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Mr. John F. Keenan, Senate Chair and Mr. Jeffrey Sánchez, House Chair
Joint Committee on Public Health
The 188th General Court of the Commonwealth of Massachusetts
Boston, Massachusetts

Testimony from William J. Lawton, M.D. regarding House Bill 1998 “Compassionate Aid in Dying”

Dear Chairman Keenan and Chairman Sánchez,

I thank you for the opportunity to express my views regarding House Bill 1998. I recognize the good intentions of the sponsors of this bill, and their concern for those who are at the end of their lives and may be suffering. As a physician I have been caring for patients for 50 years in my field of Internal Medicine and my specialty of Kidney Diseases and hypertension. I have dealt with end of life issues for many decades in the care of patients needing to decide whether to undergo kidney dialysis and transplantation, or face certain death. I wish to go on record as strongly opposing this Bill.

A) Views of Well-Respected Physician Organizations:

- I think that the views of physicians are best summarized in the statement of Medical Ethics from the American Medical Association and I share these views. “Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., 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 to 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 abandoned 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.” (AMA’s Code of Medical Ethics: Opinion 2.211; AMA Membership: 217,490)

- Our own Massachusetts Medical Society (24,000 members) has also been opposed to Physician Assisted Suicide.
In December 2011, the chief policymaking body of the Massachusetts Medical Society voted to oppose physician-assisted suicide. (This vote reaffirmed a policy established in 1999.) The policy also reaffirmed the Society's support for patient dignity and the alleviation of pain and suffering at the end of life: "The Massachusetts Medical Society will provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and patient's family."
- Christian Medical & Dental Associations (USA; 16,000 members) and International Christian Medical Fellowship (100 countries): These groups oppose physician assisted suicide and support the Code of Ethics of the American Medical Association.
- Poll of American Doctors: 67% oppose physician assisted suicide. Respondents oppose physician assisted suicide on 2 major grounds: 1) It violates the physician's oath to do no harm; and 2) It will likely lead to euthanasia, which is much more objectionable. (Reported New England Journal of Medicine; September, 2013; on-line poll of 5205 physicians)
- The World Medical Association (representing 106 national medical associations) earlier in 2013, reaffirmed its opposition to physician assisted suicide. "Physicians-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient. Euthanasia, that is the Act of deliberately ending the life of a patient, even at the patient's own request, or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness."

B) Personal concerns based on my years of patient care:

1) Violation of our Physician oath and Patient Trust: This Bill will have a profoundly negative effect on the traditional trust built during the physician-patient relationship. Our patients trust us to protect and preserve their lives, in an atmosphere of personal caring, careful listening by the physician, and respecting their autonomy. If patients are aware that their doctors may also be licensed-to-kill, they may become very wary of their doctor's decisions and lose trust in their doctor's devotion to their best interests. Without the prohibition of physician assisted suicide, the practice of medicine will cease to be an ethical and trustworthy profession. We will be turning the clock back over 2500 years to a time when ancient Greek and Roman physicians supported voluntary death, and physicians gave patients the poisons they requested. (Ian Dowbiggin, PHD; A Merciful End: The Euthanasia Movement in Modern America, 2003)

2) Doctor prescribed suicide is not needed: Under current laws, every patient, and his or her designated decision-maker, has the right to refuse prolonging life by artificial means. I cannot tell you how many patients and families I have spent time with, discussing the pros and cons of postponing death by artificial means (kidney dialysis). These discussions have often been prolonged as family members gather, and have regularly involved a team approach with nurses, social workers, and chaplains as part of the team. I don't need to tell this Committee that physicians desire, above all, the well-being of their patients – with complex decisions made for each patient's best welfare and protection – and within their own emotional, family, social, cultural, and religious framework. I have sat many times with my patients, by now often friends, as they have chosen to not proceed with dialysis....or are dying from other terminal illnesses. The profession of being a physician, as I was taught in Medical School, is to “cure sometimes, relieve often, and comfort always”. These principles still guide our profession today. To this end, adequate and appropriate medications, especially pain-relieving medications, are prescribed to provide relief.

One of the major advances in patient care in my lifetime has been the Hospice Care movement. As many of you know, the care of the dying patients, especially in a home setting, and with participation of the patient in decisions, began in the United Kingdom in 1967, and was first started in the U.S. in our neighboring state in Branford, Connecticut in 1974. Over the past 40 years, Hospice has allowed dying patients to receive the care needed, under the guidance of their physician, but generally in the home, or a home-like setting in a hospital. They are comforted by loved ones, have some freedom from anxiety by participating in decisions, and obtain the medications needed to alleviate pain and suffering.

3) We must not ignore time-tested wisdom: The opposition of the medical community to physician assisted suicide is based on collective wisdom over millennia, and should not be discarded lightly. As I mentioned, physician assisted suicide was widespread 2500 years ago and before. To provide a code of ethical standards, which I am sure was needed to allay patient fears, Hippocrates wrote his oath in the 5th century B.C. This oath historically has been taken by physicians and other healthcare professionals swearing to practice medicine honestly. The Hippocratic Oath includes the statement: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.” There have been revisions of the Hippocratic Oath especially in recent years. A more modern restatement of the Hippocratic Oath in 1995 maintains this prohibition against physician assisted suicide : “I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked” (Worcester Guild, Southbridge, MA) Almost all physicians today, generally at the beginning of Medical School, do take an oath dedicated to the welfare of their patients.

In addition, as we look at our collective wisdom over time, we find uniformity in the great religions of the world. In the U.S., approximately 78% are Christian, nearly 2% Jewish, 0.7% Buddhist, 0.6% Muslim, 0.4% Hindu, and 1.5% other faiths (latest Pew Research poll, 2007). All of these faiths have prohibitions against suicide. If a law is passed to authorize physician-assisted suicide, people of faith will feel threatened and will further lose their trust in their physicians.

4) Slippery Slope to Euthanasia: If we legalize allowing patients to “self-administer” life-ending medication, there is not much difference between that and euthanasia. In fact, the current bill allows

“near-euthanasia” since pro-life hospitals would not be able to prevent physicians from performing assisted deaths in their very hospitals.

5) Vulnerability of marginalized citizens: I am also concerned about the disadvantaged citizens in our state. With the financial crisis we have in health-care costs, there will be considerable pressure on the poor, the elderly, the disabled, the terminally ill, those with mental illness, and other disadvantaged and institutionalized individuals. No matter how carefully safeguards and guidelines are attempted, the actual practice will be implemented through the biases that exist in society. Groups like the World Medical Association were founded after World War II to promote ethical treatment of patients and to prevent the atrocities that occurred in Nazi Germany. Our marginalized citizens continue to be vulnerable today.

6) Pressure and Coercion: There will be pressure by families, to stop their relative from accumulating more medical costs and to protect the “financial status” of the survivors. How quickly will the “right to die” become the “duty to die”? Will Grandpa or Grandma feel guilty about “being a burden” to their loved ones, and take ‘cues’ from hearing comments about healthcare costs?

7) Financial incentives for premature deaths: I am also worried about financial incentives for government payers, HMO’s, and insurance carriers, as well as to heirs. It is always cheaper to provide suicide mediation, than to provide actual health care.

8) Cover-Up of Abuse: From experience in Oregon’s assisted-suicide, reporting by state bureaucrats is done in a bare-bones annual report. There is a clever mandate in the law, the “the information collected shall not be a public record, and may not be made available for inspection by the public.” Violators are expected to self-report themselves. There are no penalties for non-reporting, nor the possibility of media or watchdog review. Only a sample of the records is reviewed by the government, the state government does not verify their accuracy and the state then destroys the records.

C) Concerns with specific features in the Bill 1998

- This bill eliminates the 15-day waiting period. Therefore, a patient could ask his/her physician for pills and commit suicide on the same day. I have had experience with a number of patients in whom depression was a major factor, clouding their judgment. One older patient who comes to mind wanted to stop dialysis due to multiple health problems not related to dialysis, including depression. I had a lengthy meeting with this gentleman and his wife, addressed each of his medical problems and devised a plan for each. He was willing to then postpone stopping dialysis, we treated each of his problems including depression, and he enjoyed several more years of quality life.
- The bill allows a physician to ‘waive’ the need for a second opinion before administering life-ending medication. I can assure you that no physician is infallible, and a second opinion is a vital safeguard.

- Pro-life hospitals would be unable to prevent doctors from performing assisted suicide in their facilities. This provision abridges the right of conscience and violates the First Amendment to our United States Constitution and the right of conscience in Article II under “A Declaration of the Rights of the Inhabitants of the Commonwealth of Massachusetts” in our state Constitution.
- Physicians would be required to refer a patient to a physician who would write the prescription for lethal medication. Again, this violates the rights of conscience of the individual physician.

In closing, I again thank you for the opportunity to present my testimony to you. I regret that I am unable to be present at the public hearing on December 17th. I may be contacted for further comment and clarification if you wish at: 508-865-4147 or by e-mail: lawtonwj1@gmail.com.

Respectfully submitted,

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