Written Testimony of Danielle Pimentel, J.D.
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In Opposition to House Bill No. 190, "An Act Relating to Removing the Residency Requirement from Vermont's Patient Choice at End-of-Life Laws"
Submitted to the House Committee on Human Services
February 14, 2023

Dear Chairwomen Wood, Vice-Chair Brumsted, and Members of the Committee:

My name is Danielle Pimentel, and I serve as Policy Counsel at Americans United for Life (AUL). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states. Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law. As Policy Counsel, I specialize in life-related legislation, constitutional law, and end-of-life policy.

Thank you for the opportunity to testify in opposition to H.B. 190 (the bill). Passage of this bill will remove the residency requirement from Vermont's physician-assisted suicide statute. In effect, this bill allows a non-resident to obtain suicide assistance in Vermont and opens the state for suicide tourism. I recently submitted written testimony against S.B. 26, which is an identical bill to H.B. 190. For the same reasons I opposed S.B. 26, I urge you to oppose H.B. 190:

I. The Bill Furthers the Harms Created by Vermont's Physician-Assisted Suicide Statute

Although Vermont's assisted suicide statute has "safeguard" provisions, in effect, these protections cannot adequately protect vulnerable end-of-life patients, including people living in poverty, the elderly, and those living with disabilities. However, if the legislature removes Vermont's residency requirement, vulnerable persons *in other states* could become subject to the same coercion and abuse. Out of

[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 10, 2023).
[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 10, 2023).

the eleven jurisdictions that allow for physician-assisted suicide, ten states have residency requirements.[3] Yet, suicide activists have pushed to deregulate physician-assisted suicide and eliminate residency requirements.

Removing Vermont's residency requirement opens the state for suicide tourism by out-of-state residents. This is especially concerning given that in 2022, Vermont permitted the use of telemedicine within physician-assisted suicide and dropped the second reflection period that occurred between the informed consent process and when a physician could write a prescription.[4] Additionally, there is ongoing litigation against Vermont's residency requirement in *Bluestein v. Scott*.[5] If a court blocks the residency requirements or if state officials agree to not enforce them, then out-of-state residents will either be able to travel to Vermont for suicide assistance or use telemedicine to obtain suicide assistance in their home states. This bill will have a similar effect, creating additional informed consent issues and conflicts of law issues.

a. This Bill Creates Additional Informed Consent Issues

This bill targets vulnerable end-of-life patients in other states who do not actually desire to end their lives but are dealing with depression and hopelessness. Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management. Rather, state reports show that the majority of patients seek assisted suicide because of the challenges they face living with severe illnesses or disabilities. In 2021, only 26.9% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control, or concern about it" as a reason for choosing suicide by physician.[6]

Further, scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[7] "[A]round 25–50% of patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed."[8] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[9] Their

[3] Oregon officials have agreed to not enforce Oregon's residency requirements. Gideonse v. Brown, No. 3:21-cv-1568 (D. Or. dismissed Mar. 28, 2022).
[4] VT. STAT. ANN. tit. 18 § 5283.
[5] Bluestein v. Scott, No. 2:22-CV-160 (D. Vt. Aug. 25, 2022).
[6] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13 (Feb. 28, 2022); WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).
[7] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).
[8] *Id*. at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").
[9] *Id*.

psychiatric disability also may impair decision-making "such as the decision to end one's life."[10] Despite the high probability that patients seeking physician-assisted suicide have impaired decision-making due to depression, physicians in Vermont are nevertheless prescribing lethal drugs to these patients. This bill will only open the door for physicians to engage in this same abuse towards out-of-state residents.

Additionally, the bill will encourage "doctor shopping", where an out-of-state resident will seek a physician in Vermont if a physician in their home state refuses or denies prescribing lethal drugs to the patient.[11] This is concerning because government data shows that the median duration of an assisted suicide patient-physician relationship *was only five weeks*.[12] Doctor shopping also raises serious concerns about a physician's ability to diagnose depression and accurately determine the new patient's life expectancy.

Doctors have difficulty in accurately dating terminal illness life expectancy. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. Actually, it is common for medical prognoses of a short life expectancy to be wrong."[13] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[14] This bill allows Vermont physicians to prescribe lethal drugs to out-of-state residents even though they do not have a pre-existing patient/physician relationship. Consequently, this will increase the rate of physicians inaccurately dating out-of-state patients' life expectancies and make it harder for physicians to identify depression in out-of-state patients.

b. The Bill Creates Conflicts of Law Issues

If passed, this bill will wreak havoc in Vermont and other jurisdictions. Under conflicts of law principles, states cannot apply the criminal laws of another state. Therefore, even though suicide assistance laws often have carved out exceptions for homicide laws, the criminal law exemptions of an anti-life state cannot be applied as a defense in a pro-life state.

Under Vermont's physician-assisted suicide statute, an individual who is with the end-of-life patient at the time they self-administer the lethal drug cannot be held civilly or criminally liable for being present or for not preventing the end-of-life patient from taking the lethal drugs. However, this is not a viable defense in states

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[10] *Id*.
[11] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 27 (2019).
[12] OR. PUB. HEALTH DIV., *supra* note 6, at 13.
[13] NAT'L COUNCIL ON DISABILITY, *supra* note 11, at 21.
[14] *Id*. at 22.

where physician-assisted suicide is illegal. Additionally, Vermont's physician-assisted suicide statute allows physicians to provide prescriptions for lethal drugs to pharmacists. As a result, a non-Vermont pharmacy could end up dispensing lethal drugs to a patient in a state where such practice is illegal. Thus, this bill could lead to pro-life states prosecuting pharmacies or anyone assisting patients in their suicide.

II. Physicians Use Experimental Drugs on Vulnerable Patients Seeking Suicide Assistance

Physicians are obligated to serve their patients as healers, "to keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[15] Yet, physicians are using experimental lethal drugs when assisting in suicide. Notably, there is no standardized drug nor required dosage for assisted suicide. "Of course, there is no federally approved drug for which the primary indication is the cessation of mental or physical suffering by the termination of life."[16] Federally, the Food and Drug Act regulates pharmaceuticals and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[17] Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[18] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[19] As the U.S. Food and Drug Administration ("FDA") notes on its website, "[c]ompounded drugs are not FDA-approved. This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients."[20] As the Atlantic reported in 2019, "[n]o medical association oversees aid in dying, and no government committee helps fund the research. In states where the practice is legal, state governments provide guidance about which patients qualify, but say nothing

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[15] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth.'" Roe v. Wade, 410 U.S. 113, 131–132 (1973), *overruled on other grounds*, Dobbs v. Jackson Women's Health Org. 142 S. Ct. 2228 (2022).

[16] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in* Gonzales v. Oregon, 15 TEMP. POL. & CIV. RTS. L. REV. 323, 339 (2006).

[17] *Id*. at 340.

[18] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429–430 (2017).

[19] *See* Robert Wood et al., *Attending Physicians Packet*, END OF LIFE WASH. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors' experiments with different lethal drug compounds).

[20] *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies.

about which drugs to prescribe."[21] In result, assisted suicide proponents have experimented their lethal drugs on end-of-life patients with "no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients."[22] This bill allows Vermont physicians to expand their use of experimental drugs on vulnerable end-of-life patients to include non-residents.

III. Increasing Access to Physician-Assisted Suicide May Also Increase Non-Assisted Suicide

The cultural narrative around legalizing physician-assisted suicide has led to a "suicide contagion," or the Werther Effect.[23] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[24] For example, studies have demonstrated that legalizing suicide by physician in certain states has led to a rise in overall suicide rates—assisted and unassisted—in those states.[25] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[26] Unfortunately, these effects are even greater for individuals older than 65, which has seen a 14.5% increase in overall suicide rates for that demographic.[27] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[28]

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[21] Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, THE ATL. (Jan. 22, 2019), https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/.

[22] *Id*.

[23] *See, e.g.*, Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOV'T (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.,* Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effectswerther-vs-papageno-alexa-moody/.

[24] *See id*.; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide,* 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCHIVES SUICIDE RSCH. 137 (2004).

[25] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015), https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, Suicide Prevention: *Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CTR. (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-makethings-better-or-worse-prof-david-albert-jones.pdf.

[26] *Id.*

[27] *Id*.

[28] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, (Jan-Feb 2015), https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").

H.B. 190 targets vulnerable individuals who are suffering from depression and hopelessness and communicates the message that their lives are not worth living. This bill will only stoke the flames of the suicide contagion, which may result in more unassisted suicides. Vulnerable individuals are worthy of life and equal protection under the law, and state prohibitions on assisted suicide reflect and reinforce the well-supported policy "that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy."[29]

IV. Conclusion

In sum, this bill furthers the harms of physician-assisted suicide, allows physicians to use experimental drugs on vulnerable out-of-state patients, and may lead to a rise in non-assisted suicides. For these reasons, I urge the Committee to oppose H.B. 190.

Respectfully Submitted,

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[29] Washington v. Glucksberg, 521 U.S. 702, 731–32 (1997).