The Honorable Senator Jason M. Lewis, Chair

The Honorable Representative Kate Hogan, Chair

Joint Committee on Public Health

Dear Senator Lewis, Representative Hogan and Members of the Joint Committee on Public Health,

In this season of Thanksgiving we are so grateful for your sincere and conscientious desire to serve all the people of Massachusetts with tireless commitment and zeal. We know you deal with controversial issues every day as you seek to understand the various viewpoints and make balanced decisions for the betterment of all citizens in our Commonwealth.

On September 26, 2017 you patiently heard many viewpoints on H1194 and S1225, An Act relative to end of life options commonly referred to as "Physician Assisted Suicide". Since that date you have continued to review the many papers and opinions presented to you.

On October 2, 2017 a written testimony was sent to you by Representative Louis Kafka in which he presented a detailed response to issues and claims presented by those opposed to "Physician Assisted Suicide". This is a follow up to Representative Kafka's letter. We are now providing factual information to correct misrepresentations in Representative Kafka's letter.

Medical research and experience strongly back opposition to Physician Assisted Suicide (PAS) as presented in the following reasons which illustrate why the Commonwealth of Massachusetts should focus on compassionate care rather than lethal "solutions".

1. **Suicide Rates in states that currently allow PAS have been higher than in other states**.

   While it is true that suicide rates have risen nationally, as well as in Oregon over several years, statistical studies have shown that the rate of increase in states that have implemented physician assisted suicide has been higher than in other states. According to a study published by the *Southern Medical Journal* the introduction of assisted suicide was associated with a 6.3% increase in total suicides even when differences between states, such as socioeconomic status, were taken into account.[1] This means that states where assisted suicide became legal had greater increases in their rate of suicide than did states where it was not legal, even when other factors that affect suicide rates were included in the statistical analysis.

   Controlling for various socioeconomic factors, unobservable state and year effects, and state-specific linear trends, we found that legalizing PAS [physician-assisted suicide] was associated with a 6.3% (95% confidence interval 2.70%–9.9%)

[1] Jones, D. A., & Paton, D. (2015). How does legalization of physician assisted suicide affect rates of suicide? *Southern medical journal*, *180*(10), 599-604.

increase in total suicides *(including assisted suicides). This effect was larger in the individuals older than 65 years (14.5%, CI 6.4%–22.7%).*

2. Doctors cannot accurately predict life expectancy.

Assisted suicide measures typically hinge on a physician's prediction of life expectancy. The Washington, DC assisted suicide measure, for example, stipulates:

"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within 6 months.

Yet research has shown that when it comes to predicting life expectancy, "reasonable medical judgment" is usually *wrong*.

A 2012 study of such predictions related to prostate cancer patients found, "Overall, respondents were within 1 year of actual life expectancy only 15.9% of the time; on average, respondents were 67.4% inaccurate in relation to actual survival."

Such dismal prediction rates led researchers to conclude, "Physicians do poorly at predicting life expectancy and tend to underestimate how long patients have left to live. This overall inaccuracy raises the question of whether physicians should refine screening and treatment criteria, find a better proxy or dispose of the criteria altogether."[2]

3. Home-stored lethal chemicals are unlocked loaded guns.

Assisted suicide measures provide for patients to obtain lethal chemicals and then simply store them in their own homes. Storing lethal prescriptions in the home is the equivalent of storing unlocked loaded guns around the house.

A 2016 survey published online in *JAMA Internal Medicine* found that nearly 60 percent of Americans have leftover narcotics in their homes, 20 percent have shared those with another person and fewer than nine percent kept medications in a location that could be locked. Given this pattern, the likelihood of lethal prescriptions falling into the hands of individuals, including children, other than the patient, is dangerously high.[3]

4. Patients already have the ability to decline extraordinary measures that only prolong death, and to receive aggressive pain relief and palliative care.

The law and medical practice have long provided for the ceasing of extraordinary measures for patients that simply prolong death. Much progress has been made in pain control technology and in recognizing the value of aggressive pain control—including when it has

[2] Kevin M.Y.B. Leung, MD;* Wilma M Hopman, MD;† Jun Kawakami, MD, FRCSC, "Challenging the 10-year rule .The accuracy of patient life expectancy predictions by physicians in relation to prostate cancer management," Can Urol Assoc J 2012;6(5):367-73. http://dx.doi.org/10.5489/cuaj.11161 Abstract.

[3] Alene Kennedy-Hendricks, PhD1,2; Andrea Gielen, ScD1,3,4; Eileen McDonald, MS3,4; et al Emma E. McGinty, PhD, MS1,2,4,5; Wendy Shields, MPH1,4; Colleen L. Barry, PhD, MPP1,2,5, "Medication Sharing, Storage, and Disposal Practices for Opioid Medications Among US Adults," *JAMA* Intern Med. 2016;176(7):1027-1029. doi:10.1001/jamainternmed.2016.2543.

the secondary, unintended effect of hastening death. Palliative care offers compassionate and effective comfort to patients in their last days, as well as the support of loved ones.

In fact, such progress in recognizing the time for natural death, in aggressively treating pain and in providing compassionate palliative care is strong evidence that make legalizing assisted suicide even less reasonable. Yet still more progress can be made in the legal arena regarding aggressive pain control; this was in part the impetus for the bipartisan bill introduced in 1999 by Senators Nickles and Lieberman, the Pain Relief Promotion Act.

As the American College of Physicians and American Society of Internal Medicine have observed, "We must solve the real and pressing problems of inadequate care, not avoid them through solutions such as physician-assisted suicide. A broad right to physician-assisted suicide could undermine efforts to marshal the needed resources, and the will, to ensure humane and dignified care for all persons facing terminal illness or severe disability."[4]

5. Empowering doctors to kill disempowers patients.

Once policy makers in the Netherlands and Belgium discarded the Hippocratic ethic in favor of assisted suicide and euthanasia, the dike of patient protections broke and a sea of medical killing swept in.

A report published in a 2011 edition of the journal *Current Oncology,* entitled, "Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls," revealed that in the Netherlands, "For every five people euthanized, one is euthanized without having given explicit consent." The report also noted, "In Belgium, the rate of involuntary and non-voluntary euthanasia deaths (that is, without explicit consent) is three times higher than it is in the Netherlands."[5]

6. Financial and personal pressures create a "duty to die."

The dangerous power of judging lives as unworthy does not come into effect only when physicians or politicians inflict on victims their power to kill with impunity; it can also insidiously infect patients' self-perception and lead to voluntary deaths. "Maybe my life really is not worth living. Maybe I really am a burden to my loved ones and to society. Maybe I owe it to everyone to kill myself."

Former US Surgeon General Dr. C. Everett Koop personally observed many, especially elderly, patients who felt a sense of what Dr. Koop came to identify as a "duty to die."

[4] L. Snyder and D. Sulmasy, "Physician-Assisted Suicide" (Position Paper of the American College of Physicians and American Society of Internal Medicine), 135 Annals of Internal Medicine (2001) 209-16 at 214.

[5] J. Pereira, MBChB MSc, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls," Curr Oncol. 2011 Apr; 18(2): e38–e45. PMCID: PMC3070710.

In 1985, Dr. Koop prophetically noted regarding assisted suicide, "Two other forces are now at the crossroads: the decline of medical ethics and the push for health cost containment."[6]

When cash-strapped governments condone and legalize suicide, it is hard for patients to escape the sense that as far as the government is concerned, suicide is a cost-saving preferred option. Media have reported on instances of government payers favoring assisted suicide over paying for patient care.

Financial factors contributing to a vulnerable patient's sense of a "duty to die" include insurers and government entities that balk at paying for lifesaving drugs, the prospect of depleting resources that otherwise would pass on to loved ones as an inheritance and even subtle pressure from heirs to accelerate the dying process under a guise of compassion. Even the way a careless or uncaring physician negatively presents a prognosis can influence patients to choose early death.

7. The minority and poor are impacted in increased portion by PAS legislation.

Despite the endorsement of the American Civil Liberties Union, the message sent to the poor by legalizing assisted suicide is that lives that are led in marginal circumstances are not worth living. This cultural shift may not be evident to the ACLU, but the importance of social conditions and attitudes in influencing suicide rates was statistically demonstrated as early as the end of the nineteenth century by the sociologist Emile Durkheim in his book *Suicide*. A recent population-based study that used the latest social science methodologies also supports the claim that social conditions influence suicide.[7] Furthermore, the pressure that a poor person feels his or her family suffers as a result of his or her illness is not in any way reduced by the opinions of the ACLU and may still make suicide an attractive action.

8. Undiagnosed depressed but treatable patients will choose suicide.

Research shows that nine out of ten people who die by suicide suffer from clinical depression or another diagnosable mental disorder.[8] The sense of hopelessness that severely depressed patients experience can deter them from seeking the help they desperately need.

Instead of making sure that severely depressed patients experiencing hopelessness receive a psychological examination or treatment for depression, assisted suicide measures require merely a suggestion of help before handing the patient a bottle of lethal pills.

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[6] C. Everett Koop, MD, banquet address, National Right to Life Committee, Washington, DC, June 22, 1985. Transcript available online at https://profiles.nlm.nih.gov/ps/access/QQBBFR.ocr

[7] Denney, J. T., Wadsworth, T., Rogers, R. G., & Pampel, F. C. (2015). Suicide in the city: do characteristics of place really influence risk?. *Social science quarterly*, *96*(2), 313-329.

[8] Keith Hawton, Carolina Casañas i Comabella, Camilla Haw, Kate Saunders, "Risk factors for suicide in individuals with depression: A systematic review," *Journal of Affective Disorders* Volume 147, Issues 1–3, May 2013, Pages 17–28, http://dx.doi.org/10.1016/j.jad.2013.01.004

Normally, and especially given the rising epidemic of teen suicides, government and social organizations seek to provide messages and resources to discourage suicide and to maximize interventions and treatment of depressed individuals in order to prevent suicides. Government-sponsored suicide turns that approach on its head, instead facilitating the suicide choice and sending a message, "Depressed and despairing of life? Here's an easy way out."

9. Assisted suicide encourages judgment of the disabled as "life unworthy of life."

Members of the disability-rights group Not Dead Yet strongly oppose legalizing assisted suicide because it encourages and facilitates the devaluing of their lives:

> *[I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.*[9]

The idea of ridding society of the vulnerable, including the disabled, has a long and sordid history. One reason why the school of Hippocrates gained ascendancy in ancient times is that before Hippocratic protections, physicians possessed the fearful power of poisoning their patients. Undergirding this poisonous power was the notion, expressed by Plato, that "Mentally and physically ill persons should be left to death; they do not have the right to live."

Centuries later, the Nazis revived this deadly outlook on the disabled, dismissing the values of such individuals as "life unworthy of life" ("Lebensunwertes Leben"). Today this lethal, utilitarian judgment of life as unworthy of life seeks new roots in the capital of the United States, in the process sending a chilling message to the disabled and other vulnerable patient communities.

10. Legalization of Physician Assisted Suicide removes hope of the possibility of a medical breakthrough.

Some of the finest medical institutions and research centers in the world are located in the Commonwealth of Massachusetts. Every day there are medical breakthroughs impacting individuals with terminal illness. This was tragically brought home after Brittany Maynard (29 years old) had her highly publicized PAS for her glioblastoma in November 2014....and the following March, TIME magazine's cover article included a woman with the same brain tumor, who had 'no trace of the tumor' after new therapy. Also, former Marine J.J. Hanson (N.Y.) has the same diagnosis as Brittany about the same time, and with therapy is still alive 3 years later.

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[9] Diane Coleman, "Assisted Suicide Laws Create Discriminatory Double Standard for Who Gets Suicide Prevention and Who Gets Suicide Assistance: Not Dead Yet Responds to Autonomy, Inc.," Disability and Health Journal, Vol. 3, No. 1 (January 2010), p. 48.

11. Physician assisted suicide provides neither compassion nor choice: the proponents have a hidden agenda for their long-range goals:

a) Physician Assisted Suicide does not provide compassion or choice:

Choice is actually limited by legalizing PAS by governmental agencies and insurance companies. The definition of compassion is "to suffer with". PAS does not provide compassion, but rather abandonment of the patient at the end of life. Once lethal medication is prescribed, the doctor abandons the patient and is very rarely present at the time of death. In Oregon, the model for H.1194/S.1225,the prescribing physician was present only 10% of the time)Oregon Death with Dignity Act; Data Summary 2016).

b) Proponents for Physician Assisted Suicide (Compassion & Choices) Seek Involuntary Euthanasia:

Compassion & Choices is responsible for promoting the dangerous laws to permit state sanctioned suicide. Compassion & Choices is the rebranded Hemlock Society which was founded in 1980 by Derek Humphry to promote legalization of assisted suicide. Derek Humphry's views are embodied in the Hemlock Society, USA and World Federation of Right to Die Societies of which he was president. Both groups support the decriminalization of voluntary euthanasia. Going even further Derek Humphry supports involuntary euthanasia. In his book published in 1998, "Freedom to Die", he wrote supportively of using assisted suicide as "one measure of cost containment". He wrote that "the elderly are putting a strain on the health care system that will only increase and cannot be sustained." He wrote of a "duty to die".

Even more disturbing are the views of Compassion & Choices current president Barbara Coombs Lee. She prefers to expand the list of those who can receive lethal drugs to include those who have any kind of discomfort. In USA Today on April 17, 2015, Barbara Coombs Lee congratulated our close neighbors in Canada on its astounding Supreme Court decision that allows euthanasia for virtually any reason and possibly for those people whose wishes are unknown. In a press release she wrote, "We are heartened as availability of aid in dying in Canada will have an impact here, especially in border states." The situation in Canada is bleak. The Canadian Supreme Court, February 6, 2015, found a constitutional right to 'termination of life" for anyone who has an "irremediable medical condition….that is intolerable to the individual." Advocates of assisted suicide have involuntary euthanasia as an ultimate goal.

The strategy and dangers are clear: The major proponent for doctor prescribed suicide is the former Hemlock Society, rebranded as Compassion & Choices, based in Colorado. The group is supported by big out-of-state money. Supporters of legalizing assisted suicide have their own hidden agenda to change the American society to a culture of death, with involuntary euthanasia as its goal. There appears to be a plan to promote the ultimate goals in small steps to not alarm the general American public, primarily using highly emotional personal testimonies.

We sincerely appreciate your valuable time and consideration in reviewing the above positions and references presented in this letter.

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