill-afford in Maryland. The bill also threatens to damage the reputations of Maryland's prestigious academic medical centers, which are a vital engine to our state's economy.

The End of Life Option Act would provide a new license for doctors to violate basic principles of medical ethics and to end the lives of vulnerable patients using experimental drug cocktails 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 reading my testimony as you consider this bill. I ask for an UNFAVORABLE report.

Joseph E. Marine, MD
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Canada pressures veterans to pursue MAID.pdf

Uploaded by: Justin Kuk
Position: UNF

Politics

RCMP called to investigate multiple cases of veterans being offered medically assisted death

Veterans Affairs Minister Lawrence MacAulay apologizes for 'appalling interactions'

Murray Brewster · CBC News · Posted: Nov 24, 2022 11:30 PM EST | Last Updated: November 25, 2022

Four — perhaps even five — Canadian military veterans were given the option of medically-assisted death (MAID) by a now-suspended Veterans Affairs Canada caseworker, the country's veterans minister told a House of Commons committee late Thursday.

Lawrence MacAulay said the matter is now being turned over to the RCMP for investigation and his department's internal review is ongoing.

"We expect all Veterans Affairs candidate employees to interact with veterans with care, compassion and respect and the actions of this one employee is simply disgusting," MacAulay told the veterans affairs committee. "And I condemn this behaviour in the strongest terms."

- **'Horrifying' that Veterans Affairs worker raised assisted suicide with troubled veteran, group says**
- **Years after medical assistance in dying became legal, the debate rages on**

He went on to say there was "no way to justify" the actions and he wasn't about to defend the employee.

Last summer, Global News first reported a case where a veteran claimed to have been pressured by a veterans affairs case worker to consider medically assisted dying.

Veterans Affairs Minister Lawrence MacAulay said the matter is now being turned over to the RCMP for investigation. (Adrian Wyld/The Canadian Press)

That prompted MacAulay to order an internal investigation, which has now uncovered a total of four cases where veterans were allegedly offered MAID — all apparently by the same caseworker.

Earlier Thursday, the National Post reported on a possible fifth case involving a still-serving member of the military who told the podcast *Tango Romeo* that he was also unexpectedly offered MAID by a caseworker in November of last year.

MacAulay told the all-party committee that the most recent revelation was not among the cases his staff has uncovered and he urged the veteran who spoke in the

Conservative MP — and veterans committee vice-chair — Blake Richards questioned whether the minister and the veterans department had a clear indication on the scope of the problem.

Cause for alarm, says Tory MP

The fact the fifth case may have escaped the attention of the department review is cause for alarm, he said

"So in that case, either something was missed in this investigation, or there is another employee involved," Richards said. "Now, it's a matter of determining which of those two things it is. In either case, that's concerning."

Based upon what he sees, Richard said he believes the veterans department "investigation is not nearly thorough enough."

He said that might mean "there's a need for an outside investigation."

- **Senators ponder how far to go to protect charter rights in assisted-dying bill**

MacAulay walked the committee through what his department knew, thus far, saying the first case that came to light occurred last summer where the caseworker repeatedly pushed the notion of MAID to an unnamed veteran who had called seeking help with post-traumatic stress.

A second occasion reported happened last May where the same caseworker provided assisted dying information to a veteran.

Minister apologizes

The fourth known case apparently happened in 2019, where a veteran called VAC specifically asking for information about assistance in taking his own life.

MacAulay offered an apology.

"I am sorry you had to endure these appalling interactions, and we're doing everything we can to ensure this never happens again," the minister said.

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To the Senate Judicial Proceedings Committee:

I am writing to urge you to oppose SB 443. As someone who advocates for the value, honor, and legal protection of all life from conception to natural death, I want to acknowledge that this issue is not identical to abortion. While abortion involves the involuntary ending of an innocent human life, the "aid in dying" legal measures introduced by this bill involve the voluntary ending of the life of a person facing a terminal illness likely to result in death within six months. I also want to acknowledge that the bill attempts to include safeguards against an individual making a rash decision to pursue aid in dying and against any form of coercion that could influence a person to pursue such means of death. Additionally, the bill includes provisions to protect the conscientious objection of healthcare providers and health care facilities that cannot morally participate in the proposed aid in dying program. Despite these efforts, I have concerns about this bill for the following reasons.

First, I am concerned that this bill will desensitize the Maryland public to accept "aid in dying" as a normal part of public life and will pave the way for the legislature to loosen the requirements for those who qualify to request aid in dying. The fact that the bill insists on referring to the proposed program as "aid in dying" instead of assisted suicide suggests that the authors of the bill want to control language to change the public's perception on this issue.

To see where this bill may lead, we only need to look to our neighbors to the north. Canada instituted Medical Assistance in Dying (MAID) in 2016. In the first year of the program, 1018 MAID deaths were recorded. By 2022, the number had grown to 13,241 – an increase of 1200%. Additionally, the requirements for participating in MAID are more widely defined than in SB 443. Canadians qualify to participate in MAID if they have a serious illness, disease, or disability, are in an advanced state of decline that cannot be reversed, experience unbearable physical or mental suffering from their illness, disease, disability or state of decline that cannot be relieved under conditions that they consider acceptable. There are reports from Canada that citizens are qualifying for MAID for psychological distress and depression. It is not hard to imagine a situation, five to ten years after SB 443 is enacted, in which the Maryland public has become numb to aid in dying and the legislature feels emboldened to widen the scope of the program to include not just terminal illnesses but additional disabilities and distresses, as well.

Second, despite the efforts of the drafters of SB 443 to provide harsh penalties for anyone who coerces another person into pursing aid in dying, it is likely that coercion will still occur. I have linked an article that describes how a Canadian veterans affairs caseworker attempted to pressure veterans into applying for MAID. I have also linked a study titled "The Realities of Medical Assistance in Dying in Canada" that describes the health ministry's failure to properly track data and provide proper oversight. Additionally, the article explains how the Canadian medical system is prioritizing access to MAID over patient safety and well-being and offering MAID as though it is one of many standard treatment options. In 2022, a total of 13,241 Canadians participated in MAID which accounted for 4.1% of all deaths in Canada. I find this shocking and appalling. I think that the Maryland legislature is demonstrating an extreme level of hubris if we do not look at the failures of the Canadian MAID system with tremendous caution. Similar failures would put Maryland's most vulnerable citizens – people with physical and mental disabilities, people from low socio-economic backgrounds, and people with a history of trauma – at heighted risk from an "aid in dying" system.

Third, this bill would introduce fatal medications into Maryland's approved pharmaceutical system. Even though these medications are supposed to be regulated and controlled, it is not hard to envision them leaking out in the black market and resulting in an increase of successful suicide attempts for people of all ages and health conditions.

I recognize that this bill was most likely written from a place of empathy, with a desire to not prolong the pain of Marylanders suffering from terminal illnesses, and with a hope to bring closure to families with a loved one suffering from a terminal illness. However, I believe that there are too many potentially devastating unintended consequences that are likely to be realized if this bill is enacted. To be the just and flourishing society that this legislative body is commissioned to pursue, I believe that as a state we must have a change in heart to value all life from conception to natural death. SB 443 will only further erode those values, desensitize our culture towards death, and open the door for truly disturbing actions in the future. As a state legislature, many of you have already abandoned your duty to protect the life of all Marylanders from conception. Please do not make the same mistake by failing to protect life on the other end.

Thank you for your consideration.

Sincerely,

Justin Kuk

Baltimore, Maryland

the-realities-of-medical-assistance-in-dying-in-ca

Palliative and Supportive Care

cambridge.org/pax

Review Article

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The realities of Medical Assistance in Dying in Canada

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Abstract

In 2015, the Canadian Supreme Court declared that an absolute Criminal Code prohibition on assisted suicide and euthanasia was unconstitutional. In response, the Canadian parliament enacted Bill C-14 in 2016 permitting assisted suicide and euthanasia for the end-of-life context, which it termed "Medical Assistance in Dying" (MAiD). In 2021, Bill C-7 expanded eligibility for MAiD to those with disabilities not approaching their natural death. By 2021, MAiD accounted for 3.3% of all deaths in Canada with some areas of Canada presently reporting MAiD death rates upward of 7%. In 2021, Canada had 10,064 deaths by MAiD, surpassing all jurisdictions for yearly reported assisted deaths.

Objectives. To examine the impact of the Canadian MAiD program and analyze its safeguards.

Methods. A working group of physicians from diverse practice backgrounds and a legal expert, several with bioethics expertise, reviewed Canadian MAiD data and case reports. Grey literature was also considered, including fact-checked and reliable Canadian mainstream newspapers and parliamentary committee hearings considering the expansion of MAiD.

Results. Several scientific studies and reviews, provincial and correctional system authorities have identified issues with MAiD practice. As well, there is a growing accumulation of narrative accounts detailing people getting MAiD due to suffering associated with a lack of access to medical, disability, and social support.

Significance of results. The Canadian MAiD regime is lacking the safeguards, data collection, and oversight necessary to protect Canadians against premature death. The authors have identified these policy gaps and used MAiD cases to illustrate these findings.

Introduction

In 2015, the Canadian Supreme Court, in *Carter v Canada*, declared that an absolute Criminal Code prohibition on assisted suicide and euthanasia was an unjustifiable interference with the constitutional right to life, liberty, and security of the person (Supreme Court of Canada 2015). In response, the Canadian parliament enacted Bill C-14 in 2016 (Parliament of Canada 2016). This legislation introduced an exemption permitting assisted suicide and euthanasia for capable, consenting adults with a serious disease, illness, or disability, with a "reasonably foreseeable natural death" (RFND) an irreversible decline of capability, and intolerable suffering (psychologically and/or physically). In Canada, both euthanasia and assisted suicide are collectively referred to as "Medical Assistance in Dying" (MAiD), but euthanasia, which is the administering of a lethal injection by a healthcare provider, accounts for almost every MAiD case to date (Government of Canada 2022).

In 2021, eligibility for the Canadian MAiD regime was further expanded through legislation, Bill C-7 (Parliament of Canada 2021). The legislation introduced a regime of 2 MAiD pathways. Several safeguards from the initial regime were removed from what was now called "Track 1," a pathway for which an applicant still has to have an RFND. Bill C-7 added "Track 2," a new pathway for those with a serious disease, illness, or disability and an irreversible decline of capabilities, but who are not approaching their natural death. This means de facto persons with disabilities. A delayed implementation clause for Track 2 ("sunset clause") stipulated that those with sole mental disorders would become eligible for MAiD in March 2023 (Gaind 2022a).

Bill C-7 was the government's response to a single lower court judgment in the province of Quebec (Truchon), which ruled that the RFND requirement was unconstitutional (Cours Supérieure Quebec 2019). Unusually, the federal government did not appeal the ruling despite having compelling reasons to do so (Lemmens and Jacobs 2019). Despite the fact that

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the case did not deal with mental illness, and that the Supreme Court explicitly stated in the *Carter* case (Supreme Court of Canada 2015) that it was not ruling on MAiD for mental illness (Lemmens et al. 2023; Lemmens et al. 2019), the law nevertheless included mental illnesses as forthcoming qualifying diagnoses.

Since its legalization in 2016, the number of deaths by MAiD in Canada has risen dramatically each year. Within 3 years of its introduction, 2% of all deaths in Canada were by MAiD, and by 2021, MAiD had increased to 3.3% of all deaths in Canada (Government of Canada 2022). Some areas of Canada presently are reporting MAiD death rates upwards of 7% (Gentile and Boily 2023; Heath Canada testimony 2022). In 2021, Canada had 10,064 deaths by MAiD, surpassing all other countries for yearly reported assisted deaths (Buchholz 2022). It has been noted that California, which has roughly the same population, also legalized medically assisted death in 2016, but in comparison, only 486 people died using the California's assisted suicide program in 2021(Pullman 2023; Raikin 2022). Given the expanded Canadian legislation was just enacted in March 2021 and mental illness is planned to be a qualifying condition in the near future, MAiD death rates are expected to rise further.

Our working group published a 2-piece synopsis of MAiD in Canada, for which we refer you to the *World Medical Journal* (Coelho et al. 2022a; Gaind et al. 2022). Our present goal is to identify policy gaps in the Canadian MAiD regime as other jurisdictions are considering legalizing similar practices (Convention Citoyenne Cese sur la fin de vie 2023; Minnesota legislature 2023; Scottish Parliament 2022; White and Willmott 2022).

Methods

A working group comprising physicians from diverse practice backgrounds and a health law expert, several with bioethics expertise, conducted an in-depth review of Bill C-14 and Bill C-7 legislation. We reviewed official annual reports on MAiD in Canada. As well, we reviewed all parliamentary committee hearings considering the expansion of MAiD. This includes the Justice, Pre-Senate and Senate hearings on Bill C-7, as well as the Special Joint Committee on MAiD hearings and report. Grey literature was also considered, including fact-checked and reliable Canadian mainstream newspapers and published case reports. We identified policy gaps discussed below, using illustrative examples to highlight our findings.

Results

Inadequate data collection

Our official Health Canada Annual Reports on MAiD lack the stringent data collection parameters necessary to detect problems in the MAiD regime. The responsible federal government department, Health Canada, admitted during parliamentary committee testimony that these statistics largely reflect MAiD providers ticking boxes (Heath Canada testimony 2022). The data are acquired from the MAiD providers via self-reporting. There is no mechanism for objectively, prospectively, or retroactively identifying or uncovering any errors or abuses of the process. Providing assisted suicide and euthanasia outside the parameters of the law remains prohibited. MAiD providers filling out the forms know that any deviation of the key criteria may result in criminal prosecution, making self-declarations of error or deviation unlikely.

By way of example, the Health Canada Annual Report on MAiD states that patients dying by MAiD had high rates of access to palliative care. In contrast, an independent study demonstrated that palliative care access before MAiD provision was actually much lower than purported (Munro et al. 2020). An independent review article determined that monitoring of MAiD is grossly deficient (Kotalik 2020). Furthermore, cases of noncompliance with MAiD law and policy have been documented by different oversight bodies such as the Chief Coroner of Ontario (Government of Ontario 2022), the Commission on end-of-life care in Quebec (Commission sur les soins de fin de vie 2019), and the Correctional Investigator of Canada (Office of the Correctional Investigator 2020).

As well, narrative accounts are accumulating in the media about people applying and getting MAiD due to suffering associated with lack of access to medical, disability and social support, and often with intersecting components of disability and mental health issues (The Fifth Estate 2023; Zhu 2022). None of these cases or issues were identified by the Health Canada Annual Reports on MAiD.

Lack of oversight

Alan Nichols, who had a hearing and cognitive disability, had recurrent episodes of depression but lived independently. Following a police wellness check, he was involuntarily admitted under the Mental Health Act in British Columbia. Initially diagnosed as suicidal, he was soon after deemed capable of requesting MAiD. He received euthanasia 40 days after his admission, against the objections of his family, who was informed 4 days before the procedure. This occurred under the earlier legal framework where disability was not sufficient for eligibility and RFND was a necessary requirement. The local health authorities stated that the law allows "those who are on a trajectory toward death in a wide range of circumstances" to receive MAID and gave the family no specific diagnosis as basis for his qualification for MAiD (Lemmens 2021). When the family complained to the federal police (Royal Canadian Mounted Police [RCMP]), it suggested this was to be addressed by the professional regulatory authority, the Royal College of Physicians and Surgeons (RCPS). The RCPS indicated it would not conduct a disciplinary investigation unless the RCMP launched a criminal investigation. The RCMP then provided the family with Alan's MAiD application form which indicated he had identified "hearing loss" as the relevant medical diagnosis for his request. Despite contacting the medical and civil authorities, and writing over 40 letters, his family has not found any legal recourse (Nichols 2022).

Donna Duncan suffered a concussion, and it took over a year for her to receive the correct specialized care, during which time she continued to deteriorate. She received MAiD within days of her initial assessment. According to her daughters, she had no known terminal diagnosis. A police investigation into the circumstances surrounding her MAiD death did not proceed, after the hospital refused to cooperate. Records were not released as the hospital claimed the adult daughters were not acting in the "best interests" of the deceased (Anderssen 2023; Daflos 2022a; Duncan and Duncan 2022).

Rather than the government accepting responsibility for setting up procedures for investigation, the Justice Minister stated that oversight must be provided by family members complaining after the fact to initiate disciplinary actions or police investigations (The Fifth Estate 2023). Yet, the experiences of family members who have tried to pursue concerns suggest that cases cannot be transparently reviewed, and health authorities have invoked "best interest exceptions" to rebuff requests for access to medical records (Anderssen 2023).

Prioritizing access to MAiD over patient safety and needs

Sathya Dhara Kovac, 44, ended her life through the MAiD program. Kovac lived with a degenerative disease and her condition was worsening, but she wanted to live. However, she lacked the home care resources to do so. "Ultimately it was not a genetic disease that took me out, it was a system," Kovac wrote in an obituary to loved ones (Hoye 2022).

The Supreme Court's decision that spurred the partial legalization of MAiD did not create an explicit "right to die with dignity" and left it to the legislature to design a "strict regulatory regime" (Lemmens et al. 2023). Regardless, the decision is being interpreted by many as creating a positive right of access to MAiD, even when other forms of medical care are available and when psychosocial suffering can be ameliorated.

This view of MAiD as a right has arguably been formalized by the medical profession's regulatory college in Ontario which now requires physicians to provide an effective referral when a patient requests MAiD, even if the physician is a conscientious objector (College of Physicians and Surgeons of Ontario 2021). New Health Canada Model Practice Standards put forward that anyone who objects to providing MAiD, even if only in specific cases for specific circumstances (thus arguably even if that objection is based on an opinion that medical professional standards of care have not been met), is conscientiously objecting (Health Canada 2023), and thus would need to make an effective referral in provinces that require it.

At a recorded training session for MAiD assessors and providers, an attendee questioned this worrisome prioritization of access to MAiD when there are concerns about contextual vulnerability. The expert's response was clear that facilitation of the pathway to MAiD is paramount. The attendee asked, "Given the vulnerability of patients who are maybe requesting MAiD because of socioeconomic reasons … do you save yourself that moral and ethical distress by withdrawing?" The MAiD expert responded, "If withdrawing is about protecting your conscience, you have [an] absolute right to do so." But he added, "You'll then have to refer the person on to somebody else, who may hopefully fulfill the request in the end" (Raikin 2022).

The federal government's commitment to making MAiD universally available across the country, including by imposing funding obligations on provincial health authorities, is emphasized in the preamble of Bill C-14 (Parliament of Canada 2016). Meanwhile, Canada's funding for health-care and social support services remains below the Organization for Economic Cooperation and Development average (Whitelaw et al. 2022). Disability Inclusion Minister Carla Qualtrough seemed to acknowledge such concerns and admitted that "it is easier to access MAiD than to get a wheelchair in some parts of the country" (Qualtrough 2020). While most basic health-care services are publicly funded, there is no positive right to health care in Canada (Court of Appeal for British Columbia 2022; Government of Canada 2016; Henteleff et al. 2011; Supreme Court of Canada 2002). There are significant gaps in public funding for pharmaceuticals, mental health counseling, and dental care, for example, and there are long wait times for many publicly funded medical services and disability supports. Patients are therefore being guaranteed MAiD but not mental health care, palliative care, disability supports, and myriad other essential health services.

The Canadian parliamentary budget office estimated the potential cost savings of expanding MAiD as significant (Parliamentary Budget Officer 2021). The fact that providing state facilitated death is more cost-effective than providing supported health-care and community support to facilitate living well raises concerns about conflicting interests: any country facing financial pressures ought to be concerned about perverse cost-cutting incentives that are built into a health-care system.

Proactively offering MAiD to patients as though it is 1 of many standard treatment options

A military veteran and former Paralympian who has been trying to get a wheelchair ramp installed at her home for the past 5 years testified that she was offered MAiD by her caseworker, and it has been confirmed that at least 4 other veterans were also offered the option of MAID when trying to access resources and care (Yun 2022).

In New Zealand (Parliamentary Counsel Office, New Zealand 2019) and Victoria (Department of Health Victoria (Australia) 2019), medical personnel are prohibited from initiating discussions about assisted death. In Canada, the Canadian Association of MAiD Assessors and Providers (CAMAP) recommends that all those who "might qualify should be offered MAiD" as part of the informed consent process (Canadian Association of MAID Assessors and Providers 2020). No other country in the world has normalized assisted suicide or euthanasia in this way as a potential first line therapeutic option to address suffering. Offering MAiD to a patient who has not raised it could be interpreted as an indication that their suffering will likely become intolerable, and that MAiD is the recommended way out, impacting patient hope and resilience.

Further, Canada has a documented history of health-care providers' biases leading to negative perceptions of certain patients and subsequent negative health outcomes. For example, Indigenous people continue to face racism, even in seeking basic health care. A tragic story of health-care bias played out in the province of Quebec where Joyce Echaquan, a 37-year-old Atikamekw Nation mother of 7, died from apparent hospital negligence while being racially abused (Godin 2020). A British Columbia provincial report entitled, "In Plain Sight," notes that "84% of Indigenous peoples described personal experiences of racism and discrimination that discouraged them from seeking necessary care, and that reduced access to care, negatively affecting their health" (Government of British Columbia 2020).

The Disability Filibuster, a national disability grassroots initiative formed in opposition to Bill C7 and the expansion of MAiD, states in a recent letter regarding the safety of seeking medical services: "People spoke of being afraid to seek medical help because they were worried about their physician raising the possibility of MAiD. Some even went so far as to say they will be avoiding medical care" (Disability Filibuster 2022).

The problem of undefined terminology in the legislation

A man had a small stroke, affecting his balance and swallowing. The prognosis was that this man would be able to eat normally and regain most of his balance. The patient was depressed and isolated due to the COVID-19 outbreak on his ward. He declined all therapy and requested euthanasia. Neither of his MAiD assessors had expertise in stroke recovery. In this acute phase, while struggling with his mood and isolation, and with no therapy to gauge his final level of function, he received MAiD. He had no terminal diagnoses, but due to the fact that he was temporarily slightly undernourished, his MAiD assessors considered him Track 1 eligible (Coelho 2022a).

There is voluminous scientific research showing the right care for serious conditions can unquestionably lead to adjustment and recovery. For new serious illness or injury, suicidality is often present at the outset, but it does not persist over the long run (Nafilyan et al. 2023). In a recent Canadian study, which followed patients with spinal cord injuries, half of the participants reported suicidal ideation during the first 2 years of experiencing their injury. However, in retrospect, none of the participants thought that they would have been able to make an informed decision about MAiD in the early years after their injury, and none wanted MAiD after they had time to adjust to living in the community (Tchajkova et al. 2021).

The language in the Canadian MAiD legislation is imprecise and makes clear determinations and consistent implementation of clinical practice standards for MAiD difficult. Due to the imprecise term, "reasonably foreseeable natural death" (RFND), physicians' interpretations of eligibility have been challenged in the courts. In 1 such case, it was ruled that a patient's death does not have to be imminent, and their condition does not have to be terminal to meet the criteria for RFND (A.B. v. Canada (Attorney General) 2017; Germano 2017). Thus, for those whose deaths are considered to have a RFND (Track 1), some will have many years or even a decade of life left to live, and yet they can legally receive MAiD the same day they request it if 2 assessors agree (McMorrow et al. 2020).

Suffering is subjectively defined and can be rooted in psychosocial distress

Dying with Dignity, a Canadian lobby group for legalizing and expanding MAiD, continues to claim on its Myths and Facts page that "FACT: Suffering from a lack of social supports alone does not qualify a person for MAiD. No one can receive MAiD on the basis of inadequate housing, disability supports, or home care (Dying with Dignity Canada 2021)." However, increasing evidence, including the words of those who have themselves chosen MAiD, shows this claim to be misleading. Here is just 1 example of the many stories emerging:

A national CTV news story recounted how "Sophia" was unable to secure affordable housing compatible with her chemical sensitivities. She chose MAiD because she could not find a healthy and affordable place to live given her meager disability support income, and prior to her death by MAiD recorded a video where she stated "the government sees me as expendable trash" (Favaro 2022).

For those who are not dying (Track 2), Canada requires that the 2 MAiD assessors (medical doctor or nurse practitioner) conduct detailed assessments of patient eligibility. The timing to die by lethal injection is set at a minimum of 90 days after the first MAiD assessment is completed. To qualify for MAiD, a patient must be in a situation of irreversible decline of capability and experience intolerable psychological or physical suffering. These terms are not further defined by the legislation, and suffering is treated as purely subjective. If the patient says their suffering is intolerable, there is no requirement for further validation or requirement for clinicians to agree that there are no other options to address the suffering. A Canadian disability inclusion analysis report on the impact of the pandemic on disabled persons noted that persons with disabilities were encouraged to explore the option of MAiD for a lack of resources to live when they had not been contemplating this option. The report further highlights that a lack of social, economic, and health support increases the perception of intolerable suffering in persons with disabilities (Life Work Well Research Centre University of Guelph, DAWN Canada 2021).

No standard treatments must have been tried first or even be available

In Belgium and the Netherlands, 2 other jurisdictions that allow euthanasia outside the end-of-life context, before euthanasia can be provided the physicians must agree that there are no further medical or social support options that can relieve a patient's suffering. In Canada, patients are required to be advised of treatment options that may exist. For Track 2 cases, physicians have to verify that patients considered all other options, but it is left unclear what "considered" really means. There is no requirement that standard best-practice treatments have been appropriately attempted, or even that they are accessible (Lemmens et al. 2021). Tragically, some people are choosing to die while on wait lists for potentially effective treatment or because they are refused care.

A short film, titled "All is Beauty," along with its advertising trailers, was promoted by Simons (an upscale department store in Canada). In the series, a young woman is encircled by people on a beach, in a candle-lit forest, and in other settings that depict a romantic and lovely tableau of her final days before MAiD. "Even now, as I seek help to end my life, … there is still so much beauty," says Jennyfer Hatch. However, a national news agency has revealed that Jennyfer was the same woman who spoke up earlier (under a pseudonym) about her difficulties accessing treatment, prompting her to seek MAiD as a last-ditch effort for access to palliative care. Hatch died by MAiD in October 2022 at age 37. She was unsuccessful in her attempts to receive other care (Daflos 2022b).

Access to medical and social care in Canada is often not timely, which can compound patient suffering and desperation. For example, the average wait time to be treated by a psychiatrist can exceed by up to 5 times the 90-day waiting period to access a lethal injection (Moir and Barua 2021). This means that a person seeking death while awaiting treatment from a psychiatrist could die by MAiD long before they get access to appropriate treatment. The wait times for many other specialized health-care and social support services, including pain clinics, specialized long-term care homes, community-based housing, and disability benefits, also far exceed the 90-day assessment period (Lemmens and Krakowitz-Broker 2020). This highlights the need for comprehensive approaches to addressing suffering, rather than providing MAiD as the path of least resistance.

The issue of suicide contagion

After a national TV documentary showed a gentleman's euthanasia procedure in a positive light, a woman felt that MAiD was attractive and would be good for her. She is in her mid-life, has a recent spinal cord injury and hasn't had time to adjust, receive peer support or proper symptom control, nor reach maximal recovery, but she does now quality for Track 2 MAID within 90 days (Coelho 2022b).

We have long known that publicized suicides can lead to more people choosing suicide (Sinyor et al. 2018). Well-known is how suicide rates went up when Robin Williams completed suicide (Fink et al. 2018). This can also be seen in suicide clustering among Indigenous youth where 1 suicide can set off a series of suicides in a community (CBC news 2013). As well, literature has shown that increased exposure to lethal means increases rates of suicide (Miller and Hemenway 2008).

There is a claim being made, in direct opposition to suicide prevention research, that access to euthanasia and assisted suicide is allowing for a humane option that will reduce suicide rates and violent means to end one's life. Canada's federal Justice Minister came under fire for advancing this argument. He stated, "remember that suicide generally is available to people. This is a group within the population who, for physical reasons and possibly mental reasons, can't make that choice themselves to do it themselves. And ultimately, this provides a more humane way for them to make a decision they otherwise could have made if they were able in some other way" (Raj 2022).

In reality, the evidence from reviews does not support the hypothesis that introducing MAiD reduces rates of (non-assisted) suicide (Doherty et al. 2022; Jones 2022). Further, data on suicide rates would not factor in people who may have been ambivalent and would never have attempted or completed suicide, but who chose to receive MAiD following social normalization of assisted suicide. In our view, the Justice Minister should be concerned about suicide contagion rather than normalizing what he acknowledges MAiD to be: "a species of suicide" (The Fifth Estate 2023).

Discussion

A human rights outcry

Three United Nations human rights experts (Quinn et al. 2021), over a 100 Canadian disability and social justice organizations (Vulnerable Persons Standard 2021), Indigenous advocacy groups (Levitz 2020), and hundreds of medical (Physicians Together with Vulnerable Canadians 2020) and legal experts have argued that Canada's euthanasia and assisted suicide laws put the lives of marginalized and vulnerable Canadians at risk (Kaiser et al. 2021).

Criticism is growing as an increasing number of media reports regarding worrisome MAiD stories are emerging in the Canadian press. Yet, those who support the expansion of MAiD tend to reject the claim that social service failures can create and sustain the predicaments that can make death an attractive choice.

Dr. Stephanie Green, President of CAMAP admits, "Our health system is woefully inadequate in serving our population with these resources." Even so, she adds, "I do not think we can hold these patients hostage" (Alberga 2022). She seemingly condones the use of MAiD despite the lack of political will to provide necessary psychosocial supports. Bioethicists supporting MAiD expansion have argued that limiting MAiD for reasons of psychosocial suffering "would translate into removing the agency of decisionally capable patients without offering them a way out of their predicament" and have remarkably claimed that providing MAiD in response to social suffering caused by "unjust social circumstances" is a form of "harm reduction" (Schuklenk 2022; Wiebe and Mullin 2023). This is particularly troubling considering that harm reduction strategies precisely aim at saving lives. In addition to distorting the concept of "harm reduction," from an equity and diversity point of view, the claim reflects a perspective based on privilege. This wrongly suggests MAiD is supporting the autonomy of marginalized people who are rather being driven to death by poverty and lack of care, despite knowing how to address poverty and improve care. Dr. Ellen Wiebe, a prolific MAiD provider (430 people as of May 2022) has said she will provide MAiD while people are on waitlists for medical treatment (Wiebe 2022). Although choices for MAiD in dire circumstances might be understandable, we put forward that they are to be considered the result of structural coercion, which undermines meaningful autonomy.

Health Canada is providing $3.3 million in funding to CAMAP to develop and implement a national, "accredited" MAiD curriculum. Video recordings of CAMAP experts teaching MAiD trainees appears to reveal the following: (1) doctor shopping for opinions that align with their own MAiD evaluation is acceptable; (2) poverty is a defensible rationale for MAiD, and (3) family anger is the biggest problem MAiD assessors face (Raikin 2022). CAMAP, which organized the session where these ideas are put forward, is officially funded to guide MAiD delivery in Canada.

Growing concern over expansion of MAiD to those with sole mental illness

The Canadian government legislated that MAiD would be provided to Canadians with sole mental disorders by March 2023 (Coelho et al. 2022b). In December 2022, under intense media scrutiny, coupled with rising criticism from psychiatrists, mental health advocates, and those with lived experience, the federal government announced that it would delay the March 2023 implementation (Major 2022) for 1 year (Zimonjic 2023) but would still go ahead with the expansion. This despite the fact that the world-renowned Centre for Addiction and Mental Health (2017), the Canadian Association for Suicide Prevention (2021), the Canadian Mental Health Association (2022), Ontario Association for Act and Fact (2018), and myriad other organizations stand in opposition (EAG 2022). A recent survey showed that the overwhelming majority of Ontario (the largest province in Canada) psychiatrists who responded said that they oppose MAiD solely on the grounds of mental illness (Gaind 2022b).

Evidence-based reviews, including the Expert Advisory Group in 2020 and a recent publication by Nicolini et al, conclude that predictions of irremediability for mental illnesses are at best, no better than chance (EAG 2020 ; Nicolini et al. 2022). The Council of Canadian Academies reported on MAiD for mental illness and highlighted the known risk of providing psychiatric MAiD to suicidal individuals who would otherwise recover with suicide prevention strategies (Council of Canadian Academies 2018). Yet these evidence-based cautions are dismissed by some MAiD expansionists at times with outright "alternate facts" (Gaind 2023).

Therefore, patients with mental illness, a population known for a high prevalence of psychosocial suffering, will be wrongly informed, during periods of despair and hopelessness, that their conditions are "irremediable" and will not improve, despite this being impossible to predict. In response to concerns that irremediability of any individual's mental illness could never be predicted (a legal requirement to provide MAiD for mental illness in Canada), Dr. Justine Dembo, a MAiD activist and psychiatrist who sat on the 2022 federal panel on MAiD for mental illness, suggested she would simply advise the patient of the uncertainty that they could recover so they could make their own "informed decision" to receive MAiD, despite the fact that legal reporting forms require indicating that the medical condition is irremediable (Hanomansing 2023).

On top of offering MAiD under false pretenses for mental illness, equally concerning is the fact that in the few European countries that provide euthanasia for mental illness, the majority of those requesting it are women and marginalized individuals disproportionately seeking relief from suffering, not from their mental illnesses per se, but because of marginalization, including unresolved social and economic suffering and loneliness, all of which are remediable problems (Kim et al. 2016; Verhofstadt et al. 2017).

We know that lack of access to care for mental health needs is a major problem in Canada (Centre for Addiction and Mental Health 2022).

The facile notion, repeated often by Justice Minister Lametti, that "we must relieve suffering immediately," distracts from the root causes, and potential solutions, of that suffering.

What next?

Beyond the sustained push to facilitate access to MAiD, a Canadian parliamentary committee has recently, following a short process of expert hearings and review, made recommendations to expand MAiD for mature minors and allow advance directives (Special Joint Committee on Medical Assistance in Dying 2023). The Canadian government officially responded to these recommendations by declining to commit to further expansion at this time (Government of Canada 2023). However, the province of Quebec has already passed Bill 11 which among other changes, obliges all palliative care homes to provide MAiD and allows for MAiD by advance request for situations of dementia (National Assembly of Quebec 2023).

The cases we discussed here reveal a troubling normalization of MAiD as "standard treatment" for a broad range of suffering, including suffering caused or augmented by socioeconomic factors. Some commentators have lauded the Canadian system for endorsing that citizens opt for MAID to avoid being a burden on their families or society (Hanania 2023). In that context it is worrisome that 35.7 % of those who received MAiD in 2021 identified the perception of being a burden on family, friends, or caregivers, as a component of their intolerable suffering (Government of Canada 2022). Others have defended MAiD as a fully autonomous choice to avoid suffering in oppressed people who cannot access adequate socioeconomic resources (Wiebe and Mullin 2023). It reveals how we have moved further away from MAiD being the rare exception the Supreme Court originally appears to have envisioned. This is happening in a context of significant constraints on health-care and social support services, which puts pressure on individuals to consider MAiD as an accessible tool to relieve suffering. The rapid expansion of MAiD offers cost-savings for governments, creating arguably perverse incentives not to address the inadequacies of the health-care system which would protect against premature wrongful death.

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Testimony Against SB443 Suicide.pdf

Uploaded by: Katherine Adelaide

Position: UNF

SB 443-END OF LIFE OPTION ACT

TESTIMONY OF KATHERINE ADELAIDE, JD, A RESIDENT OF MARYLAND

February 7, 2024

To whom it may concern:

Thank you for the opportunity to submit written testimony on this bill.

I have testified AGAINST these types of bills for many years.

My 95-year-old father passed away naturally at home with his family of Alzheimer's in 2018.

My testimony then, having observed his final days with hospital hospice and then home hospice, was that these types of bills are completely unnecessary as hospice can be used essentially to accomplish the same goals of diminishing pain and shortening lifespan if so desired by the parient. I heard arguments that it was urgent that nobody suffer even for two extra weeks to justify physician assisted suicide. My conclusion then, as it is now, is that you simply cannot legislate enough safeguards to make this process safe or equitable, as I believe it is naturally discriminatory against elderly women of color, the depressed and the disabled. Nobody cheats death and there is never any excuse for any third party to hasten anybody's death.

Self-murder is a life and death decision that must be made entirely by the individual and not facilitated by the government or their agents, including insurance agencies, in any way, much less funded by taxpayers money. We all have "free will," but the role of government is to protect life, not hasten death.

My mother passed on September 7th 2023 at age 91, less than 6 months ago, and her story is a little bit different than my father's.

She had osteoporosis and broke her pelvis in three places last year. I witnessed firsthand quite possibly the most excruciating pain a person can be in and did round the clock care for almost a month. It was the most difficult thing to watch and I felt helpless. Despite my best efforts at comfort care, she begged for assisted suicide from exhaustion, confusion and severe pain, but the nurse thank goodness told her that it was not legal in Virginia and within a few hours she forgot about that idea and focused on getting through each hour and miraculously with lots of support the pelvis fractured finally healed and she went on to have a very good quality of life for eight more months. None of us knows the future and I value every moment of that extra time with her and I know she did also. I'm so grateful that Virginia had not passed assisted suicide where in her pain and desperation she would have made a decision that would have decimated her family relationships forever.

The only real end of life options are love and care, including psychiatric care, service/ emotional support animals, music and a multitude of other support systems for the dying.

There is no dignity in death by self-murder assisted by the government, but there can be models of courage and support as healthy end life options.

We need to celebrate the process of end of life because even painful memories can be transformative for patients and future generations.

I had an elderly friend with a terminal brain tumor who could no longer speak. I asked his family if it was okay if I asked him to hang on from Thanksgiving until after my birthday on January 3rd because I couldn't bear to lose him during the holidays.

I told the family I would abide by their decision, but I encouraged them to find the good in each remaining moment of his life because it would come to an end and that was all the memories, good and bad, they were going to have and they agreed that most likely years down the road they would remember small, special moments in those extra days, not the suffering, his or theirs.

I received a phone message on January 4th from his family that my good friend Herb had passed peacefully in the wee hours.

What a testament to the power of love as an End of Life option, my heartfelt honesty of not wanting to lose him during the holidays and his miraculous response to hang on.

I am so grateful that my mother did not exercise her free will to commit suicide and not experience all the good memories of those final eight months. I am equally grateful that the government of Virginia did not interfere with her final days, but continued to provide positive support via assisted living services.

I urge you to do the same and give this bill an unfavorable report.

Thank you.

Sincerely,

Katherine Adelaide. JD

301-575-4889

2023-02-07 Kathleen O'Neal Senate Testimony.pdf

Uploaded by: Kathleen O'Neal

Position: UNF

Senate Testimony

Kathleen Nicole O’Neal – SB443

I am here today to voice my opposition to SB443, the “End-of-Life Option Act.” All legislative interventions of this sort are problematic as they seek to impose ableist and ageist double standards surrounding those whose deaths by suicide we seek to oppose and prevent and those whose deaths by suicide we seek to enable, aid, abet, and encourage. When people with illnesses and disabilities receive the message that, because of their illnesses and disabilities, dignity for them amounts to choosing to end their lives or foregoing life-sustaining care, this is a deadly and malicious form of disability and often age discrimination. In lieu of offering resources, access, healthcare, and paths to greater autonomy that can make disabled lives less painful, freer, more meaningful, and less stressful, we send disabled and sick people the message that they are “better off dead.” This is an incredibly irresponsible and cruel message for citizens, governmental officials, and medical providers to send to sick and disabled people.

In his groundbreaking work on suicide, the eminent psychology professor Dr. Thomas Joiner, who currently serves as a professor at Florida State University and has published multiple scholarly books about suicide, notes three motivating factors which he claims are present anytime an individual decides to take his life. If any of these factors are not present, an individual will not seek to end his life. These criteria apply to all suicides, including but not limited to those covered under the umbrella of Medical Aid in Dying (MAID).

The first factor Dr. Joiner notes is that of “learned fearlessness” – a process by which an individual becomes increasingly inured to inflicting pain or injury on oneself. Because we are psychologically hardwired not to seek to end our own lives, this is a capacity that must be built up over time, often under unusual circumstances.

Poignantly for our purposes, Dr. Joiner’s other two criteria for suicidality are “perceived burdensomeness” and “failed belongingness.” People decide to end their lives because they see themselves as a burden on others. They worry that they are undermining the well-being of those close to them by continuing to live their lives. And such people feel excluded from and marginalized from a larger sense of family, friendship, community, and/or occupational contributions. Put simply, people decide to end their lives because they feel like a burden and they feel alienated and alone.

Contrary to popular beliefs, empirical evidence indicates that it is not unmanageable physical pain which typically drives individuals to seek out assisted suicide. It is this sense of alienation and fear of being a burden which drives suicide among the disabled and non-disabled alike. In a society in which people are already marginalized on the basis of disability, illness, and age, the last thing such individuals need is the government or medical professionals confirming the notion – engendered by oppression and discrimination – that such people really are “better off dead.”

SB443 - End of Life Option Act DFL of MD Testimony

Uploaded by: Kathy Kelly

Position: UNF

OPPOSE SB443 - TESTIMONY BY KATHY KELLY, DEMOCRATS FOR LIFE OF MARYLAND

Democrats for Life of Maryland, which is a chapter of Democrats for Life of America (DFLA), opposes SB443, End of Life Option Act sponsored by Senator Jeff Waldstreicher and other senators. Democrats for Life opposes Assisted Suicide, and notes in its Issue Statement on this matter, that pain is not even among the top reasons that people request assisted suicide, but rather people seek it because they fear they will be a burden on others. For this reason, Democrats for Life supports palliative care, and points with caution to the example of the Netherlands, where euthanasia was first limited to perceived cases of “hopeless or unbearable suffering,” but later assisted suicide cases involved conditions such as blindness or depression.

We are concerned that Maryland is throwing support to a bill which encourages people to consider seeking assisted suicide instead of prioritizing their need to seek treatment of various health issues (including depression). We also point to the fact that in November 2023, the AMA rejected a resolution to support physician-assisted suicide; indeed, it even rejected an option to be neutral on this issue. Instead, the AMA supported its current code, which states that 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. In fact, it maintains that physicians must aggressively respond to the needs of the patient at the end of life. We can see for the need to exercise precaution in the suicide issue by looking to the example of the distinguished physician and scientist Dr. Jerome Lejeune, whose discovery of the genetic basis of Down Syndrome was later used by others to search for and target preborn children with that condition for death, rather than keeping a focus on more research into this condition and additional support for those who bear it. With assisted suicide, there are similar slippery slopes.

To learn more about the drawbacks of assisted suicide, we encourage you to view the documentary by The Dignity Mandate, a Maryland nonprofit dedicated to raising awareness of policy issues that undermine human dignity:
Shining the Light on Assisted Suicide
https://thedignitymandate.org/documentary

Democrats for Life of Maryland encourages you to table this bill, and not allow it to go to a vote on the Senate floor.

Kathy Kelly
Director, Democrats for Life of Maryland
8200 Wisconsin Ave. Apt. 905, Bethesda, MD 20814
DFL of MD Facebook: https://www.facebook.com/MDDEMS4Life

Boanca LTE 112223.pdf

Uploaded by: KerriAnn Boanca
Position: UNF

Doctors are Human and Make Diagnostic Mistakes

I am Dr. KerriAnn Boanca, a Hospice and Palliative Medicine Fellow at MedStar Washington Hospital Center in Washington D.C. I am opposed to SB 443, legislation to legalize assisted suicide in Maryland.

If organized medicine endorsed, normalized, and encouraged assisted suicide as healthcare, my husband, who at age 25 was diagnosed with pancreatic cancer, may not be alive today at the hands of a physician. But, in fact, he is alive and well. Doctors get it wrong all the time. We are all human.

As a hospice and palliative medicine fellow, I help patients every day to prepare to die in a comfortable and dignified manner. At times that includes the withdrawal or withholding of life sustaining therapies. But that is far different from prescribing lethal drugs which results in the deliberate termination of a human life. The creation of a new and lethal pathophysiologic process that is solely intended to make the patient dead is not ethically equivalent to allowing for the preexisting pathology to run its natural course.

Medicine cannot cure every illness. But we as physicians can always heal and together with interdisciplinary colleagues, we are able to tend to total pain with proper palliative and hospice care. The facilitation, endorsement and active participation in suicide is not a healing act. We have a duty as physicians and as the medical community at large to preserve life until its natural end and to comfort those who are dying. There is no neutrality or even support on a topic that touches medicine at its very core.

I urge Maryland legislators to reject attempts to legalize assisted suicide, making the job of physicians harder, and the life of patients precarious.

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Appendix B Drug Info Aid-In-Dying Prescription.pdf

Uploaded by: Kristen Holt
Position: UNF

Appendix B: Drug Information For Aid-in-Dying Prescription

Table 1. DDMAPh is the current oral medication regimen recommended from American Clinicians Academy on Medical Aid in Dying (acamaid.org).[1] The drug information provided is a reference on the medications' common medical uses, dosing, and toxicities.

Recommended Dose	Class	Use	Therapeutic Dose Range[2]	Above Max Daily Dose	Toxicity[3]
Digoxin 100 mg	Cardiac glycoside – positive inotropic effects (modifying force and speed of contraction of the muscles) Positive inotropes: - Slow the heart rate. - Makes cardiac muscles contractions stronger. - Raise cardiac output of blood pumped out.	1. **Atrial fibrillation** rate control alternative. Supraventricular tachyarrhythmias. 2. **Heart Failure** with a reduced ejection fraction. Target serum digoxin concentration 0.5 to <0.9 ng/mL. Use declining.	0.25 mg to 0.5 mg once (loading dose) then 0.125 mg to 0.25 mg once daily.	200 x	Narrow Therapeutic Index (Therapeutic precision is required to avoid toxicity). - **Cardiac arrest** from 10 mg of digoxin or more. - **Severe bradycardia, heart block, vomiting, shock.** - Hyperkalemia (potassium greater than 5 meq/L) (not the cause of death).
Diazepam 1 gm	Benzodiazepine	1. **Anxiety.** 2. Muscle spasm alternative. 3. Seizures first line. 4. Alcohol withdrawal.	Up to 40 mg / day in divided doses.	25 x	Safe up to 2000 mg with only minor toxicity. - Risks from concomitant use **with opioids. Leads to profound sedation, respiratory depression, coma, death.**

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[1] American Clinicians Academy on Medical Aid in Dying. https://www.acamaid.org/pharmacologyinfoupdates/ Accessed February 5, 2024

[2] Lexicomp. https://online.lexi.com/lco/action/home Accessed February 5, 2024.

[3] Micromedex. https://www.micromedexsolutions.com/micromedex2/librarian/ Accessed February 6, 2024.

Updated 2/7/2024

Recommended Dose	Class	Use	Therapeutic Dose Range[1]	Above Max Daily Dose	Toxicity[2]
Morphine 15 gm	Opioid, analgesic	1. Acute pain / Chronic pain 2. **Pain and sedation** critically ill patients in the ICU (off label).	May give orally up to 30 mg every 4 hours as needed for severe, acute pain in hospitalized opioid naïve patients at low risk for respiratory depression (180 mg / day in divided doses).	83 x (500 x single dose max)	- Euphoria - **Respiratory depression,** - **Hypoxia, rarely seizures from hypoxia.** - **Coma.** - **Bradycardia**
Amitriptyline 8 gm	Tricyclic Antidepressant / Anticholinergic	1. **Major depressive disorder** alternative	Initial dose max 50 mg / day. Titrate up over weeks to usual dose of 100 to 300 mg/ day.	160 x – 27x	- Greater than 5 mg/kg (eg: 250 mg in a 50 kg – 110 lbs adult) - **Coma** - **Seizures,** - **Ventricular dysrhythmias,** - **Respiratory failure** - **Hypotension** - Slowed GI motility retaining oral drug.
Phenobarbital 5 gm	Barbiturate Antiseizure agent	1. **Sedation** before surgery 2. Second line for seizure. (status epilepticus). 3. Seizures maintenance dose	Max 400 mg / day.	13 x	- Use **with opioids may result in profound sedation, respiratory depression, coma, death.** - Death is most commonly caused by respiratory depression and cardiovascular collapse. (Coma, hypotension, decreased heart contractility, hypothermia, and respiratory failure).

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[1] Lexicomp. https://online.lexi.com/lco/action/home Accessed February 5, 2024.

[2] Micromedex. https://www.micromedexsolutions.com/micromedex2/librarian/ Accessed Febrary 6, 2024.

Kristen Holt Written Testimony SB443 240207.pdf

Uploaded by: Kristen Holt

Position: UNF

BILL: Senate Bill 443
TITLE: End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).
COMMITTEE: Judicial Proceedings
DATE: February 8, 2024 1:00 pm
WHO: **Kristen Holt, Pharm.D., MPH**
POSITION: **OPPOSE**

Committee Chair, the Honorable Senator William Smith, Jr and the Judicial Proceedings Committee,

As a Clinical Pharmacist with a background in Health Policy from Harvard School of Public Health, I thank you for the opportunity to comment on Senate Bill 443. I am grateful for your shared compassionate aspirations to alleviate the suffering of others with a terminal illness.

I request an **UNFAVORABLE vote on SB 443**.

SB 443 would allow a physician to prescribe a lethal medication for self-administration to a patient with a prognosis of a terminal diagnosis who is “more likely than not” to die within the next 6 months.

For medical colleagues, I provided in Appendix A and B the current lethal protocol from the American Clinicians Academy on Medical Aid in Dying which recommends for example 200 times the therapeutic dose of digoxin.[1] Unlike palliative use of opioids moments before passing to make a patient comfortable, this regimen intentionally overdoses an individual potentially months before expected demise.

With almost two decades of dedication to assuring the safe use of these medications, receiving a script like this is viscerally nauseating. I agree with the American Medical Association assessment.

> ***“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. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life.”***[2]

For the sake of clarity, I define “Physician Assisted Suicide” according to the AMA Code of Medical Ethics.

> *“’Physician-assisted suicide’ occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).”*[2]

Objection #1: SB 443 “End of Life Option” is misleading and makes the demise difficult to track. The provisions of SB 443 are what the AMA definition above calls “physician-assisted suicide". The End-Of-Life Option Act claims that “actions taken in accordance with this subtitle do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide.” (Page 16, line 19-21). For record keeping, this intentional demise “shall be deemed to be a death from natural causes, specifically as a result of the terminal illness…” (Page 16, line 1). In actuality, the cause of death is not the disease, which is the reason for the clinician’s lethal intervention.

Objection #2: For a pharmacist who conscientiously objects, there is no explicit immunity from civil liability or employer ramifications, but only immunity from board disciplinary action. The American Society Of Health System Pharmacists (ASHP) recognizes the “right of pharmacists, as health care providers, and other pharmacy employees to decline to participate in therapies they consider to be morally, religiously or ethically troubling."[3] While there are civil protections granted for participants in assisted suicide, there is no explicit civil protection for opting out. (Page 17, line 6-14). It is stated that health care provider participation is voluntary, but only mentions physicians may not be required by an employer to participate. (Page 19, line 20-24).

Objection #3: A mental health assessment of the patient should be required not contingent on a prescriber confirming impaired judgment. (Page 11, line 22-27). Suicide regardless of health status is considered by an individual when they feel trapped in an emotionally painful situation and see immediate death as the only alternative. It would be important to confirm a psychological or psychiatric evaluation as we would do for any person wishing to hasten their death.

Objection #4: SB 443 allows the lethal medication or regimen to be self-administered at the timing of the patient without supervision from a healthcare professional. Unlike life-saving prescription use, assisted suicide regimens are not vetted through a well-studied clinical trial process. Depending on the medication(s) used it could be distressing for the individual.[4] Moreover, the medication could be indefinitely in the patient's possession and could be accessible to others including minors for unintended use.

Objection #5: Misuse and unintended consequences are concerning. The maximum penalty of up to $10,000 or 10 years of imprisonment for forging a written request seems insufficient to deter fraud and abuse for example by a clinician or nursing home facility. There are no stipulations for individuals caught multiple times. (Page 20, line 10-22)

Objection #6: Prognostic timing of terminal illness accuracy can be quite variable. Depending on the disease, the clinician, and the prognostic models used, [5] the accuracy of timing terminal illness demise can be variable**.** The bill's second opinion requirement does help add some validation, however, it would be important to establish the highest standards around actuarial predicted models versus just clinician assessment.

Objection #7: Over the last decade in the US, suicide has increased substantially and this bill lends credence to self-harm as an acceptable option in Maryland.[6, 7] Rising suicide rates and associated suicide prevention efforts have taken the forefront in healthcare.[8] With good reason, it is the commitment of healthcare providers to reaffirm the courage and dignity of our patients with compassion and clinical excellence. This is particularly essential for those near the end of life.

Objection #8: Barriers to access will be contested in pursuit of equity. Between 2016-2021, just 5 years after signed into law, the Medical Assistance in Dying Program accounted for more than 3% of all deaths in Canada.[9] While first limited to adults with terminal illness, it has since broadened to any "ir-remediable" and "intolerable" condition. In March 2024, it is scheduled to expand to include the mentally ill, however officials are seeking a legislative extension for another 3 years.[10]

Objection #9: There are spiritual and ethical ramifications unquantified. Often discounted in public health discussions founded in materialism are considerations of spirituality. Day one of ethics class at Harvard School of Public Health, my professor announced he required us to discount discussions of God in class. A rockstar female ED physician in Boston, originally from Nigeria, retorted, "God is integral to the discussion. An afterlife completely changes the ethical equation." Pursuit of this kind of knowledge can potentially change outcomes in favor of full human flourishing.

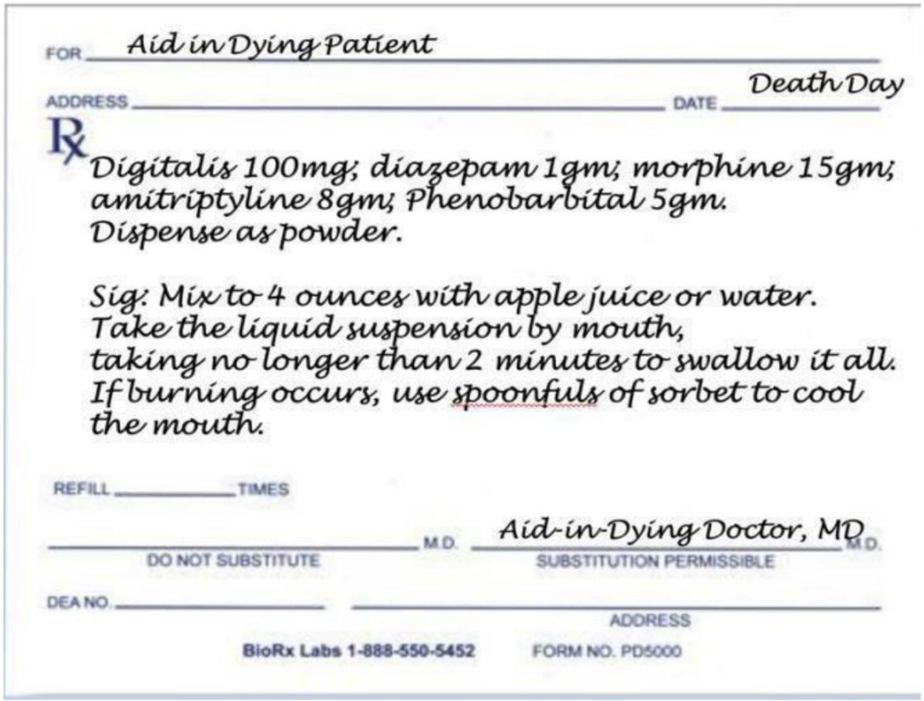
Thank you for taking these concerns into consideration and for an unfavorable report on SB 443.

Sincerely,

Kristen E. Holt, Pharm.D., MPH

Appendix A: Currently Recommended Aid-in-Dying Prescription

Figure 1. Prescription Recommended From American Clinicians Academy on Medical Aid in Dying (acamaid.org).



FOR Aid in Dying Patient

ADDRESS DATE Death Day

℞ Digitalis 100mg; diazepam 1gm; morphine 15gm;
amitriptyline 8gm; Phenobarbital 5gm.
Dispense as powder.

Sig: Mix to 4 ounces with apple juice or water.
Take the liquid suspension by mouth,
taking no longer than 2 minutes to swallow it all.
If burning occurs, use spoonfuls of sorbet to cool
the mouth.

REFILL ______ TIMES

______ M.D. DO NOT SUBSTITUTE

Aid-in-Dying Doctor, MD M.D. SUBSTITUTION PERMISSIBLE

DEA NO. ______

ADDRESS

BioRx Labs 1-888-550-5452 FORM NO. PD5000

Step #1 Pre-medications for nausea/vomiting:
Ondansetron 8mg, Metoclopramide 20mg (10mg tabs, #2)
Sig: Take all three pills at least 30 minutes before proceeding to the next step.

Step #2: DDMAPh (At least 30 minutes after Step #1):
Digoxin 100mg;
Diazepam 1gm;
Morphine 15gm;
Amitriptyline 8gm;
Phenobarbital 5gm.
Dispense as powder, in a 4 ounce bottle if available.

Recommended Dose	Therapeutic Dose Range[11]	Above Max Daily Dose
Digoxin 100 mg	0.25 mg to 0.5 mg once then 0.125 mg to 0.25 mg once daily.	200 x
Diazepam 1 gm	Up to 40 mg / day in divided doses.	25 x
Morphine 15 gm	May give orally up to 30 mg every 4 hours as needed for severe, acute pain in hospitalized patients at low risk for respiratory depression in opioid naïve patients (180 mg / day in divided doses)	83 x (500 x single dose max)
Amitriptyline 8 gm	Initial dose max 50 mg / day. Titrate up over weeks to 100-300 mg/ day.	160 x – 27x
Phenobarbital 5 gm	Max 400 mg / day.	13 x

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[1] American Clinicians Academy on Medical Aid in Dying. https://www.acamaid.org/pharmacologyinfoupdates/ Accessed February 5, 2024

[2] AMA. Code of Medical Ethics. Physician-Assisted Suicide. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide. Accessed February 5, 2024.

[3] ASHP Statement of Pharmacist's Decision-making on Assisted Suicide. Pharmacist's Right of Conscience and Patient's Right of Access to Therapy. American Society of Health System Pharmacists. https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacists-decision-making-assisted-suicide.ashx Accessed February 5, 2024. *(copy and paste into browser to view)*.

[4] Jennie Dear. The Doctors Who Invented a New Way to Help People Die. The Atlantic. January 22, 2019. https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/

[5] UCSF. https://eprognosis.ucsf.edu/calculators.php. Accessed February 5, 2024.

[6] CDC. https://www.cdc.gov/suicide/suicide-data-statistics.html Accessed February 5, 2024.

[7] Preventing Suicide. CDC. https://www.cdc.gov/suicide/pdf/NCIPC-Suicide-FactSheet-508_FINAL.pdf Accessed February 5, 2024.

[8] The Joint Commission. National Patient Safety Goal for Suicide Prevention. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf Accessed February 5, 2024.

[9] Rupa Subramanya. "Scheduled to Die: The Rise of Canada's Assisted Suicide Program" https://www.thefp.com/p/scheduled-to-die-the-rise-of-canadas October 11, 2022. Accessed February 5, 2024.

[10] Canada MAID Overview. https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html Accessed February 5, 2024.

[11] Lexicomp. https://online.lexi.com/lco/action/home Accessed February 5, 2024.

UNFAVORABLE.SB443.HB403.MDRTL.L.Bogley.pdf

Uploaded by: Laura Bogley

Position: UNF

Opposition Statement SB443/HB403

Assisted Suicide/ ‘End of Life Option Act’
Laura Bogley, JD
Executive Director, Maryland Right to Life

Assisted Suicide is Wrong for Maryland

On behalf of the Board of Directors of Maryland Right to Life, and medically vulnerable people across our state, we strongly oppose the so-called “End of Life Option Act” and the legalization of “assisted suicide” or voluntary euthanasia. By licensing doctors and other medical providers to prescribe lethal drugs to bring about a person’s death, the state would be reducing the standard of medical care for all people with potentially disparate impact on the poor and underinsured.

Despite 270 failed attempts by proponents to enact this law nationwide, 40 states including Maryland, have repeatedly rejected licensing doctors to kill by assisted suicide. The Maryland Department of Health does not have the ability to provide effective oversight of Assisted Suicide practices and any proposed safeguards are only as good as the state’s enforcement. This bill is the wrong policy for Maryland, particularly as we are experiencing an epidemic of suicide, especially among youth and veterans.

PAS Creates Healthcare Disparities

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.

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. This suggests a lack of access to alternatives to lethal prescription for those on government insurance.

Leading Medical Associations and Disability Rights Organizations Oppose Assisted Suicide

More than a dozen national medical organizations oppose Assisted Suicide. In fact, the **American Medical Association** voted in the Fall of 2023 to maintain its longstanding position against Physician Assisted Suicide stating

> *"Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations."* [1]

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[1] https://code-medical-ethics.ama-assn.org/ethics-opinions/euthanasia

23 national disability rights organizations oppose Assisted Suicide including the National Council on Disability, Disability Rights Education and Defense Fund and the World Institute on Disability. 14 national religious organizations stand in opposition including Agudath Israel, the Southern Baptist Convention and the Unites States Conference of Catholic Bishops.

Safeguards for Patients Ineffective

Proponents of this bill are concerned with immunity of doctors and other providers who kill their patients, but across the country they have rejected safeguards for patients as "barriers to care".

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** refused stating:

> *"There are other states who currently have this legislation who are looking to remove some of the regulatory roadblocks."*

In states where this policy has been enacted, the proponents have attempted to amend the law to remove existing protections for patients including the following:

- Non-physicians and pharmacists to participate in assisted suicide.
- No lethal diagnosis required. PAS prescribed for mental health reasons including depression.
- Minors may request suicide without parental consent.
- Waiting period requirements eliminated.
- Residency requirement eliminated .

Oregon Law is Cautionary Tale, Not Model

This bill is based on the Oregon law, which in no model law, but a cautionary tale of the slippery slope to euthanasia. We have the benefit of looking at two decades of history in Oregon to evaluate the credibility of the safeguards in this legislation. The dangers presented to vulnerable populations far outweigh any perceived benefit being sold by the bill's out-of-state, well-funded proponents.

Oregon data reveals that the vast majority (70%) of those being prescribed suicide were on government insurance and there was a steep decline in mental health evaluations. Oregon also reported a 6.3% increase in suicide rates among the general population following legalization.

Oregon is an example of failed oversight and as a result serious abuses have come to light. In fact Dr. Katrina Hedberg, of the **Oregon Department of Human Services** and a proponent of the law stated

> *"We are not given the resources to investigate [assisted suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to assert ourselves."*[2]

Unfortunately, substantially similar language in Oregon law has only wrought problems rather than protections for patients' rights. The following illustrate immense problems with this legislation based on the data available to us, including:

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[2] DHS news release, "No authority to investigate Death with Dignity case, DHS says," March 4, 2005.

- the violation of physician’s Hippocratic Oath to heal not kill
- the reality of coercion and undue influence
- the denial of lifesaving alternatives
- the gravely flawed definition of terminal illness
- the mandate to falsify death certificates
- 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 indefinite requirement of self-administration, especially for those with disabilities
- the lack of oversight and accurate data collection
- the inability 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.

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.[3] 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.

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[3] 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).

Data from Oregon's experience show only 4.9% of patients were referred for an evaluation in over 19 years of the practice.[4] 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.[5] 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.

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.[6]

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).[7] 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).[8] 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

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[4] 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

[5] Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

[6] 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.

[7] 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

[8] Ibid.

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[9], 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.[10] 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.

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[11], advertised their willingness to connect patients with willing doctors on their Washington chapter's website[12], and promoted their referral program on their Vermont chapter's website[13].

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.[14]

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

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9 Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

10 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

11 "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/>

12 "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/>

13 "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>

14 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.

physician and did not refer the patient back to Dr. Bentz. Two weeks later, the patient ingested the lethal prescription and died.[15]

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 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.[16]

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

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15 Patients Rights Council

16 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

reason since legalization of the policy).[17] 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.[18] 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 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."[19]

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.[20]

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17 Ibid. The annual reports are available online at http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

18 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

19 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.

20 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/>.

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.[21] 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.

FALLACY 4: "The Patient Must Self-Administer"

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.[22] Realistically, this means **lethal injection euthanasia** is merely a court challenge away from being legal in Maryland, if this bill would pass.

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[21] 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.

[22] 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.

During the 2019 House of Delegates hearing on this bill, Dr. Michael Strauss, the leading Physician promoting the bill, unintentionally revealed the truth that 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."[23]

FALLACY 5: "The State Will Punish Violations"

There are numerous concerns about the ability of the state to adequately monitor and prevent violations of this bill, if it would become law. The Maryland Department of Health already is overstretched and the medical boards have little responsibility to report violations and take disciplinary action.

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.

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.

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23 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.

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 profits and support the concerns of people with disabilities, the underinsured and the medically vulnerable by issuing an unfavorable report on this deadly 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.

For the sake of vulnerable populations across our state, we respectfully request that you maintain your opposition to legal Assisted Suicide and issue an **unfavorable report** on the deadly "End of Life Options Act".

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Oppose SB0443 - HB0403.pdf

Uploaded by: Laura Jones

Position: UNF

Oppose SB0443/HB0403 End-of-Life Option Act
Laura Jones – Co-founder of The Dignity Mandate
Annapolis, MD
410-246-5561

When someone believes there is no longer a reason to live, society has a mandate to protect them from committing suicide. This is especially true for people weakened by illness. Our current Maryland law prevents assisted suicide. Do not reverse course and open the door to legal victimization of people when they are sick. The powerful will always win.

We will all be weak and vulnerable when we become sick. When our doctor presents death by drug overdose as a treatment for our illness, it will make us consider if our life is worth living. With every new choice comes a responsibility. Are we responsible for deciding when we will die? Some people might like this choice, but there will be many more will be lured into dying an untimely and wrongful death.

Reporters cannot even mention suicide without printing information to a suicide hotline, because people may fall victim to the act simply by considering the idea. (See reporting on suicide)

Imagine how much more persuasive it will be when our doctor is presenting it as a medical treatment.

Suicide should not be offered as a legitimate medical option. This makes every person facing a terminal illness responsible for deciding if they should end their life or continue to be a burden on others who care for them. I do not want the weight of this decision on my shoulders when I am become sick. When we are sick and fighting to live, who will have the energy to go on if we think others might be better off if we were dead.

This bill is fashioned after the Oregon Law and 48% (On average over 25 years) choose to end their life because they felt like a burden. (See page 14 of the Oregon Death with Dignity annual report) We are all going to be a burden when we become sick.

If you want to keep the government out of our private doctor patient relationship, and protect us from falling victim to suicide, then you must oppose SB0443.

Maryland is the state with premier healthcare. Keep it that way. Invest your energies in supporting cutting edge treatments for pain control, cancer cures, and improving hospice and palliative care.

America holds great promise as long as you do not succumb to the pressures of high paid lobbyist. If you feel their pressure now, just wait until you are beat down by a terminal illness and "death by choice" is calling you to hasten toyour death.

Oppose SB0443/HB0403– while you have the strength to do it.

Oregon Death with Dignity Act

2022 Data Summary

Oregon Health Authority
PUBLIC HEALTH DIVISION

Acknowledgments

Report written by: Public Health Division, Center for Health Statistics

Date: March 8, 2023

For more information, see: http://www.healthoregon.org/dwd.

Contact: DWDA.INFO@state.or.us

Executive summary

The Oregon Death with Dignity Act (DWDA) allows terminally ill patients who meet specific qualifications to end their lives through voluntary self-administration of a lethal dose of medications prescribed by a physician for that purpose. The Act requires the Oregon Health Authority (OHA) to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report.

In 2022, 431 people were reported to have received prescriptions under the DWDA. As of January 20, 2023, 278 people had died in 2022 from ingesting the prescribed medications, including 32 who had received prescriptions in previous years. Demographic characteristics of DWDA patients were similar to those of previous years: most patients were age 65 years or older (85%) and white (96%). The most common diagnosis was cancer (64%), followed by heart disease (12%) and neurological disease (10%). OHA made no referrals to the Oregon Medical Board for failure to comply with DWDA reporting requirements.

Introduction

The Oregon Death with Dignity Act (DWDA) allows terminally ill patients who meet specific qualifications to end their lives through voluntary self-administration of a lethal dose of medications prescribed by a physician for that purpose. The Act requires the Oregon Health Authority (OHA) to collect information about the patients and physicians who participate in the Act and to publish an annual statistical report.

The DWDA outlines specific patient requirements to participate. A patient must be 1) 18 years of age or older, 2) capable of making and communicating health care decisions to health care practitioners, and 3) diagnosed with a terminal illness that will lead to death within six months. The attending and consulting physicians must determine whether a patient meets these requirements and report that fact to OHA at the time a prescription is written. When OHA identifies any instance of noncompliance with the statutory requirements, it reports the instance to the appropriate licensing board.

Data presented in this summary, including the number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of the medications (DWDA deaths), are based on required reporting forms and death certificates received by OHA as of January 20, 2023. More information on the reporting process, required forms and annual reports is available at http://www.healthoregon.org/dwd.

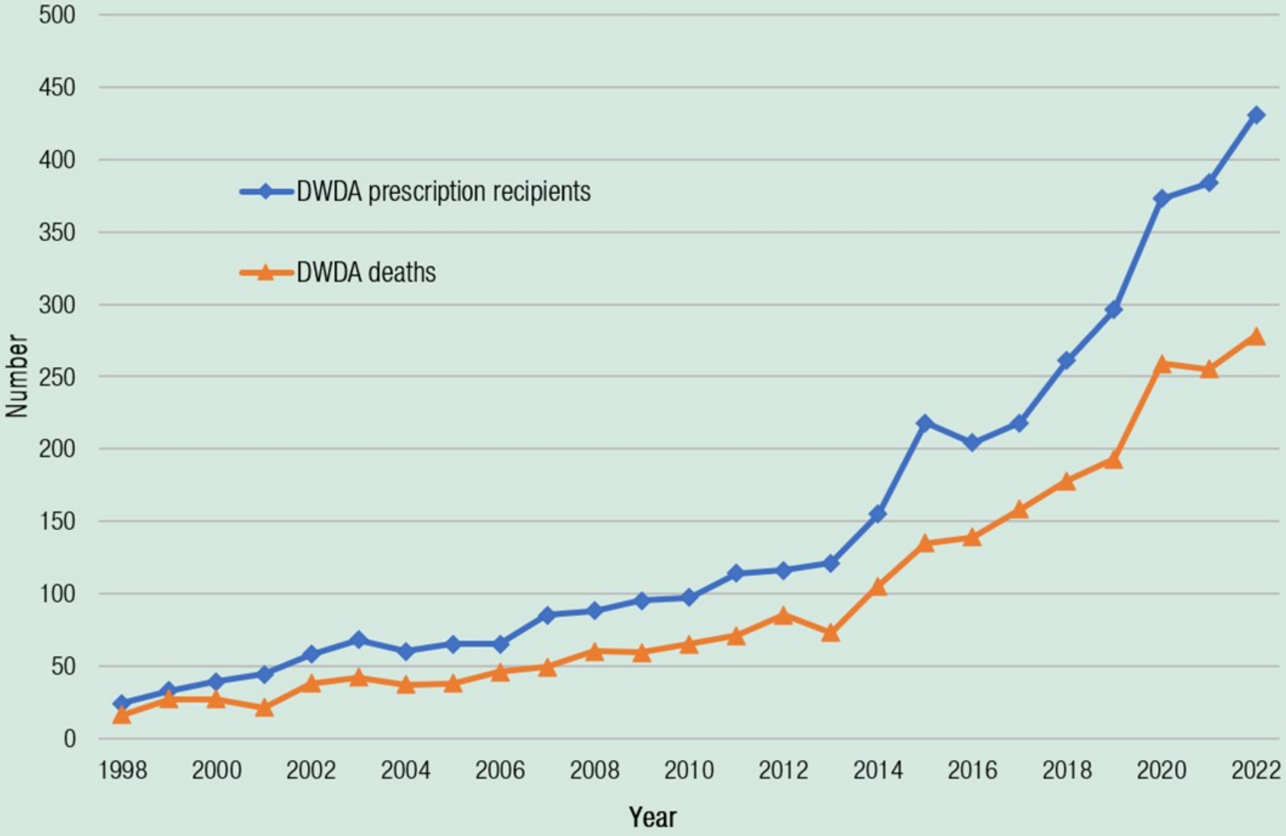
Patient residency requirement

In October 2021, a lawsuit was filed against the State of Oregon in U.S. District Court for the District of Oregon, alleging that the residency requirement in the Act violated the Privileges and Immunities Clause and the Dormant Commerce Clause of the United States Constitution, in part because it bars Oregon health care providers from providing medical aid in dying to non-resident patients. In a settlement on March 28, 2022, the State agreed not to enforce the residency requirement in the Act and to submit a legislative concept that would repeal the residency requirement in ORS 127.800(11), ORS 127.805(1), ORS 127.815(1)(b), and ORS 127.860.

In accordance with the settlement, House Bill 2279 was introduced in the 2023 session of the Oregon Legislative Assembly. If the bill becomes law, it will remove all text in the Act related to the residency requirement for patients receiving medical aid in dying. No other changes to the text of the Act are proposed in this bill.

Information on a patient's state of residence is not collected during the DWDA prescription process. Residence and other demographic information are collected from the death certificate. OHA does not receive death certificates from other states unless the decedent was an Oregon resident. Therefore, if an Oregon DWDA patient dies out of state and was not a resident of Oregon, OHA is unlikely to obtain notice of the death. The out-of-state deaths reported in Table 1 thus may not represent all DWDA deaths from out-of-state residents who obtained a DWDA prescription from an Oregon health care provider.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998–2022



*As of January 20 , 2023

See Table 2 for detailed information

Participation summary and trends

During 2022, 431 people received prescriptions for lethal doses of medications under the provisions of the Oregon DWDA, compared to 384 reported during 2021 (Figure 1). As of January 20, 2023, OHA had received reports of 278 people who died during 2022 from ingesting the medications prescribed under the DWDA, an increase from 255 in 2021.

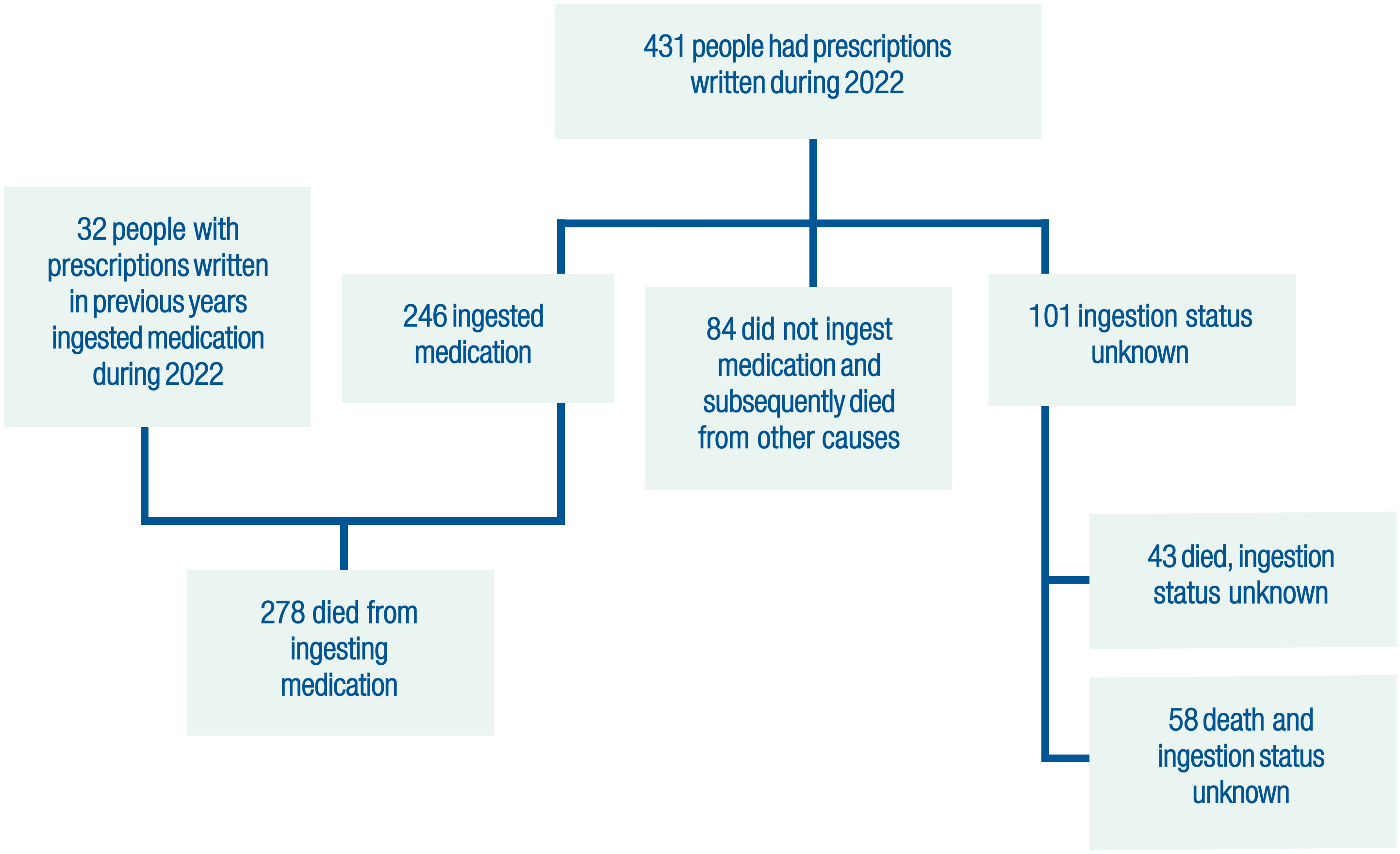
Since the law was passed in 1997, a total of 3,712 people have received prescriptions under the DWDA and 2,454 people (66%) have died from ingesting the medications. During 2022, DWDA deaths accounted for an estimated 0.6% of total deaths in Oregon.*

Figure 2 shows a summary of DWDA prescriptions written and medications ingested. Of the 431 patients for whom prescriptions were written during 2022, 246 (57%) died from ingesting the medication. An additional 84 (19%) did not take the medications and later died of other causes.

At the time of reporting, ingestion status was unknown for 101 patients prescribed DWDA medications in 2022. Of these, 43 patients died but follow-up information is not yet available. For the remaining 58 patients, both death and ingestion status are not yet known (Figure 2). In all, 16 patients (6% of DWDA deaths) outlived their prognosis (i.e., lived more than six months after their prescription date).

** The percentage of total deaths is calculated using the total number of deaths occurring in Oregon during 2021 (45,028), the most recent year for which final death data are available.*

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2022, as of January 20, 2023



Patient characteristics

Table 1 shows the characteristics and end-of-life care for 2022 DWDA deaths, updated data for 2021 DWDA deaths, combined data for 1998–2020 DWDA deaths, and total DWDA deaths. Of the 278 DWDA deaths during 2022, most patients were aged 65 years or older (85%) and white (96%). The median age at death was 75 years. Forty-nine percent of patients had at least a bachelor's degree.

Patients' most common underlying illness was cancer (64%), followed by heart disease (12%) and neurological disease (10%).

Most patients died at home (92%), and most were enrolled in hospice care (91%). Excluding unknown cases, all patients had some form of health insurance. The percentage of patients with private insurance declined slightly from 2021 (from 22% to 20%), while patients with Medicare or Medicaid insurance saw a slight increase (from 78% to 80%).

As in previous years, the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (89%), loss of autonomy (86%), and loss of dignity (62%).

DWDA process

A total of 146 physicians wrote 431 prescriptions during 2022 (1–51 prescriptions per physician; 78% of physicians wrote one or two prescriptions). The number of attending physicians has increased most years (Table 2). Around half of attending and consulting physicians practiced in the Portland metropolitan area (53% and 50%, respectively), while fewer than 30% practiced in the other northwestern counties (Table 3). Three patients were referred for psychological or psychiatric evaluation. During 2022, OHA referred no physicians to the Oregon Medical Board for failure to comply with DWDA reporting requirements.

Since 2020, the DWDA provides an exemption to the statutory waiting periods for patients expected to live fewer than 15 days after the time of their first oral request for medication. In 2022, 109 patients (25% of DWDA prescription recipients) were granted exemptions.

Prescribing physicians were present at time of death for 36 (13%) of the patients who ingested DWDA medications. Thirty-seven patients (13%) had other health care providers present, and volunteers were present for 51 deaths (18%). Data on time from ingestion to death are available for 165 DWDA deaths (59%) during 2022.* Among those patients, time from ingestion until death ranged from three minutes to 68 hours, with a median time of 52 minutes (Table 1).

The medications prescribed to DWDA patients (since 2013) are shown in Figure 3 (see also Table 1). More than 70% of ingestions in 2022 involved the drug combination DDMAPh, which consists of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital. The drug combination DDMA, consisting of diazepam, digoxin, morphine sulfate, and amitriptyline, accounted for 28% of ingestions. Table 4 shows the duration from ingestion to death by medication prescribed for all known cases. Median time until death was somewhat shorter after DDMAPh (42 minutes) than after DDMA (49 minutes). All drug combinations have shown longer median times until death than the barbiturates secobarbital and pentobarbital, which are no longer readily available.

Includes all reports, not just those from licensed health care providers.

Figure 3: Medication used in DWDA ingestions, 2013-2022

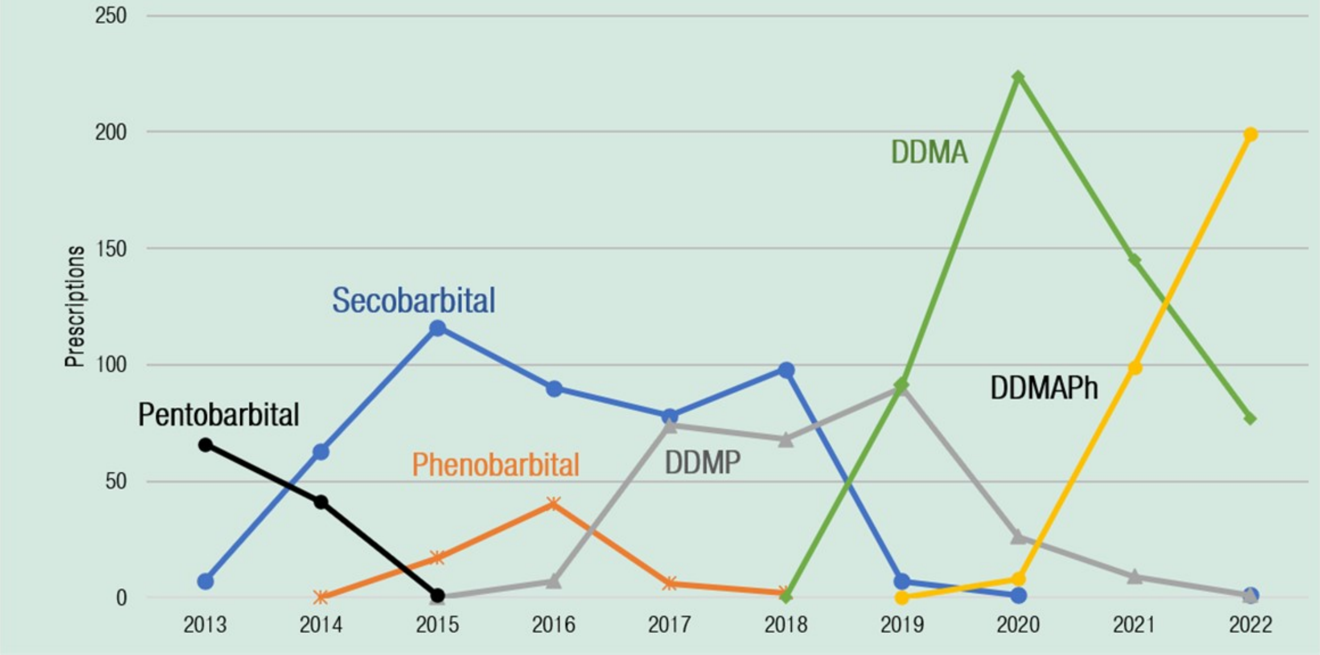


Table 1. Characteristics and end-of-life care of 2,454 DWDA patients who have died from ingesting a lethal dose of medication as of January 20, 2023, Oregon, 1998-2022

Characteristics	2022		2021		1998-2020		Total	
	(N=278)		(N=255)		(N=1,921)		(N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
Sex								
Male	138	(49.6)	140	(54.9)	1,012	(52.7)	1,290	(52.6)
Female	140	(50.4)	115	(45.1)	909	(47.3)	1,164	(47.4)
Age								
18-34	1	(0.4)	1	(0.4)	11	(0.6)	13	(0.5)
35-44	3	(1.1)	2	(0.8)	36	(1.9)	41	(1.7)
45-54	12	(4.3)	13	(5.1)	109	(5.7)	134	(5.5)
55-64	27	(9.7)	32	(12.5)	340	(17.7)	399	(16.3)
65-74	90	(32.4)	76	(29.8)	586	(30.5)	752	(30.6)
75-84	91	(32.7)	84	(32.9)	522	(27.2)	697	(28.4)
85+	54	(19.4)	47	(18.4)	317	(16.5)	418	(17.0)
Median years (range)	75	(29-99)	75	(28-101)	72	(25-102)	73	(25-102)
Race and ethnicity								
White	267	(96.0)	242	(94.9)	1,849	(96.5)	2,358	(96.3)
African American	1	(0.4)	0	(0.0)	1	(0.1)	2	(0.1)
American Indian	2	(0.7)	1	(0.4)	3	(0.2)	6	(0.2)
Asian	5	(1.8)	6	(2.4)	26	(1.4)	37	(1.5)
Pacific Islander	0	(0.0)	0	(0.0)	1	(0.1)	1	(0.0)
Other	0	(0.0)	0	(0.0)	6	(0.3)	6	(0.2)
Two or more races	1	(0.4)	0	(0.0)	8	(0.4)	9	(0.4)
Hispanic (any race)	2	(0.7)	6	(2.4)	22	(1.1)	30	(1.2)
Unknown	*0*		*0*		*5*		*5*	
Marital status								
Married (including Registered Domestic Partner)	129	(46.7)	116	(45.8)	881	(46.1)	1,126	(46.1)
Widowed	46	(16.7)	51	(20.2)	423	(22.1)	520	(21.3)
Never married	22	(8.0)	22	(8.7)	158	(8.3)	202	(8.3)
Divorced	79	(28.6)	64	(25.3)	450	(23.5)	593	(24.3)
Unknown	*2*		*2*		*9*		*13*	
Education								
8th grade or less	5	(1.8)	1	(0.4)	23	(1.2)	29	(1.2)
9th-12th grade, no diploma	8	(2.9)	7	(2.8)	79	(4.1)	94	(3.9)
High school graduate/GED	59	(21.3)	61	(24.2)	407	(21.4)	527	(21.7)
Some college	51	(18.4)	51	(20.2)	387	(20.3)	489	(20.1)
Associate degree	18	(6.5)	15	(6.0)	175	(9.2)	208	(8.5)
Bachelor's degree	61	(22.0)	62	(24.6)	460	(24.1)	583	(24.0)
Master's degree	58	(20.9)	35	(13.9)	232	(12.2)	325	(13.4)
Doctorate or professional degree	17	(6.1)	20	(7.9)	142	(7.5)	179	(7.4)
Unknown	*1*		*3*		*16*		*20*	

Characteristics	2022 (N=278)		2021 (N=255)		1998-2020 (N=1,921)		Total (N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
Residence county / region[2]								
Clackamas	21	(7.6)	21	(8.2)	192	(10.1)	234	(9.6)
Deschutes	17	(6.1)	27	(10.6)	85	(4.5)	129	(5.3)
Jackson	17	(6.1)	12	(4.7)	133	(7.0)	162	(6.6)
Lane	32	(11.5)	26	(10.2)	207	(10.8)	265	(10.8)
Marion	23	(8.3)	13	(5.1)	185	(9.7)	221	(9.0)
Multnomah	72	(25.9)	58	(22.7)	414	(21.7)	544	(22.3)
Washington	33	(11.9)	21	(8.2)	193	(10.1)	247	(10.1)
Other northwest counties	31	(11.2)	48	(18.8)	293	(15.3)	372	(15.2)
Southern Oregon	18	(6.5)	19	(7.5)	144	(7.5)	181	(7.4)
Central Oregon / Columbia Gorge	8	(2.9)	6	(2.4)	31	(1.6)	45	(1.8)
Eastern Oregon	3	(1.1)	4	(1.6)	33	(1.7)	40	(1.6)
Out of state	3	(1.1)	0	(0.0)	0	(0.0)	3	(0.1)
Unknown	*0*		*0*		*11*		*11*	
End-of-life care								
Hospice								
Enrolled	254	(91.4)	248	(97.3)	1,713	(90.8)	2,215	(91.5)
Not enrolled	24	(8.6)	7	(2.7)	174	(9.2)	205	(8.5)
Unknown	*0*		*0*		*34*		*34*	
Insurance								
Private	43	(20.5)	41	(21.9)	768	(44.5)	852	(40.2)
Medicare, Medicaid or Other Govt.	167	(79.5)	145	(77.5)	938	(54.4)	1,250	(58.9)
None	0	(0.0)	1	(0.5)	18	(1.0)	19	(0.9)
Unknown	*68*		*68*		*197*		*333*	
Underlying illness								
Cancer	**178**	**(64.0)**	**158**	**(62.0)**	**1,420**	**(73.9)**	**1,756**	**(71.6)**
Lip, oral cavity, and pharynx	6	(2.2)	3	(1.2)	41	(2.1)	50	(2.0)
Digestive organs	45	(16.2)	36	(14.1)	378	(19.7)	459	(18.7)
Pancreas	*16*	*(5.8)*	*9*	*(3.5)*	*125*	*(6.5)*	*150*	*(6.1)*
Colon	*5*	*(1.8)*	*8*	*(3.1)*	*98*	*(5.1)*	*111*	*(4.5)*
Other digestive organs	*24*	*(8.6)*	*19*	*(7.5)*	*155*	*(8.1)*	*198*	*(8.1)*
Respiratory and intrathoracic organs	32	(11.5)	24	(9.4)	303	(15.8)	359	(14.6)
Lung and bronchus	*31*	*(11.2)*	*23*	*(9.0)*	*284*	*(14.8)*	*338*	*(13.8)*
Other respiratory and intrathoracic organs	*1*	*(0.4)*	*1*	*(0.4)*	*19*	*(1.0)*	*21*	*(0.9)*
Melanoma and other skin	0	(0.0)	5	(2.0)	44	(2.3)	49	(2.0)
Mesothelial and soft tissue	7	(2.5)	6	(2.4)	34	(1.8)	47	(1.9)
Breast	13	(4.7)	12	(4.7)	129	(6.7)	154	(6.3)
Female genital organs	17	(6.1)	15	(5.9)	106	(5.5)	138	(5.6)
Prostate	14	(5.0)	16	(6.3)	89	(4.6)	119	(4.8)
Urinary tract	6	(2.2)	9	(3.5)	54	(2.8)	69	(2.8)

Characteristics	2022		2021		1998-2020		Total	
	(N=278)		(N=255)		(N=1,921)		(N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
-Cancer, continued-								
Eye, brain, central nervous system	14	(5.0)	5	(2.0)	59	(3.1)	78	(3.2)
Brain	*14*	*(5.0)*	*5*	*(2.0)*	*53*	*(2.8)*	*72*	*(2.9)*
Eye and central nervous system	*0*	*(0.0)*	*0*	*(0.0)*	*6*	*(0.3)*	*6*	*(0.2)*
Thyroid and other endocrine	0	(0.0)	1	(0.4)	7	(0.4)	8	(0.3)
Ill-defined, secondary, and unspecified sites	8	(2.9)	6	(2.4)	50	(2.6)	64	(2.6)
Lymphoma and leukemia	9	(3.2)	16	(6.3)	86	(4.5)	111	(4.5)
Other cancers	7	(2.5)	4	(1.6)	40	(2.1)	51	(2.1)
Neurological disease	**27**	**(9.7)**	**35**	**(13.7)**	**207**	**(10.8)**	**269**	**(11.0)**
Amyotrophic lateral sclerosis	15	(5.4)	22	(8.6)	146	(7.6)	183	(7.5)
Other neurological diseases	12	(4.3)	13	(5.1)	61	(3.2)	86	(3.5)
Heart/circulatory disease	**32**	**(11.5)**	**29**	**(11.4)**	**105**	**(5.5)**	**166**	**(6.8)**
Respiratory disease [e.g., COPD]	**27**	**(9.7)**	**19**	**(7.5)**	**109**	**(5.7)**	**155**	**(6.3)**
Endocrine/metabolic disease [e.g., diabetes]	**4**	**(1.4)**	**5**	**(2.0)**	**19**	**(1.0)**	**28**	**(1.1)**
Gastrointestinal disease [e.g., liver disease]	**4**	**(1.4)**	**3**	**(1.2)**	**17**	**(0.9)**	**24**	**(1.0)**
Infectious disease [e.g., HIV/AIDS]	**2**	**(0.7)**	**0**	**(0.0)**	**14**	**(0.7)**	**16**	**(0.7)**
Other illnesses	**4**	**(1.4)**	**6**	**(2.4)**	**30**	**(1.6)**	**40**	**(1.6)**
DWDA process								
Outlived 6-month prognosis	16	(5.8)	11	(4.3)	77	(4.0)	104	(4.2)
Referred for psychiatric evaluation	3	(1.1)	2	(0.8)	69	(3.6)	74	(3.0)
Patient informed family of decision[3]	257	(95.5)	238	(95.6)	1,731	(95.9)	2,226	(95.8)
Patient died at								
Home (patient, family or friend)	255	(91.7)	240	(94.1)	1,773	(92.6)	2,268	(92.6)
Assisted living or foster care facility	18	(6.5)	13	(5.1)	92	(4.8)	123	(5.0)
Nursing home	0	(0.0)	2	(0.8)	18	(0.9)	20	(0.8)
Hospital	1	(0.4)	0	(0.0)	4	(0.2)	5	(0.2)
Hospice facility	1	(0.4)	0	(0.0)	3	(0.2)	4	(0.2)
Other	3	(1.1)	0	(0.0)	25	(1.3)	28	(1.1)
Unknown	*0*		*0*		*6*		*6*	
Lethal medication[4]								
DDMAPh	199	(71.6)	99	(38.8)	8	(0.4)	306	(12.5)
DDMA	77	(27.7)	145	(56.9)	315	(16.4)	537	(21.9)
DDMP-2	1	(0.4)	8	(3.1)	194	(10.1)	203	(8.3)
DDMP-1	0	(0.0)	1	(0.4)	71	(3.7)	72	(2.9)
Secobarbital	1	(0.4)	0	(0.0)	860	(44.8)	861	(35.1)
Pentobarbital	0	(0.0)	0	(0.0)	386	(20.1)	386	(15.7)
Phenobarbital	0	(0.0)	0	(0.0)	65	(3.4)	65	(2.6)
Other	0	(0.0)	2	(0.8)	22	(1.1)	24	(1.0)

Characteristics	2022		2021		1998-2020		Total	
	(N=278)		(N=255)		(N=1,921)		(N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
End-of-life concerns[5]								
Less able to engage in activities making life enjoyable	247	(88.8)	233	(91.4)	1,728	(90.0)	2,208	(90.0)
Losing autonomy	240	(86.3)	236	(92.5)	1,740	(90.6)	2,216	(90.3)
Loss of dignity[6]	172	(61.9)	174	(68.2)	1,320	(73.7)	1,666	(71.7)
Burden on family, friends/caregivers	129	(46.4)	136	(53.3)	914	(47.6)	1,179	(48.0)
Losing control of bodily functions	124	(44.6)	122	(47.8)	831	(43.3)	1,077	(43.9)
Inadequate pain control, or concern about it	87	(31.3)	69	(27.1)	530	(27.6)	686	(28.0)
Financial implications of treatment	17	(6.1)	20	(7.8)	88	(4.6)	125	(5.1)
Health care provider present (collected since 2001)	**(N=278)**		**(N=255)**		**(N=1,849)**		**(N=2,382)**	
When medication was ingested								
Prescribing physician	44	(24.4)	47	(28.5)	287	(29.0)	460	(28.2)
Other provider, prescribing physician not present	30	(16.7)	36	(21.8)	433	(43.8)	581	(35.6)
Volunteer	55	(30.6)	47	(28.5)	102	(10.3)	273	(16.7)
No provider or volunteer	51	(28.3)	35	(21.2)	166	(16.8)	318	(19.5)
Unknown	*98*		*90*		*861*		*1,049*	
At time of death								
Prescribing physician	36	(12.9)	37	(14.5)	265	(14.5)	338	(14.3)
Other provider, prescribing physician not present	37	(13.3)	42	(16.5)	439	(24.0)	518	(22.0)
Volunteer	51	(18.3)	44	(17.3)	111	(6.1)	206	(8.7)
No provider or volunteer	154	(55.4)	132	(51.8)	1,011	(55.4)	1,297	(55.0)
Unknown	*0*		*0*		*23*		*23*	
Complications[7]	**(N=278)**		**(N=255)**		**(N=1,921)**		**(N=2,454)**	
Difficulty ingesting/regurgitated	5		5		33		43	
Seizures	0		0		3		3	
Other	1		1		16		18	
None	66		71		777		914	
Unknown	*206*		*178*		*1,092*		*1,476*	
Other outcomes								
Regained consciousness after ingesting DWDA medications	0		1		8		9	
Timing of DWDA event								
Duration (weeks) of patient-physician relationship								
Median	5		5		12		10	
Range	0 - 1083		0 - 940		0 - 2138		0 - 2138	
Patients with information available	*276*		*253*		*1,903*		*2,432*	
Patients with information unknown	*2*		*2*		*18*		*22*	

Characteristics	2022		2021		1998-2020		Total	
	(N=278)		(N=255)		(N=1,921)		(N=2,454)	
	N	(%)[1]	N	(%)[1]	N	(%)[1]	N	(%)[1]
Duration (days) between first request and death								
Median	30		30		45		41	
Range	1 - 1859		1 - 1095		1 - 1503		0 - 1859	
Patients with information available	*278*		*255*		*1,919*		*2,452*	
Patients with information unknown	*0*		*0*		*2*		*2*	
Duration (minutes) between ingestion and unconsciousness								
Median	5		5		5		5	
Range	1 - 300		1 - 45		1 - 240		1 - 300	
Patients with information available	*150*		*149*		*1,005*		*1,304*	
Patients with information unknown	*128*		*106*		*916*		*1,150*	
Duration between ingestion and death								
Median (minutes)	52		33		30		30	
Range	3 min - 68 hrs		2 min - 24 hrs		1 min - 104 hrs		1 min - 104 hrs	
Patients with information available	*165*		*158*		*1,043*		*1,366*	
Patients with information unknown	*113*		*97*		*878*		*1,088*	

N indicates the number of patients.

1 Unknowns are excluded when calculating percentages.

2 **Other northwest counties:** Benton, Clatsop, Columbia, Lincoln, Linn, Polk, Tillamook, and Yamhill.
Southern: Coos, Curry, Douglas, Josephine, Klamath, and Lake.
Central/Columbia Gorge: Crook, Gilliam, Hood River, Jefferson, Sherman, Wasco, and Wheeler.
Eastern: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, and Wallowa.

3 First recorded in 2001. Since then, 97 patients (4.1%) have chosen not to inform their families, and 42 patients (1.8%) have had no family to inform. Information is unknown for 19 patients.

4 **DDMAPh** is a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.
DDMA is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.
DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15g.
Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.

5 Affirmative answers only (“Don’t know” included in negative answers). Categories are not mutually exclusive.

6 First asked in 2003. Data available for 2,325 patients.

7 Information about complications is reported only when a physician or another health care provider is present at time of death. Due to the high number of unknowns for this item, percentages are not calculated.

Table 2. Number of DWDA prescription recipients, DWDA deaths, and attending physicians, 1998-2022

Year	Prescription recipients	DWDA deaths	Attending physicians
1998	24	16	n/a
1999	33	27	n/a
2000	39	27	22
2001	44	21	33
2002	58	38	33
2003	68	42	42
2004	60	37	40
2005	65	38	40
2006	65	46	41
2007	85	49	46
2008	88	60	60
2009	95	59	64
2010	97	65	59
2011	114	71	62
2012	116	85	62
2013	121	73	62
2014	155	105	83
2015	218	135	106
2016	204	139	101
2017	218	158	92
2018	261	178	108
2019	296	193	113
2020	373	259	142
2021	384	255	132
2022	431	278	146
Total	**3,712**	**2,454**	

Table 3. Primary location of practice, DWDA physicians, 2022

Region[2]	Attending physicians		Consulting physicians	
	N	(%)[1]	N	(%)[1]
Metro counties (Clackamas, Multnomah, Washington)	78	(53.4)	112	(50.2)
Northwest Oregon (excludes Metro counties)	38	(26.0)	60	(26.9)
Southern Oregon	21	(14.4)	35	(15.7)
Central Oregon / Columbia Gorge	9	(6.2)	16	(7.2)
Eastern Oregon	0	(0.0)	0	(0.0)
Unknown	*0*		*1*	

1 Unknowns are excluded when calculating percentages.

2 **Northwest Oregon:** Benton, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Polk, Tillamook, and Yamhill.
Southern Oregon: Coos, Curry, Douglas, Jackson, Josephine, Klamath, and Lake.
Central / Columbia Gorge: Crook, Deschutes, Gilliam, Hood River, Jefferson, Sherman, Wasco and Wheeler.
Eastern Oregon: Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union and, Wallowa.

Table 4. Duration between ingestion and death, DWDA deaths, 2001-2022

Drug (%)	Total	Unknown duration	Known duration	<1 hour	1-6 hours	>6 hours	Median (minutes)	Mean (minutes)	Range	Regained consciousness[6]
Secobarbital[1]	793	403	390 (100.0)	294 (75.4)	69 (17.7)	27 (6.9)	25	137	2 min - 83 hrs	5
DDMA[2]	537	201	336 (100.0)	190 (56.5)	140 (41.7)	6 (1.8)	49	78	1 min - 19 hrs	1
Pentobarbital[1]	384	156	228 (100.0)	188 (82.5)	31 (13.6)	9 (3.9)	20	97	1 min - 104 hrs	0
DDMAPh[3]	306	124	182 (100.0)	110 (60.4)	64 (35.2)	8 (4.4)	42	105	5 min - 68 hrs	0
DDMP-2[4]	203	98	105 (100.0)	46 (43.8)	36 (34.3)	23 (21.9)	85	254	2 min - 47 hrs	2
DDMP-1[4]	72	47	25 (100.0)	12 (48.0)	7 (28.0)	6 (24.0)	77	223	10 min - 21 hrs	0
Phenobarbital[5]	65	43	22 (100.0)	4 (18.2)	13 (59.1)	5 (22.7)	73	439	20 min - 72 hrs	0
Other	24	6	18 (100.0)	7 (38.9)	8 (44.4)	3 (16.7)	71	237	10 min - 24 hrs	1
TOTAL	**2,384**	**1,078**	**1,306 (100.0)**	**851 (65.2)**	**368 (28.2)**	**87 (6.7)**	**30**	**129**	1 min - 104 hrs	**9**

1 Secobarbital has been unavailable for DWDA use since 2019; penobarbital since 2015.
2 DDMA is a combination of diazepam, digoxin, morphine sulfate, and amitriptyline.
3 DDMAPh is a combination of diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital.
4 DDMP is a combination of diazepam, digoxin, morphine sulfate, and propranolol. DDMP-1 contains 10g of morphine sulfate; DDMP-2 contains 15 g.
5 Phenobarbital is dispensed as a combination of phenobarbital, chloral hydrate, and morphine sulfate.
6 Patients who regained consciousness after ingestion are not considered DWDA deaths, and are not included in the other columns in this table.

NOTE: Table includes all reported durations, not just those from licensed providers. Complete information not available before 2001. Unknown values are excluded when calculating percentages.

Oregon Health Authority
PUBLIC HEALTH DIVISION
http://www.healthoregon.org/dwd
DWDA.info@state.or.us

Opposition to SB 443 End of Life Option.pdf

Uploaded by: Lorraine Jaffe
Position: UNF

I am writing in opposition to SB 443 "End–of–Life Option Act."

My husband had a heart condition that needed treatment for 20 years. We enjoyed our 20 years together. If this bill had existed back then, the insurance company would probably have encouraged my husband's doctor to suggest suicide over treatment as they have done on the west coast. The passage of physician-assisted suicide in the states of Oregon and Washington has led to a disproportionately large number of society's most vulnerable taking their lives. Indeed, some advocates for physician-assisted suicide grossly point to the potential "cost-savings" for taxpayers.

https://www.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/

If this bill passes, there would be terrible unintended consequences for people with disabilities. They would become victims of government overreach. The disabled patients who could not afford to pay for treatments, would be encouraged to commit suicide. You may not want this to happen but unfortunately, in this current climate, that is what would happen.

Proponents of the bill also argue that it is intended for people who are terminally ill. But the meaning of "terminal illness" has changed over time, thanks to medical breakthroughs. It is possible to live with "terminal" diseases. Emily Ward for example: https://conquer-magazine.com/issues/2020/vol-6-no-1-february-2020/1194-defying-the-odds-how-i-ve-survived-a-male-dominated-terminal-cancer-for-7-years. Ms. Ward was a nurse and was therefore able to advocate for herself and was not afraid to ask doctors questions. She had the support from doctors who wanted to help her. Steffi Dawn Ilagan survived lymphoma: https://conquer-magazine.com/issues/2022/vol-8-no-6-december-2022/1958:you-only-live-t-w-i-c-e-a-cancer-warrior-s-motto. She was lucky to have financial support from her family in order to fight it. **Unfortunately, another side-effect of SB 443 would be to create an atmosphere where patients who do not have a medical background or who do not have the money to seek out doctors who will help them will receive unequal treatment. Patients who cannot advocate for themselves or who do not have money will be encouraged to accept a death sentence. This would be the final injustice for the underserved.**

Many in the medical profession have come out strongly against physician-assisted suicide. Just to name a few of the medical groups:

- American Medical Association
- American College of Physicians
- Maryland Chapter of the American College of Physicians
- Maryland Psychiatric Society

We can just look to other countries that have passed this to see what will happen. For example, the Netherlands adopted euthanasia over thirty years ago, and the results are disturbing to say the least.

The Current Oncology (Vol. 18, No. 2, 2011) journal summarizes the results of the Dutch experiment with euthanasia:

https://www.ncbi.nlm.nih.gov/ pmc/articles/PMC3070710/pdf/ conc-18-e38.pdf

"In 30 years, the Netherlands has moved from euthanasia of people who are terminally ill, to euthanasia of those who are chronically ill; from euthanasia for physical illness, to euthanasia for mental illness, to euthanasia for psychological distress or mental suffering – and now to euthanasia simply if a person is over the age of 70 and "tired of living." **Dutch euthanasia protocols have also moved from conscious patients providing explicit consent, to unconscious patients unable to provide consent."**

To quote from the Maryland Chapter of the American College of Physicians:

"We all have fears about death. But for a doctor to prescribe a bottle of poison is neither compassion nor treatment. The physician's role is as healer and comforter. The compassionate choice for Maryland is to promote access to high quality palliative and hospice care."

I know that you want to do the right thing, but you must be very careful because your decision will affect all of the people in our state, and it will resonate throughout our country.

Your laws have consequences.

Oppose SB 443.

Thank you,

Lorraine Jaffe

Bethesda, MD

opposition to assisted suicide statement.pdf

Uploaded by: Marco Colombini

Position: UNF

Regarding End of Life Option SB 443

Professor Marco Colombini
17520 Doctor Bird Road
Sandy Spring, MD 20860

I oppose the so-called "End of Life Option" better known as Assisted Suicide. While it seems compassionate, in practice it has resulted in many abuses. Where Assisted Suicide has been legalized, with time it was extended to minors, even without parental consent, and to those suffering from mental health issues as minor as depression. Disability rights groups recognize the many dangers the bill poses to those with intellectual and developmental disabilities.

People thinking about suicide should receive counselling and the reasons for wanting to commit suicide should be addressed and other solutions found.

There is also the problem of the suicide pills falling into the wrong hands. Many individuals who fill the lethal prescription-typically 100 pills, decide against taking it and the drugs can then be misused. This is particularly irresponsible, as we are experiencing an opioid crisis nationwide.

Assisted Suicide laws make suicide socially acceptable and where it has been legalized patients are encouraged to kill themselves rather than be approved for expensive medical treatments.

Therefore I urge you to oppose legislation to legalize Assisted Suicide.

2.7.24 MARGARET CARTER part 1 Cover sheet to Page

Uploaded by: Margaret Carter
Position: UNF

Cover Sheet and Supporting Documents submitted
by Margaret Carter to Judiciary Proceedings
Committee on SB 443

In every jurisdiction where assisted suicide is legalized, safeguards are imposed to prevent abuse and protect the vulnerable. However, in the name of "access," those safeguards are inevitably relaxed or removed. Dutch ethicist Theo Boer initially championed Physician Assisted Suicide (PAS) legislation in the Netherlands. But since 2014 he has warned legislators both in Europe and North America about the "Slippery Slope" that Physician Assisted Suidide presents. He argues that safeguards are inevitably removed through judicial fiat, legislation or through a change in the attitudes of medical practitioners and the general population.

In the U.S. Oregon was the one of the first states to implement PAS. And it is often touted as a model for other states. Proponents note that the law is mostly unchanged since it was implemented 25 years ago. However, there have indeed been significant changes in the law itself and in the way it is implemented.

- The "waiting period" for the monumental decision to choose PAS has been reduced from 15 days to 48 hours.
- While initially 31.3% of individuals seeking PAS were required to undergo a psychiatric evaluation, now only 1.1 % receive that important evaluation.
- While the law was passed in hopes that it would relieve unbearable suffering for people who were already close to death, many of those who now receive the lethal overdoses do not cite pain as their motivation. Instead, they cite "financial concerns or the "fear of being a burden."
- The requirement that PAS applicants be Oregon residents has been removed,
- Accurate data on "complications" is now unavailable to researchers.
- Reduction in the length of physician-patient relationship from an average of 18 weeks in 2010 to five weeks in 2022.
- Oregon legislators continue to propose legislation to expand PAS "access" to an increasing number of people.

While Oregon is well behind the Netherlands, where doctors are now euthanizing infants with Spina Bifida and the elderly with dementia, Boer's prediction of inevitable expansion still holds true. Oregon is not a "model" for Maryland. Instead it should serve as a cautionary tale.

All facts and figures cited above were drawn from the documents which are abstracted in this cover sheet and included in this packet.

Pages 1-2: Op Ed by Theo Boer in the *Calgary Herald,* July 2014. Boer describes the "Slippery Slope" of PAS and warns legislators "Don't go there....Once the Genie is out of the bottle, it is unlikely to ever go back in again."

Pages 2-4: In a 2022 Op Ed in the popular French publication *Le Monde* Boer warns the French people of the “dehumanizing choice” that is PAS.

Pages 5-7: David Jones blog, *British Medical Journal Medical Ethics.com* :“Twenty-Five Years of the ‘Oregon model’ of assisted suicide: the data are not reassuring.”

Pages 8-14: Study from *the British Medical Journal of Supportive and Palliative Care* by Claude Regnard, Ana Worthington, Ilora Finley, *Oregon Death with Dignity Act Access: 25 year analysis.*

Pages 15-19: U.S. Conference of Catholic Bishops “Assisted Suicide and Euthanasia: from Voluntary to Involuntary, ” complete with footnotes and citations.

Pages 20-22: March 9, 2023 article from the *Oregon Register-Guard* entitled “Proposed changes to Oregon’s 25-year-old Death with Dignity Act could expand access.”

Opinion

Boer: I was wrong — euthanasia has a slippery slope

In 2001, the Netherlands was the first country in the world to legalize euthanasia and, along with it, assisted suicide. Various safeguards were put in place to show who should qualify, and doctors acting in accordance with these safeguards would not be prosecuted.

calgaryherald

Published Jul 17, 2014 • 3 minute read

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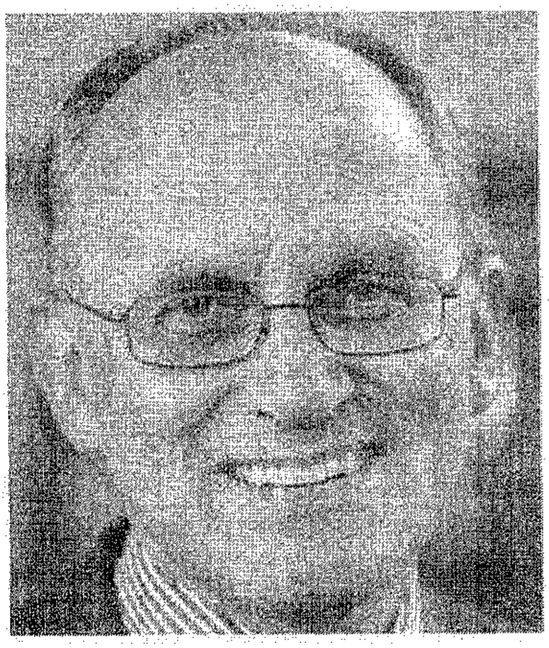

Theo Boer

In 2001, the Netherlands was the first country in the world to legalize euthanasia and, along with it, assisted suicide. Various safeguards were put in place to show who should qualify, and doctors acting in accordance with these safeguards would not be prosecuted.

Because each case is unique, five regional review committees were installed to assess every case and to decide whether it complied with the law. For five years after the law became effective, such physician-induced deaths remained level — and even fell in some years. In 2007, I

(2)

wrote that "there doesn't need to be a slippery slope when it comes to euthanasia. A good euthanasia law, in combination with the euthanasia review procedure, provides the warrants for a stable and relatively low number of euthanasia."

Most of my colleagues drew the same conclusion.

But we were wrong — terribly wrong, in fact. In hindsight, the stabilization in the numbers was just a temporary pause. Beginning in 2008, the numbers of these deaths show an increase of 15 per cent annually, year after year. The annual report of the committees for 2012 recorded 4,188 cases (compared with 1,882 in 2002). Last year saw a continuation of this trend, and I expect the 6,000 line to be crossed this year or the next. Euthanasia is on the way to becoming a default mode of dying for cancer patients.

Alongside this escalation, other developments have taken place. Under the name End of Life Clinic, the Dutch Right to Die Society NVVE founded a network of travelling euthanizing doctors. Whereas the law presupposes (but does not require) an established doctor-patient relationship, in which death might be the end of a period of treatment and interaction, doctors of the End of Life Clinic have only two options: administer life-ending drugs or send the patient away.

On average, these physicians see a patient three times before administering drugs to end their life. Hundreds of cases were conducted by the End of Life Clinic. The group shows no signs of being satisfied even with these developments. They will not rest until a lethal pill is made available to anyone over 70 years who wishes to die. Some slopes truly are slippery.

Other developments include a shift in the type of patients who receive these treatments. Whereas in the first years after 2002, hardly any patients with psychiatric illnesses or dementia appear in reports, these numbers are now sharply on the rise. Cases have been reported in which a large part of the suffering of those given euthanasia or assisted suicide consisted of being aged, lonely or bereaved. Some of these patients could have lived for years or decades.

Whereas the law sees assisted suicide and euthanasia as an exception, public opinion is shifting toward considering them rights, with corresponding duties on doctors to act.

A law that is now in the making obliges doctors who refuse to administer euthanasia to refer their patients to a "willing" colleague. Pressure on doctors to conform to patients' (or in some cases, relatives') wishes can be intense. Pressure from relatives, in combination with a patient's concern for the well-being of his beloved, is in some cases an important factor behind a euthanasia request. Not even the review committees, despite hard and conscientious work, have been able to halt these developments.

I used to be a supporter of legislation. But now, with 12 years of experience, I take a different view. At the very least, wait for an honest and intellectually satisfying analysis of the reasons behind the explosive increase in the numbers. Is it because the law should have had better safeguards? Or is it because the mere existence of such a law is an invitation to see assisted suicide and euthanasia as a normality instead of a last resort?

Before those questions are answered, don't go there.

Once the genie is out of the bottle, it is not likely to ever go back in again.

Theo Boer is professor of ethics at the Protestant Theological University at Groningen, Netherlands. For nine years, he was a member of a regional euthanasia review committee. The views expressed in this article, which was written for Britain's Daily Mail, represent his views as a professional ethicist, not of any institution.

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OPINION • HEALTH

Assisted dying: 'What is seen as an opportunity by some has become an urge to give in to despair for others'

OP-ED

Theo Boer

Theo Boer, the former regulator of assisted dying in the Netherlands, informs the French of the evolution and unintended consequences of the euthanasia law in his country.

Published on December 4, 2022, at 4:58 am (Paris), updated on December 4, 2022, at 4:59 am | 3 min.

In your country, a citizens' convention that may lead to the legalization of assisted suicide and euthanasia will be held from December 2022 to March 2023. After the 2002 legalization of euthanasia in the Netherlands, I supported the law and worked from 2005 to 2014 for the authorities in charge of monitoring euthanasia cases. I was convinced that the Dutch had found the right balance between compassion, respect for human life and guaranteeing individual freedoms. However, over the years, I have become increasingly concerned about certain trends.

After an initial stable period, we have seen a dramatic increase in the number of euthanasia cases from 2,000 in 2002 to 7,800 in 2021, with a continued increase in 2022. In some parts of the Netherlands, up to 15% of deaths are the result of intentional deaths. The outgoing director of the Euthanasia Expertise Center (EEC) – which provides assisted dying support to more than 1,000 patients per year – expects the number of euthanasias to double in the near future.

We have also seen changes in the way legal criteria are interpreted. In the early years of euthanasia in the Netherlands, it was almost exclusively available to mentally competent and terminally ill adults. After a few decades, the practice was extended to the chronically ill, the disabled, people with psychiatric problems, non-autonomous adults with living wills and young children. We're currently discussing an extension to elderly people without existing medical conditions.

A dehumanizing choice

Given this data, one can expect that advocates of assisted dying in France will argue for a more restricted law than the one in the Netherlands. But here is my prediction: Any legislation allowing assisted dying will be perceived by some as an injustice and will be challenged in court.

Take Canada, for instance, where euthanasia became legal in 2016. Less than two years later, the Superior Court of Quebec ruled that the concept of terminal illness in Canadian law is discriminatory and unconstitutional.

Why allow euthanasia only for terminally ill patients, who already have access to an ever-widening range of palliative care, when the chronically ill tend to suffer more intensely and for much longer? In 2020, we decided to include psychiatric patients as well. This created a slippery slope with legal issues, making the next steps easily predictable. Why only allow assisted dying for people suffering from a disease, and not for those who suffer from lack of meaning, marginalization, loneliness, and life itself?

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Twenty five years of the 'Oregon model' of assisted suicide: the data are not reassuring

Posted on October 27, 2023

By David Jones.

On 27 October 1997, 'physician-assisted suicide became a legal medical option for terminally ill Oregonians'. There are now 25 years of reports on the implementation of the Death With Dignity (DWD) Act. These give some insight into how the practice has changed since it was first introduced. The reports are all available online and an article has just been published analysing all 25 years. What do these reports show?

First and most obviously there has been a dramatic increase in numbers from 16 in 1998 to 278 in 2022. At the same time, the proportion referred for psychiatric evaluation prior to assisted suicide has dropped from 31.3% to 1.1%.

The 25-year review also highlights changes in the drugs used and in the rate of complications. Between 2010 and 2022 complications were reported on average in 11% of cases. In 2022, reported complications fell to 6%. Unfortunately this is not so reassuring as it seems, as an increasing percentage of data on complications is missing. In 2022 there was no data on complications for 74% of cases.

The reports also show shifts in the reasons given for seeking assisted death, with more citing the fear of being a burden and more citing financial concerns. The figures vary from year to year but in both cases the trend is clear. The increasing number of people seeking death because they feel they are a burden to others does not speak well of changes in social attitudes in Oregon since the DWD Act came into force.

Another shift evident in these reports relates to language. The first sentence of the first report refers to 'physician assisted suicide'. This phrase is used in the first line of every report until the ninth report for 2006. This change in language was not associated with any change in practice in Oregon but it may have reflected political efforts in other States to pass similar laws. After 9 years Oregon was still the only State in the United States to have legalised physician assisted suicide. This political motivation is acknowledged by the philosopher Gerald Dworkin, an advocate of such laws: 'the use of the term "Physician-assisted suicide" is now politically incorrect, for tactical reasons. I understand that the popular prejudice against suicide makes it more difficult to rally support for the bills I favor.'

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The term 'assisted suicide' nevertheless remains the ordinary term in Europe and was used by Margo MacDonald MSP for the Assisted Suicide (Scotland) Bill she introduced in November 2013. That bill, which was rejected by the Scottish Parliament, was largely based on Oregon's DWD Act. In 2017, the American Association of Suicidology adopted a statement opposing the characterising of assisted deaths as 'suicide'. However, in March this year that statement was quietly 'retired', a move welcomed by some disability groups. The language of physician assisted suicide remains in use by the American Medical Association. It also has the advantage of distinguishing self-administration of lethal drugs (assisted suicide) from administration by doctors (euthanasia).

If political debates outside Oregon influenced its shift in use of language, they may also account for the recent expansion of the DWD Act. Before 2016 there were only three States with such legislation (Oregon, Washington, Vermont) and one where assisted suicide was legal through case law (Montana). However, by 2021 there were ten jurisdictions with statute laws plus Montana where assisted suicide remained legal by case law. It is remarkable that, before 2019 neither Oregon nor any other jurisdiction in the United States had amended their law on physician assisted suicide. However, in the four years since 2020, there have been seven amendments to such laws across five states: in Oregon in 2020 and 2023; in Vermont 2022, and 2023; in California in 2022; in Washington in 2023; and in Hawaii in 2023 and an amendment has been introduced in New Jersey. This amounts to six out of the ten jurisdictions with such legislation. All these changes expand access, for example, waive waiting times, allow nurses to prescribe the lethal medication, or drop residency requirements. Until 2019 it had been possible to argue that there was 'no evidence of a "slippery slope"' because 'The Oregon law has remained unchanged since 1997'. This is no longer true. In recent years there has been a wave of expansion of such laws and further expansion is surely to be expected.

This increase in the number of States with assisted suicide and increase in number of deaths has also allowed more data on the secondary impact of legislation. In 2015 there were some indications of an association between legalisation of physician assisted suicide in the United States and increases in unassisted suicide. However, the association was not statistically significant once linear trends were included. In contrast, US data analysed in 2022 by two different methods showed a statistically significant increase in unassisted suicide after physician assisted suicide was introduced. Association does not, of course, demonstrate causation, but neither is such an association grounds for reassurance.

We now have twenty five years of data from Oregon and data from an increasing number of other States with similar laws. However, the more we know, the less reassuring the 'Oregon model' of assisted suicide seems to be.

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Competing interests: None declared

Other content recommended for you

Assisted dying and medical practice: questions and considerations for healthcare organisations
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Oregon Death with Dignity Act access: 25 year analysis
Claud Regnard et al., Support Palliat Care, 2023

Punishable by death—how the US anti-abortion movement ended up proposing the death penalty
Rebecca Kluchin et al., The BMJ, 2023

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A not-so-noble death: figured speech, friendship and suicide in Philippians 1:21-26

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Oregon Death with Dignity Act access: 25 year analysis

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ABSTRACT

Objectives Assisted dying has been legally available in Oregon in the USA for 25 years, since when official reports have been published each year detailing the number of people who have used this option as well as sociodemographic and information about the process. The aim of this study was to examine changes over time in these data.

Methods We collated and reviewed data on 2454 assisted deaths included in annual reports on assisted deaths published by the Oregon Health Authority from 1998 to 2022. Descriptive statistics were used to describe time trends.

Results The number of assisted deaths in Oregon increased from 16 in 1998 to 278 in 2022. Over this time, patients' health funding status changed from predominantly private (65%) to predominantly government support (79.5%), and there was an increase in patients feeling a burden and describing financial concerns as reasons for choosing an assisted death. There has been a reduction in the length of the physician–patient relationship from 18 weeks in 2010 to 5 weeks in 2022, and the proportion referred for psychiatric assessment remains low (1%). Data are frequently missing, particularly around complications.

Conclusions The number and characteristics of people accessing assisted deaths, and the process, have changed since data collection started in 1998. Prospective studies are needed to examine the relationship between socioeconomic factors and the desire for an assisted death in Oregon.

INTRODUCTION

Since 1998, the Oregon Health Authority (OHA) has published an annual data report.[1] This includes aggregate information on the demographics of those accessing an assisted death, their diagnoses, health funding status, lethal drugs used, patient concerns, the nature and extent of care provided, complications, and the timings of an assisted death.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Oregon has had assisted dying legislation for 25 years.

WHAT THIS STUDY ADDS

- ⇒ Many aspects have changed with rising numbers, expanding criteria and sociodemographic changes.
- ⇒ Much of the data on complications are missing and many variables are not collected, especially around decision-making, drug efficacy and the nature of palliative care support.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- ⇒ Oregon's changing trends in assisted dying require detailed prospective studies examining how socioeconomic factors influence the wish for an assisted death.

Assisted dying is a term which in Oregon's legislation covers only self-administered lethal drugs (physician-assisted suicide (PAS)). In other jurisdictions it also covers clinician-injected drugs (euthanasia) or both.[2,3] In 1997, Oregon enacted the Death with Dignity Act (DWDA). This legislation allows residents ≥18 years of age, capable of making and communicating healthcare decisions, and diagnosed with a terminal illness that will reasonably lead to death within 6 months, to end their lives through the voluntary self-administration of lethal drugs prescribed by a physician for that purpose. Annually, the OHA publishes an annual report containing data on the implementation of the legislation. The annual data report for 2022 provides the 25th year's data.

The official notification requirements vary between jurisdictions. Official reports contain limited characteristics such as total numbers, patient age or broad summaries, without standardised international reporting.[4–6] Oregon reports are the most detailed, and as some jurisdictions consider 'assisted dying' legislation

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based on Oregon, it is important to examine trends in a quarter of a century's data from their experience. The aim of this study was to examine detailed changes over time in the data from Oregon.

METHODS

Starting in 2022, we examined the data contained in every PAS report published by the OHA from 1998 to 2021, adding data from the latest 2022 report in March 2023.[1] We manually extracted information on the number of patients who were prescribed PAS drugs under the DWDA, sociodemographic data such as insurance status, information on the motivations for hastening death, the underlying illness which qualified them for PAS, and the number and types of lethal drugs prescribed under the legislation. Data were extracted into Microsoft Excel, which was used to describe data and trends from 1998 to 2022. Percentages and proportions were calculated, and trends examined graphically. Linear trend lines were generated with Excel's graph function.

RESULTS

Change in numbers of participants

Over 25 years, 2,454 individuals have died from an assisted death. In 1998, 24 prescriptions were written for PAS drugs and 16 patients died from ingesting these drugs. On average, the number of PAS drugs prescribed under the legislation increased by 13% each year and the number of patients who died by ingesting these drugs by 16% annually (figure 1, left panel). In 2022, 431 prescriptions were written, and 278 patients died by PAS. The proportion of deaths following ingestion of prescribed drugs compared with the prescriptions written increased slightly, from an average of 58% in the first decade (1998–2007) to 66% in the second decade (2008–2017), following which it has been stable at an average of 67% over the last 5 years.

Changes in the sociodemographic characteristics and end-of-life care concerns of participants

There has been little change in the mean age of PAS patients of 72.5 years. The proportion of PAS patients aged 75 or more has remained stable, being 48% in 2006 and 51% in 2022.

In the first decade of legislation of PAS in Oregon, an average of 65% of participants were privately insured (figure 1, right panel). Since 2008, this proportion has reversed; in 2022, 20.5% of those who died by PAS held private health insurance, while the majority (79.5%) had government insurance through Medicare or Medicaid.

The percentage of PAS patients who cited being a burden on family and friends increased during the time period (figure 2, left panel). The number of patients reporting financial concerns about treatment as an end-of-life concern is low, though there is evidence of an increase over the time period (up to 8.4% in 2021) (figure 2, right panel). In the first 5 years of PAS, an average of 30% of participants were concerned about being a burden. Since 2017, this concern has been cited by around half of those who die by PAS (46% in 2022).

Changes in patient eligibility

Eligibility under the DWDA requires that patients have been diagnosed with an illness that will reasonably lead to death within 6 months. Cancer remains the main diagnosis of PAS patients, though the proportion has reduced over the time period from an average of 80% in the first 5 years to 64% in 2022. In 2022, 109 patients (25% of prescription recipients) were granted an exemption from the usual 15-day reflection period on the basis that they were terminal. Since 2010, patients with a range of non-cancer diagnoses have received PAS including non-terminal illnesses such arthritis, arteritis, complications from a fall, hernia, sclerosis, 'stenosis' and anorexia nervosa.

Referrals for psychiatric evaluation have declined as a percentage of assisted deaths (figure 3, left panel). In the first 3 years after enactment (1998–2000), a psychiatric assessment was sought in an average of

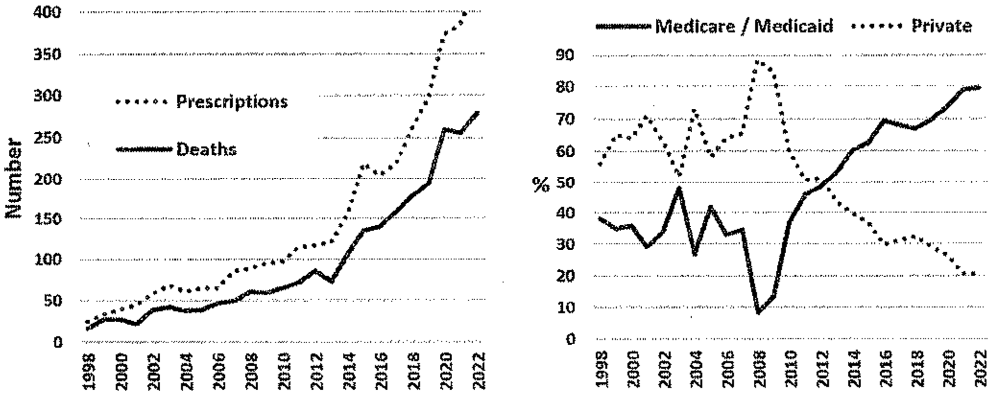

Figure 1 (Left) Numbers of PAS deaths; (Right) percentage of PAS patients with government funding.

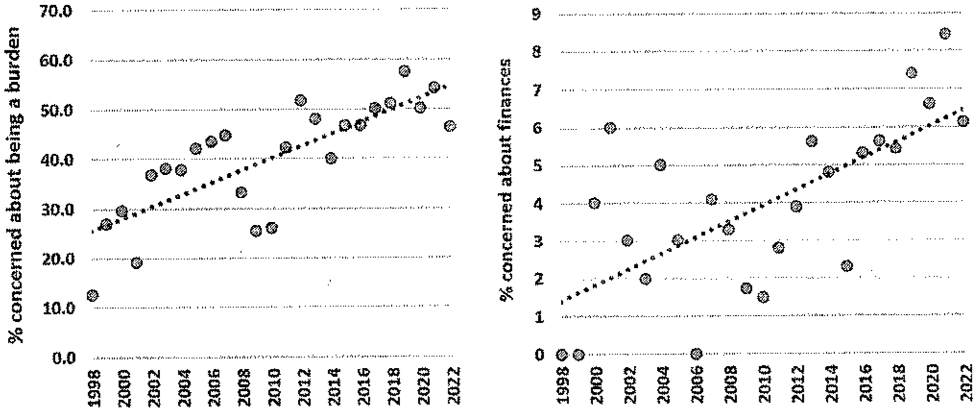

Figure 2 (Left) Percentage of PAS patients with concerns about financial implications of treatment; (Right) Percentage of those concerned about being a burden.

28% of cases. By 2003 this had dropped to 5%, and in 2022, 1% of patients who died from PAS underwent psychiatric evaluation. Since 2010 there has been a reduction in both the median duration of the physician–patient relationship and the time from the first request to death (figure 3, right panel). In 2010 the median physician–patient duration was 18 weeks, dropping to 5 weeks in 2022. The time from the first request to death had reduced from 9.1 weeks in 2010 to 4.3 weeks in 2022.

PAS drugs

From 1998 to 2015, the most common drugs used for PAS were barbiturates, with phenobarbital, secobarbital or pentobarbital used alone. It is now standard for drug combinations to be used, with different combinations being used in the last 8 years, although the dose of each constituent drug is not reported: 2015–2022: DDMAP (diazepam, digoxin, morphine sulfate and propranolol); 2018–2022: DDMA (diazepam, digoxin, morphine sulfate and amitriptyline); 2019–2022: DDMA-Ph (DDMA plus phenobarbital). The 2022 report states that the combinations have resulted in longer times from ingestion to death (3 mins to 68 hours; median 52 min), compared with an aggregate range of 1–104 hours, with a median of 30 min over the 25 years. The number of prescriptions per doctor has increased from an average of 1.6/doctor in the first 5 years to 1998, to an average of 2.7/doctor between 2018 to 2022 (figure 4, left panel).

Stated complications following the ingestion of PAS drugs have included difficulty in ingesting drugs, regurgitation, seizures, regaining consciousness and 'other' complications that are not described. Complications associated with PAS drugs were reported in an average of 11% between 2010 and 2022, with a peak of 14.8% in 2015 (figure 4, right panel). In 2022 complications were identified in 6% of patients, though data on complications was missing in 206 patients (74%). Over the last 25 years, nine patients have regained consciousness.

In Oregon in 2022, 46% of patients did not take their prescriptions. Of these, 84 died of other causes. In 101 patients the ingestion status was not known, only that 43 died. In 58 patients the status of death and ingestion was unknown at the time of the report.

DISCUSSION

Number of deaths

The 25 years of OHA's official data reports show that the number of assisted deaths rose slowly for the first

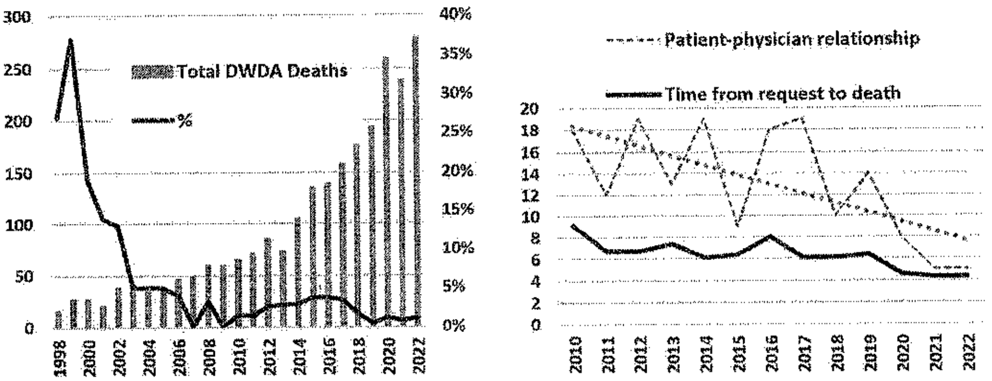

Figure 3 (Left) Percentage of PAS patients referred for psychiatric evaluation; (Right) Duration of physician–patient relationship (includes trend line) and time from first request to death in weeks.

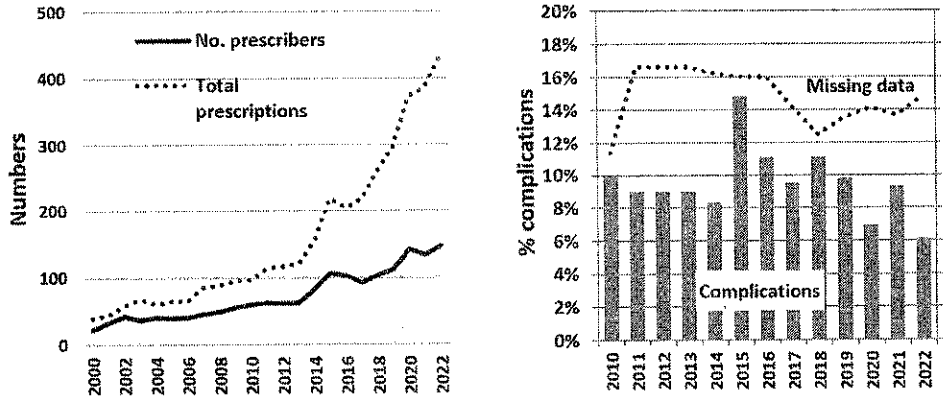

Figure 4 (Left) Total number of PAS prescribers compared with prescriptions; (Right) Percentage of PAS complications (bars) and percentage of missing data on complications (dotted line).

15 years following legislation, then accelerated. When this is considered as the prevalence of PAS deaths overall, the trend is confirmed, with an increase in 2014 from 0.06% (1998) to 0.24% (2012), a slight drop in 2013 to 0.22%, then a steeper rise of 0.66% in 2020 when reporting this statistic ceased. During the pandemic (2021) PAS deaths fell slightly, but numbers rose again in 2022. This trend is similar to that seen elsewhere.[7] However, it is notable that Oregon PAS deaths remain at a lower prevalence than when euthanasia is also legalised: in 2021 officially notified medically-assisted deaths constituted 4.5% of all deaths in the Netherlands and 3.3% in Canada.

Change in demographics of those accessing PAS

Among Oregonians accessing legal PAS, the proportion of people with government health funding (Medicare and Medicaid) has increased relative to those with private health funding. Since 1999, the Oregon OHA reports have not differentiated between Medicare and Medicaid, but only the latter covers the costs of PAS. Medicare is federal insurance for adults ages 65 and older, whereas Medicaid is an insurance option for adults deemed below the poverty line and its availability expanded through the Oregon Health Plan in 2008/9 and 2014. The relative increase in PAS among those receiving state funded medical aid changed from 2008 onwards (see figure 1, right panel), but the influence of state funding on uptake can only be analysed with a breakdown of the numbers funded by each system. Unfortunately the destruction of OHA records after 1 year makes retrospective analysis impossible.

Patients' end-of-life concerns are reported across eight categories, allowing several concerns to be reported. It is unclear whether these are the patients' direct reports or those reported retrospectively by the clinician. Concerns cited about 'losing autonomy' (91%) and 'less able to enjoy activities making life enjoyable' (90%) remain dominant across each year. Over time, there has been an increase in the proportion of patients including concern about being a burden on their caregivers and in those expressing financial concerns about their treatment.

The OHA reports reveal a higher uptake of PAS among those with higher educational levels, but income levels are not given. In Belgium, lower education levels are associated with less intense pain and symptom alleviation, but income was not examined.[8] It is possible to have a high education attainment, but be on a low income. Other vulnerabilities are becoming clearer. For example, patients with mental health issues asking for assisted death in the Netherlands were more likely than the general population to be female, single, of lower educational background and with a history of sexual abuse.[9] In Switzerland, although PAS was associated with higher socioeconomic status, PAS was also more common in females and situations indicating vulnerability such as living alone or being divorced.[10] In 2018 an Oregon Health Statistics official acknowledged that they will accept PAS requests if the patient has refused treatment for financial reasons.[11] Although socioeconomic data already exist for some medical conditions in Oregon,[12] these have not been linked to PAS requests.

Recently the cost benefit to individuals and to society of assisted deaths have been discussed in relation to quality-adjusted life years (QALYs).[12] Economic arguments in support of assisted deaths include the avoidance of possible negative quality of life of the patient, and freeing up healthcare resources for others including organs for transplantation.[13] Canada's C-14 Bill has been estimated to provide a net cost saving overall of $C86.9 million in 2021 (gross healthcare cost reduction $C109.2 million less $C22.3 million cost of administering MAiD (Medical Assistance in Dying)).[14] A 2019, a US Gallup poll found a quarter of respondents reported they or a family member had been put off treatment for a serious medical condition because of the cost.[15] In 2020, 31.6 million people in the USA (9.7% of the population) had no medical insurance.[16]

12

There is a dearth of studies linking socioeconomic vulnerability and PAS data. The change in health funding in Oregon is unlikely to be due to a lag in data since the change to state funding started 15 years ago. Detailed studies are needed to explain the marked change in medical funding for PAS patients in Oregon.

Factors influencing the wish to die

The very low referral rate for psychiatric evaluation could be the result of an efficient screening process. However, there is evidence that depression and existential issues such as hopelessness can influence a wish to die and are commonly missed by doctors.[17 18] Loneliness is known to be associated with depression which, in turn, increases the likelihood of a wish to die.[19] Elder abuse, which can be difficult to identify, has become a major public health issue in both the USA and the UK,[20 21] and in Oregon, elevated rates of non-assisted suicide have been observed in older women.[6 22] The OHA data show that the duration of the patient–physician relationship is now almost the same as the time from first request to the assisted death. This steady reduction in the physician–patient relationship in Oregon may have made it more difficult to identify treatable factors influencing the wish to die, but there is a lack of recent data on how many Oregon PAS patients have a treatable depression.

PAS drugs

Until 2014, most prescriptions in Oregon were for secobarbital (54.2%) or phenobarbital (42.8%). US barbiturate availability fell in 2014 as barbiturates were used in state executions and prices rose over sevenfold from 2010 to 2016 (US$387.52 to $2878.09).[23] Attempts to improve their efficiency in inducing unconsciousness and in time to death have resulted in different drug combinations since 2015. Despite some collation of data by the American Clinicians Academy on Medical Aid in Dying, no research institution has orchestrated studies to evaluate the mode of action and efficacy normally required of clinical processes, with ethical and clinical safeguards for patients.[24 25]

In 2022, 146 Oregon physicians wrote prescriptions, one of whom wrote 51 prescriptions. These doctors represent <0.9% of the 16 621 active medical licensees.[26] There is a lack of data on whether this results in difficulty seeking a prescriber, whether those writing few prescriptions have limited experience of assessing eligibility, and what happens to the nearly half of prescribed PAS drugs that are unused.

Oregon does not provide data on what proportion of PAS deaths take a particularly long time to die. Washington reported that in 2021 31% of patients died within 30 min and 16% took more than 2 hours to die. Although the time was unknown in 17.9%, the Washington reports provide no information on the drugs used and whether they were changed to achieve shorter dying times.[27]

The Oregon OHA reports show that complications affect one in nine patients on average, although Oregon does not include prolonged deaths or patients who regained consciousness in their complication percentages. A peak in the complication rate (14.8%) in 2015 coincides with a switch to drug combinations. However, the true incidence of complications is unknown since in 2022 data on complications were missing in 206/278 (74%) of assisted deaths.[1]

Changes in criteria

Oregon is often given as an example of stable assisted dying legislation.[28 29] In January 2020 Oregon waived the statutory 15-day waiting period for patients estimated to have a shorter prognosis, resulting in a quarter being granted this exemption in 2022.[1] In 2022, 16 patients (6%) outlived their 6-month prognosis following prescription of PAS drugs, but there is no detail on how many had treatable conditions or had been misdiagnosed. In 2017 the OHA confirmed that incurable terminal illness is when there is an affirmative response to the question 'should the disease be allowed to take its course, absent further treatment, is the patient likely to die within 6 months?'.[11] Any patient has the right to refuse treatment, but it is concerning that there is a lack of data on why they refused treatment and how they were advised and counselled.

For example, in 2021 anorexia nervosa was one of the diagnoses listed, but without any details of comorbidities, if this was an isolated case, or whether the clinician misjudged the prognosis or misapplied the law. Anorexia nervosa in any young adult with capacity is terminal if it persists, but it can be challenging to determine the point at which treatment cannot succeed.

In 2022 a federal lawsuit brought by an Oregon doctor forced Oregon to allow non-residents to access PAS.

Palliative care

In 2022, 92% of people requesting PAS were enrolled in hospice care and the mean for 1998–2020 was 90.8%. However, there are no data on what services were provided and the term 'palliative care' is not mentioned in any reports, nor the duration of enrolment. Unlike in the UK, enrolment in hospice care was described to Lord Mackay's Select committee as 'pretty much a one way street' for 'comfort only', as other interventions would no longer be paid for.[30]

In 2012, a study looked at the policies of 56 Oregon hospice programmes regarding the state's PAS legislation; 36 hospices (64%) were not directly involved in, or actively opposed to, PAS.[31] Although many of the hospices were willing to have PAS discussions and refer to PAS doctors, nine (16%) hospices were clear that any involvement violated their policies. In addition, 31 (55%) of hospices had policies specifically preventing their staff from being present during the ingestion of

PAS drugs. A more recent study interviewed 10 experienced professionals in Oregon, and some stated that hospice organisations continued to be unsupportive of Oregon's PAS legislation.[32] The lack of information on whether Oregon PAS patients are receiving care from specialist, interdisciplinary palliative care, or a single, non-specialist practitioner makes it difficult to evaluate whether adequate palliative care was received before PAS in Oregon.

Limitations of analysis

We limited our analysis to descriptive trends. Retrospective analyses for PAS in Oregon are limited to the content of published reports since Oregon destroys all source records 1 year after each annual report, making verification of data impossible.[33] In addition, missing data for some variables (eg, complications) is high and Oregon does not collect data on how or why PAS decisions were made, pre-evaluation or post-mortem review of cases and the details of rejected requests.

We have found no evidence of the completeness or otherwise of the notification process. As there is no prescription monitoring service in Oregon, it is not possible to triangulate data on prescribed lethal drugs, their ingestion and disposal of unused drugs. As physicians are not required to be present when lethal drugs are taken, data provided for the reports depends on information from whoever was present and from provider questionnaires.

CONCLUSIONS

Oregon is often cited as a stable example of assisted dying legislation. Despite Oregon producing detailed and regular post-death reports of value, there are considerable gaps in the data across US states.[34] Most importantly, there is no monitoring in any form of the quality of the consultation in which the decision was made to prescribe lethal drugs.[35] Although population mortality follow-back studies have been used to study end-of-life care, these have limitations.[36] Detailed, prospective studies that include socioeconomic and clinical information are essential to understand fully the changes seen in Oregon PAS data.

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2.7.24 MARGARET CARTER part 2 pages 15 to 22 _000

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Assisted Suicide and Euthanasia: From Voluntary to Involuntary

While promoted in the name of personal autonomy, physician-assisted suicide (providing lethal drugs so patients can take their own lives) and euthanasia (direct killing of patients by doctors) do not remain limited to cases in which the victim gave his or her voluntary consent. This agenda ultimately embraces coercion and the death of unwilling victims.[1]

The Case of the Netherlands

Since 1973 a series of court decisions has established that Dutch doctors need not fear punishment or prosecution if they kill, or assist the suicides of, patients in "unbearable suffering" who make a voluntary request to die. When the Dutch government studied actual practice in 1991, it found: 2300 cases of voluntary euthanasia every year; 400 assisted suicides; and 1040 cases in which doctors killed patients without their knowledge or consent. In this last category, 72% of the patients had never expressed an interest in having their lives taken, and 14% were fully competent. In addition, 8100 patients died from overdoses of pain medications intended primarily to end life rather than relieve pain, and 61% of the time (4941 cases) this was done without the patient's consent.

Patients Rights Council, *Background About Euthanasia in the Netherlands*, at www.patientsrightscouncil.org/site/holland-background/.

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In one recent case, A Dutch physician slipped a sedative into an elderly dementia patient's coffee after deciding it was time for her to receive euthanasia. When the patient awoke and struggled against what was being done, the doctor told the patient's family to hold her down while the lethal injection was administered. The doctor was "cleared of any wrongdoing" by a regional review committee, which said "the doctor acted in good faith."

R. Roberts, "Doctor who asked dementia patient's family to hold her down while she gave lethal injection cleared," *The Independent* (London), 5 February 2017, at http://www.independent.co.uk/news/world/europe/doctor-netherlands-lethal-injection-dementia-euthanasia-a7564061.html.

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Writes one investigator into Dutch practice: "Some euthanasia advocates defend the need for doctors to make decisions to end the lives of competent patients without discussion with them. One euthanasia advocate gave me as an example a case where a doctor had terminated the life of

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[1] On how assisted suicide laws in Oregon and Washington open the door to ending the life of people unable to give voluntary and informed consent, also see USCCB Secretariat of Pro-Life Activities, *Assisted Suicide Laws in Oregon and Washington: What Safeguards?*, at http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/OR-and-WA-Safeguards-FACTSHEET.pdf.

a nun a few days before she would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death. He did not argue, however, when asked why she should not have been permitted to die in the way she wanted… Other advocates admit that a system in which doctors become used to playing a predominant role in making decisions about ending life encourages some to feel entitled to make decisions without consulting patients."

H. Hendin, "Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience," 25.1 *Suicide & Life-Threatening Behavior* 193-204 (Spring 1995) at 201-2. For other cases see R. Fenigsen, "Other People's Lives: Reflections on Medicine, Ethics, and Euthanasia," 26.3 *Issues in Law & Medicine* 239-79 (Spring 2011) at 278.

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While patients with clinical depression or other mental disorders cannot be expected to make a rational request for assisted suicide, in Oregon and Washington only 4% of patients receive a psychological evaluation to exclude such cases (see documentation in note 1 above). In the Netherlands, Belgium and Switzerland, such mental illness can actually be the sole reason for a physically healthy patient to *receive* assisted suicide or euthanasia. A 2016 study reviewing 66 such cases in the Netherlands showed that most of the patients were women, most suffered from depression, and 35% had no independent psychiatric input or consultants had disagreed.

B. Carey, "Assisted Suicide Study Questions Its Use for Mentally Ill," *The New York Times*, Feb. 10, 2016, at https://www.nytimes.com/2016/02/11/health/assisted-suicide-mental-disorders.html; S. Kim et al., "Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014," 73.4 *JAMA Psychiatry* 362-8 (2016) at 362.

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Newborn children, of course, cannot make a voluntary request for euthanasia. Yet in 1993, a Dutch physician was acquitted of wrongdoing after he gave a lethal injection to a four-day-old infant with spina bifida, because he allegedly faced a conflict between his duties to preserve life and to relieve suffering. By 1995, Dutch physicians had published an account of 22 similar cases. Parents had consented to the injections; however, in all but four cases it was the physicians who first made the proposal. That year the Dutch Association of Paediatrics approved the "Groningen Protocol," which set standards for such nonvoluntary taking of life and found all 22 cases to be in accord with acceptable medical practice.

T. De Jong, "Deliberate termination of life of newborns with spina bifida, a critical reappraisal," 24 *Child's Nervous System* 13-28 (2008) at 15-17.

Killing Without Consent in Belgium

In Belgium, where voluntary euthanasia was legalized with supposed "safeguards" in 2002, a 2010 study showed that half of nurses involved in the practice – 120 out of 248 – had taken the lives of patients without their request or consent. "We should take a warning from this that wherever you draw the line, people will go up to it and beyond it," said Dr. Peter Saunders of Great Britain's Care Not Killing campaign. "Once you have legalised voluntary euthanasia, involuntary euthanasia will inevitably follow."

S. Caldwell, "Warning to Britain as almost half of Belgium's euthanasia nurses admit to killing without consent," in *The Daily Mail* (London), June 10, 2010, at www.dailymail.co.uk/news/article-1285423/Half-Belgiums-euthanasia-nurses-admit-killing-consent.html .

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In a study of 208 deaths in Belgium in 2007 involving "the use of life-ending drugs," physicians reported that 66 of these deaths (about 32%) were "without an explicit request." The study notes: "Use of life-ending drugs without an explicit request mostly involved patients 80 years or older, those with a disease other than cancer and those in hospital. Of the deaths without an explicit request, the decision was not discussed with the patient in 77.9% of cases."

K. Chambaere et al., "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey," 182.9 *Canadian Medical Association Journal* 895-901 (June 15, 2010) at 895, http://www.cmaj.ca/content/182/9/895.full.

Children and Euthanasia

In 2014 Belgium became the first country to end age limits on euthanasia, extending the practice to terminally ill children of any age. The first child killed under this policy died in 2016. Since 2002 the Netherlands has allowed euthanasia for children aged 12 or older; but in 2015, the Dutch Paediatricians Association began urging that the Netherlands follow Belgium in rejecting any such "arbitrary age limit" so younger children can request euthanasia.

Y. Logghe, "First child dies by legal euthanasia in Belgium," *Associated Press*, Sept. 19, 2016, at http://www.cbsnews.com/news/child-dies-by-euthanasia-in-belgium-where-assistance-in-dying-is-legal/; J. Huggler, "Give children under 12 the right to die, say Dutch paediatricians," *The Telegraph* (London), June 19, 2015, at http://www.telegraph.co.uk/news/worldnews/europe/netherlands/11686716/Give-children-under-12-the-right-to-die-say-Dutch-paediatricians.html.

The Trend in the United States

The assisted suicide movement in the United States, as well, has shown that this agenda will not be limited to cases where a voluntary request is made by a competent patient.

Criticizing the murder conviction of Richard Rodriguez, a man who said he had fatally shot his ailing and elderly father out of sympathy, the executive director of Hemlock Society USA (now renamed "Compassion and Choices") stated: "A judicial determination should be made when it is necessary to hasten the death of an individual whether it be a demented parent, a suffering, severely disabled spouse or a child. Consultants should evaluate what other ways might be used to alleviate the suffering and, if none are available or are unsuccessful, a non-violent, gentle means should be available to end the person's life."

Faye Girsh of Hemlock Society USA, "Mercy Killing: A Position Statement Regarding Richard Rodriguez," *PR Newswire*, December 3, 1997, quoted in Patients Rights Council, 12.1 *IAETF Update* (Jan.-March 1998), http://www.patientsrightscouncil.org/site/update012/.

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In 2014, Barbara Coombs Lee as president of Compassion & Choices reaffirmed this stand at a forum in Connecticut. Noting that current legislation in the U.S. does not cover patients with dementia or other conditions preventing an informed choice, she said: "It is an issue for another day *but is no less compelling*."

L. Foster, "Compassion & Choices Draws Full House at Real Art Ways for Panel Discussion, Film," *CT News Junkie*, Oct. 10, 2014, at http://www.ctnewsjunkie.com/archives/entry/compassion_choices_draws_full_house_for_panel_discussion_film/ (emphasis added).

* * *

Writes the founder of the Hemlock Society: "In attempting to answer Why Now?, one must look at the realities of the increasing cost of health care in an aging society, because *in the final analysis, economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice*.... Is there, in fact, a duty to die – a responsibility within the family unit – that should remain voluntary *but expected nevertheless*?"

D. Humphry and M. Clement, *Freedom to Die: People, Politics, and the Right-to-Die Movement* (St. Martin's Press 1998) at 313 (emphasis added).

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Oregon has taken steps toward an "expected" earlier death for patients whose care costs the government money. In 1995, Oregon's State Health Services Commission voted 10-to-1 to include physician-assisted suicide as a form of "comfort care" for all low-income terminally ill patients covered by Oregon's Medicaid rationing program. In response to criticisms that Oregonians never voted to support assisted suicide with taxpayer money, the head of Oregon's Medical Assistance Program replied: "These are cheap prescriptions, and health care provider time will not be significant" (See Patients Right Council, *IAETF Update*, op. cit.). Since then, some patients on the Oregon Health Plan have received letters from the state saying it will not pay for drugs that may help stave off their death but will fully cover assisted suicide. "It was horrible," said one woman, cancer patient Barbara Wagner. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live." Hemlock founder Derek Humphry responded that the Oregon Health Plan's approach is sound.

S. James, "Death Drugs Cause Uproar in Oregon," *ABC News*, August 6, 2008, at http://abcnews.go.com/Health/story?id=5517492&page=1 .

* * *

California insurers have also begun exerting this economic pressure on patients. California cancer patient Stephanie Packer says her insurance company initially indicated it would cover a new chemotherapy drug, but after the state's assisted suicide law passed it rejected her claim, confirming that it would cover assisted suicide and "you would only have to pay $1.20 for the medication." And Nevada physician Dr. Brian Callister testifies that when he tried to transfer patients to Oregon and California for treatments not available in his state, insurers in both states rejected his effort and instead volunteered, "would you consider assisted suicide?" Dr. Callister says both patients had good chances for a cure with treatment but will be terminal without it.

B. Richardson, "Assisted-suicide law prompts insurance company to deny coverage to terminally ill California woman," *The Washington Times*, Oct. 20, 2016, at http://www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/; Id., "Insurance companies denied treatment to patients, offered to pay for assisted suicide, doctor claims," *The Washington Times*, May 31, 2017, at http://www.washingtontimes.com/news/2017/may/31/insurance-companies-denied-treatment-to-patients-o/.

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According to the National Council on Disability, such cost pressures create an especially toxic environment when combined with longstanding social prejudice against the value of a life with disabilities: "The dangers of permitting physician-assisted suicide are large indeed. The pressures upon people with disabilities to choose to end their lives, and the insidious appropriation by others of the right to make that choice for them are already way too common in our society. These pressures are increasing and will continue to grow as managed health care and limitations upon health care resources precipitate increased 'rationing' of health care services and health care financing…. There is no doubt that people with disabilities are among society's most likely candidates for ending their lives. As the experience in the Netherlands demonstrates, there is also little doubt that legalizing assisted suicide generates strong pressures upon individuals and families to utilize that option, and leads very quickly to coercion and involuntary euthanasia."

National Council on Disability, "Assisted Suicide: A Disability Perspective," Position Paper of March 24, 1997, reprinted in 14.3 *Issues in Law & Medicine* 273-99 (Spring 1998) at 298.

6/28/17

20

The Register-Guard

NEWS

Proposed changes to Oregon's 25-year-old Death with Dignity Act could expand access

Tatiana Parafiniuk-Talesnick
Register-Guard

Published 2:29 p.m. PT March 9, 2023

What the bill does:

Oregon Senate Bill 891 proposes several changes to the state's Death with Dignity Act:

- Allow physician assistants and nurse practitioners to also prescribe the medication.
- Repeal the residency requirement so people living out-of-state could travel to Oregon to die.
- Allow providers to deliver the prescription to pharmacists electronically.
- Reduce the waiting period from 15 days to 48 hours after a patient makes a first oral request for medication.
- Allow electronic filing of certain reports.
- Remove the requirement that one witness not be an employee, operator or owner of the health care facility where the terminally ill person is a patient or resident.

Facing death: Death doulas, volunteers help Oregonians die on their own terms

The backstory:

Oregon in 1997 became the first to legalize Death with Dignity, physician-assisted dying for people with terminal illnesses.

Since then, nine states have followed and seven others are considering it.

It allows people with terminal illnesses to end their lives through the self-administration of medication prescribed by a physician for that purpose.

21

But the steps to participate can be cumbersome.

Participants must be diagnosed with a terminal illness by two doctors, meaning the doctors believe the illness would end their life in six months or less. The physician must wait 15 days after the first oral request before writing the prescription, unless the patient will die within the waiting period and the patient has made a second request orally or in writing.

The dying person must be an Oregon resident, considered mentally capable of making their own health care decisions and physically capable of taking the medication.

Not everyone who gets the prescription uses it.

As of January 2022, 3,280 people had received prescriptions since the law passed and 2,159 people, or 66%, died from ingesting them.

In a March 2022 settlement agreement, the Oregon Health Authority, Oregon Medical Board and Multnomah County District Attorney's Office agreed not to enforce the residency requirement for physicians assisting Death with Dignity patients after a lawsuit filed in federal court challenged the law's residency requirement.

Who's behind it:

The Senate Committee On Judiciary introduced the bill. That committee is chaired by Sen. Floyd Prozanski, D-Eugene. Sen. Kim Thatcher, D-Keizer, is the vice chair.

Where it is in the legislative process:

A public hearing was held March 6.

Supporters of the bill included End of Life Choices Oregon and the Oregon Department of Justice. Opponents included Oregon Right to Life and Physicians for Compassionate Care Education Foundation.

People who testified in favor said the original measure is out of date.

Kimberly McCullough, legislative director of the Oregon Department of Justice, submitted testimony that said all qualified patients should be able to access medical aid in dying "irrespective of where they reside."

Those who testified against the bill shared concerns that the proposed modifications would undermine the safeguards Oregonians originally voted for and potentially allow mental illness or expenses to motivate people to end their life.

The bill is not yet scheduled for a Senate vote.

Contact reporter Tatiana Parafiniuk-Talesnick at Tatiana@registerguard.com or 541-521-7512, and follow her on Twitter @TatianaSophiaPT.

2024 PAS testimony.pdf

Uploaded by: Maria Hayden
Position: UNF

SB0443 End of Life Option Act
Maria M. Hayden BSN RN VABC
Oppose

I am a resident of Ellicott City, a wife and mother of five children, and a registered nurse of 38 years. I am writing to urge an unfavorable opinion on SB0443 which would allow a doctor to prescribe 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. Medications and methods of pain management in both palliative and hospice care are excellent and are continually improving. But the pain that is much harder to alleviate is the cascade of guilt and suffering that occurs in a family and a community *after* a suicide has taken place. When someone takes his own life it can be devastating to a family and friends for generations. Families feel guilt that they were either unaware of the patient's despair, or unable to help.

We know from studies in Oregon that a primary reason a patient resorts to PAS is that he or she 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 and helping them feel valued. The scar of suicide on a family can be a far greater burden than their loved-one's illness was while alive.

We know that 30% of patients prescribed these drugs do change their minds. How many souls who did die 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?

This bill makes suicide too accessible, too easy, and too acceptable. Life expectancy can be difficult to determine. So many people have stories of loved ones who far out-lived their prognosis.

Depression may not be adequately evaluated or treated. We know from Oregon that very few PAS patients (3%) were actually seen by psychiatrists.

Doctors will be minimally familiar with the patient to whom they are prescribing death. Mainstream doctors who know the patients in their practice and are trained to heal will not be participating in PAS. Therefore, a few doctors in the state will be sought out and they in no way be certain that PAS is appropriate or the patient fulfills criteria, or is capable of making this decision.

Families won't be notified of the PAS to give them an opportunity to help the patient and perhaps alleviate whatever is prompting the decision. Physicians need not witness the ingestion of pills which leave great risk for coercion by friends or family. Patients could also suffer terribly from vomiting, seizing, and respiratory depression after ingesting the poison. 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 SB0443 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?

This bill 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?

SB0443 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.

pdf-END OF LIFE OPTION- ASSISTED SUICIDE LEGISLATI

Uploaded by: Mariateresa Alvarez-Sanchez

Position: UNF

February 7, 2024

HB403/SB443 Assisted Suicide

Dear Legislators, PLEASE STOP THE END-OF-LIFE OPTION, ASSISTED SUICIDE LEGISLATION, and PLEASE, do not make yourselves responsible before God for the crimes committed against the soul of every dying person by signing the End-of-life Legislation.

God will judge very harshly lawmakers who make laws against His divine will or laws. Assisting someone to die is murder, a crime, a possible condemnation for the soul, and a great sin against God's 5th Commandment: "Thou shalt not kill."

We must understand that suffering is a way of purification for the soul and for others, but if the soul didn't purify itself before the person died, it must do so after this life, and IT IS MORE PAINFUL because there is life after this life, and some of these souls can even be damned in hell forever. Please, encourage people to HELP THE DYING to die in peace by praying before them and NOT to kill them because it can condemn them, as well as the person (s) who assisted in committing the crime.

By saving the souls of the dying and of those who assist in committing suicide, YOU, LAWMAKERS, SAVE YOUR OWN SOULS. DO NOT SIGN THE END-OF-LIFE OPTION, ASSISTED SUICIDE LEGISLATION!

pdf-END OF LIFE OPTION- ASSISTED SUICIDE LEGISLATI

Uploaded by: Mariateresa Alvarez-Sanchez

Position: UNF

HB403/SB443 Assisted Suicide

Dear Legislators, PLEASE OPOSE END-OF-LIFE OPTION or ASSISTED SUICIDE LEGISLATION. That law is against the principles that our founding fathers stated in the Declaration of Independence and the Constitution of the United States: LIFE and LIBERTY. Assisting someone to take their life or passing a bill that allows it is murder, a crime, and not to mention it's against God's 5th Commandment: "Thou shalt not kill."

Lawmakers nationwide reject Assisted Suicide. The Maryland General Assembly has rejected some form of this bill at least six 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--and yourselves, legislators. Again, PLEASE OPPOSE LEGISLATION TO LEGALIZE ASSISTED SUICIDE.

2024 PAS Opposition.pdf

Uploaded by: Martha Schaerr

Position: UNF

Oppose SB0443/HB0403 End-of-Life-Options Act

Martha Schaerr

240-277-1601

This law will change a moral question into a therapeutic one; and if you pass it, you will be responsible for the death of people who don't really want to die.

They just haven't understood—as many of the disabled and underserved members of our society have long experienced—that meaningful lives don't require vacations, a driver's license, a job, or even a pain-free body.

We can see this happening in Oregon from the "Oregon Death with Dignity Act 2022 Data Summary." Since 1998, the reasons by far most cited by those requesting lethal prescriptions are "less able to engage in activities making life enjoyable (90%), losing autonomy (90.3%), and loss of dignity (71.7%). Every year the number of people accessing lethal prescriptions is rising.

According to Maryland Matters,

> In D.C., where 45% of the population is Black, 22 of 24 patients who have utilized the option are white. the CNS analysis found. One patient was Black, while another was Hispanic.
> Similar trends have appeared in other states that have legalized aid in dying. In California, among most racially diverse jurisdictions with an aid-in-dying law, 0.8% of patients have been Black.
> As Maryland considers medical aid in dying, here's how it's playing out in D.C. | News | times-news.com

While some think this disparity is a question of access to medical care, I think it's a statement of the religious faith of minorities.

The reasons people request aid in dying (as recorded in Oregon) are concerns almost everyone has as they come closer to death. Instituting medical aid in dying as a policy reduces opportunities for family and friends to find meaning in their lives. This is a religious question, a moral one—not a therapeutic one.

My mother has trigeminal neuralgia, called "the suicide disease" because of the agonizing unpredictable pain it causes. Although 86, she has always been active--caring for her home, large extended family, garden, orchard and farm animals. The powerful drugs used to dull the pain caused side effects so debilitating that she sat in front of the TV all day. She was too shaky and dizzy to walk or bathe herself, too confused to cook or even crochet. This tragedy in her life has brought many loving acts and conversations in our family that have given her—and us—an increased understanding of the meaning of our lives.

Oppose SB0443 End-of-Life-Option-Act_Mary Hand_Feb

Uploaded by: Mary Hand

Position: UNF

Oppose SB0443/HB0403 End-of-Life Option Act
Name: Mary Hand
Phone: 301-219-2552

As a Registered Nurse for 50 years, I have been dedicated to delivering science-based patient care—at the bedside and through state and national guidelines and evidence-based policies for health care professionals. As such I worked closely with physicians, pharmacists, and other health care providers in private, public, VA, and military hospitals, and later in clinical research settings, and on interdisciplinary committees at the National Institutes of Health and the American College of Cardiology/American Heart Association. I have deep concerns about the impact this legislation would have on my physician and pharmacy colleagues, and on professional nursing practice.

In terms of my professional colleagues, medical-aid-in-dying proponents want the terminally ill person to be able to make the decision about when and how to die. But it is far from an autonomous process as physicians and pharmacists would be legally required to be involved irrespective of their professional standard and ethical beliefs. Medical doctors would be asked to provide a prescription for a lethal dose of drugs to patients who want to die, even though there are currently available sanctioned, palliative and hospice care modalities that render compassion, care, and yes, control with their end-of-life journey. The American Medical Association has retained its opposition to assisted suicide reaffirming (November 13, 2023), that the legalization of physician-assisted-suicide is fundamentally incompatible with the physician's role as a healer. Pharmacists would be called upon to mix the lethal dose of poison drugs for these patients. Such drug combinations are <u>not</u> standardized, not FDA tested, and not approved for use to end human life.

And though <u>not</u> specifically called out in SB 443, <u>nurses</u> would inevitably be pulled in to assist the physicians in the Senate Bill's requirements for them, at almost every point in the process (one of their collaborative roles is to extend physicians' "reach" in many health care settings today). This could include the physician's administrative requirements for documentation (e.g., SB 443, p. 10-B), informing the patient of feasible alternatives and health care treatment options including palliative care and hospice care (SB 443, p. 10-C), facilitating referrals to consulting physicians (SB 443, p. 11-D), or submitting to the pharmacist, "by any means authorized by law" (SB 443 p. 13, 9-II-3), the prescription for the lethal potion, and for the drugs (e.g., anti-nausea drugs), to counter the immediate noxious effects of ingestion of the poison.

Further, hospice is mentioned (SB, p. 3-F-2), which could present a situation for a hospice nurse whose comfort and compassionate care for the patient and the patient's loved ones, intrinsic to hospice, would be interrupted with a medical-aid-in-dying request that would be fraught with professional and ethical conflicts for the hospice nurse, who in most instances would not be permitted to stay while the patient ingests the poison to end their lives. The potential ethical dilemma for hospice nurses is that they would need to abandon their patients, knowing the lethal potion's immediate effects (difficulty swallowing the bitter and intensely burning drink, regurgitation, seizures), and a range of times of death (3 min-68 hours; median 52 min.) Over half of hospices in Oregon in the 25-year analysis (Regnard, Worthington, Finlay, 2023), prevented their staff from being present during the ingestion of the medication.

An American Nurses Association (ANA) position paper on the nurses' role when a patient requests medical aid in dying (ANA 2019) states that the delivery of high-quality, compassionate, holistic, and patient-centered care, including end-of life care is central to nurse practice. It says that the nurse should never abandon or refuse to provide comfort and safety measures to the patient who has chosen medical-aid-in-dying though the nurse may inform their employer of their "conscience-based objection to being so involved so they can be appropriately assigned." It further says that a patient may request that a nurse be present when the patient ingests the aid in dying drug but if elected to do so, "should understand their boundaries." The Nursing Code of Ethics stresses that nurses "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and *may not act with the sole intent to end life*."

During COVID, nurses were the ones with the early COVID patients who were dying, providing comfort and compassionate care because their loved ones were not allowed to be present. That is the essence of nursing—holding the patients' hand/keeping them comfortable at the point of inevitable death.

However, this law is not needed! Palliative care and hospice care are sanctioned treatment modalities that need to be deployed more, especially in minority communities and the underserved. There are documented racial and ethnic disparities in palliative and hospice care, that should be a clarion call for more inclusive policies (Johnson 2013).

I respectfully urge you to vote against this legislation that would upend the existing science-based, professionally sanctioned, and compassionate end-of-life care that nursing and their health care colleagues--physicians and pharmacists--render to dying patients and their families.

Oppose SB0443/HB0403 End-of-Life Option Act
Name: Mary Hand
Phone: 301-219-2552

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Oppose SB 433.pdf

Uploaded by: Mary Jo Witte

Position: UNF

Oppose SB 433: End of Life Option Act

This act is an assault on the dignity of every human life. It preys on the most vulnerable at a time when we, as a society and community, should be offering compassion and care to those in most need. This attitude makes people feel like a burden. Have we become so heartless that instead of giving people the help we all deserve, that we instead offer death by their own hand without even notifying relatives??

What does this way of thinking reveal about our senators and legislators that you would even suggest this kind of treatment??

This act violates medical ethics meant to save lives and do no harm. The American Medical Association voted against physician assisted suicide in November 2023. It's contrary to medical ethics codes and to all legitimate morality.

This dangerous legislation needs to be defeated now.

Oppose SB 433.

End of Life Option - Assisted Suicide.pdf

Uploaded by: Mary Miller

Position: UNF

Please oppose End of Life Option - 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 six 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.

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.

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

For these reasons, please oppose legislation to legalize Assisted Suicide.

TASH Testimony in opposition to SB0443.pdf

Uploaded by: Michael Brogioli
Position: UNF

TASH Testimony in opposition to SB0443/HB0403 “End-of-Life Option Act”
February 8, 2024

My name is Michael Brogioli; I am a Marylander who serves as Executive Director of TASH, a national disability advocacy organization that seeks to advance equity, opportunity and inclusion for all people with disabilities with a focus on those with the most significant support needs.

TASH has long opposed physician-assisted suicide and therefore urges this committee and the Maryland Assembly at large to oppose the End-of-Life Option Act. We know that there is a long and ongoing history of discrimination against people with disabilities in medical and other settings, and that legalized assisted suicide further endangers people with disabilities who are disproportionately subject to abuse and neglect including documented history of the denial of basic rights and medical care, including nutrition and hydration. This proposed legislation underscores ableist beliefs about the value and quality of the lives of people with disabilities and is contrary to the purpose of the Americans with Disabilities Act.

There is compelling research that demonstrates that psychological and social distress are primary reasons for individuals to request assisted suicide. This distress undercuts the notion that requests for assisted suicide are truly ‘voluntary’ and fully informed. Experiences in other states such as Oregon and California demonstrate the dangers of assisted suicide and the inadequacy of purported safeguards. We are especially concerned that this legislation could put the lives of people with intellectual and developmental disabilities at extraordinary risk including through coercion and abuse and a lack of truly informed consent.

We urge legislators to consider existing alternatives to assisted suicide that respect the dignity and value of disabled lives, including legal alternatives that currently exist in all states on refusing treatment, on receiving pain medication, hospice care, and palliative care, all of which can effectively reduce and relieve discomfort and pain during the dying process.

Lastly, we are deeply concerned that legalized assisted suicide will indeed be a slippery slope that could result in covert and even overt pressure upon people with disabilities, especially those with the most significant support needs, who may already face stigma and discrimination based on their disabilities. The current system of health services, particularly managed care, provides economic incentives for rationing health care, and can lead to the encouragement of physician-assisted suicide. Thank for you this opportunity to state our opposition to this legislation.

PAS - Please vote NO from Michael Vernon.pdf

Uploaded by: Michael Vernon
Position: UNF

Mr. Michael Vernon
1363 Morgans Ridge Lane
Crownsville, MD. 21032

Oppose Physician Assisted Suicide

Dear Delegate Schmidt,

The Maryland General Assembly has refused to legalize Physician Assisted Suicide (PAS) during six previous legislative sessions, but I am concerned that another round of so-called "medical aid in dying" (MAID) legislation will be introduced in the upcoming 2024 session.

Terms like MAID, Death with Dignity, or End-of-Life Option have been rejected by the American Medical Association (AMA), which has affirmed that Physician Assisted Suicide (PAS) is the most accurate description of this practice. The AMA opposes the legalization of PAS because it is fundamentally incompatible with the physician's role as a healer.

Notably, the legalization of PAS does not grant someone the personal autonomy to decide how they will die. Instead, it gives people the legal right to ask the medical community to help them commit suicide. It will corrupt the medical establishment by coopting the services of doctors, psychiatrists, pharmacists, hospice nurses, and medical examiners.

The bill calls upon medical professionals to change the way they serve the public in the following ways:

- **Medical doctors** are asked to provide a prescription for a lethal dose of drugs to patients who want to die, even if there are alternate treatments available to help them live.
- **Psychiatrists** may be consulted to evaluate people with the expectation they can deem them to be of sound mind when they want to kill themselves by drug overdose.
- **Pharmacists** would be the ones to combine the lethal dose of drugs for patients. Such drug combinations are not standardized. They have not been tested or approved by the FDA for use to end human life.
- **Nurses** who work within hospice and palliative care would need to add the lethal drugs to a liquid to enable the individual to drink the lethal dose. They first need to administer an anti-nausea medication. Complications such as seizures, vomiting, and gasping for air may occur.
- **Medical examiners** must falsify the death certificate and report the cause of death as an illness, not a drug overdose.
- **Emergency personnel, law enforcement and suicide prevention agencies** will not be able to follow well established protocols to prevent people from intentional death by drug overdose.

This law is not needed! Suicide is already too easy, and death by accidental opioid overdose is far too common. People who want to have full autonomy to end their life must do it on their own without the help of anyone, especially the medical professionals we rely on to help us stay alive. No law should expect medical professionals to offer suicide as a "medical treatment" for illness.

As a constituent (or state your profession) in your District, I ask you to oppose any bill that makes medical professionals complicit in the suicide of their patients. Please let me know how you will vote.

Thank you for your consideration.

Sincerely,

Michael A. Vernon 1/24/24

UNF SB443.pdf

Uploaded by: Nancy Paltell
Position: UNF

Senate Bill 443 - End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
Feb. 8, 2024

Nancy E. Paltell, Ph.D.
North Beach, MD

OPPOSE

SB 443 should receive an unfavorable report because it is ***dangerous*** and ***unnecessary.***

I oppose SB 443 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 443 is UNNECESSARY

SB 443 is unnecessary because suicide is legal and widespread in Maryland. Sixteen years ago, my brother-in-law committed suicide in Maryland using the method described in SB 443. 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 443 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 443.

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 443 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 443 ***promotes*** suicide by trying to make it mainstream, legitimate, and acceptable. In fact, SB 443 promotes suicide by making it "health care."

SB 443 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 443 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,

Nancy E. Paltell, Ph.D.
794 Cedar Ave.
North Beach, MD 20714
nancypaltell@gmail.com

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[1] Oregon Health Authority, "Suicide Trends," 2017.

[2] Oregon Health Authority News Release, 09/09/10

Oppose SB0443:HB0403 2024.pdf

Uploaded by: Nancy Weisman

Position: UNF

Oppose SB0443/HB0403

End-of-Life Option Act

Nancy W. Weisman, PhD
301-254-4558

Thank you, Delegates, for your service to our community. I am Nancy Weisman. I've lived in Maryland for over 30 years where I practice clinical psychology.

Here are four reasons why I believe this bill must not pass:

1) It has nothing to do with Choice or Autonomy
2) It endangers Public Health and Safety
3) It corrupts Medicine and endangers patients
4) It erodes Trust both public, in the institution of Medicine, and private, in the doctor-patient relationship

Choice and Autonomy to end one's life by suicide are not restricted by our current laws - when faced with terminal illness or any other calamity**.** Children under ten have taken their own lives - much to grief of their parents, neighbors, and all feeling people. Additionally, there are common (legal) practices to hasten death: passively, by withholding fluid and nutrition as well as more actively, by doubling-up on the morphine drip. (Warraich 2017). What this bill calls a "right to choose" is really a right to recruit accomplices - an invitation to social disaster.

Public Health and Safety are endangered when doctors are licensed to kill. It is incoherent to charge doctors with both healing and terminating lives. Moreover, establishing such a policy destroys a critical social and psychological barrier against killing - which can be seen in the ever rising murder and suicide rates, especially among the young.

Corrupts Medicine and Endangers Patients. From the time of Hippocrates until the late 20th century, "Western medicine has regarded the killing of patients, even on request, as a profound violation of the deepest meaning of the medical profession." (JAMA 1988) The idea of dispensing death within medical channels, by means of medical decisions, facilitated by doctors and other health professionals is a gross distortion of the medical profession. As we've seen in Europe, what is now voluntary for terminally ill adults will soon be involuntary and include psychiatric and chronic illness, even in children. In Belgium. an 11 year with cystic fibrosis, a chronic condition, was put to death with parental and medical consent; two years after his death, treatment for CF was available. In Ireland, a technician came to remove the ventilator of filmmaker and ALS patient, Simon Fitzmaurice. Only great and sustained effort on the part of Fitzmaurice and his family saved his life. It wasn't that the medical established disliked him or his illness, but the "therapeutic imperative" to save him suffering required removing the ventilator. "Don't you know it's only going to worse? Why would you want to live?" They asked him.

The "therapeutic imperative" mentality has reached our shores. Consider:
"Will you forgive me for saving you? (Terry McGowan, NEJM) The doctor saved a toddler, beaten in her home - twice. The baby's mother and grandmother were happy and grateful, but the doctor worried, "Did I save you for a good life? Are you glad I did?" The doctor asks herself if she should have let the baby die rather than go back to a bad home. She confuses the province of Child Protective Services with medicine. She confuses fixing a problem with ending a life.

"We didn't save his life - we did better." (C. Winebrenner, Washington Post/Kevin MD 2/2017) A man was found without a pulse and brought into the ER. After an hour, his pulse is restored. Rather than stabilize him and send him up to the ICU, the doctor in charge called in his family, wife and grown daughter, and declared, "His life of holding hands, his life of living is gone," though there were no signs of brain death. Yet the doctor firmly admonished the family to stop treatment and let him die rather than face the uncertainty of recovery.

Contrast that to NY Marathon doctor, Theodore Strange, who responded to a stranger's call for help and restored an unconscious woman's pulse - more than once, sending her off in an ambulance. She lived, recovered, and calls him every December to thank him for another Christmas.

Erodes Trust, both public and private. In the words of four prominent physician-ethicists:

"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**.

"We call on fellow physicians to say that we will not deliberately kill. We must also say to each of our fellow physicians that we will not tolerate killing of patients…we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing." Willard Gaylin,MD, Leon Kass,MD. Edward Pellegrino,MD, Mark Siegler, MD. Doctors must not kill. JAMA, 1988.

Don't license doctors to kill.

Please **don't** pass this bill.

PHYSCIAN ASSISTED SUICIDE TESTIMONEY   2024 MD .pd

Uploaded by: Nicole LeBlanc
Position: UNF

SB443 End of Life Option
OPPOSED
Nicole LeBlanc
Silver Spring, MD

Hello Judiciary Committee

My name is Nicole LeBlanc from Silver Spring MD , I'm on the Autism Spectrum .I am here to ask that you strongly oppose the Doctor Assisted Suicide bill otherwise known as "Death with Dignity" . This piece of legislation concerns and affects me greatly because of the message that it is sending to people with disabilities, the elderly and our young people. On a personal level in 2008 I had a cousin who was a cancer survivor who committed suicide out of middle of nowhere.

By legalizing PAS we are creating a double standing where some folks get suicide prevention and others get physician assisted suicide which is in clear violation of the ADA. PAS is often not freely chosen because people with disabilities don't want to be seen as a burden on their families, which leads it to being the only option.

With so many inequities in our healthcare and long term care system it is not possible for our vulnerable citizens to be given real choices at the end of life. Studies have shown that medical professionals tend to misjudge our quality of life based on the fact that we are dependent on others for support in our everyday lives. As we have seen during the COVID19 pandemic our society and healthcare system is very ableist towards people with disability and chronic conditions. For instance many COVID long haulers have dealt with ableism in our healthcare system.

Our society should be focused on investing in robust end of life care and suicide prevention. For instance the Autism Community has a higher rate of suicide than the general population . It is estimated that the rate is up to 50% in this population and a high number of them are undiagnosed or late diagnosed and have high IQ's and higher rates of trauma, anxiety and mental health challenges. Now more than ever we must invest in suicide prevention and robust end of life palitative care for those who need it.

If MD to adopt a law similar to the Oregon style law it would conflict with our Adult Protective Services statutes because it devalues people with disabilities and would work against the intent of the APS statue which is to protect vulnerable folks from abuse.

People with Disabilities want and need a robust Home-Community Based Services System , mental health and quality health care Not Physician Assisted Suicide! Please VOTE NO on this Bill.

Thank You for listening to my testimony

Testimony against 2024 Assited Suicide Bill.pdf

Uploaded by: Oswaldo Castro

Position: UNF

I strongly oppose the bill entitled “**End-of-Life-Option Act” (SB0443)** for the following reasons:

1. It legalizes helping vulnerable and terminally ill people kill themselves. Suicide is always wrong and suicidal ideation is a medical condition requiring evaluation and treatment, not its acceptance or promotion.
2. The bill normalizes and “mainstreams” suicide under some circumstances, inevitably leading to increased suicide rates in the general population. This “suicide contagion” has been documented in states where physician assisted suicide is legal.
3. The bill will undermine trust in medical professionals. It perverts the life-preserving and health-promoting mission of medical care providers by turning them into suicide enablers for vulnerable people who trusted them.
4. The bill requires health care providers to lie when signing the death certificate: they must certify the manner of death as due to natural causes, instead of suicide, the true cause.
5. The very name of the proposed bill, “End-of-Life Option”, and the use of terms such as “aid in dying” in the bill’s text appear deceptive. They conflate *end of life or dying*, the eventual fate for all of us, with complicity in *ending a life or killing*.

Oswaldo Castro, MD
12500 Park Potomac Ave., #604 S
Potomac, MD, 20854

7 February 2024 - Statement to Maryland Senate on

Uploaded by: Paul Schilling

Position: UNF

Statement By Maryland Citizen In Opposition to SB443
(“Assisted Suicide” Bill)
Senate Judicial Proceedings Committee
March 8, 2024 Legislative Hearing

I write as a Maryland citizen and resident to express my strong opposition to SB443, the assisted suicide legislation currently before the Judicial Proceedings Committee of the Maryland State Senate.

The campaign to force assisted suicide on our beautiful State of Maryland began in 2015. Then Marylanders saw the campaign’s opening salvos, part of a nationwide push to overturn laws protecting the sanctity of life and to implement “assisted suicide” schemes. Given the anti-life culture fostered by Maryland’s liberal abortion laws and the one-party control of the Maryland General Assembly, proponents saw Maryland as fertile ground for their schemes. Announced opposition by Maryland’s then newly elected Governor Larry Hogan caused the effort to stall but did not cause proponents to abandon the campaign. Enactment of assisted suicide became a “cause”, almost a religion for them and they continue to press forward.

Initially, the campaign focused on changing the terms of the debate from one about the sanctity of human life to one about “choice” and “compassion”. Subtle efforts were made to play upon people’s own fear of death and on compassion for a loved one suffering from terminal illness. Efforts were made to shift focus onto suffering individuals – subtly suggesting their lives are essentially meaningless - and onto the movement’s “heroes”, those seeking to take their own lives or assist others to do so.

Legislatively, the focus became not one of substance but on procedure. Much was made about the supposedly limited circumstances under which assisted suicide would be allowed to take place, the supposed procedural safeguards and the supposed wisdom of other jurisdictions which have enacted similar measures. Of course, once the sanctity of human life is cast aside, these protections can be modified or eliminated and other states’ experience is not necessarily relevant or desirable for Marylanders.

Since the campaign began, assisted suicide legislation has been passed in several other states and in Canada. From these has emerged a variety of “horror” stories. Older people were pressured to avoid supposedly “expensive” treatments and, under the legislation, to take their own life. Severely disabled Canadian military veterans were advised to take their own lives rather than continue to press for help with their conditions. The Canadian incidents are particularly heart-wrenching for me as one who has experience in working closely with veterans. Our disabled American veterans deserve a better ending than the dark future of this legislation.

In the end this legislation is nothing more than a means to legitimize the taking of the lives of those who are not wanted. Such is the inevitable result for those societies that, by rejecting the sanctity of life, begin a slide into darkness. Among the most horrific examples of such societies is Adolph Hitler’s Nazi regime. Under various Nazi euthanasia schemes began in the 1930’s, thousands had their lives deemed to be of no value and were put to death.

In contrast to that dark side, there are numerous heroes on the pro-life side. These are individuals whose choice of life over death in the face of debilitating disease serves as an example for all. President Franklin Delano Roosevelt suffered terribly from a brutally crippling disease during his presidency yet refused to surrender to it, leading the nation through the Depression and to victory in World War Two. Pope John Paul II, in his later years, suffered from a debilitating and ultimately fatal disease yet deliberately put his struggle into public view to inspire others and show the meaning of suffering in human existence. In our own lives, all of us know someone who, despite their struggle with disease or terminal illness, chose life and thereby became an example to us.

Ultimately at issue here is the principle of the sanctity of human life. Assisted suicide is an attack on that principle. It seeks to create exceptions to the principle and carve out categories of people who do not enjoy its full protection. We claim to be a civilized society in which all are valued and protected. If we are to be, we must uphold the sanctity of human life against all such attacks. If we do not, then we will be taking a step on the dark road down to barbarism. “Assisted suicide” must have no place in the State of Maryland.

Reject SB443.

Paul Schilling

Agudah testimony - SB443 - PAS - unf - 2024.pdf

Uploaded by: Rabbi Ariel Sadwin
Position: UNF

Agudath Israel of Maryland אגודת ישראל במרילנד
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Rabbi Ariel Sadwin
Executive Director
Mr. Avi Lencz
Associate Director

SENATE JUDICIAL PROCEEDINGS COMMITTEE

FEBRUARY 8, 2023

SENATE BILL 443

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 443 – 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 443 – Thank you.

SB 443 2024 End of Life Option Act RobertMurray.p

Uploaded by: Robert Murray

Position: UNF

SB443/HB403 – End-of-Life Option Act - AGAINST

Submitted by:

Robert Murray

706 Cypress Road

Severna Park, MD 21146

410.440.8005 robert.i.murray@hotmail.com

Why Oppose Senate Bill 443 and House Bill 403

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. ***A niece of mine commented to my mother who had dementia that she 'should hurry up and die so that she did not waste her inheritance.'*** She actually spoke this to her. I am certain that if this legislation were in place, fellow Marylanders will fall victim to greedy family members.

- 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 SB443.

SB0443 Testimony by Robert Nelson 020824.pdf

Uploaded by: Robert Nelson
Position: UNF

SB0443–Oppose

Testimony by Robert Nelson to the Judicial Proceedings Committee

February 8, 2024

My name is Robert Nelson, Vice Chair, Board of Trustees at Living Word International Christian Church in Silver Spring.

I'm here today to testify in opposition to SB0443, 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 SB0443.

Bob Nelson
Vice Chair, Board of Trustees
Living Word International Christian Church
bnelson@lwicc.org

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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.

SB0433_PDF.pdf
Uploaded by: Roxann Montgomery
Position: UNF

Please do not enact SB0443 End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

This text of this 21 page bill certainly reflects due diligence in attempting to document requirements and prohibitions for an individual to request aid in dying. The problem is that there are so many junctures in this process where the attending physician is charged with making life-ending decisions without having adequate knowledge of the individual who is making the request.

The bill states that the attending physician "MEANS THE LICENSED PHYSICIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE MEDICAL CARE OF THE INDIVIDUAL AND TREATMENT OF THE INDIVIDUAL'S TERMINAL ILLNESS." The text of the bill states that the attending physician, when presented with an individuals written request, shall determine whether the individual:
(I) IS A QUALIFIED INDIVIDUAL;
(II) HAS MADE AN INFORMED DECISION; AND
(III) HAS VOLUNTARILY REQUESTED AID IN DYING.

(I) Qualification equates to residency which is reasonably straight forward to prove with the any of the documents listed in the text of the bill.

(II) An informed decision DOESN'T REQUIRE a mental health evaluation of the individual. The bill states:

(C) AN ATTENDING PHYSICIAN SHALL ENSURE THAT AN INDIVIDUAL MAKES AN INFORMED DECISION BY INFORMING THE INDIVIDUAL OF:
(1) THE INDIVIDUAL'S MEDICAL DIAGNOSIS;
(2) THE INDIVIDUAL'S PROGNOSIS;
(3) THE POTENTIAL RISKS ASSOCIATED WITH SELF-ADMINISTERING THE MEDICATION TO BE PRESCRIBED FOR AID IN DYING;
(4) THE PROBABLE RESULT OF SELF-ADMINISTERING THE MEDICATION TO BE PRESCRIBED FOR AID IN DYING; AND
(5) ANY FEASIBLE ALTERNATIVES AND HEALTH CARE TREATMENT OPTIONS, INCLUDING PALLIATIVE CARE AND HOSPICE.

In the absence of being absolutely certain that the requesting individual has the mental health and emotional stamina to understand these 5 pieces of information, merely providing the information is not safeguarding the individual who is requesting assistance in dying.

The bill does require the attending physician to refer the individual to a consulting physician who is additionally required to IF REQUIRED

UNDER § 5-6A-06 OF THIS SUBTITLE, REFER THE INDIVIDUAL FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT

And 5-6A-06 states:
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, THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED MENTAL
"SB0443.txt" [readonly] 136L, 6410C 1,1 Top

Margolis written testimony SB0443 2-5-24.pdf

Uploaded by: Russell Margolis

Position: UNF

Russell L. Margolis, M.D.
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February 6, 2024

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 0443: 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 0443, 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). Arguments that this will not occur in the United States are spurious; there are already examples in which assisted-suicide has been provided to individuals in their mid-30s with potentially treatable psychiatric disorders (eg, Guadiani, 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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2024 SB 443 PAS Testimony.pdf

Uploaded by: Sallie Taylor

Position: UNF

February 7, 2024

Dear Chairman Smith and
Members of the Judicial Proceeding Committee:

I would like to make a plea for sound public policy. As you consider the Death with Dignity Act, SB 443, please refer to the recent Oregan Study, "Oregon Death with Dignity Act access: 25-year analysis," findings that people are increasing ending their lives because they do not want to be a financial burden not due to unbearable pain. The research concludes that "there was an increase in patients feeling a burden and describing financial concerns as reasons for choosing an assisted death."

What starts out as an option, becomes an expectation. Maryland public policy should prioritize research and development of pain reducing therapies for those with a terminal illness or suffering from painful health conditions over legalizing suicide. Spare these desperately ill people from the additional burden that they will face if physician assisted suicide is legal. Please oppose SB 443.

Sincerely,
Sallie Taylor
1260 Guilford Road
Eldersburg, Maryland
21784

SB 443 Nettina testimony.pdf

Uploaded by: Sandra Nettina

Position: UNF

Prime Care
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Oppose - Senate Bill 443

End-of-Life Option Act (The Honorable Elijah E. Cummings and The Honorable Shane E. Pendergrass Act)
Presented to the Judicial Proceedings Committee
February 7, 2024

I would like to present you with an explanation of why giving people who are terminally ill the ability to end their own lives when they choose is not the most compassionate and caring way to provide comfort and dignity in the dying process. I am a nurse practitioner with over 35 years-experience. I founded my practice, Prime Care House Calls, almost 10 years ago to offer primary and palliative care to people at home. I believe that SB 443 misses the mark in trying to ease suffering as people face death. This bill creates a number of potential dangers such as lack of accounting for large doses of a controlled substance that may not be used, depression and other emotional problems easily going without treatment, preventing someone from having the chance to live longer if the 6-month prognosis is incorrect, and the poor or disadvantaged feeling societal pressure to use this option. This is the wrong precedent to set if we want to be a just and nondiscriminatory society.

What would the ideal scenario look like, if you were watching your loved one losing a battle with cancer or other serious illness? Many of us have been through this, and what played out may not have been the ideal scenario, especially in the hospital or nursing home. But what could it and should it be? A calm, comfortable home environment, surrounded by loved ones…symptoms controlled through the help of palliative care specialists and caregivers…. sharing stories, memories, hugs, and a few tears with your loved one? Or would it be the shock of learning that your loved one chose to end his or her life alone through a mixture of toxic pills; then wondering why they did not share this decision with you. Or if they did share their decision, could you watch them struggle to take multiple very potent pills, perhaps gagging and fighting off nausea, then watch them fall into a delirium with their body fight to breath? What if they vomited, or could not take all the pills? What would you do?

What I believe would be the most compassionate option would eliminate the need for aid in dying in Maryland. Most of my patients are older than 65, have multiple chronic illnesses that have taken their toll, cancers that have reoccurred, or other serious illnesses that have caused debility. About 20% of my patients are enrolled in hospice home care programs and about 50% have individually designed palliative care plans. About half of my hospice patients outlive the traditional “6 months or less” prognosis, and many have been receiving hospice services for a year or longer, or have improved and been discharged from hospice services.

When people need a shift in focus from cure to care, they unfortunately may not be presented with many resources. They may feel that if aggressive treatment is a failure that they are just being sent home to die. However, what if we could send them home to live, to feel better, and to savor the time with their loved ones until the time of natural death? Or even better, what if we could predict which treatments cause more suffering than benefit, and educate people to make informed decisions earlier in care? We already know that hospice care can provide tremendous comfort to people, but even with the great hospice services in Maryland, we need more resources. Rather than resorting to assisted suicide, I would like to see the following:
*Expanded palliative care programs—these would focus on symptom management, optimizing quality of life, and providing emotional support to the patient and family whether attempting curative treatment or not.
*More research into life preserving treatments and comfort measures, including cost-benefit analyses about different treatment options for realistic decision making throughout the trajectory of illness.
*Insurance reimbursement for caregivers and social workers to provide support for people who wish to remain at home as they decline.
*Increased focus on mental health care providers trained in death and dying, loss, and living with serious illness, who are insurance reimbursable and visit people at home.
*More education and public awareness of all care options.
These options are not expensive. Palliative care and home care services for one month cost much less than one short hospitalization. And I know that no one is suggesting assisted suicide as a cost saving measure.

So much of what this legislature does is protect the people of Maryland. You and your predecessors have given us choices in health care. You gave me the ability to start my solo practice as a nurse practitioner and it has been my privilege to serve over 500 people over the past 9 years who otherwise might not have accessed health care and received the services they needed. You approved the use of the Medical Orders for Life Sustaining Treatment (MOLST) form. People can now choose their medical orders ahead of time; so that they can experience a natural death with the benefit of comfort care, rather than resuscitation and invasive treatment, if they so choose. I ask you to continue to protect the people of Maryland and focus on caring until natural death, not promoting the assisting and taking of one's own life.

Please realize that the passage of SB 433 would cause a shift in societal norms and values which cannot be turned back. There is a line between stopping aggressive treatment to focus on comfort measures to end suffering and actively and intentionally bringing about one's death, the definition of suicide. Help us teach our children that we care about the sick and vulnerable and are a culture that values each individual life, not just the well and strong. I respectfully ask the committee members to give SB 443 an unfavorable report.

Sincerely,

S Nettina

Sandra Nettina, Nurse Practitioner

PAS 2024 Statement to the Senate Judicial Proceedi

Uploaded by: Sandy Christiansen

Position: UNF

Statement to the Senate Judicial Proceedings Committee
February 8, 2024
Re: SB443
Unfavorable, oppose

My name is Dr. Sandy Christiansen and I'm a board-certified obstetrician/gynecologist licensed in the state of Maryland, the Director of the Maryland Chapter of the Academy of Medical Ethics, and the National Medical Director of Care Net.

I am opposed to SB 443 because it violates the sacred covenant between doctor and patient to first do no harm. Physicians are healers, not killers and have the right to practice in congruence with their moral framework. Further, physicians are not vending machines to dispense a requested product, in fact patients' trust in physicians is eroded if they cannot be certain the doctor will act in their best interest.

This bill gives physicians too much power over their patients and allows physicians' biases to enter into life/death decisions.[i] 1 Studies show that physicians perceive disabled people to have a lower quality of life compared to how the disabled view themselves.[ii]

There are many things wrong with this bill including:

- 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[iii]
- 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![iv] Our duty is to eradicate the pain—not the patient. To give physicians that 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.[v] 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.*[vi]*”*

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.[vii],[viii]*”*

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. 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.[ix]”

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. And now Canada is permitting those suffering with mental illness to end their lives instead of treating the very symptom they are experiencing!

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, or worse, feel a "duty to die" so they won't be a burden? 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 will help stop the slide.
I'm asking for an unfavorable vote on SB 443.

Sincerely,

Sandy Christiansen, MD, FACOG
Care Net National Medical Director
Director of the Maryland Chapter of the Academy of Medical Ethics
Frederick, MD 21703

Care Net: *a non-profit organization that supports one of the largest networks of pregnancy centers in North America. With 1,200 affiliates and 30,000 volunteers, we provide immediate support to women and men considering abortion, to equip them for a life decision. Last year alone, our pregnancy centers provided clients with more than $62 million in free services.*

The AAME was founded to protect and promote the historic values that have provided the longstanding foundation for western medical care. It comprises healthcare professionals that subscribe to the traditional values of the Hippocratic Oath.

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[i] 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
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[viii] Greek Medicine (2002, Sept 16)- The Hippocratic Oath. (n.d.). Retrieved from http://www.nlm.nih.gov/hmd/greek/greek_oath.html

[ix] https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide

SB443 Oppose End of Life Act.pdf

Uploaded by: Sarah Miicke

Position: UNF

BALTIMORE
JEWISH
COUNCIL

Senate Bill 443– End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Judicial Proceedings Committee
February 8, 2024

OPPOSE

Background: Senate Bill 443, 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 443.

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.

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BALTIMORE JEWISH COUNCIL
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Member of the Jewish Council for Public Affairs

Baltimore Jewish Council is an agency of The Associated
The Associated
Jewish Federation of Baltimore

WrittenTestimony.pdf
Uploaded by: SHARON HANSEN
Position: UNF

Oppose SB0443/HB0403

Sharon Hansen, RN, CHPN

406-591-7579

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, 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 as 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 with our hospice team "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, guilt and suffering 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-a true disservice to another human being.

This situation was anything but ideal nor a peaceful passing-It had been several hours before this patient finally died and 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 of 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 that I couldn't continue to bear, nor wanted to bear. 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-that they DO MATTER and the importance of their precious life. THEIR life is NOT dispensable- no matter the situation, the pain and emotional hardships that arise, **<u>they still matter</u>**.

If it's 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 we still matter ...even to our last breath.

ReddochWrittenOppositionEOLOptionActSB0443(HB0403)

Uploaded by: Shirley Reddoch

Position: UNF

Shirley Reddoch, MD
Columbia, Maryland
Ph: 410-884-0407

Written Testimony: **OPPOSE SB0443/(HB0403) End-Of-Life Option Act**

As a physician clinician and medical educator of some 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 true health and safety promoting efforts of members of this Assembly.**
I trust this Assembly acknowledges the increasing mental health issues including depression and anxiety that cross all age groups and demographics, not to mention suicides and suicide attempts; Likewise, many Assembly members speak to the need to improve and expand mental/behavioral health services, and recognize key drivers of destructive and self-destructive behaviors:
1) Ease of access to increasingly efficient means of self-destruction: Guns and drugs lead 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, burned out, and buying into feelings of being a burden ---- of being "less than."

Consider that this End-of-Life Option, if enacted, has governmentally reinforced a person's existential fears regarding self-worth, family or societal burden, and unrelievable pain and suffering near end of life.

This bill is state sanctioned assisted suicide.

No amount of legislation or funding, to boost mental health services, or promote gun safety, or offer much needed care for the unhoused, incarcerated, immigrant, un/undereducated, disabled 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.

One cannot even adequately cover the sea change of care in Canada since similar legislation was enacted a mere 8 years ago and rapidly expanded).

This bill may be sold as cost neutral, with minimal if any administrative burden, and relieving the prescriber and the state of any legal culpability but to accept it for those reasons is shortsighted and, if not otherwise, self-serving.
<u>In actuality, this end-of-life option is extremely manipulable, justifying, if not promoting, secretive actions of the patient at their most vulnerable moments and, also lying on a public health record—the death certificate.</u>
This bill flies in the face of any promotion of truth and transparency in government and arbitrarily redefines Health Care.

This legislation will impact the numbers, make up and attitudes of those entering medicine and other health care professions. I regularly meet and work with compassionate young medical

students eager to get to know and care for patients when they begin their clinical rotations, and then hear what factors into their practice decisions as their clinical experience grows. I hear the distress, too, of those who heard another student attending a national student conference say in awe, that their attending physician invited them to administer a lethal dose of medication to a "terminal" patient, saying that they were given the opportunity to end that patient's suffering. A medical student who has so much yet to learn about medicine and caring for patients has just been sold a lie.

Our young and future generations will bear the weight and pay the price.

Please Oppose SB0443/(HB0403) End-Of-Life Option Act

Respectfully Submitted,
Shirley Reddoch, MD
Pediatrician, Pediatric Hematologist/Oncologist

SB 443 Judicial Proceedings.pdf

Uploaded by: Sidney Marcus
Position: UNF

February 8, 2024

Senate Judicial Proceedings Committee

SB 443

Physician Assisted Suicide

Unfavorable report

I am asking the committee to provide an unfavorable report on SB 0443 for the following reasons.

First:

I am a 78-year-old, life-long resident of the state of Maryland. I have lived in the same house in Waldorf for 51 years. As an advocate for the elderly and disabled, I have opposed similar bills for about 9 years now.

I served as an Army Ranger in the jungles of Vietnam and drank green water out of bomb craters. I was diagnosed with Agent Orange related prostate cancer 5 years ago (I underwent treatment 4 years ago and am cancer free at this time). Three and one-half years ago a drunk driver crashed his car into me and I spent 7 weeks in the Prince George's shock trauma unit and 7 weeks in inpatient therapy and became disabled.

I fear that if SB 443 becomes law, private insurance companies might find it more cost effective to deny medical treatment and instead prescribe suicide pills. If this bill becomes law, I may find it necessary to move out of Maryland to receive necessary medical treatment.

Nine years ago, I was advocating for others. Now as I have become elderly and disabled, this bill pertains to me.

Second:

Veteran suicide has reached a crisis level in both America and Maryland. Governor Moore is supporting (and funding) initiatives to eliminate veteran suicides. I find it ironic that Maryland Legislature is trying to make physician assisted suicide acceptable to Maryland residents, while the Executive branch is spending taxpayer dollars to reduce suicide. Maybe SB 443 should be amended to exclude veterans.

Thank you,

Sidney O. Marcus III

4830 Quade Circle
Waldorf, MD 20602
(301) 843-8546

SB443 - Opposition - Susan Marble Barranca.pdf

Uploaded by: Susan Marble Barranca

Position: UNF

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TESTIMONY IN OPPOSITION TO SB443 - End-of-Life Option Act

Good afternoon Committee Members, Chairman Smith and Vice-Chairman Waldstreicher.

My name is Susan Marble Barranca - if I look familiar to you, it's because I worked for some years here at the Maryland General Assembly. I left to care for my husband, who died of Lewy Body Disease this past September 16th. Lewy Body Disease is very closely related to Parkinson's Disease, which of course was what Richard Israel and Pip Moyer (the original individuals for whom this bill was named) died of.

My background is in the law with a J.D., and philosophy - specifically ethics - with a PhD. I taught at University of Maryland, Global Campus, as well as teaching Medical Ethics at Notre Dame of Maryland.

Like many of you, I have sat through almost every hearing on the various iterations of this bill since it was introduced in 2015. I've heard all the arguments - for and against - as well as the various amendments offered. It's always amazed me that each time the bill is reintroduced, it starts back at square one, with any amendment that *did* manage to get approved stripped out again. It seems no effort is being made to address the objections that are raised every year.

Even though it feels negligent not to make the usual arguments, I promise to clench my teeth and *not* do so. You will hear enough of them, I'm sure, to remind you of how they go.

I have just 2 minutes - maybe just 1 depending on how many people signed up - so I can't speak at length on anything. I will submit my full testimony in writing. The two new arguments I would like to bring up in opposition to this bill are:

1. The impact of Physician Assisted Suicide on people of color, and
2. The effect of redefined words on informed consent.

It is apparently well-known that people of color both oppose physician-assisted suicide more than do whites, as well as availing themselves of it less than do whites. What is *not* known, is why. This gap has remained steady over the years. The organization Compassion and Choices, which supports this bill, has an article on its website acknowledging this gap, which they address as a failure to access what they call "end of life services." They acknowledge the "importance of understanding how end-of-life care decisions are informed by previous lived experiences with racism and how utilization, treatment preferences and outcomes can differ across racial and ethnic groups" but their stated "mission is to ensure that everyone is empowered to chart their own end-of-life journey. This will only be made possible by recognizing, confronting, and addressing the systemic barriers that create the inequalities in end-of-life care utilization that we see reflected in this data." (Compassion and Choices, available online: https://www.compassionandchoices.org/news/racial-inequalities-persist-in-end-of-life-care-for-dementia-patients)

An earlier article by Georgetown University Professors Patricia King and Leslie Wolf also documented the racial disparity in both approval and utilization of physician assisted suicide, and in light of the racially charged history of the relationship of blacks and the medical profession (which I know has been a topic of concern already in this Legislative body) argues that some significant steps to better understand other ongoing racial disparities and disparate outcomes in medical treatment, prognosis, and results must take place before "PAS becomes an option in our health care system":

> “Central to our argument is the view that this society does not have a sufficient understanding of how and why competent individuals are rendered vulnerable near the end of life. We are especially concerned that inadequate attention has been given to the sociohistorical and cultural contexts in which competent individuals function.”

(King, Patricia A. and Wolf, Leslie E., "Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African- American Experience" (1998). Minnesota Law Review. 2053. Available online: https://scholarship.law.umn.edu/mlr/2053)

This is an area that needs further study. Unfortunately, with the passage of especially California’s Physician Assisted Suicide bill in 2016, there will be an ever-greater opportunity to see how this plays out in communities of color, interacting with a medical profession that is still suspected of not treating patients of color fairly or equitably. Surely the better course, however, is to first shore up equal treatment before adding yet another variable - an end of life “option” that will likely further increase distrust of the medical profession in that community. Distrust, as we know, operates to undermine compliance with treatment options as well as to discourage seeking medical assistance until it is too late - which is exactly what was found in the study cited by Compassion and Choices. (See Pei-Jung Lin, PhD; Yingying Zhu, PhD; Natalia Olchanski, PhD; et al, “Racial and Ethnic Differences in Hospice Use and Hospitalizations at End-of-Life Among Medicare Beneficiaries With Dementia”, Available online: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793176) We should not pass this bill before knowing how it will impact communities of color.

Second, I want to address the effect of redefining words on informed consent.

I take as my starting point the essay “Live Not By Lies”, by Aleksander Solzhenitsyn, which was published on February 12, 1974, the day he was arrested in Russia. He was exiled to the West the next day, where he was hailed as a hero. In the essay, Solzhenitsyn criticizes the Soviet Union, but also his fellow citizens. They may feel impotent to act, he said, but they have recourse to the truth. At the very least, they must refuse to participate in the lie, he tells them:

> "Never knowingly support lies! Having understood where the lies begin . . . step back from that gangrenous edge! Let us not glue back the flaking scales of the Ideology, not gather back its crumbling bones, nor patch together its decomposing garb, and we will be amazed how swiftly and helplessly the lies will fall away, and that which is destined to be naked will be exposed as such to the world."

(Available online: https://journals.sagepub.com/doi/pdf/10.1080/03064220408537357)

I notice that the procedure in SB443 - The End of Life Option Act - is called "aid in dying" - rather than physician assisted suicide. In fact, the bill expressly notes that this is NOT suicide. Section 5–6A–11 (D)(2) I suspect the beginning of a lie.

Aid in dying is defined by the bill as the "medical practice of a physician prescribing medication to a qualified individual that the qualified individual may self-administer to bring about the qualified individual's death." Section 5–6A–01 (B)

That sounds an awful lot like suicide. Administering a drug to bring about your death would certainly qualify as "intentionally causing one's own death", which is the definition of suicide.

Likewise, the word "medication" is used to describe the drugs that will bring about this death. Medication is defined by the FDA as "a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." (FDA Glossary of Terms, available online: https://www.fda.gov/drugs/drug-approvals-and-databases/drugsfda-glossary-terms#:~:text=A substance intended for use,any function of the body.) Medication, then, is intended to *help* the patient. This bill uses the word to describe a substance that does *not* “help” the patient in any traditionally understood manner. It kills.

The word “drug” - by contrast - can have either a positive or a negative effect. “All medicines are drugs; not all drugs are medicines.” (“The Difference Between a Drug and a Medicine?” available online: https://pharmafactz.com/what-is-the-difference-between-a-drug-and-a-medicine/)

Then there is the word “poison”, and we might note that both medicines and drugs can also be poisons. As the founder of toxicology in the 16th century said: “All things are poisons and nothing is without poison, only the dosage makes a thing not poison.” (Paracelsus, *Id.*) The Black’s Law Dictionary definition of poison is “A substance having an inherent deleterious property which renders it, when taken into the system, capable of destroying life.” Again, it sounds like what is being “prescribed” by the process contemplated in this bill is a poison - certainly by the dosage, as well as the intended effect.

While we’re at it, we should also take a look at “prescribe” - which, when associated with a doctor, also carries with it a positive connotation. Medical prescriptions, then, are “a written direction for a therapeutic or corrective agent, specifically: one for the preparation and use of a medicine.” (Merriam Webster Dictionary, available online: https://www.merriam-webster.com/dictionary/prescriptions). It would seem to be an oxymoron to speak of “prescribing" a poison, intended to end the life of the patient. Another oxymoron is “lethal medication.” A final oxymoron is to consider death as a “treatment option” by physicians.

The current form to be used as the “REQUEST FOR MEDICATION FOR AID IN DYING” reads as follows:

I AM SUFFERING FROM ________________________, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED WILL, MORE LIKELY THAN NOT, RESULT IN DEATH

WITHIN 6 MONTHS. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS, MY PROGNOSIS, THE NATURE OF MEDICATION TO BE PRESCRIBED TO AID ME IN DYING, THE POTENTIAL ASSOCIATED RISKS, THE EXPECTED RESULT, THE FEASIBLE ALTERNATIVES, AND THE ADDITIONAL HEALTH CARE TREATMENT OPTIONS INCLUDING PALLIATIVE CARE AND HOSPICE.

I HAVE ORALLY REQUESTED THAT MY ATTENDING PHYSICIAN PRESCRIBE MEDICATION THAT I MAY SELF–ADMINISTER FOR AID IN DYING, AND I NOW CONFIRM THIS REQUEST. I AUTHORIZE MY ATTENDING PHYSICIAN TO CONTACT A PHARMACIST TO FILL THE PRESCRIPTION FOR THE MEDICATION ON MY REQUEST.

I UNDERSTAND THE FULL IMPORT OF THIS REQUEST AND I EXPECT TO DIE IF AND WHEN I TAKE THE MEDICATION TO BE PRESCRIBED. I FURTHER UNDERSTAND THAT, ALTHOUGH MOST DEATHS OCCUR WITHIN 3 HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN HAS COUNSELED ME ABOUT THIS POSSIBILITY.

Imagine if the Request for Medication for Aid in Dying (which incorporates the informed consent provisions contained in Section 5–6A–04 (C)) took out the euphemistic language and instead used the words commonly associated with the actual meaning intended, It would read something like this:

“REQUEST FOR POISON TO END MY LIFE”

I AM SUFFERING FROM ________________________, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED WILL, MORE LIKELY THAN NOT, RESULT IN DEATH WITHIN 6 MONTHS. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS, MY PROGNOSIS, THE NATURE OF **THE POISON** TO BE **DISPENSED** TO **ME TO ENABLE ME TO END MY LIFE [WHICH IS TO COMMIT SUICIDE],** THE POTENTIAL ASSOCIATED RISKS, THE EXPECTED RESULT - **NAMELY IMMEDIATE**

DEATH, THE FEASIBLE ALTERNATIVES, AND THE ADDITIONAL HEALTH CARE TREATMENT OPTIONS INCLUDING PALLIATIVE CARE AND HOSPICE.

I HAVE ORALLY REQUESTED THAT MY ATTENDING PHYSICIAN **DISPENSE POISON** THAT I MAY SELF–ADMINISTER **TO END MY LIFE**, AND I NOW CONFIRM THIS REQUEST. I AUTHORIZE MY ATTENDING PHYSICIAN TO CONTACT A PHARMACIST TO FILL THE **ORDER** FOR THE **POISON** ON MY REQUEST.

I UNDERSTAND THE FULL IMPORT OF THIS REQUEST AND I EXPECT TO DIE IF AND WHEN I TAKE THE **POISON** TO BE **ORDERED FOR ME**. I FURTHER UNDERSTAND THAT, ALTHOUGH MOST DEATHS OCCUR WITHIN 3 HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN HAS COUNSELED ME ABOUT THIS POSSIBILITY.

Can we have true “informed consent” when we are playing these word games?

Finally - some practical questions relating to what this bill proposes, and how it characterizes those things. If this is truly nothing more than medical “aid in dying” - why do we require the person ‘dying’ to administer the ‘medication’ himself? Surely doctors and other medical professionals provide medical aid, they don’t expect the patient to administer their own medical treatment.

If it’s not a killing, why could we not have the doctor administer the drug directly, in a form that was much more comfortable and easy? In past years, we’ve heard at length about the difficulties ingesting the poison and the unpleasantness of attempting to swallow large quantities of the bitter drug, not to mention the allegation that some terminal medical conditions would prevent an otherwise “qualified individual” from self-administering the poison.

Why make the dying person go through multiple requests - oral and written - supposedly making him “understand” what he is actually doing (which is actually to kill himself now, rather than to wait to die) all while using language designed to mask what is really going on?

One obvious problem is that Maryland Criminal Code Section 2-201 (a) (3) explicitly provides that a "A murder is in the first degree if it is: . . . committed by poison." Redefining the words, however, doesn't do away with the underlying facts of what this bill proposes. Moreover, the failure to provide adequate control over the dispensed poison sets us up for future nonconsensual poisonings.

Alexander Solzhenitsyn had it right: "Never knowingly support a lie. Having understood where the lies begin . . . step back from that gangrenous edge." ("Live Not By Lies, available online: https://journals.sagepub.com/doi/pdf/10.1080/03064220408537357) Respectfully, the lies begin in these euphemistic re-definitions.

How would this bill fare if we used only words of truth in it? This would require us to confront the fact that by common law, we have traditionally condemned both suicide and physician-assisted suicide. Pretending that this is not a killing, but merely "aid in dying" or an "end of life option" does not adequately present what is actually being proposed. What is being proposed is to have a doctor authorize the dispensing of a lethal dose of poison to a "qualified person" (believed to be suffering from a terminal disease) so that he or she may kill themselves rather than die of the disease.

This is a new argument. And a challenge. If what is proposed is acceptable - use the words that truthfully express what is now sought to be made legal - something that has been illegal for all of human history. There is a burden of proof that requires the proponents of this bill to show why - now - our laws must suddenly change in spite of the long history outlawing it and the many objections that this honorable Committee has heard repeatedly each year - objections that are not answered. To those objections, I would add the issue raised by the racial disparities both in objection to this physician-assisted suicide as well as utilization of it, and the efficacy of an "informed consent" that is couched in misleading and euphemistic terms.

In conclusion, if we want to be truly "compassionate" - I pray that our compassion will be directed towards caring for the patient, not mangling our language to enable him to kill himself - encouraging him - or her - to think he is doing no more than 'aiding himself in dying'. Additionally, if we truly care about racial disparities and potential vulnerabilities from past abuses, we will be cautious moving forward without further inquiry before enabling a practice that has such potential to increase distrust of the medical profession by people of color and exacerbate disparities along racial lines.

I respectfully request an Unfavorable Report on SB443.

Susan Seifried's Testimony on End of Life Option A
Uploaded by: Susan Seifried
Position: UNF

Oppose SB0443/HB0403 End-of-Life Option Act
Susan Seifried
410-507-8739

Currently, it's illegal for anyone to help an individual commit suicide in Maryland. Perpetrators of the crime face prosecution and prison time. Existing Maryland laws outlawing assisted suicide provide for equal protection of all Marylanders regardless of race, creed, age, or disability.

That legislatively enshrined guarantee of life-saving protection for all Marylanders without discrimination would end with the enactment of the End of Life Option Act. The legislation empowering physicians to help patients kill themselves targets vulnerable senior citizens who would be the first to have their protections irrevocably stripped away. Other vulnerable populations would soon follow suit, since the Act would supercede and nullify long-standing laws that once protected them.

As many of us know from sad personal experience, suicide is already a far too easy thing to accomplish. The thousands of Marylanders who chose their dying day didn't ask the State's permission to do so. They made an autonomous decision not in accord with any State-dictated protocol.

Do proponents of the End of Life Option Act truly believe that Marylanders want the government to insert itself into this extremely personal, most intimate decision of a lifetime? The stated goal of the legislation is to provide patients with a self-chosen, compassionate exit from this life. Is it possible that an unstated and unintended benefit also could be that physician-assisted suicide is a proven way to help jurisdictions dramatically cut healthcare costs? To reap those benefits, all that needs to be done is to convince vulnerable individuals, vulnerable Maryland constituents, that they'd be doing their families a favor by ending their lives.

SB0443.pdf

Uploaded by: Suzanne Duffy

Position: UNF

SB0443 might be the worst bill of this horrific 2024 General Assembly legislative session. Shame on these purveyors of death: Senators Waldstreicher, Kagan, King, West, Lam, Hettleman, Elfreth, Zucker, Smith, Lewis Young, Kramer, Feldman, and Guzzone
Call it what it is: **Euthanasia, Assisted Suicide, Mercy Killing or Murder.** The idea of sugar coating this with a title such as “End of Life Option” doesn’t change the fact or the action. Just because you change the name of an evil act does it somehow make it more palpable for public consumption? It seems so, otherwise you would call it what it is murder.

Canada halts controversial assisted suicide program for mentally ill due to lack of doctors willing to participate

By Kendall Tietz, Fox News

Published Feb. 3, 2024, 5:24 p.m. ET

Please say NO to this divine violation and act of killing those no longer wanted or deemed valuable by some in society. Whatever you choose to do, know there is a price to pay-a divine judgment, if not in this lifetime it **will be** in the next. This bill is as bad as it was last year and the year before, perhaps worse now knowing what many of us know. Seems like another Agenda20 depopulation tactic.

“opponents of assisted suicide often argue that the practice devalues human life and that no one should actively seek to die; some make this argument for religious reasons, though not all do. Those who are skeptical of the practice also argue that physician-assisted suicide may be a mistake in cases of human error or random luck. Someone who is told they have six months to live, for example, may have received an **inaccurate prognosis** and end up living several more years; in rare cases, the terminal illness in question enters **an improbable remission.**” from a **Psychology Today article**

Those of us that believe in miracles and have faith in a higher power could never see this in any other way than an utter travesty and a complete lack of respect and full disregard to the gift of life itself.

Thank you for listening, only you can live with the decisions and choices you are making on behalf of the entire populace of the state of Maryland and its communities. Just know that at least half of us do not agree with 95% of the proposed 2024 legislative bills or the direction where all of this is heading, yes, to a complete free fall and ruination of a healthy prosperous society.

Seriously concerned citizen,

Suzanne Price
Anne Arundel Co

Tom Jones on Senate Bill 443.pdf

Uploaded by: Tom Jones
Position: UNF

Oppose - Senate Bill 443

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

Presented to the Senate Judicial Proceedings Committee

February 8, 2024

By **TOM JONES**
508 Post Oak Rd, Annapolis, MD 21401
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I oppose SB443 because of its impact on suicide rates. I have had a parent and child who suffered from mental illness and suicidality and I find this prospect terrifying. There are multiple, peer reviewed studies that show legalizing PAS increases suicide rates. In previous years I testified how supporters of this bill claim the studies show the opposite. My written testimony contains correspondence I have had with the authors labelling their claims are "inaccurate" and "misleading." Their study showed a **6.3% increase in total suicides**.

There is a misconception that there are no records of abuse of the law. My written testimony references two articles that identify 20 cases of abuse of the law ranging from possible murder and fraud to providing lethal prescriptions to people with long histories of depression and suicidality. These 20 cases have come to light despite the former Director of Health for Oregon stating her department was not resourced or required to enforce the law and the Portland Tribune writing "all the precautions built into the Death with Dignity Act are for naught." Imagine how many more cases there would be if the safeguards in this bill were enforceable.

References:

"How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?", Dr. David Paton and Dr. Albert Jones, The Southern Medical Association Journal, 2015.

"Is assisted suicide a substitute for unassisted suicide?" Dr. David Paton and Sourafel Girma, European Economic Review, Volume 145, June, 2022.

"Physician Assisted Suicide in Oregon: A Medical Perspective", Herbery Hendin and Kathleen Foley, Michigan Law Review Volume 106, Issue 8, 2008.

"Some Oregon and Washington State Assisted Suicide Abuses and Complications" Disability Rights Education & Defense Fund, https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf

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

Dear Tom,

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

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

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

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

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

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

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

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

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

Yours sincerely,

David

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

Dr Jones/Dr Paton

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

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

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

Thanks much for any help or insight you can provide.
Tom Jones
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

SB443 Opposition Written Testimony (2-7-24).pdf

Uploaded by: Tom Taylor

Position: UNF

Testimony in Opposition to the End-of-Life Option Act (SB443)

This testimony is in opposition to the End-of-Life Option Act (SB443).

This 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. The legislation lacks strong safeguards to protect these vulnerable groups.

I am particularly concerned about the following:

- Assisted suicide violates medical ethics to save lives and do no harm. Major medical associations oppose physician assisted suicide. Just last November, the American Medical Association reaffirmed its opposition to physician-assisted suicide: "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. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life." Similarly, the American College of Physicians (ACP) Code of Ethics states: "The College does not support legalization of physician-assisted suicide or euthanasia. After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns."

- Maryland's leading 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. This results in a lack of true informed consent. Disability groups are fighting physician assisted suicide because it says their lives are not worth living. The CDC website reports that suicide ideation is higher among people with disabilities, and cites research showing that "the prevalence of reported mental distress, which is a risk factor for suicide, was 4.6 times higher among people with disabilities."

- There is no requirement that a person receive a psychological evaluation before a life-ending prescription is written. As an example from another jurisdiction (Washington state), just 4% of individuals who died from physician assisted suicide were referred for a mental health evaluation before being prescribed lethal drugs (Washington State Department of Health, Death with Dignity Act Report 2019). In Colorado, drugs have been prescribed for eating disorders, which is a treatable disease (*Colorado Sun*, March 14, 2022).

- Individuals report pressure to die via physician assisted suicide as opposed to getting treatment for cancer, mental health needs, dementia, or even because they were homeless or suicidal.

- A Nevada physician who treated patients from Oregon and California has reported cases of insurance abuse connected to physician-assisted suicide. In a commentary in the *Las Vegas Review-Journal*, he wrote:

  > *"Sadly, such real abuses are already being witnessed in states where PAS is legal. Since PAS became legal in California and Oregon, I have experienced firsthand the abuses that PAS incentivizes.*
  >
  > *I cared for two patients in my hospital in Northern Nevada who were seeking transfers to their home states of California and Oregon for lifesaving treatments. With these particular*

> *treatment options, both patients had an excellent chance of cure. Without the treatments, both would likely die from their diseases.*
>
> *When I spoke with the medical directors of the patients' insurance companies, both of them told me they would cover assisted suicide but would not approve coverage for lifesaving treatment. Neither the patients nor I had requested assisted suicide, yet it was readily offered. Instead of the best treatment options, my patients were offered the cheapest option — a quick death through lethal medications. This was perfectly legal to do in those states but certainly unethical."* (*Dr. T. Brian Callister, M.D., Feb. 9, 2019)*

- Assisted suicide encourages people to feel like a burden to their families. According to data from Oregon and California, about half of those dying by assisted suicide reported that they did not want to be a "burden" on their families or caregivers.

- Loneliness and isolation are recognized as significant problems in today's society. Harvard political scientist, author of the influential book *Bowling Alone*, has identified declining social capital as a concern in America as well. Does this increasing isolation lead to worries about being a burden? And should we be making greater efforts to foster inclusion and engagement for our aging citizens to counter worries about becoming a burden? Do those facing end-of-life circumstances feel disconnected due to breaches in community life, or to our society's strong emphasis on usefulness? Our focus should be more centered on solutions to this isolation and disconnect, and on fostering stronger community association, rather than on promoting assisted death.

- The legislation lacks real safeguards to protect people. Where assisted suicide is legal, safeguards like waiting periods are being shortened or waived.

- Assisted suicide sends a confusing message that suicide is OK, even as the state engages in systemic efforts to prevent suicides among the general population through the Maryland Office of Suicide Prevention. States that have legalized assisted suicide have experienced increased suicide rates in general. Young people are particularly susceptible to suicide. Among youth and young adults (ages 10–24), the CDC website reports that "suicide rates for this age group increased 52.2% between 2000-2021." The CDC also reports that suicide rates are higher among veterans: "Veterans have an adjusted suicide rate that is 57.3% greater than the non-veteran U.S. adult population. Veterans account for about 13.9% of suicides among adults in the United States," according to the website. Assisted suicide sends a conflicting message to these vulnerable groups. just as it sends a message of less worthiness to those with disabilities, as identified in an earlier point above.

- There is no way to accurately diagnose life expectancy. Individuals can request physician-assisted suicide if diagnosed with a terminal illness and given six months or less to live. However, medical prognoses are based on averages that often prove incorrect, and people frequently outlive these projections.

In considering this legislation, we must ask ourselves if the terminally ill might consider assisted suicide in part because of a decline in a sense of community in our society, leaving many aging individuals feeling lonely and isolated, and questioning their meaning in a society that stresses usefulness to such a high degree, and that perhaps pays too little attention to the lifelong wisdom they have gained.

For these reasons, I strongly urge an unfavorable report on SB443. Instead, we should give maximum attention to making sure that quality palliative end-of-life care is readily available to all Maryland residents who need it.

As a former president of the American College of Physicians (ACP), the medical association named earlier in this testimony, stated: “As a society, we need to work to improve hospice and palliative care, including awareness and access.”

Let us set our sights, therefore, on accompanying terminally ill persons with high-quality palliative and medical care combined with human closeness and a strong sense of community connection that assures them of compassion and meaning throughout the final stage of life.

The previously-cited ACP official well describes the path forward that Maryland, in particular, and society, in general, should follow:

> *“Through effective communication, high quality care, compassionate support, and the right resources for hospice and palliative care, physicians can help patients control many aspects of how they live out life’s last chapter.”*

Please give an unfavorable report on SB443. Thank you for your consideration of my views.

Sincerely,

Tom Taylor
11-G Laurel Hill Road
Greenbelt, MD 20770

YAHALOM TESTIMONY - SB 443 - UNF - 2024.pdf

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Position: UNF

YahalomMD
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SENATE JUDICIAL PROCEEDINGS COMMITTEE

FEBRUARY 8, 2024

SENATE BILL 443

END–OF–LIFE OPTION ACT

(THE HONORABLE ELIJAH E. CUMMINGS AND THE HONORABLE SHANE E. PENDERGRASS ACT)

OPPOSE

Yahalom Maryland, a division of Agudath Israel of Maryland, serves as a point of contact for individuals, families, and local organizations within the Orthodox Jewish community who seek assistance in navigating issues related to physical, intellectual, and developmental disabilities. Today we speak on their behalf.

Yahalom Maryland stands in conjunction with the accepted consensus of disability advocacy groups in opposition to Senate Bill 443 – the Hon. Elijah E. Cummings and the Hon. Shane E. Pendergrass End-of-Life Option Act.

The example of the state of physician-assisted suicide in Canada, our country's neighbor, provides a sobering lesson on the abuses brought on by legalization. In one case, an individual who had been put on suicide watch was pushed to choose euthanasia, justified only by the fact that he was suffering from hearing loss. Alarm bells rung by his family and medical help, warning that his suffering was due to his depression and that he was being improperly pressured, were ignored. Such cases, according to disability groups, are not rare.[1] Military veterans suffering from post-traumatic stress disorder and who self-reported suicidal thoughts were pressured to consider assisted suicide,[2] including, in one case, a paraplegic veteran who received an offer to choose suicide in response to her request for installation of a home wheelchair ramp.[3] Individuals with histories of sexual abuse, anorexia, and other mental illnesses who reported suffering from depression were told that it would be hard to obtain proper treatment but that they could choose suicide.[4] Patient "advocates" repeatedly bring up the topic without being prompted, and even encourage the patients to choose physician-assisted euthanasia.[5] The frightening expansion of

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[1] https://apnews.com/article/covid-science-health-toronto-7c631558a457188d2bd2b5cfd360a867

[2] https://www.cbc.ca/news/politics/veterans-maid-rcmp-investigation-1.6663885

[3] https://www.cbc.ca/news/politics/christine-gauthier-assisted-death-macaulay-1.6671721

[4] https://www.theglobeandmail.com/canada/british-columbia/article-maid-suicide-patient-vancouver/

[5] https://nationalpost.com/news/canada/canada-maid-medical-aid-in-dying-consent-doctors

medically-assisted euthanasia has prompted concern from a variety of groups, including experts from the UN Human Rights Council.[6]

We are all-too-familiar with well-intentioned individuals who casually and condescendingly assume that the quality of life of individuals with disabilities is less than the quality of the lives of other, “normal” people, with assumptions that the pain and trials they may face are insurmountable, and with confident but incorrect proclamations by medical staff assuming that they can predict the future with total and complete accuracy. SB 443 opens the door to determining that some lives are worth more than others, and incentivizes abuse of the rights of the vulnerable. SB 443 undermines public trust in the medical and pharmacology professions by having them serve as agents of death. SB 443 incentivizes those who find vulnerable individuals burdensome to attempt to influence them to choose death. SB 443 also puts the responsibility for the initial judgement of the patient’s mental health state on the attending physician, despite the fact that such physicians posses no particular expertise in mental health.

For all these reasons and more, we respectfully ask that you firmly reject Senate Bill 443.

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[6] https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=26002

sb0443F.pdf

Uploaded by: Vickie Hoffmann

Position: UNF

SENATE BILL 443

J1 4lr0404
SB 845/23 – JPR CF HB 403

By: **Senators Waldstreicher, Lam, Elfreth, Gile, Kelly, Lewis Young, Smith, West, and M. Washington**
Introduced and read first time: January 22, 2024
Assigned to: Judicial Proceedings

A BILL ENTITLED

AN ACT concerning

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

FOR the purpose of authorizing an individual to request aid in dying by making certain requests; establishing requirements and prohibitions governing aid in dying, including requirements related to requests for aid in dying, consulting physicians, mental health assessments, the disposal of drugs prescribed for aid in dying, health care facility policies, and the effect of aid in dying on insurance policies; authorizing a pharmacist to dispense medication for aid in dying only to certain individuals under certain circumstances; providing that the death of a qualified individual by reason of self–administration of certain medication shall be deemed to be a death from certain natural causes for certain purposes; providing that this Act does not authorize certain individuals to end another individual's life by certain means; providing that participation by a health care provider in aid in dying is voluntary; authorizing the Maryland Insurance Commissioner to enforce certain provisions of this Act; establishing that a licensed health care professional does not violate the statutory prohibition on assisted suicide by taking certain actions in accordance with this Act; and generally relating to aid in dying.

BY repealing and reenacting, with amendments,
Article – Criminal Law
Section 3–103
Annotated Code of Maryland
(2021 Replacement Volume and 2023 Supplement)

BY adding to
Article – Health – General
Section 5–6A–01 through 5–6A–16 to be under the new subtitle "Subtitle 6A. The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass

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EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

End–of–Life Option Act”
Annotated Code of Maryland
(2023 Replacement Volume)

BY adding to
Article – Insurance
Section 27–208.1
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Criminal Law

3–103.

(a) A licensed health care professional does not violate § 3–102 of this subtitle by administering or prescribing a procedure or administering, prescribing, or dispensing a medication to relieve pain, even if the medication or procedure may hasten death or increase the risk of death, unless the licensed health care professional knowingly administers or prescribes the procedure or administers, prescribes, or dispenses the medication to cause death.

(b) A licensed health care professional does not violate § 3–102 of this subtitle by withholding or withdrawing a medically administered life–sustaining procedure:

(1) in compliance with Title 5, Subtitle 6 of the Health – General Article; or

(2) in accordance with reasonable medical practice.

(C) A LICENSED HEALTH CARE PROFESSIONAL DOES NOT VIOLATE § 3–102 OF THIS SUBTITLE BY TAKING ANY ACTION IN ACCORDANCE WITH TITLE 5, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE.

[(c)**] (D)** (1) Unless the family member knowingly administers a procedure or administers or dispenses a medication to cause death, a family member does not violate § 3–102 of this subtitle if the family member:

(i) is a caregiver for a patient enrolled in a licensed hospice program; and

(ii) administers the procedure or administers or dispenses the medication to relieve pain under the supervision of a health care professional.

(2) Paragraph (1) of this subsection applies even if the medication or

procedure hastens death or increases the risk of death.

Article – Health – General

SUBTITLE 6A. THE HONORABLE ELIJAH E. CUMMINGS AND THE HONORABLE SHANE E. PENDERGRASS END–OF–LIFE OPTION ACT.

5–6A–01.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "AID IN DYING" MEANS THE MEDICAL PRACTICE OF A PHYSICIAN PRESCRIBING MEDICATION TO A QUALIFIED INDIVIDUAL THAT THE QUALIFIED INDIVIDUAL MAY SELF–ADMINISTER TO BRING ABOUT THE QUALIFIED INDIVIDUAL'S DEATH.

(C) "ATTENDING PHYSICIAN" MEANS THE LICENSED PHYSICIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE MEDICAL CARE OF THE INDIVIDUAL AND TREATMENT OF THE INDIVIDUAL'S TERMINAL ILLNESS.

(D) "CAPACITY TO MAKE MEDICAL DECISIONS" MEANS THE ABILITY OF AN INDIVIDUAL TO:

(1) UNDERSTAND THE NATURE AND CONSEQUENCES OF A HEALTH CARE DECISION;

(2) UNDERSTAND THE SIGNIFICANT BENEFITS, RISKS, AND ALTERNATIVES OF A HEALTH CARE DECISION; AND

(3) MAKE AND COMMUNICATE AN INFORMED DECISION TO HEALTH CARE PROVIDERS, INCLUDING COMMUNICATION THROUGH ANOTHER INDIVIDUAL FAMILIAR WITH THE INDIVIDUAL'S MANNER OF COMMUNICATING, IF THE OTHER INDIVIDUAL IS AVAILABLE.

(E) "CONSULTING PHYSICIAN" MEANS A LICENSED PHYSICIAN WHO IS QUALIFIED BY SPECIALTY OR EXPERIENCE TO CONFIRM A PROFESSIONAL DIAGNOSIS AND PROGNOSIS REGARDING AN INDIVIDUAL'S TERMINAL ILLNESS.

(F) "HEALTH CARE FACILITY" MEANS:

(1) A HOSPITAL, AS DEFINED IN § 19–301 OF THIS ARTICLE;

(2) A HOSPICE FACILITY, AS DEFINED IN § 19–901 OF THIS ARTICLE;

(3) AN ASSISTED LIVING PROGRAM, AS DEFINED IN § 19–1801 OF THIS ARTICLE; OR

(4) A NURSING HOME, AS DEFINED IN § 19–1401 OF THIS ARTICLE.

(G) "HEALTH CARE PROVIDER" MEANS AN INDIVIDUAL LICENSED OR CERTIFIED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE OR DISPENSE MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION.

(H) "INFORMED DECISION" MEANS A DECISION BY AN INDIVIDUAL THAT IS:

(1) BASED ON AN UNDERSTANDING AND ACKNOWLEDGMENT OF THE RELEVANT FACTS; AND

(2) MADE AFTER RECEIVING THE INFORMATION REQUIRED UNDER § 5–6A–04(C) OF THIS SUBTITLE.

(I) "LICENSED MENTAL HEALTH PROFESSIONAL" MEANS A LICENSED PSYCHIATRIST OR A LICENSED PSYCHOLOGIST.

(J) "LICENSED PHYSICIAN" MEANS A PHYSICIAN WHO IS LICENSED TO PRACTICE MEDICINE IN THE STATE.

(K) "LICENSED PSYCHIATRIST" MEANS A PSYCHIATRIST WHO IS LICENSED TO PRACTICE MEDICINE IN THE STATE.

(L) "LICENSED PSYCHOLOGIST" MEANS A PSYCHOLOGIST WHO IS LICENSED TO PRACTICE PSYCHOLOGY IN THE STATE.

(M) "MENTAL HEALTH PROFESSIONAL ASSESSMENT" MEANS ONE OR MORE CONSULTATIONS BETWEEN AN INDIVIDUAL AND A LICENSED MENTAL HEALTH PROFESSIONAL FOR THE PURPOSE OF DETERMINING THAT THE INDIVIDUAL:

(1) HAS THE CAPACITY TO MAKE MEDICAL DECISIONS; AND

(2) IS NOT SUFFERING FROM IMPAIRED JUDGMENT DUE TO A MENTAL DISORDER.

(N) "PALLIATIVE CARE" MEANS HEALTH CARE CENTERED ON A TERMINALLY ILL INDIVIDUAL AND THE INDIVIDUAL'S FAMILY THAT:

(1) OPTIMIZES THE INDIVIDUAL'S QUALITY OF LIFE BY ANTICIPATING, PREVENTING, AND TREATING THE INDIVIDUAL'S SUFFERING

THROUGHOUT THE CONTINUUM OF THE INDIVIDUAL'S TERMINAL ILLNESS;

(2) ADDRESSES THE PHYSICAL, EMOTIONAL, SOCIAL, AND SPIRITUAL NEEDS OF THE INDIVIDUAL;

(3) FACILITATES INDIVIDUAL AUTONOMY, THE INDIVIDUAL'S ACCESS TO INFORMATION, AND INDIVIDUAL CHOICE; AND

(4) INCLUDES DISCUSSIONS BETWEEN THE INDIVIDUAL AND A HEALTH CARE PROVIDER CONCERNING THE INDIVIDUAL'S GOALS FOR TREATMENT AND APPROPRIATE TREATMENT OPTIONS AVAILABLE TO THE INDIVIDUAL, INCLUDING HOSPICE CARE AND COMPREHENSIVE PAIN AND SYMPTOM MANAGEMENT.

(O) "PHARMACIST" MEANS A PHARMACIST WHO IS LICENSED TO PRACTICE PHARMACY IN THE STATE.

(P) "QUALIFIED INDIVIDUAL" MEANS AN INDIVIDUAL WHO:

(1) IS AN ADULT;

(2) HAS THE CAPACITY TO MAKE MEDICAL DECISIONS;

(3) IS A RESIDENT OF THE STATE;

(4) HAS A TERMINAL ILLNESS; AND

(5) HAS THE ABILITY TO SELF–ADMINISTER MEDICATION.

(Q) "RELATIVE" MEANS:

(1) A SPOUSE;

(2) A CHILD;

(3) A GRANDCHILD;

(4) A SIBLING;

(5) A PARENT; OR

(6) A GRANDPARENT.

(R) (1) "SELF–ADMINISTER" MEANS A QUALIFIED INDIVIDUAL'S AFFIRMATIVE, CONSCIOUS, AND VOLUNTARY ACT OF INGESTING MEDICATION

PRESCRIBED UNDER § 5–6A–07(A) OF THIS SUBTITLE TO BRING ABOUT THE INDIVIDUAL'S DEATH.

(2) "SELF–ADMINISTER" DOES NOT INCLUDE TAKING MEDICATION BY PARENTERAL INJECTION OR INFUSION.

(S) "TERMINAL ILLNESS" MEANS A MEDICAL CONDITION THAT, WITHIN REASONABLE MEDICAL JUDGMENT, INVOLVES A PROGNOSIS FOR AN INDIVIDUAL THAT LIKELY WILL RESULT IN THE INDIVIDUAL'S DEATH WITHIN 6 MONTHS.

(T) "WRITTEN REQUEST" MEANS A WRITTEN REQUEST FOR AID IN DYING.

5–6A–02.

(A) AN INDIVIDUAL MAY REQUEST AID IN DYING BY:

(1) MAKING AN INITIAL ORAL REQUEST TO THE INDIVIDUAL'S ATTENDING PHYSICIAN;

(2) AFTER MAKING AN INITIAL ORAL REQUEST, MAKING A WRITTEN REQUEST TO THE INDIVIDUAL'S ATTENDING PHYSICIAN, IN ACCORDANCE WITH § 5–6A–03 OF THIS SUBTITLE; AND

(3) MAKING A SECOND ORAL REQUEST TO THE INDIVIDUAL'S ATTENDING PHYSICIAN AT LEAST:

(I) 15 DAYS AFTER MAKING THE INITIAL ORAL REQUEST; AND

(II) 48 HOURS AFTER MAKING THE WRITTEN REQUEST.

(B) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, NO OTHER INDIVIDUAL, INCLUDING AN AGENT UNDER AN ADVANCE DIRECTIVE, AN ATTORNEY IN FACT UNDER A DURABLE POWER OF ATTORNEY, A GUARDIAN, OR A CONSERVATOR, MAY REQUEST AID IN DYING ON BEHALF OF AN INDIVIDUAL.

(C) AT LEAST ONE OF THE ORAL REQUESTS MADE UNDER SUBSECTION (A) OF THIS SECTION SHALL BE MADE WHILE THE INDIVIDUAL IS ALONE WITH THE ATTENDING PHYSICIAN.

5–6A–03.

(A) A WRITTEN REQUEST FOR AID IN DYING REQUIRED UNDER § 5–6A–02(A)(2) OF THIS SUBTITLE SHALL BE:

(1) IN SUBSTANTIALLY THE SAME FORM SET FORTH IN SUBSECTION (C) OF THIS SECTION;

(2) SIGNED AND DATED BY THE INDIVIDUAL; AND

(3) WITNESSED BY AT LEAST TWO OTHER INDIVIDUALS WHO, IN THE PRESENCE OF THE INDIVIDUAL, ATTEST THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE INDIVIDUAL IS:

(I) OF SOUND MIND; AND

(II) ACTING VOLUNTARILY AND NOT BEING COERCED TO SIGN THE WRITTEN REQUEST.

(B) (1) ONLY ONE OF THE WITNESSES UNDER SUBSECTION (A)(3) OF THIS SECTION MAY BE:

(I) A RELATIVE OF THE INDIVIDUAL BY BLOOD, MARRIAGE, OR ADOPTION; OR

(II) AT THE TIME THE WRITTEN REQUEST IS SIGNED BY THE INDIVIDUAL, ENTITLED TO ANY BENEFIT ON THE INDIVIDUAL'S DEATH.

(2) THE INDIVIDUAL'S ATTENDING PHYSICIAN MAY NOT BE A WITNESS.

(C) A WRITTEN REQUEST UNDER THIS SECTION SHALL BE IN SUBSTANTIALLY THE FOLLOWING FORM:

MARYLAND REQUEST FOR MEDICATION FOR AID IN DYING

BY: ______________________________ DATE OF BIRTH: ___________________
(PRINT NAME) (MONTH/DAY/YEAR)

I, ____________________________________, AM AN ADULT OF SOUND MIND.

I AM A RESIDENT OF THE STATE OF MARYLAND.

I AM SUFFERING FROM _________________________, WHICH MY ATTENDING PHYSICIAN HAS DETERMINED WILL, MORE LIKELY THAN NOT, RESULT IN DEATH WITHIN 6 MONTHS. I HAVE BEEN FULLY INFORMED OF MY DIAGNOSIS, MY PROGNOSIS, THE NATURE OF MEDICATION TO BE PRESCRIBED TO AID ME IN DYING, THE POTENTIAL ASSOCIATED RISKS, THE EXPECTED RESULT, THE FEASIBLE ALTERNATIVES, AND THE ADDITIONAL HEALTH CARE TREATMENT OPTIONS,

INCLUDING PALLIATIVE CARE AND HOSPICE.

I HAVE ORALLY REQUESTED THAT MY ATTENDING PHYSICIAN PRESCRIBE MEDICATION THAT I MAY SELF–ADMINISTER FOR AID IN DYING, AND I NOW CONFIRM THIS REQUEST. I AUTHORIZE MY ATTENDING PHYSICIAN TO CONTACT A PHARMACIST TO FILL THE PRESCRIPTION FOR THE MEDICATION ON MY REQUEST.

INITIAL ONE:

_____ I HAVE INFORMED MY FAMILY OF MY DECISION AND TAKEN THEIR OPINIONS INTO CONSIDERATION.
_____ I HAVE DECIDED NOT TO INFORM MY FAMILY OF MY DECISION.
_____ I HAVE NO FAMILY TO INFORM OF MY DECISION.

I UNDERSTAND THAT I HAVE THE RIGHT TO RESCIND THIS REQUEST AT ANY TIME.

I UNDERSTAND THE FULL IMPORT OF THIS REQUEST AND I EXPECT TO DIE IF AND WHEN I TAKE THE MEDICATION TO BE PRESCRIBED. I FURTHER UNDERSTAND THAT, ALTHOUGH MOST DEATHS OCCUR WITHIN 3 HOURS, MY DEATH MAY TAKE LONGER, AND MY ATTENDING PHYSICIAN HAS COUNSELED ME ABOUT THIS POSSIBILITY.

I MAKE THIS REQUEST VOLUNTARILY AND WITHOUT RESERVATION, AND I ACCEPT FULL RESPONSIBILITY FOR MY DECISION TO REQUEST AID IN DYING.

SIGNED: ____ DATED: _____________________

DECLARATION OF WITNESSES

I UNDERSTAND THAT, UNDER MARYLAND LAW, A WITNESS TO A REQUEST FOR MEDICATION FOR AID IN DYING MAY NOT BE THE INDIVIDUAL'S ATTENDING PHYSICIAN. FURTHER, ONLY ONE OF THE WITNESSES MAY BE:

1. A RELATIVE OF THE INDIVIDUAL BY BLOOD, MARRIAGE, OR ADOPTION; OR

2. AT THE TIME THE WRITTEN REQUEST IS SIGNED BY THE INDIVIDUAL, ENTITLED TO ANY BENEFIT ON THE INDIVIDUAL'S DEATH.

BY SIGNING BELOW ON THE DATE THE INDIVIDUAL NAMED ABOVE SIGNS, I DECLARE THAT:

THE INDIVIDUAL MAKING AND SIGNING THE ABOVE REQUEST:

1. IS PERSONALLY KNOWN TO ME OR HAS PROVIDED PROOF OF IDENTITY;

2. SIGNED THIS REQUEST IN MY PRESENCE ON THE DATE OF THE INDIVIDUAL'S SIGNATURE;

3. APPEARS TO BE OF SOUND MIND AND NOT UNDER DURESS, FRAUD, OR UNDUE INFLUENCE; AND

4. IS NOT AN INDIVIDUAL FOR WHOM I AM THE ATTENDING PHYSICIAN.

WITNESS 1
(CHECK ONE)

_____________ I AM:

_____________ I AM NOT:

1. A RELATIVE OF THE INDIVIDUAL BY BLOOD, MARRIAGE, OR ADOPTION; OR

2. AT THE TIME THE REQUEST IS SIGNED, ENTITLED TO ANY BENEFIT ON THE INDIVIDUAL'S DEATH.

PRINTED NAME OF WITNESS 1 ______________________________
SIGNATURE OF WITNESS 1 ____________________________ DATE _______________.

WITNESS 2
(CHECK ONE)

_____________ I AM:

_____________ I AM NOT:

1. A RELATIVE OF THE INDIVIDUAL BY BLOOD, MARRIAGE, OR ADOPTION; OR

2. AT THE TIME THE REQUEST IS SIGNED, ENTITLED TO ANY BENEFIT ON THE INDIVIDUAL'S DEATH.

PRINTED NAME OF WITNESS 2 _______________________________
SIGNATURE OF WITNESS 2 ____________________________ DATE _______________.

5–6A–04.

(A) (1) WHEN AN ATTENDING PHYSICIAN IS PRESENTED WITH AN INDIVIDUAL'S WRITTEN REQUEST, THE ATTENDING PHYSICIAN SHALL DETERMINE

WHETHER THE INDIVIDUAL:

(I) IS A QUALIFIED INDIVIDUAL;

(II) HAS MADE AN INFORMED DECISION; AND

(III) HAS VOLUNTARILY REQUESTED AID IN DYING.

(2) AN INDIVIDUAL IS NOT A QUALIFIED INDIVIDUAL SOLELY DUE TO AGE, DISABILITY, OR A SPECIFIC ILLNESS.

(B) FOR PURPOSES OF DETERMINING THAT AN INDIVIDUAL IS A QUALIFIED INDIVIDUAL, AN ATTENDING PHYSICIAN SHALL ACCEPT AS PROOF OF THE INDIVIDUAL'S RESIDENCY IN THE STATE:

(1) POSSESSION OF A VALID MARYLAND DRIVER'S LICENSE OR IDENTIFICATION CARD ISSUED BY THE MOTOR VEHICLE ADMINISTRATION;

(2) REGISTRATION TO VOTE IN THE STATE;

(3) EVIDENCE OF OWNING OR LEASING PROPERTY IN THE STATE;

(4) A COPY OF A MARYLAND RESIDENT TAX RETURN FOR THE MOST RECENT TAX YEAR; OR

(5) BASED ON THE INDIVIDUAL'S TREATMENT HISTORY AND MEDICAL RECORDS, THE ATTENDING PHYSICIAN'S PERSONAL KNOWLEDGE OF THE INDIVIDUAL'S RESIDENCY IN THE STATE.

(C) AN ATTENDING PHYSICIAN SHALL ENSURE THAT AN INDIVIDUAL MAKES AN INFORMED DECISION BY INFORMING THE INDIVIDUAL OF:

(1) THE INDIVIDUAL'S MEDICAL DIAGNOSIS;

(2) THE INDIVIDUAL'S PROGNOSIS;

(3) THE POTENTIAL RISKS ASSOCIATED WITH SELF–ADMINISTERING THE MEDICATION TO BE PRESCRIBED FOR AID IN DYING;

(4) THE PROBABLE RESULT OF SELF–ADMINISTERING THE MEDICATION TO BE PRESCRIBED FOR AID IN DYING; AND

(5) ANY FEASIBLE ALTERNATIVES AND HEALTH CARE TREATMENT OPTIONS, INCLUDING PALLIATIVE CARE AND HOSPICE.

(D) SUBJECT TO § 5–6A–06 OF THIS SUBTITLE, IF THE ATTENDING PHYSICIAN DETERMINES THAT AN INDIVIDUAL IS A QUALIFIED INDIVIDUAL, HAS MADE AN INFORMED DECISION, AND HAS VOLUNTARILY REQUESTED AID IN DYING, THE ATTENDING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A CONSULTING PHYSICIAN TO CARRY OUT THE DUTIES REQUIRED UNDER § 5–6A–05 OF THIS SUBTITLE.

5–6A–05.

A CONSULTING PHYSICIAN TO WHOM AN INDIVIDUAL HAS BEEN REFERRED UNDER § 5–6A–04(D) OF THIS SUBTITLE SHALL:

(1) EXAMINE THE INDIVIDUAL AND THE INDIVIDUAL'S RELEVANT MEDICAL RECORDS;

(2) CONFIRM THE ATTENDING PHYSICIAN'S DIAGNOSIS THAT THE INDIVIDUAL HAS A TERMINAL ILLNESS;

(3) IF REQUIRED UNDER § 5–6A–06 OF THIS SUBTITLE, REFER THE INDIVIDUAL FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT;

(4) VERIFY THAT THE INDIVIDUAL IS A QUALIFIED INDIVIDUAL, HAS MADE AN INFORMED DECISION, AND HAS VOLUNTARILY REQUESTED AID IN DYING; AND

(5) DOCUMENT THE FULFILLMENT OF THE CONSULTING PHYSICIAN'S DUTIES UNDER THIS SECTION IN WRITING.

5–6A–06.

(A) 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, THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN SHALL REFER THE INDIVIDUAL TO A LICENSED MENTAL HEALTH PROFESSIONAL FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT.

(B) IF AN INDIVIDUAL IS REFERRED FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT UNDER SUBSECTION (A) OF THIS SECTION, AN ATTENDING PHYSICIAN MAY NOT PROVIDE THE INDIVIDUAL MEDICATION FOR AID IN DYING UNTIL THE LICENSED MENTAL HEALTH PROFESSIONAL PROVIDING THE MENTAL HEALTH PROFESSIONAL ASSESSMENT:

(1) DETERMINES THAT THE INDIVIDUAL HAS THE CAPACITY TO MAKE

MEDICAL DECISIONS AND IS NOT SUFFERING FROM A CONDITION THAT IS CAUSING IMPAIRED JUDGMENT; AND

(2) COMMUNICATES THIS DETERMINATION TO THE ATTENDING PHYSICIAN AND THE CONSULTING PHYSICIAN IN WRITING.

5–6A–07.

(A) AFTER THE ATTENDING PHYSICIAN AND THE CONSULTING PHYSICIAN HAVE FULFILLED THE REQUIREMENTS UNDER §§ 5–6A–04 AND 5–6A–05 OF THIS SUBTITLE, AND AFTER THE QUALIFIED INDIVIDUAL SUBMITS A SECOND ORAL REQUEST FOR AID IN DYING, AS REQUIRED UNDER § 5–6A–02 OF THIS SUBTITLE, THE ATTENDING PHYSICIAN SHALL:

(1) INFORM THE QUALIFIED INDIVIDUAL THAT IT IS THE DECISION OF THE QUALIFIED INDIVIDUAL AS TO WHETHER AND WHEN TO SELF–ADMINISTER THE MEDICATION PRESCRIBED FOR AID IN DYING;

(2) (I) INFORM THE QUALIFIED INDIVIDUAL THAT THE QUALIFIED INDIVIDUAL MAY WISH TO NOTIFY NEXT OF KIN OF THE REQUEST FOR AID IN DYING; AND

(II) INFORM THE QUALIFIED INDIVIDUAL THAT A FAILURE TO NOTIFY NEXT OF KIN IS NOT A BASIS FOR DENIAL OF THE REQUEST FOR AID IN DYING;

(3) COUNSEL THE QUALIFIED INDIVIDUAL CONCERNING THE IMPORTANCE OF:

(I) HAVING ANOTHER INDIVIDUAL PRESENT WHEN THE QUALIFIED INDIVIDUAL SELF–ADMINISTERS THE MEDICATION PRESCRIBED FOR AID IN DYING;

(II) NOT TAKING THE MEDICATION IN A PUBLIC PLACE; AND

(III) PARTICIPATING IN A HOSPICE PROGRAM;

(4) ENCOURAGE THE QUALIFIED INDIVIDUAL TO PREPARE AN ADVANCE DIRECTIVE;

(5) CONFIRM THAT THE QUALIFIED INDIVIDUAL'S REQUEST DOES NOT ARISE FROM COERCION OR UNDUE INFLUENCE BY ANOTHER INDIVIDUAL BY DISCUSSING WITH THE QUALIFIED INDIVIDUAL, OUTSIDE THE PRESENCE OF ANY OTHER INDIVIDUAL EXCEPT FOR AN INTERPRETER, WHETHER THE QUALIFIED

INDIVIDUAL IS FEELING COERCED OR UNDULY INFLUENCED BY ANOTHER INDIVIDUAL;

(6) INFORM THE QUALIFIED INDIVIDUAL THAT THE QUALIFIED INDIVIDUAL MAY RESCIND THE REQUEST FOR AID IN DYING AT ANY TIME AND IN ANY MANNER;

(7) VERIFY, IMMEDIATELY BEFORE WRITING THE PRESCRIPTION FOR MEDICATION FOR AID IN DYING, THAT THE QUALIFIED INDIVIDUAL IS MAKING AN INFORMED DECISION;

(8) FULFILL THE DOCUMENTATION REQUIREMENTS ESTABLISHED UNDER § 5–6A–08 OF THIS SUBTITLE; AND

(9) (I) IF THE ATTENDING PHYSICIAN HOLDS A DISPENSING PERMIT FROM THE STATE BOARD OF PHYSICIANS AND WISHES TO DISPENSE THE MEDICATION, DISPENSE TO THE QUALIFIED INDIVIDUAL:

1. THE PRESCRIBED MEDICATION FOR AID IN DYING; AND

2. ANY ANCILLARY MEDICATIONS NEEDED TO MINIMIZE THE QUALIFIED INDIVIDUAL'S DISCOMFORT; OR

(II) IF THE ATTENDING PHYSICIAN DOES NOT HOLD A DISPENSING PERMIT OR DOES NOT WISH TO DISPENSE THE MEDICATION FOR AID IN DYING, AND THE QUALIFIED INDIVIDUAL REQUESTS AND PROVIDES WRITTEN CONSENT FOR THE MEDICATION FOR AID IN DYING TO BE DISPENSED BY A PHARMACIST:

1. CONTACT A PHARMACIST;

2. INFORM THE PHARMACIST OF THE PRESCRIPTION FOR MEDICATION FOR AID IN DYING; AND

3. SUBMIT THE PRESCRIPTION FOR MEDICATION FOR AID IN DYING TO THE PHARMACIST BY ANY MEANS AUTHORIZED BY LAW.

(B) A PHARMACIST WHO HAS BEEN CONTACTED AND INFORMED BY AN ATTENDING PHYSICIAN AND TO WHOM AN ATTENDING PHYSICIAN HAS SUBMITTED A PRESCRIPTION FOR MEDICATION FOR AID IN DYING IN ACCORDANCE WITH THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION MAY DISPENSE THE MEDICATION FOR AID IN DYING AND ANY ANCILLARY MEDICATION ONLY TO THE QUALIFIED INDIVIDUAL, THE ATTENDING PHYSICIAN, OR AN EXPRESSLY IDENTIFIED

AGENT OF THE QUALIFIED INDIVIDUAL.

(C) IF A QUALIFIED INDIVIDUAL SELF–ADMINISTERS MEDICATION FOR AID IN DYING AND DIES, THE ATTENDING PHYSICIAN MAY SIGN THE QUALIFIED INDIVIDUAL'S DEATH CERTIFICATE.

5–6A–08.

(A) WITH RESPECT TO A REQUEST BY A QUALIFIED INDIVIDUAL FOR AID IN DYING, THE ATTENDING PHYSICIAN SHALL ENSURE THAT THE MEDICAL RECORD OF THE QUALIFIED INDIVIDUAL DOCUMENTS OR CONTAINS:

(1) THE BASIS FOR DETERMINING THAT THE QUALIFIED INDIVIDUAL IS AN ADULT AND A RESIDENT OF THE STATE;

(2) ALL ORAL AND WRITTEN REQUESTS BY THE QUALIFIED INDIVIDUAL FOR MEDICATION FOR AID IN DYING;

(3) THE ATTENDING PHYSICIAN'S:

(I) DIAGNOSIS OF THE QUALIFIED INDIVIDUAL'S TERMINAL ILLNESS AND PROGNOSIS; AND

(II) DETERMINATION THAT THE QUALIFIED INDIVIDUAL HAS THE CAPACITY TO MAKE MEDICAL DECISIONS, HAS MADE AN INFORMED DECISION, AND HAS VOLUNTARILY REQUESTED AID IN DYING;

(4) DOCUMENTATION THAT THE CONSULTING PHYSICIAN HAS FULFILLED THE CONSULTING PHYSICIAN'S DUTIES UNDER § 5–6A–05 OF THIS SUBTITLE;

(5) A REPORT OF THE OUTCOME OF AND DETERMINATIONS MADE DURING THE MENTAL HEALTH PROFESSIONAL ASSESSMENT IF:

(I) THE QUALIFIED INDIVIDUAL WAS REFERRED FOR A MENTAL HEALTH PROFESSIONAL ASSESSMENT IN ACCORDANCE WITH § 5–6A–06 OF THIS SUBTITLE; AND

(II) THE MENTAL HEALTH PROFESSIONAL ASSESSMENT WAS PROVIDED;

(6) DOCUMENTATION OF THE ATTENDING PHYSICIAN'S OFFER TO THE QUALIFIED INDIVIDUAL TO RESCIND THE QUALIFIED INDIVIDUAL'S REQUEST FOR MEDICATION FOR AID IN DYING AT THE TIME THE ATTENDING PHYSICIAN

WROTE THE PRESCRIPTION FOR THE MEDICATION FOR THE QUALIFIED INDIVIDUAL; AND

(7) A STATEMENT BY THE ATTENDING PHYSICIAN:

(I) INDICATING THAT ALL REQUIREMENTS FOR AID IN DYING UNDER THIS SUBTITLE HAVE BEEN MET; AND

(II) SPECIFYING THE STEPS TAKEN TO CARRY OUT THE QUALIFIED INDIVIDUAL'S REQUEST FOR AID IN DYING, INCLUDING THE MEDICATION PRESCRIBED FOR AID IN DYING.

(B) THE ATTENDING PHYSICIAN SHALL SUBMIT TO THE DEPARTMENT ANY INFORMATION REGARDING IMPLEMENTATION OF THIS SUBTITLE REQUIRED BY REGULATIONS ADOPTED UNDER § 5–6A–09(A) OF THIS SUBTITLE.

5–6A–09.

(A) THE DEPARTMENT SHALL ADOPT REGULATIONS TO FACILITATE THE COLLECTION OF INFORMATION UNDER § 5–6A–08(B) OF THIS SUBTITLE.

(B) THE DEPARTMENT SHALL PRODUCE AND MAKE AVAILABLE TO THE PUBLIC AN ANNUAL STATISTICAL REPORT OF INFORMATION COLLECTED UNDER SUBSECTION (A) OF THIS SECTION.

(C) RECORDS OR INFORMATION COLLECTED OR MAINTAINED UNDER THIS SUBTITLE ARE NOT SUBJECT TO SUBPOENA OR DISCOVERY AND MAY NOT BE INTRODUCED INTO EVIDENCE IN ANY JUDICIAL OR ADMINISTRATIVE PROCEEDING, EXCEPT TO RESOLVE MATTERS CONCERNING COMPLIANCE WITH THIS SUBTITLE OR AS OTHERWISE SPECIFICALLY PROVIDED BY LAW.

5–6A–10.

A PERSON THAT, AFTER A QUALIFIED INDIVIDUAL'S DEATH, IS IN POSSESSION OF MEDICATION PRESCRIBED FOR AID IN DYING THAT HAS NOT BEEN SELF–ADMINISTERED SHALL DISPOSE OF THE MEDICATION IN A LAWFUL MANNER.

5–6A–11.

(A) FOR ALL LEGAL RIGHTS AND OBLIGATIONS, RECORD–KEEPING PURPOSES, AND OTHER PURPOSES GOVERNED BY THE LAWS OF THE STATE, WHETHER CONTRACTUAL, CIVIL, CRIMINAL, OR OTHERWISE, THE DEATH OF A QUALIFIED INDIVIDUAL BY REASON OF THE SELF–ADMINISTRATION OF MEDICATION PRESCRIBED UNDER THIS SUBTITLE SHALL BE DEEMED TO BE A DEATH FROM

NATURAL CAUSES, SPECIFICALLY AS A RESULT OF THE TERMINAL ILLNESS FROM WHICH THE QUALIFIED INDIVIDUAL SUFFERED.

(B) A PROVISION IN A CONTRACT OR ANY OTHER LEGAL INSTRUMENT THAT IS CONTRARY TO SUBSECTION (A) OF THIS SECTION IS VOID.

(C) SUBSECTION (A) OF THIS SECTION MAY NOT BE CONSTRUED TO PROHIBIT THE PROSECUTION OF A PERSON FOR MURDER OR ATTEMPTED MURDER IF THE PERSON, WITH THE INTENT OR EFFECT OF CAUSING THE INDIVIDUAL'S DEATH:

(1) WILLFULLY ALTERS OR FORGES A REQUEST FOR AID IN DYING;

(2) CONCEALS OR DESTROYS A RESCISSION OF A REQUEST FOR AID IN DYING;

(3) COERCES OR EXERTS UNDUE INFLUENCE ON AN INDIVIDUAL TO COMPLETE A REQUEST FOR AID IN DYING; OR

(4) COERCES OR EXERTS UNDUE INFLUENCE ON AN INDIVIDUAL TO DESTROY A RESCISSION OF A REQUEST FOR AID IN DYING.

(D) (1) THIS SUBTITLE DOES NOT AUTHORIZE A LICENSED PHYSICIAN OR ANY OTHER PERSON TO END AN INDIVIDUAL'S LIFE BY LETHAL INJECTION, MERCY KILLING, OR ACTIVE EUTHANASIA.

(2) ACTIONS TAKEN IN ACCORDANCE WITH THIS SUBTITLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED SUICIDE, MERCY KILLING, OR HOMICIDE.

5–6A–12.

(A) A PROVISION IN AN INSURANCE POLICY, AN ANNUITY, A CONTRACT, OR ANY OTHER AGREEMENT, ISSUED OR MADE ON OR AFTER OCTOBER 1, 2024, IS NOT VALID TO THE EXTENT THAT THE PROVISION WOULD ATTACH CONSEQUENCES TO OR OTHERWISE RESTRICT OR INFLUENCE AN INDIVIDUAL'S DECISION TO MAKE OR RESCIND A REQUEST FOR AID IN DYING UNDER THIS SUBTITLE.

(B) AN OBLIGATION UNDER A CONTRACT EXISTING ON OCTOBER 1, 2024, MAY NOT BE CONDITIONED ON OR AFFECTED BY THE MAKING OR RESCINDING OF A REQUEST FOR AID IN DYING UNDER THIS SUBTITLE.

(C) A QUALIFIED INDIVIDUAL'S ACT OF SELF–ADMINISTERING MEDICATION FOR AID IN DYING MAY NOT HAVE AN EFFECT UNDER A LIFE INSURANCE POLICY, A

HEALTH INSURANCE POLICY OR CONTRACT, OR AN ANNUITY CONTRACT THAT DIFFERS FROM THE EFFECT UNDER THE POLICY OR CONTRACT OF THE QUALIFIED INDIVIDUAL'S DEATH FROM NATURAL CAUSES.

5–6A–13.

(A) EXCEPT AS PROVIDED IN § 5–6A–14(C) OF THIS SUBTITLE:

(1) A PERSON MAY NOT BE SUBJECT TO CIVIL OR CRIMINAL LIABILITY OR PROFESSIONAL DISCIPLINARY ACTION FOR PARTICIPATING IN GOOD–FAITH COMPLIANCE WITH THIS SUBTITLE, INCLUDING BEING PRESENT WHEN A QUALIFIED INDIVIDUAL SELF–ADMINISTERS MEDICATION PRESCRIBED FOR AID IN DYING; AND

(2) A PROFESSIONAL ORGANIZATION OR ASSOCIATION, A HEALTH CARE PROVIDER, OR A HEALTH OCCUPATION BOARD MAY NOT SUBJECT A PERSON TO CENSURE, DISCIPLINE, SUSPENSION, LOSS OF LICENSE, LOSS OF PRIVILEGES, LOSS OF MEMBERSHIP, OR ANY OTHER PENALTY FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN GOOD–FAITH COMPLIANCE WITH THIS SUBTITLE.

(B) 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; OR

(2) PROVIDE THE SOLE BASIS FOR THE APPOINTMENT OF A GUARDIAN OR CONSERVATOR.

5–6A–14.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "NOTIFY" MEANS TO PROVIDE A SEPARATE STATEMENT IN WRITING TO A HEALTH CARE PROVIDER SPECIFICALLY INFORMING THE HEALTH CARE PROVIDER, BEFORE THE HEALTH CARE PROVIDER'S PARTICIPATION IN AID IN DYING, OF A HEALTH CARE FACILITY'S POLICY ABOUT PARTICIPATION IN AID IN DYING.

(3) (I) "PARTICIPATE IN AID IN DYING" MEANS TO PERFORM THE DUTIES OF AN ATTENDING PHYSICIAN, A CONSULTING PHYSICIAN, OR A LICENSED MENTAL HEALTH PROFESSIONAL UNDER THIS SUBTITLE.

(II) "PARTICIPATE IN AID IN DYING" DOES NOT INCLUDE:

1. MAKING AN INITIAL DETERMINATION THAT AN INDIVIDUAL HAS A TERMINAL ILLNESS AND INFORMING THE INDIVIDUAL OF THE MEDICAL PROGNOSIS;

2. PROVIDING INFORMATION ABOUT THIS SUBTITLE TO AN INDIVIDUAL ON THE REQUEST OF THE INDIVIDUAL; OR

3. PROVIDING AN INDIVIDUAL, ON REQUEST OF THE INDIVIDUAL, WITH A REFERRAL TO ANOTHER PHYSICIAN.

(B) (1) A HEALTH CARE FACILITY MAY PROHIBIT A HEALTH CARE PROVIDER FROM PARTICIPATING IN AID IN DYING UNDER THIS SUBTITLE ON THE PREMISES OF THE PROHIBITING HEALTH CARE FACILITY IF THE PROHIBITING HEALTH CARE FACILITY HAS NOTIFIED ALL HEALTH CARE PROVIDERS WITH PRIVILEGES TO PRACTICE ON THE PREMISES OF THE PROHIBITING HEALTH CARE FACILITY'S POLICY REGARDING PARTICIPATING IN AID IN DYING.

(2) THIS SUBSECTION DOES NOT PROHIBIT A HEALTH CARE PROVIDER FROM PROVIDING HEALTH CARE SERVICES THAT DO NOT CONSTITUTE PARTICIPATING IN AID IN DYING UNDER THIS SUBTITLE TO AN INDIVIDUAL.

(C) A HEALTH CARE FACILITY MAY SUBJECT A HEALTH CARE PROVIDER TO THE FOLLOWING SANCTIONS IF THE SANCTIONING HEALTH CARE FACILITY HAS NOTIFIED THE SANCTIONED HEALTH CARE PROVIDER, BEFORE THE SANCTIONED HEALTH CARE PROVIDER PARTICIPATES IN AID IN DYING, THAT THE SANCTIONING HEALTH CARE FACILITY PROHIBITS PARTICIPATION IN AID IN DYING:

(1) LOSS OF PRIVILEGES, LOSS OF MEMBERSHIP, OR OTHER SANCTIONS PROVIDED UNDER THE MEDICAL STAFF BYLAWS, POLICIES, AND PROCEDURES OF THE SANCTIONING HEALTH CARE FACILITY IF THE SANCTIONED HEALTH CARE PROVIDER IS A MEMBER OF THE SANCTIONING HEALTH CARE FACILITY'S MEDICAL STAFF AND PARTICIPATES IN AID IN DYING WHILE ON THE PREMISES OF THE SANCTIONING HEALTH CARE FACILITY;

(2) TERMINATION OF A LEASE OR ANY OTHER PROPERTY CONTRACT OR OTHER NONMONETARY REMEDIES PROVIDED BY A LEASE OR OTHER PROPERTY CONTRACT, NOT INCLUDING LOSS OR RESTRICTION OF MEDICAL STAFF PRIVILEGES OR EXCLUSION FROM A PROVIDER PANEL, IF THE SANCTIONED HEALTH CARE PROVIDER PARTICIPATES IN AID IN DYING WHILE ON THE PREMISES OF THE SANCTIONING HEALTH CARE FACILITY OR ON PROPERTY THAT IS OWNED BY OR UNDER THE DIRECT CONTROL OF THE SANCTIONING HEALTH CARE FACILITY; OR

(3) TERMINATION OF A CONTRACT OR OTHER NONMONETARY

REMEDIES PROVIDED BY A CONTRACT IF THE SANCTIONED HEALTH CARE PROVIDER PARTICIPATES IN AID IN DYING WHILE ACTING IN THE COURSE AND SCOPE OF THE SANCTIONED HEALTH CARE PROVIDER'S CAPACITY AS AN EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE SANCTIONING HEALTH CARE FACILITY.

(D) SUBSECTION (B) OF THIS SECTION DOES NOT PROHIBIT:

(1) A HEALTH CARE PROVIDER FROM PARTICIPATING IN AID IN DYING:

(I) WHILE ACTING OUTSIDE THE COURSE AND SCOPE OF THE HEALTH CARE PROVIDER'S CAPACITY AS AN EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE SANCTIONING HEALTH CARE FACILITY; OR

(II) OFF THE PREMISES OF THE SANCTIONING HEALTH CARE FACILITY OR OFF ANY PROPERTY THAT IS OWNED BY OR UNDER THE DIRECT CONTROL OF THE SANCTIONING HEALTH CARE FACILITY; OR

(2) AN INDIVIDUAL FROM CONTRACTING WITH THE INDIVIDUAL'S ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN TO ACT OUTSIDE THE COURSE AND SCOPE OF THE ATTENDING PHYSICIAN'S OR CONSULTING PHYSICIAN'S CAPACITY AS AN EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE SANCTIONING HEALTH CARE FACILITY.

5–6A–15.

(A) (1) PARTICIPATION BY A HEALTH CARE PROVIDER IN AID IN DYING UNDER THIS SUBTITLE IS VOLUNTARY.

(2) A HEALTH CARE FACILITY MAY NOT REQUIRE THE PHYSICIANS ON THE MEDICAL STAFF OF THE HEALTH CARE FACILITY TO PARTICIPATE IN AID IN DYING.

(B) IF AN INDIVIDUAL REQUESTS OR INDICATES AN INTEREST IN AID IN DYING, AND THE ATTENDING PHYSICIAN OF THE INDIVIDUAL DOES NOT WISH TO PARTICIPATE IN AID IN DYING, THE ATTENDING PHYSICIAN SHALL INFORM THE INDIVIDUAL THAT THE ATTENDING PHYSICIAN DOES NOT WISH TO PARTICIPATE.

(C) ON REQUEST, AN ATTENDING PHYSICIAN EXPEDITIOUSLY SHALL TRANSFER A COPY OF AN INDIVIDUAL'S RELEVANT MEDICAL RECORDS TO ANOTHER ATTENDING PHYSICIAN IF:

(1) THE INDIVIDUAL REQUESTS OR INDICATES AN INTEREST IN AID IN DYING;

(2) THE ORIGINAL ATTENDING PHYSICIAN IS UNABLE OR UNWILLING TO PARTICIPATE IN AID IN DYING FOR THE INDIVIDUAL; AND

(3) THE INDIVIDUAL TRANSFERS THE INDIVIDUAL'S CARE TO ANOTHER ATTENDING PHYSICIAN.

(D) A HEALTH CARE FACILITY MAY ADOPT WRITTEN POLICIES PROHIBITING A LICENSED PHYSICIAN ASSOCIATED WITH THE HEALTH CARE FACILITY FROM PARTICIPATING IN AID IN DYING, IN ACCORDANCE WITH § 5–6A–14 OF THIS SUBTITLE.

5–6A–16.

(A) AN INDIVIDUAL WHO WILLFULLY ALTERS OR FORGES A WRITTEN REQUEST MADE UNDER §§ 5–6A–02 AND 5–6A–03 OF THIS SUBTITLE OR CONCEALS OR DESTROYS A RESCISSION OF AN INDIVIDUAL'S WRITTEN REQUEST WITHOUT THE AUTHORIZATION OF THE INDIVIDUAL AND WITH THE INTENT OR EFFECT OF CAUSING THE INDIVIDUAL'S DEATH IS GUILTY OF A FELONY AND ON CONVICTION IS SUBJECT TO IMPRISONMENT NOT EXCEEDING 10 YEARS OR A FINE NOT EXCEEDING $10,000 OR BOTH.

(B) AN INDIVIDUAL WHO COERCES OR EXERTS UNDUE INFLUENCE ON AN INDIVIDUAL TO MAKE A WRITTEN REQUEST UNDER §§ 5–6A–02 AND 5–6A–03 OF THIS SUBTITLE FOR THE PURPOSE OF ENDING THE INDIVIDUAL'S LIFE OR TO DESTROY A RESCISSION OF A WRITTEN REQUEST IS GUILTY OF A FELONY AND ON CONVICTION IS SUBJECT TO IMPRISONMENT NOT EXCEEDING 10 YEARS OR A FINE NOT EXCEEDING $10,000 OR BOTH.

(C) A SENTENCE IMPOSED UNDER THIS SECTION MAY BE IMPOSED SEPARATE FROM AND CONSECUTIVE TO OR CONCURRENT WITH A SENTENCE FOR ANY CRIME BASED ON THE ACT ESTABLISHING THE VIOLATION OF THIS SECTION.

(D) THIS SUBTITLE DOES NOT LIMIT ANY LIABILITY FOR CIVIL DAMAGES RESULTING FROM ANY OTHER NEGLIGENT CONDUCT OR INTENTIONAL MISCONDUCT BY ANY PERSON.

Article – Insurance

27–208.1.

(A) FOR ALL LEGAL RIGHTS AND OBLIGATIONS AND OTHER PURPOSES GOVERNED BY THIS ARTICLE, THE DEATH OF AN INDIVIDUAL BY REASON OF THE SELF–ADMINISTRATION OF MEDICATION PRESCRIBED UNDER TITLE 5, SUBTITLE

6A OF THE HEALTH – GENERAL ARTICLE SHALL BE DEEMED TO BE A DEATH FROM NATURAL CAUSES, SPECIFICALLY AS A RESULT OF THE TERMINAL ILLNESS FROM WHICH THE INDIVIDUAL SUFFERED.

(B) ACTIONS TAKEN IN ACCORDANCE WITH TITLE 5, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE DO NOT, FOR ANY PURPOSE, CONSTITUTE SUICIDE, ASSISTED SUICIDE, MERCY KILLING, OR HOMICIDE.

(C) A PROVISION IN AN INSURANCE POLICY OR CONTRACT OR AN ANNUITY CONTRACT ISSUED OR DELIVERED ON OR AFTER OCTOBER 1, 2024, IS NOT VALID TO THE EXTENT THAT THE PROVISION WOULD ATTACH CONSEQUENCES TO OR OTHERWISE RESTRICT OR INFLUENCE AN INDIVIDUAL'S DECISION TO MAKE OR RESCIND A REQUEST FOR AID IN DYING UNDER TITLE 5, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE.

(D) AN OBLIGATION UNDER AN INSURANCE POLICY OR CONTRACT OR AN ANNUITY CONTRACT EXISTING ON OCTOBER 1, 2024, MAY NOT BE CONDITIONED ON OR AFFECTED BY THE MAKING OR RESCINDING OF A REQUEST FOR AID IN DYING UNDER TITLE 5, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE.

(E) THE ACT BY AN INSURED OF SELF–ADMINISTERING MEDICATION FOR AID IN DYING UNDER TITLE 5, SUBTITLE 6A OF THE HEALTH – GENERAL ARTICLE MAY NOT HAVE AN EFFECT UNDER A LIFE INSURANCE POLICY, A HEALTH INSURANCE POLICY OR CONTRACT, OR AN ANNUITY CONTRACT THAT DIFFERS FROM THE EFFECT UNDER THE POLICY OR CONTRACT OF THE INSURED'S OR ANNUITANT'S DEATH FROM NATURAL CAUSES.

SECTION 2. AND BE IT FURTHER ENACTED, That, if any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason in a court of competent jurisdiction, the invalidity does not affect other provisions or any other application of this Act that can be given effect without the invalid provision or application, and for this purpose the provisions of this Act are declared severable.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2024.

SB443PAS 2024.pdf

Uploaded by: Vickie Hoffmann
Position: UNF

February 7, 2024

To the Members of Senate Judicial Proceedings Committee:

This is my written testimony opposing the Senate Physician Assisted Suicide Bill SB443

Again, this drive to give hurting people not health care but the ultimate health neglect has reared its ugly head.

I have been a friend and caretaker of handicapped and elderly people who will be the primary targets of such legislation. I have worked as a volunteer with the Missionaries of Charity for fourteen years and helped them take care of poor and sick people who needed long term care. I have witnessed firsthand the value that these people have as they teach us the very important lesson in a highest of human of attributes- giving care as a primary end! I have witnessed the joy that can come from faces who despite struggles and even pain know that they are loved by God and are of infinite value. What drives people to despair is not pain and handicap but being unwanted.

For this year's testimony consider two references I present these references: A study from 2020 where they found the majority of physicians are biased by the assumption that the disabled have less quality of life than abled people: "Physicians' Perceptions Of People With Disability And Their Health Care" by Lisa I. Iezzoni, MD, MSc1 et al in *Health Affairs (Millwood)* 2021

And an article from the Rehumanize Webpage, documenting the abuses that disabled and sick Canadians have been subjected to since the legalization of physician assisted suicide. Large entities such has hospital systems and insurance companies inevitably push for the cheapest not the best. https://www.rehumanizeintl.org/post/canada-s-medical-assistance-in-dying-program-is-ableist-classist-and-coercive

I urge you to vote "no" on SB443. Shut this down once for all, Lets find a better way to help the suffering.

Sincerely

Vickie Hoffmann
Kensington, Maryland

SB443. The Arc Maryland Letter of Information & Re

Uploaded by: Ande Kolp

Position: INFO

The Arc Maryland

The Arc Maryland
8601 Robert Fulton Drive, Suite 140
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SB443: End–of–Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
Judicial Proceedings Committee
February 8, 2024

Letter of Information and Request for 2 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 **only with adequate protections and data provisions**. **On the last page of this testimony, we have detailed the two (2) amendments we request the Sponsor and committee to consider.** SB443 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.

We believe additional safeguards must be added. We respectfully propose bill amendments to 1.) revise the definition of Consulting Physician and 2.) an amendment to add a data collection and reporting requirement.

Amendment 1: Change to the definition and powers of a consulting physician.
To safeguard against a person relying on the medical opinion of one doctor (or practice by extension), we request the addition of a requirement that stipulates that ***the consulting physician and/or mental health professional may not be in the same practice as the attending physician.***

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. Doctors of the same practice routinely confirm each other's opinions and therefore, allowing the consulting physician to be of the same practice is not a strong enough safeguard.

We believe this is why people, who want a true second opinion, 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) to require an impartial second opinion. We do not see this change as presenting a hindrance to a person exercising an end-of-life option. Rather, we see it as a necessary practice to meet the intention of this bill component and safeguard: a second look and <u>independent</u> opinion. As the "End of Life Option" would be an irreversible action, this safeguard is very important to us.

Amendment 2: Data Collection and Reporting Requirement.
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 require the collection and report of data related to the exercise of the end-of-life option.** We have concerns there may be disparate use of this option by people with disabilities, in addition to other marginalized populations. We are aware that the proponents' position is that there is no proof of disproportionate use of medical aid in dying in other states, citing a lack of any evidence to the contrary. Unfortunately, because other states do not keep data, there would not be evidence to either support or dispute a claim of disparate use of the End-of-Life option. Where other states have not collected this important data, we believe it is critical that Maryland commit to keeping an eye on who/what demographics of people are accessing the End-of-Life 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 proposed amendment language.)

Reference for amendment language:
https://mgaleg.maryland.gov/2019RS/amds/bil_0001/SB0311_46867201.pdf

<u>Amendment 1: Add:</u>

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 data collection and reporting requirements:

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.

In closing, we implore our representatives to continue to work to address the marginalization of people with disabilities that persists and affects equitable 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 (through amendment adoption) are put into place before considering a vote.

Respectfully submitted,
Ande Kolp, Executive Director

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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

SB0443_LOI_HPCNM_ End-of-Life Option Act.pdf

Uploaded by: Danna Kauffman

Position: INFO

Hospice & Palliative Care Network
OF MARYLAND

Letter of Information
SB443: 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

SB443, the End-of-Life Option Act, named after The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass, has been recently introduced to the Maryland legislature. Following thorough discussion, the HPCNM Board of Directors has reached a consensus to adopt a neutral stance on this bill. Nevertheless, HPCNM aims to provide valuable information related to 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. Encouraging patients to document their preferences ensures that their end-of-life decisions are well-documented.

- ***Hospice and palliative care professionals believe in respect for patient decisions.*** Hospice and palliative care professionals advocate for respect for patient decisions. Their role is not to pass judgment on the legal decisions patients make regarding the end of their lives. Instead, they focus on providing expert physical, emotional, and spiritual symptom management, and relief through all available means, **without intentionally hastening or causing death.**

- ***Hospice care provides terminally ill patients and their families with compassion, comfort, and security, replacing suffering, desperation, and loneliness***. Timely referrals to hospice can provide patients and their families with opportunities to reduce physical and emotional pain, fostering the creation of meaningful memories. The last months of life, when symptoms are controlled and support is present, can facilitate individual growth and love, providing patients death with dignity and families with closure. Unfortunately, fewer than half of eligible patients receive hospice care, and a significant portion of those referred to do so in their final days, miss out on many benefits such as comfort, emotional counseling, volunteer companionship, and spiritual care.

- ***A cultural shift needs to happen that emphasizes hospice care as "Affirming Life."*** Hospice should not be perceived as care for the brink of death or when there is no hope. Patients redefine hope for themselves when equipped with honest information, realistic expectations, and compassionate support from a team of professionals skilled in relieving distress.

About Hospice & Palliative Care Network of Maryland (HPCNM)
HPCNM represents hospice and palliative care across the State. 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 25,000 patients.

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Maryland Developmental
Disabilities Council

CREATING CHANGE • IMPROVING LIVES

Senate Judicial Proceedings Committee
February 8, 2024
SB 443: 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. The 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 often 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.

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