SENATE JUDICIARY
EXHIBIT NO. 29
DATE 3/26/13
BILL NO. HB505

TESTIMONY IN OPPOSITION TO HB 505

Mr. Chairman, Senator Murphy and Members of the Senate Judiciary Committee:

I submit this testimony in opposition to HB505. Unfortunately, other commitments require me to be out of state and prevent my personal appearance at this committee hearing. I appreciate the opportunity to testify in support of protecting and preserving end of-life-choice in Montana, so that aid in dying remains within the full spectrum of end-of-life choice available to Montanans

I am Ronald F. Waterman and appear here on behalf of myself in opposition to HB 505.

HB 505 attempts to reverse the Baxter decision, which confirmed that aid in dying to competent terminally ill persons was lawful in Montana.

HB 505 will create a substantial amount of uncertainty within the legal and medical communities. Given that the legislation defines "physician assisted suicide" as "any act by a physician of purposely aiding or soliciting another person to end the person's life," it is obvious that many acts of a physician advising a terminally ill patient will be implicated in this broad and general definition. Talking to a patient about end of life options could become an act of aiding or soliciting suicide. So could giving information to a patient about the effects which different drugs could have upon a patient or providing dosage information to a patient. The unintended consequence of this legislation will be that physicians will move away from any discussion of end of life choices with their patients. This bill will make the practice of medicine, in this area of end of life choices, worse than it currently is.

The act criminalizes more than just the acts of a physician, it criminalizes the acts of any person who aids another to commit suicide. The bill would criminalize conduct of a child who provided transportation to a parent who obtained any drugs later used to achieve a peaceful death. Indeed, it would make criminals of anyone who even spoke with any favor to another person concerning the act of achieving a peaceful death in the face of intolerable suffering associated with terminal illness.

Recognizing that it has long been public policy to allow patients to receive medication to alleviate pain during their final days, the bill attempts to differentiate and not apply to the Rights of the Terminally Ill Act, § 50-9-101, et. seq., MCA. However, HB 505 only excepts out acts performed under the Rights of the Terminally Ill Act, which "may incidentally hasten the dying person's death." However, the Rights of the Terminally Ill Act authorizes a physician and other health care professionals to cease providing life sustaining treatment, which not only "incidentally" hastens a person's death but which directly results in a persons death. HB 505, if passed, will make criminals out of even those individuals who attempt to follow the language of the Rights of the Terminally Ill Act. This includes physicians, nurses and the institutions where they practice their professions, the hospitals in this state. The conflict between this law, if passed, and The Rights of Terminally Ill Act will require extensive litigation to sort out and most likely this Act will be declared void.

HB 505 has a large number of problems with it. Most notably, however, is the fact that it will make criminals out of patients, family members, physicians and other health care professionals who attempt to allow competent terminally ill persons to make end of life choices.

HB 505 seeks to bar conduct that we know improves end of life care and poses no risks to patients.

THE EXPERIENCE WITH AID IN DYING

This Committee stands in a landscape rich with data about how the availability of aid in dying impacts end-of-life care, from the State of Oregon.

The results in Oregon have demonstrated that aid in dying does not put patients at risk,[1] as evidenced by a comprehensive report that examined the Oregon experience to assess whether vulnerable populations were at risk and concluded that there was no evidence of this.[2]

The Oregon data shows that the dire predictions of those initially opposed to the Dignity Act were unfounded, and that the option of aid in dying has not been unwillingly

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[1] *See* Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands:Evidence Concerning the Impact on Patients in 'Vulnerable' Groups*, 33 J. MED. ETHICS 591, 593-95 (2007); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act*, 285 J. AM. MED. ASS'N 2363, 2368 (2001); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote:The Silver Lining*, 124 ANNALS INTERNAL MED. 267, 267–69 (1996); Quill & Cassel, Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide:A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208, 209 (2003); Kathryn A. Smith et al., *Quality of Death and Dying in Patients who Request Physician-Assisted Death*, 14 J. PALLIATIVE MED. 445, 446-47 (2011); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV RTS. L. REV. 475, 479, 482 (2006); American Public Health Association, *APHA Policy on Patient Self-Determination at the End of Life* (2008) (During the policy development and consideration process at APHA, the Disability Section of that organization argued against adoption of the policy, claiming that it would put persons with disabilities at risk. This argument was thoroughly considered; indeed, it prompted APHA to consider the policy over a two-year policy cycle rather than a single-year cycle. After careful, evidence-based consideration of those arguments, the health policy professionals at APHA ultimately rejected them as unconvincing and adopted its policy in support of aid in dying.) Observers outside the U.S. examining the experience in the U.S. with an open practice of aid in dying have also found no evidence of harm. See, the Royal Society of Canada Expert Panel on End-of-Life Decision Making (RSC EOL Panel) (Nov. 2011) ("Despite the fears of opponents, it is also clear that the much-feared slippery slope has not emerged following decriminalization, at least not in those jurisdictions for which evidence is available. Nor is there evidence to support the claim that permitting doctors to participate in bringing about the death of a patient has harmed the doctor/patient relationship. What has emerged is evidence that the law is capable of managing the decriminalization of assisted dying and that state policies on this issue can reassure citizens of their safety and well-being." @ p. 90). A Canadian court, in considering a case about end of life choice, examined extensive data from the practice in the US with aid in dying and adopted factual findings that there was no evidence of risk or harm to patients, or to vulnerable populations including specifically persons with disabilities. *Carter v. Canada,* 2012 BCSC 886, Vancouver Registry, Docket Number S112688)(appeal pending).

[2] Battin et al., *supra.*

forced upon those who are poor, uneducated, uninsured or otherwise disadvantaged.[3] In fact, the data shows just the opposite: For example, the reports reflect that patients choosing aid in dying have a high level of education,[4] are overwhelmingly insured (100% of patients opting for aid in dying had either private health insurance, Medicare or Medicaid), and almost all (97%) were enrolled in hospice care.[5] Furthermore, the data demonstrates that aid in dying is rare: During the first fifteen years this option was openly available in Oregon, only 673 patients chose it.[6] A survey of Oregon physicians found that they granted one in six requests for aid in dying, and that only one in ten requests resulted in patients ingesting the medication.[7] Further, interestingly, more than one-third of patients who complete the process of seeking medications for aid in dying do not go on to consume them.[8] Deriving comfort from having the option to control their time of death, these patients ultimately die of their disease without exercising that control.[9]

Overall, observers studying aid in dying in Oregon have concluded that the law poses no risk to patients. Leading scholars have concluded: "I [was] worried about people being pressured to do this ... But this data confirms ... that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy."[10]

Indeed, rather than posing a risk to patients or the medical profession, the availability of aid in dying galvanized significant improvements in the care of the terminally ill in Oregon. Oregon physicians report that since aid in dying has been openly available, they have worked hard to improve end-of-life care, taking educational courses in how to treat pain associate with terminal illnesses, how to recognize depression and other psychiatric disorders, more frequently referring patients to hospice, and making

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[3] Arthur Chin et al., *Oregon's Death with Dignity Act:The First Year'sExperience*, OR. HEALTH AUTH. 1999, at 7, *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf. "Patients who chose physician-assisted suicide were *not* disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care." *Id.*; Battin et al., *supra* at 591; Kant Patel, *Euthanasia and Physician-Assisted Suicide Policy in The Netherlands and Oregon: A Comparative Analysis*, 19 J. HEALTH SOC. POL'Y 37, 51-52 (2004) (finding no empirical evidence of slippery slope in Oregon, but more potential for a slide in the Netherlands). See APHA policy, Supra

[4] *See e.g.*, Or. Dept. of Human Servs., *Annual Report on Annual Oregon's Death With Dignity Act*, OR. HEALTH AUTH., at 2, *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. [hereinafter Annual Reports].

[5] *Id.*

[6] *Id.*

[7] Linda Ganzini, et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557, 561 (2000) (finding that the availability of palliative care led some, but not all, patients to change their mind about hastening death).

[8] *See Annual Reports.*

[9] *Id.*

[10] William McCall, *Assisted-suicide Cases Down in '04; 37 Terminally Ill Oregonians Took Lethal Drug Doses*, THE COLUMBIAN, Mar. 11, 2005, at C. (quoting Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine). *See also* Straton, *supra* at 482.

such referrals earlier.[11] Surveyed on their efforts to improve end-of-life care since aid in dying became available, 30% of physicians reported increased referrals to hospice care, 76% had made efforts to improve their knowledge of pain management.[12] Hospice nurses and social workers observed an increase in physician knowledge of palliative care and willingness to refer to hospice.[13]

The availability of the option of aid in dying has significant psychological benefits for both the terminally ill and the healthy.[14] The availability of the option gives the terminally ill autonomy, control and choice, the overwhelming motivational factor behind the decision to request aid in dying.[15] Healthy Oregonians know that if they are confronted by a dying process they find unbearable, they have this additional end-of-life option. Survivors of patients who choose aid in dying suffer none of the adverse mental health impacts commonly experienced by survivors of those who commit suicide.[16]

Leading medical and health policy professional organizations which have taken a careful, evidence-based review of the experience in Oregon have adopted policy supportive of aid in dying, including the American Public Health Association, the nation's oldest and largest organization dedicated to protecting the public health of the nation.[17] The Oregon experience has caused even staunch opponents to acknowledge that

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[11] *See* Ganzini *et al.*, *supra*, at 2363, 2367-68; Lee & Tolle, *supra*, at 267-69; Quill & Cassel, *supra*; Lawrence J. Schneiderman, *Physician-Assisted Dying*, 293 J. AM. MED. ASS'N 501 (2005) (reviewing *PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE* (Timothy E. Quill, & Margaret P. Battin eds., 2004.) ("Indeed, one of the unexpected yet undeniable consequences of Oregon's Death with Dignity Act permitting physician aid in dying is that 'many important and measurable improvements in end-of-life care' occurred following the Act's implementation. Rather than becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader in providing excellent and compassionate palliative care.")

[12] Ganzini et al., *supra,* at 2363.

[13] Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past 5 Years,* 1 PALLIATIVE &SUPPORTIVE CARE 215, 218 (2003).

[14] Kathy L. Cerminara & Alina Perez, *Empirical Research Relevant to the Law:Existing Findings and Future Directions*, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512–13 (2000).

[15] *Id.* (the data from Oregon justifies optimistic view); Smith et al., *supra*, at 445, 449. *See also* Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MED. 381, 381 (2003) (finding physicians receiving requests for lethal medication perceive patients as wanting to control their deaths); Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 582 (2002) (showing nurses and social workers rated desire to control circumstances of death as most important reason for requesting aid in dying).

[16] Linda Ganzini et al. Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying, 38 Journal of Pain and Symptom Management 807 (2009).

[17] *See* Am. Pub. Health Ass', *Patients' Rights to Self-Determination at the End of Life*, POL'Y STATEMENT DATABASE (Dec. 28, 2008) http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372 ("A small fraction of dying people confront a dying process so prolonged and marked by such extreme suffering that they determine hastening impending death to be the best alternative. Many Americans believe that the option of death with dignity should be open to those facing a terminal illness marked by extreme suffering."); AM. C, LEGAL MED.POLICY ON AID IN DYING (2008) ("[T]he ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death . . . ."); AM. MED. STUDENT ASS'N 71, *available at* http://www.amsa.org/AMSA/Homepage/About/AMSAConstitution.aspx (follow "2011 AMSA Constitution, Bylaws and Internal Affairs" hyperlink) (last visited Jan. 13, 2012); AM. MED. WOMEN'S ASS'N, AMERICAN MEDICAL WOMEN'S ASSOCIATION POSITION PAPER ON AID IN DYING ¶¶ 1-2 (2007), *available at*

continued opposition to aid in dying can only be based on personal, moral or religious grounds.[18]

In Montana, the Board of Medical Examiner has adopted policy making clear how it will handle complaints regarding aid in dying. The BME can ensure safe practice with this end of life option, as it does all other medical care.

CONCLUSION

Thank you for the opportunity to share this perspective. As noted philosopher Ronald Dworkin observes:

> *We live our whole lives in the shadow of*
> *death, we die in the shadow of our whole*
> *lives. ... we worry about the effect of*
> *life's last stage on the character of life as*
> *a whole, as we might worry about the effect*
> *of a play's last scene or a poem's last*
> *stanza on the entire creative work.*[19]

Preserving aid in dying in Montana will empower each individual Montanan to determine how 'life's last stage' will be crossed.

Ronald F. Waterman

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http://www.amwa-doc.org/page3-8/PositionStatements (follow "Aid in Dying" hyperlink under "Ethical Issues" heading) (supporting the passage of aid-in-dying laws which empower mentally competent, terminally ill patients and protect participating physicians, such as that passed in Oregon, the Oregon Death with Dignity Act). See also, Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL'Y REV. 45 (2009).

[18] Daniel E. Lee, *Physician-Assisted Suicide:A Conservative Critique of Intervention*, HASTINGS CTR. REP. 1, 1, 4 (2003)..

[19] Ronald Dworkin, Life's Dominion.