18 January 2022

Dear Committee Members:

I appreciate the opportunity to offer some thoughts on S. 74 which would amend Vermont law on assisted suicide, or what is called patent choices at the end of life.

Perhaps a summary of my background and interest in this proposal would help. For over four decades I have taught healthcare ethics, mostly at Saint Michael's College, but also in seminars at the UVM College of Medicine and in other locations. As well, I served for several years on the Clinical Ethics Committee at the Former Fletcher Allen and on the UVM Medical School's Ethics Committee for Human Subjects Research. Additionally, I was a founding member of the Vermont Ethics Network. chaired Governor Kunin's bioethics advisory committee and served on the board and as President of the Vermont Alliance for Ethical Healthcare. In that latter capacity I testified on several occasions over the years as the Vermont Legislature debated various bills regarding assisted suicide.

Since 2013 physician assisted suicide has been legal in Vermont, but not without its problems, despite what some may argue. One of the principal issues with Vermont's law is that, unlike other states, very little is required regarding reporting – in fact the requirements compared to other states is minimal. Thus, it has been difficult to ascertain with any certainty how well this law is working out in practice.

The current proposal detailed in S. 74 further exacerbates an already fraught situation, removing protections for vulnerable patients who may be seeking to end their lives not fully on their own accord. While one could agree that telemedicine has been helpful – especially during this pandemic - it has its limitations, as any one of us knows. The use of this medium is especially concerning in situations of life and death, or any other monumental decision facing a patient. Which one of us, for example, would be comfortable with a telemedicine appointment when facing spinal surgery, or navigating options regarding treatment for an initial diagnosis of cancer.

The removal of the requirement for a physical examination of a patient requesting to end her or his life leaves vulnerable patients even more vulnerable. As well, most likely the physician would have no prior knowledge of the patient's history, values, family life, social situation or other factors that are key determinants of overall health and well-being. We all know from studies and our own experience that in-person communication establishes a greater level of awareness and understanding of subtle clues that can lead to probing further with the patient what course one should take. Furthermore, S. 74 does not make explicit that the "appointment" must be by video and not just audio. Does a phone conversation satisfy any of us when concerned with ultimate decisions our friends, loved ones or other others are contemplating?

The granting of immunity to pharmacists also has its perils. Who among us would not be concerned with a pharmacist who provides medication (even with a physician's prescription) when that pharmacist has concerns about whether the medication would best serve the patient's overall health? This is not to suggest that pharmacists are, by and large, guilty of this practice, but it does raise concerns about liability when immunity is waived for providing other drugs that are employed in physician assisted suicide. Because the "drugs of choice" are no longer available, physicians have been experimenting with a host of "cocktails" attempting to uncover the most efficient and reliable method of ensuring the patient dies calmly and in a relatively short manner. Pharmacists are certainly well aware of this development and would rightfully be disquieted knowing that the prescription may not act at intended. That is, the patient may be harmed when ingesting the medications. Providing immunity removes yet another safeguard and precaution around the use of these cocktails.

In recent years several studies have shown that patients can lie for up to 31 hours in agony as family members linger helplessly. For example, the New England Journal of Medicine published an extensive study documenting problems in the Netherlands in the performance of euthanasia and Assisted Suicide. In 114 cases of assisted suicide, "complications occurred in 7 percent of cases…, and problems with completion (a longer than-expected time to death, failure to induce coma, or reduction of coma followed by awakening of the patient) occurred in 16 percent of the cases." [1] The patient cannot be guaranteed of a peaceful, "dignified" death, which was confirmed by another comprehensive review of 163 studies that discuss assisted suicide and euthanasia.[2] These complications would surely cause the patient and family some distress and ought to worry any physician prescribing these medications. There are numerous other articles available for review which indicate very similar conclusions. At the very least, the law ought state that the prescribing physician should fully inform the patient and family that all may not be well after ingesting the medical "cocktail," and that the physician needs to provide a full disclosure of what can happen.

As Legislators concerned with the health and well-being of Vermont citizens, the Committee members would be advised to reconsider the proposed changes to Act 39 as outlined in S. 74.

Thank you for the opportunity to express my concerns.

Edward J. Mahoney, PhD

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[1] Groenwoud, J.H., et al., "Clinical Problems With the Performance of Euthanasia and Physician Assisted Suicide in the Netherlands," NEJM 2020, 342(8), p. 551-56.

[2] Zworth, M. et al.," Provision of medical assistance in dying: a scoping review" BMJ Open 2020. 10(7): p. e036054.