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Testimony of the Maine Medical Association in Opposition to L.D. 1270, *An Act Regarding Patient-directed Care at the End of Life*

The Joint Standing Committee on Health and Human Services
Cross Office Building, Room 209
May 15, 2015, 9:30 am

Senator Brakey, Representative Gattine and members of the Committee, I am Gordon Smith, of East Winthrop, testifying today on behalf of the Maine Medical Association which I serve as Executive Vice President. The Association represents the interests of over 3700 Maine physicians, medical students and residents.

The Maine Medical Association appreciates the good intentions of Senator Katz and the bill's co-sponsors in presenting L.D. 1270 which would authorize a physician to prescribe a fatal dose of medication to a terminally ill patient under specifically described circumstances and subject to several regulatory protections. If enacted, Maine would become one of a handful of states, including Vermont, Oregon, Washington and Montana, which allow such a practice.

Maine voters rejected similar legislation in a ballot referendum in the year 2000. Given that other states have actual experience now since that time, it certainly is reasonable for the Legislature or the voters to take another look at this. And it is understandable that some patients in extreme duress – such as those suffering from a terminal, painful debilitating illness –may decide that death is preferable to life. However, allowing physicians to participate in what amounts to assisted suicide may cause more harm than good. The provisions of the bill are fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control and would pose serious societal risks.

The Code of Ethics of the American Medical Association, enforceable against Maine physicians as standards of practice by the medical licensing boards, in Section 2.211 (attached to my testimony) prohibits a physician from taking the action called for in L.D. 1270. Passage of the proposal would put physicians in a conflicting position of honoring legal patient wishes or upholding their professional ethical code.

Rather than working with patients to end their lives, physicians should aggressively respond to patient needs at the end of life. Among the options available are hospice care, palliative care, specialty consultations, pastoral support, family counseling, conscious sedation, and other modalities. Patients

near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy and good communication.

You will hear from many opponents of some of the risks and dangers associated with this type of legislation. One significant one is that patients who may be without insurance coverage may chose suicide out of financial concerns...specifically not wishing to be a burden on their families. Such a decision should not have to be made in a just society with the resources that are available in our state and nation. A second risk is that despite the attempt in the bill to provide protections, the lives of our vulnerable elderly will be devalued...the right to die may for them become the duty to die. And finally, physicians do not wish to play God. No one knows when a person's time on this earth is up, or when our "expiration" date arrives, as my late father Ezra used to say shortly before his good death at the VA Hospice last November at the age of 91.

What a loss it would have been to our learned society if Stephen Hawking had taken advantage of this type of law had it been available in England when he was found to be terminally ill with ALS while still in college. He lives on today in his early 70's enjoying his children, grandchildren and still engaged in his research and writing.

Thank you for the opportunity to testify and I would be happy to answer any questions you may have.

AMA AMERICAN MEDICAL ASSOCIATION

Opinion 2.211 - Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient tc perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come t decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandone once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.