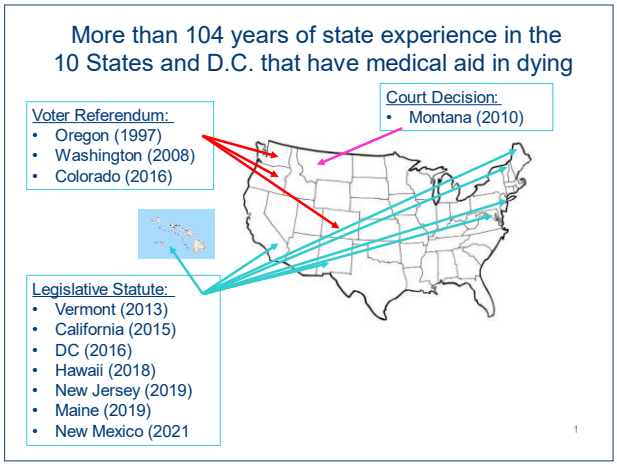
Testimony of Michael Strauss, MD, MPH -- Favorable
Regarding HB1328 and SB926 -- The End-of-Life Option Act
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)
March 2025

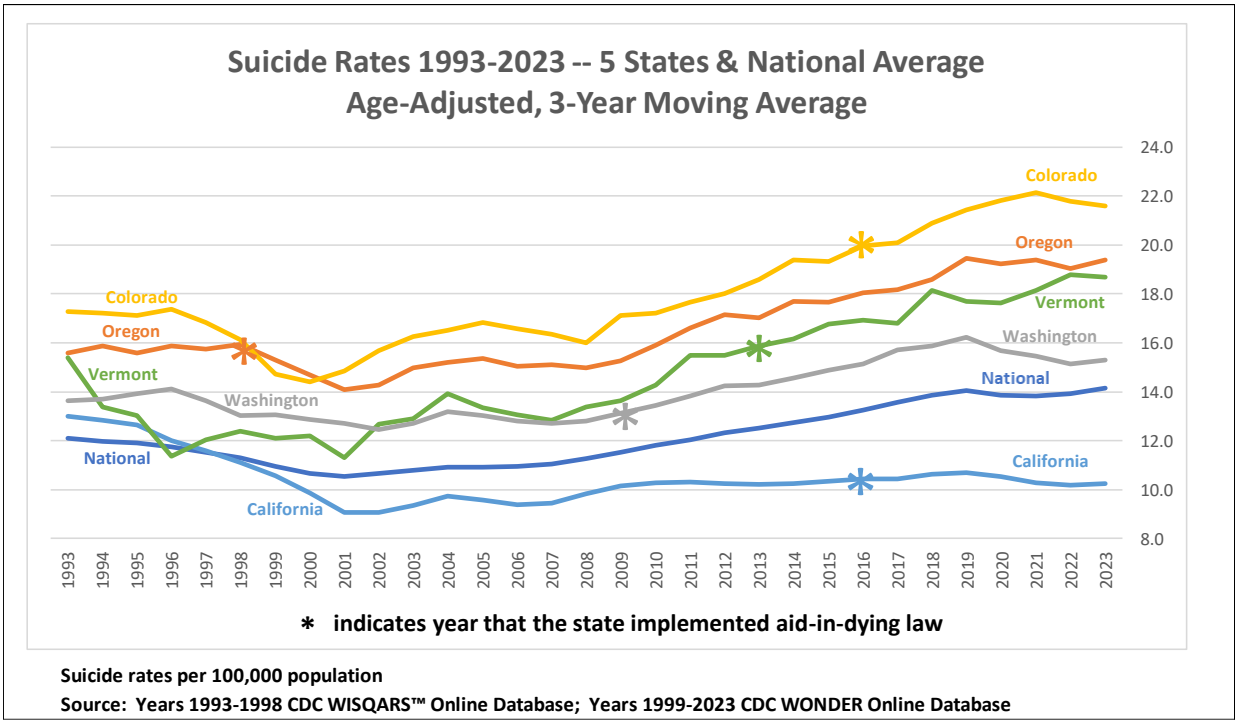
I am Dr. Michael Strauss, a board-certified internist, and I strongly support this bill.

You are hearing compelling reasons why you should support this bill. Now I want to caution you about misstatements or unrealistic hypothetical issues that opponents describe. Because we now have **104 years of experience in the 10 states and District of Columbia** that have medical aid in dying, you need to understand what has **not** happened in these states.

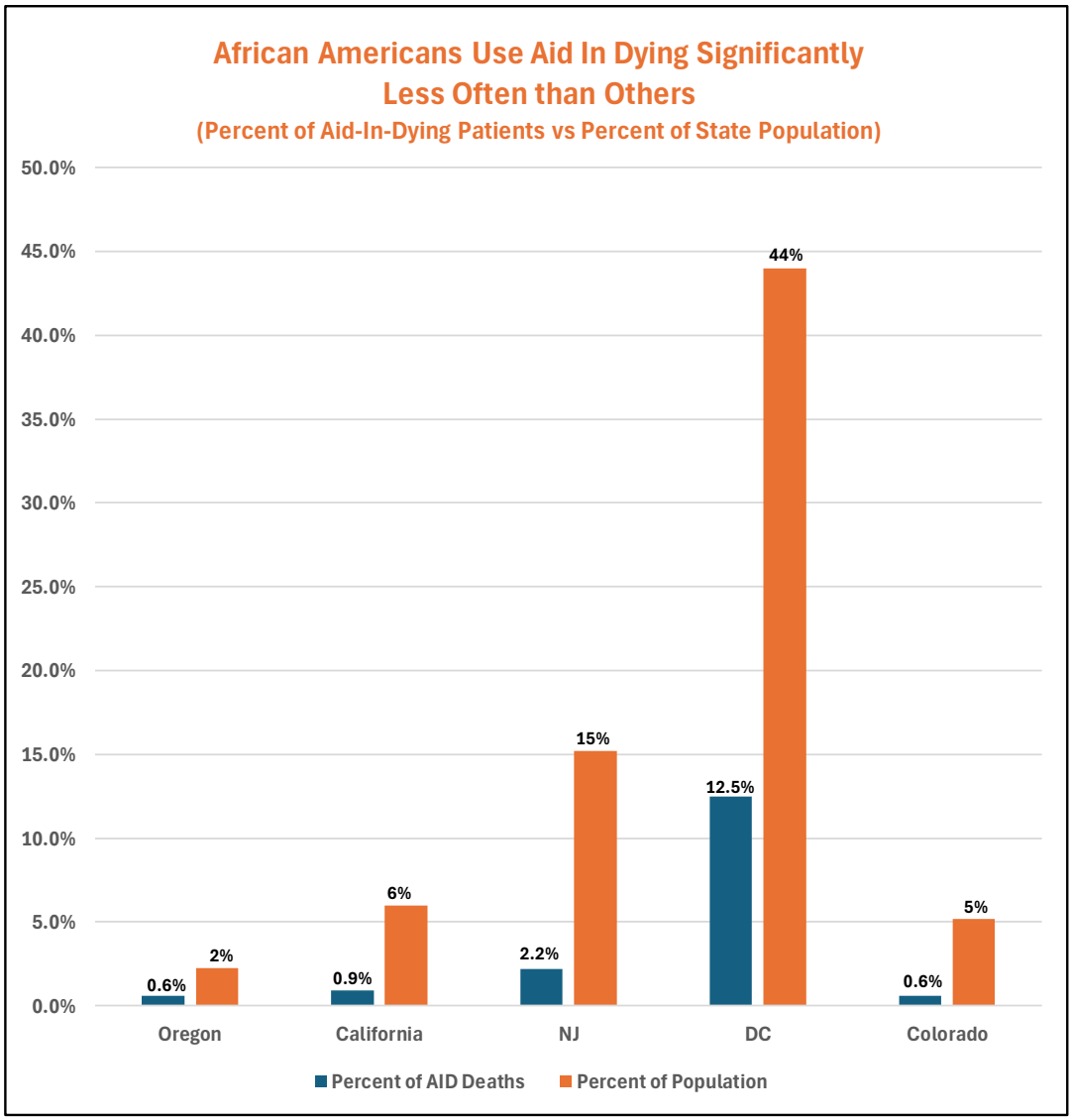


	Years with Aid in Dying
Oregon	27
Washington	16
Colorado	9
New Mexico	4
California	10
Vermont	12
New Jersey	6
Maine	6
DC	8
Hawaii	6
Total	104

Aid in Dying Does NOT Increase the Suicide Rate



Suicide rates per 100,000 population
Source: Years 1993-1998 CDC WISQARS™ Online Database; Years 1999-2023 CDC WONDER Online Database



Aid-in-dying data from most recent state reports. (OR 2024; CA 2023; NJ 2022; DC 2022; CO 2023)
Other states do not report findings by race. State population rates from 2020 Census.

- No increases in a state suicide rate beyond increases that have happened across all states, as you can see in the graph on page 1. States with higher suicide rates than the national average had higher rates before the introduction of aid in dying.
- No forced use of aid in dying in marginalized population. As the graph above shows, in the 5 states that provide aid-in-dying use by race, the percent of patients who are African American is, on average, one sixth as high as the African American percentage of each state's population. African Americans use aid in dying significantly less often than others.
- 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 problem of attending physicians evaluating capacity. Credible studies from California and 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 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 are similar.
- No credible cases of an insurance company denying medical coverage of a treatment because the patient has access to aid-in-dying.

So please, as you hear hypothetical claims today, ask whether the identified concern has ever occurred in the 104 years of state experience with medical aid in dying laws.