

## 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,

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