Testimony to House Committee on Human Services
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Summary: Under Act 39, patients in Vermont can have access to lethal prescriptions, as long as they and their doctors follow a complicated protocol prescribed by the State. The end of life, with all its complexity and subtlety, is one place where a one size fits all approach is especially contraindicated. Under Act 48, the State has laid out a plan for health care cost containment that includes rationing of medical care, enforced on physicians by financial sanctions. A new plan that puts new pressure on physicians to contain costs is especially unhelpful at a time when the practice of medicine has been expanded, through legislative fiat, to include physician assisted suicide, a procedure that demands a physician's most impartial, cautious and unhurried iudgment. Pain and suffering at the end of life is a clinical and moral problem that should be addressed exclusively through clinical and moral avenues, not legislation.

I am Dr. Robert Emmons, a psychiatrist with twenty-five years of experience in private practice. I hold the rank of Part-Time Clinical Associate Professor in the Department of Psychiatry, University of Vermont College of Medicine, where for many years, I taught ethics to residents and medical students. I am a past chair of the Ethics Committee of the Vermont District Branch of the American Psychiatric Association.

The Code of Ethics of the American Medical Association prohibits physician involvement in prescribing or advising on lethal prescriptions or any other form of patient suicide: "Physician assisted suicide is fundamentally incompatible with the physician's role as healer." I do not belong to the AMA, but I do subscribe to this principle of ethics. My code of ethics applies only to my own actions as a physician. I am not here to tell my neighbors how to live or how to end their lives, nor am I here to tell my colleagues how to practice. Rather, I am here to inform you about the clinical problems that are created as the State of Vermont gets involved simultaneously in the patient-physician relationship in two key areas: end of life care and the rationing of medical care.

Under Act 39, patients in Vermont can have access to lethal prescriptions, as long as they and their doctors follow a complicated protocol prescribed and legally enforced by the state. The protocol contains artificial timelines and clinically superfluous documentation requirements that are much less about patient welfare and much more about conferring legitimacy on a process that is banned by the profession. The end of life, with all its complexity and subtlety, is one place where a one size fits all approach is especially contraindicated.

When the dying or severely ill patient speaks of suicide as a way to shape his own destiny, the physician must determine:

a. Whether the patient has reasoned it through, or

b. The patient does not really want to end his life, but is really seeking some sort of affirmation of hope.

This is a subtle and nuanced conversation, which requires the physician's full attention to the patient's emotional state. This is not a time we want the physician to turn to his computer and queue up the protocol prescribed by Act 39. When patients and doctors get preoccupied with following externally imposed rules, the quality of clinical decision-making suffers, and we have less confidence that patient values are truly being served.

Vermont's plans for health care cost containment include rationing of medical care, enforced on physicians by financial sanctions. Under Green Mountain Care, physicians face financial penalties if they do not follow state-approved practice guidelines, or if actuarially determined budgets for care are not met. This is precisely the type of process that leads to a "one size fits all" approach to treatment. Green Mountain Care creates serious financial and ethical conflicts for physicians, *precisely at the time when patients need and deserve their most deliberative, cautious and unhurried iudgment.*

I do not believe that a Vermont physician would ever intentionally offer a lethal prescription as a way to mitigate state sponsored financial sanctions. But consider this scenario:

> Imagine a physician who starts her day with a committee meeting. Her medical director informs her and her colleagues that their Accountable Care Organization is running over budget, which means that the hospital and the doctors might be penalized financially at the end of the year. Worried and stressed after the meeting, this physician meets her first patient of the day, a patient who is suffering with pain and a potentially terminal illness. This patient requests a lethal prescription. *Do we really believe that this physician's clinical judgment will be unbiased?* A subtle shift in the unconscious mind that orients a physician to doing less rather than more can lead to consequential shifts in the response to these kinds of clinical dilemmas.

- If we want physicians to be optimally positioned to provide scientifically sound advice that accommodates the values of individual patients, then the State should not be using regulation to manage the specifics of clinical decision-making for any disorder or condition, especially the most sensitive ones.

- Likewise, no third party payer should be using financial incentives to influence the clinical decisions of doctors.

- If we want citizens to trust that there is no link between physician assisted suicide and the rationing of medical care, then the State should get out of the business of directing the end of life, or rationing care, or optimally, both.

Pain and suffering at the end of life is a clinical and moral problem that should be addressed exclusively through clinical and moral avenues. No amount of data collection by the state can ever measure a physician's conscience. Act 39 should be repealed.