HB 1328 “End of Life Options Act” **OPPOSED**. Debbie Ryan, RN, BSN, MS, NNP-BC, Garrett Park, MD

In meeting with a few legislators leading up to my testimony opposing Physician-Assisted Suicide, 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 experiences multiple encounters with each patient every day, thus developing a very close relationship with each patient.

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?”

This Legislation represents the antithesis of what it means to be a caring nurse. It serves to erode that trusting relationship, one of caring and true compassion.

In addition to this erosion, the so-called End-of-Life-Options Act ignores nurses. While there are some vague protections for “licensed Health care Providers,” those who practice in Healthcare understand this to mean Physicians, Nurse Practitioners, and Physician’s Assistants, not general nurses, the individuals who spend the most time with patients.

In its 2019 statement, The American Nurses Association has a clear advice for states where this is legal: there must be conscience protections for nurses.

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 *anyone*, well or sick, takes 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 society in delivering health care, failure to identify a patient’s depression, failure of society to unload the burdens associated with the patient’s illness, and even failure to adequately treat pain.

When one considers Beck’s Depression Inventory, a common questionnaire used to screen for depression, one realizes that those that seek PAS would qualify as clinically depressed. Among the reasons they site for choosing

PAS, as noted in the 2023 Oregon Report, is "less able to engage in activities that make life enjoyable." Couple that with the desire to end one's life, and one automatically qualifies as suffering from Depression. We should be treating this Depression, NOT offering them the tool with which to carry out suicide.

And we know from the extensive research by K.Foley at Sloan Kettering Cancer Center, that when we treat individuals' depression, they will often reverse their decision to utilize Assisted Suicide.

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 2023 Oregon Report, states that 30 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 560 individuals who filled prescriptions in 2023, 82 died of other causes, 367 died from ingestion of said prescription, and ingestion status was unknown for 141 individuals who also filled prescriptions. Doing the arithmetic, as many as 193 (560 minus 367) prescriptions were filled and unused. **So, what happened to those unused prescriptions? They are likely still in the community, but that statistic is not recorded.**
   Source: Oregon Death with Dignity Act: 2023 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.

   The Bill states that anyone in possession of unused prescriptions "shall dispose of it in a lawful manner," but it does not detail what that might mean. No "lawful" disposition is detailed. Many believe that responsible disposal includes flushing it down the toilet…are we willing to risk introducing this into our water supply and water ways?

2. **Government should preserve citizens' lives, NOT facilitate their suicide.**

   And, despite a statewide suicide hotline (988), 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. 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.
   In short, the government should be in the business of preserving the lives of its citizens, NOT facilitating their suicides. A legitimate government does not dictate which citizens receive life-saving psychiatric care and which patients do not.

3. **Physicians conscience protections are weak and force them to be complicit in a practice they find morally objectionable.**
   In this version of the Bill, even if the physician finds this practice morally objectionable, he or she is forced to comply by forwarding records to someone who will participate. On page 19 of SB 926 / HB 1328 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.

I urge you to OPPOSE SB 0926 /HB 1328, the End of life Options Act.

Sincerely,
Debbie Ryan, BSN, RN, MS, NNP-BC