EXHIBIT 7
DATE 2/18/15
HB 477

February 18, 2015

To: Montana House Judiciary Committee

From: Thomas A. Warr, MD, FACP

Re: **HB 477**

I am in favor of HB 477.

Let me first state my qualifications: I have lived and practiced medicine in Great Falls, Montana since 1989. I am ABIM certified in internal medicine, medical oncology, hematology, and hospice/palliative medicine. I was medical director of Peace Hospice for 15 years. I have supervised or was directly involved with the deaths of nearly 5000 patients.

Assisted suicide (AS) is not needed – over the years, the many patients of ours who requested AS were satisfied with hospice care. Assisted suicide is bad public policy. It stifles active effort at relief of suffering. AS is potentially hazardous to survivors of those who commit suicide.

The hospice and palliative care movement was in response to unrelieved suffering, and frankly, to prevent requests for AS. Hospice care is supported by Medicare and all 3rd party payers. The field has expanded and has become a unique medical specialty. Hospice care will improve quality of life and sometimes even prolonged life (compared to traditional acute care).

Hospice care is the standard of care for the terminally ill, recognized as such by all major medical societies, by all major Judeo-Christian religious traditions, as well as Islam, and by the US Supreme Court. These same groups and organizations do not recognize AS valuable or necessary, and in fact, discourage AS in all position statements. If you ignore this body of wisdom, you do so at the public's peril.

AS is NOT a legitimate medical procedure, nor is it a rational alternative to hospice/palliative care.

Proponents of AS cite unusual and rare anecdotes that seem to demonstrate the failure of hospice/palliative care. Based on my experience, these anecdotes are so rare as to be irrelevant in a public policy forum.

Proponents of AS concede that physical pain and suffering can be relieved by hospice/palliative care, but that existential suffering is not. In my experience, hospice/palliative care can effectively relieve existential suffering, in the vast majority of situations.

When someone is not happy with their life, they have existential suffering. Brittany Maynard refused treatment for her aggressive brain tumor, and instead relocated to Oregon from California to take advantage of the state's Death With Dignity law. She suffered existentially, not physically.

But this notorious example is unusual – note how rare they are reported in the media. Medical research suggests most people suffering existentially commonly have poor social support, complain of loneliness, and have high levels of anxiety and depression. Proponents of AS support these patients desire to end their lives. Hospice/palliative care seeks to identify and define the sources of suffering and correct them. From a public policy standpoint, I feel we should strive to better help these patients. What a poor reflection on a society that would rather subject vulnerable population to legal suicide.

Let me describe hospice care in terms of two extremes:

The first is the rare patient whose suffering cannot be relieved with usual measures. The published literature suggests this amounts to about 1-2% of all hospice patients, our experience is about 1 or 2 patients per year on Peace Hospice of Montana in Great falls. In this circumstance, a procedure called **palliative sedation** has been used.

Note that palliative sedation has been around for 20 years or more, is accepted by all medical societies, ethical and religious groups, and the US Supreme Court. At Peace Hospice, policies and procedures were written and reviewed by all relevant administrative and physician peer committees, a consent form for the patient and/or next of kin is signed and witnessed, an order set is then signed by the patient's physician and the hospice medical director. Sedating medications are then given, **as needed**, and as directed by regular clinician evaluation of the

patient's status, using the Richmond Agitation Sedation scale, generally every 4 hours. Other palliative medications and procedures are continued or enhanced. **This is an example of the standard of care, how it should be done.**

Palliative sedation follows the ethical principal of double effect: The **intent of inducing sedation is to relieve suffering** that is so severe, and refractory that a potential for an untoward side effect (hastening death) is considered acceptable, **but death is not intended. With assisted suicide, death is specifically intended** as a means for relief of suffering, and as such, this moral principal of double effect is broken: **a good outcome cannot justify a bad policy.**

Palliative sedation does not always result in death, I have had patients in which, during the sedation, better palliative treatments were employed, and the patient was able to live happily for several more weeks. It is incorrect to say that "the patient is going to die anyway."

The other extreme I would like to describe is the phenomenon of "**graduating from hospice**". Consistently, 10-15% of patients entered on hospice will stabilize or improve and be discharged, alive. Note these patients had two physicians sign certifications attesting to a prognosis of 6 months or less, yet they were wrong.

So, now you know why several Montana physicians, including me, have testified to being troubled by the **assisted suicide** that provides for a very slippery slope, and **allows a physician to be "judge, jury and executioner".**

How much effort will a physician who is biased towards assisted suicide take to relieve suffering, beyond prescribing a lethal dose of something? To a hammer, everything looks like a nail. To an AS promoting physician, all suffering looks like an opportunity to kill.

AS is too easy, just a prescription away from oblivion. AS is secretive, involves only one willing physician. The only challenge facing proponents of AS is societal acceptance that death is better than life.

Hospice care is not easy. It involves a multidisciplinary team of certified and dedicated professionals, always striving to do better. It is done in the open, with standards of care, review boards, and order sets. For hospice, suffering is a call to action: more work, effort, compassion, and loving care.

Suicide, including AS leaves a legacy of guilt and unresolved grieving. There is risk that other family members may also consider suicide as an option when facing

adversity. These facts are denied by proponents of AS. The sequelae of assisted suicide in the patient's survivors are largely unknown.

After a hospice patient dies, bereavement and grief counsellors will attend to their survivors, children included. Evaluations from survivors routinely praise hospice care.

Proponents of AS cite personal freedom (patient autonomy): Freedom to do as they wish with their lives, to be free of conventional moral and ethical constraints. I think assisted suicide is bad for our society, and for medicine. Note that "patient autonomy is defined as choosing from reasonable available treatment options, or refusing treatment. It does not mean whatever they want. Hence, a law that allows AS is not autonomy, it is just bad for everyone. If hospice care is not perfect, let's work to make it better, not legalize something bad.

Patients ask for control over their dying, as a way to feel more secure. When I get those requests, I promise my patients that I will be there for them, no matter what, and I promise that I will do everything in my power to relieve their suffering. I care for them.

Hospice has always been about the value of life, quality of life, and living. Hospice would have you live until you die. AS has always been about supporting a patient's desire to die. What a stark contrast. Who, in their right mind would support AS, especially from a public policy standpoint?

Finally, there is great ambiguity in the law about assisted suicide. It should not stand as is. I believe that assisted suicide should not be legal. I have read HB477, it specifically does not threaten the medical procedure of palliative sedation, as noted in section 1, (2), (b).

I urge you to vote "YES" to HB 477.

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