n life, there is one fact that all people must grapple with and that is 
death. However, for some people, the looming shadow of death is less 
of an existential inevitability and more of a concrete imminent finality. 
For those who know their death is imminent, for those who are terminally ill, 
death can be an end to suffering and distress. If we as human beings have 
a universal right to live, then we must also have a right to death on our own 
terms. Bill S.1225/H.1194, an Act relative to end of life options, would allow 
terminally ill, Massachusetts residents with prognoses of 6 months or less 
to live and who have been deemed mentally capable, to be prescribed with 
a medication they will self-administer to hasten their deaths. Seven other 
states – Oregon, California, Colorado, Hawaii, Washington, Virginia and 
Montana – have similar laws in place.

- The Bill
S.1225/H.1194: An Act relative to end of life options

- Elevator Speech
Good morning, Representative. We are students at Brandeis University, majoring 
in public health, and have been studying an issue that impacts us all. In life, there 
is one fact that all people must grapple with, and that is death. With that in mind, 
when death becomes unavoidable, we should be able to maintain our freedom 
and have the right to choose how we die. Patient autonomy is a core value of 
biomedicine and such autonomy should be maintained at the end of life, when 
death is inevitable and there is nothing medicine can do. An Act relative to end 
of life options (H.1194/S.1225) allows terminally ill, Massachusetts 
residents with prognoses of 6 months or less to live and who have 
been deemed mentally capable, to be prescribed with a medication 
they will self-administer to hasten their deaths.

Seven other states – Oregon, 
California, Colorado, Hawaii, 
Washington, Virginia and 
Montana – have similar laws in 
place. Research has shown, that 
many of those who have been 
prescribed with the medication 
chose not to take it, yet, the sense 
of control that these patients 
gained by having the choice to take 
the medication improved their
quality of life greatly. In 2016, in Oregon, 89.5% of patients cited loss of autonomy as why they sought the medication. 89.5% of patients cited an inability to take part in activities that give their life meaning and 65.4% cited a loss of dignity. However, only 133/204 patients, 65.2%, prescribed with the medication actually took it. Many terminally ill patients suffer from no longer having a sense of control either over their bodies or their outcomes – their deaths are guaranteed and there is nothing they can do to stop them. Please vote to move An Act relative to end of life options favorably out of the Joint Committee on Public Health so the Commonwealth’s terminally ill patients can maintain their autonomy and freedom up until the moment they die.

### Excerpts from the Storybook

**Roger Kligler’s Story**

Roger Kligler, a former primary care physician, is currently suing the state of Massachusetts for his right to die. Dr. Kligler was diagnosed with prostate cancer, and after aggressive treatment and even being in remission, his cancer returned and he was deemed terminally ill.

Dr. Kligler has had the unique experience of treating many terminally ill patients throughout this career. He has provided them with palliative care to make them as comfortable as they could be and he has removed life-sustaining treatments from those who no longer wanted to succumb slowly to their deadly diseases.

“These terminally ill people [in Oregon] did not want to die. Like me, they would have given anything to live. They just wanted the option of a graceful exit. We should all have that same right,” he said.

Dr. Kligler believes that denying medical aid in dying puts the patient’s needs behind those of physicians. From his own experiences living with a terminal illness, he believes that medical aid in dying should be a fundamental right as it gives citizens with no possible chance at living the comfort of being able to die on their own terms.

### Op-Ed

**Marlee**

I am not “pro-death;” I simply believe that every individual has the right to make whatever informed decision they deem appropriate regarding their medical care. Take any class on medical ethics and patient autonomy will be at the forefront of every discussion. Patient autonomy is a core value of biomedicine and such autonomy should be maintained at the end of life, when death is inevitable, and there is no traditional treatment option.

Imagine going to the doctor for a sore throat, and instead of telling you what you are suffering from and what your treatment options are, the doctor just sends you home with a bottle of pills and no explanation. As minor as a sore throat seems, you would not be okay with that, would you? It is your right to know every detail about your condition and it is your right to decide your treatment.

Medical aid in dying is the practice of allowing terminally ill patients with prognoses of six months or less to live, who have been deemed physically and mentally capable, to be prescribed with a medication they would self-administer to painlessly hasten their deaths. Medical aid in dying allows patients going through the physical pain of their bodies deteriorating, breaking and self-destructing more and more each day – and the psychological pain of not being able to do anything about it – to retain their patient autonomy. Medical aid in dying gives patients’ freedom over their treatment, when medically speaking, they have no treatment.

Those in opposition to medical aid in dying claim that by enacting such legislation, it is the government’s way of killing off those already at a disadvantage – the poor and the disabled. Medical aid in dying is a way of empowering patients who have no other option, thereby giving them the autonomy that they lost. If the government or their doctors used this medication without their request, that is (1) illegal and (2) against the fundamental reason why such legislation is desired.

Oregon, California, Vermont, Colorado, Hawaii, Washington, Washington D.C. and Montana currently authorize medical aid in dying. In 2016, in Oregon, 204 patients were prescribed with the medication. Only 133 took it. 89.5% cited loss of autonomy, 89.5% cited inability to participate in activities that give their lives meaning and 65.4% cited loss of dignity as main reasons for requesting the medication. And even so, only 65.2% of patients took the medication; just the sense of control they gained over their outcome by having that choice improved their quality of life greatly. Additionally, 88.6% of such patients died at home. Medical aid in dying not only allows patients to exercise and maintain their autonomy, it makes death more comfortable. It makes something that is, by nature, painful and uncomfortable, peaceful and painless.

You might be wondering why Massachusetts, one of the most liberal states, constantly ahead of the legislative bandwagon, has not authorized such a practice. Legislators and advocates have been working tirelessly to pass such a bill, since 2011. Although they have made immense progress gaining support from the public, the most recent bills, in both the House and Senate, were sent to study. I urge you to call, write or email your legislators and implore them to support the bill on medical aid and dying that will be filed next session. I urge you to call, write or email your legislators.
and educate them on why medical aid in dying is, simply, an extension of patient autonomy, a founding principle of our societally revered medical system.

Patients who seek this medication do not do so because they wish to be dead, they do so because they are already dead.

House Ways and Means Script

Our names are Javier Mendez and Marlee Nork and we are here today to talk to you about House Bill 1194, An Act relative to end of life options. We are students at Brandeis University, residing in Waltham. We are studying public health and health policy and, through our studies, have become very passionate about medical aid in dying. In life, there is one fact that all people must grapple with, and that is death. With that in mind, when death becomes unavoidable, we should be able to maintain our freedom and have the right to choose how we die. Many terminally ill patients suffer from no longer having a sense of control over their bodies or their outcomes. These patients should have the freedom and autonomy to control over their deaths when they, ultimately, have no chance at recovery. An Act relative to end of life options would allow terminally ill patients in Massachusetts with prognoses of 6 months or less to live and who have been deemed mentally capable, to be prescribed with a medication they will self-administer, to hasten their deaths.

Before we talk about the financial implications of the bill, we want to give you some background information. Seven other states – Oregon, California, Colorado, Hawaii, Washington, Virginia and Montana – have similar laws in place, Oregon being the state with the most data on the law’s effect. Oregon passed the bill in 1997 and since its inception, 1,749 patients have been prescribed with the medication and 1,127 have ingested it and died as a result. Additionally, 2016 data shows that out of the total deaths in the state, only 37.2 per 10,000 total deaths (0.372%) can be attributed to medical aid in dying. Not only do a significant number of patients choose not to take it, death with dignity accounts for less than 1% of total deaths.

The public has steadily shown an increase in support for medical aid in dying, especially in Massachusetts. The Massachusetts Medical Society recently changed its longstanding opposing stance on this bill to neutral and changed the wording it uses to describe the bill from “physician assisted suicide,” to “medical aid in dying.” According to the Death with Dignity website, polls have shown that 7 out of 10 Massachusetts voters are in favor of passing legislation allowing mentally capable, terminally ill patients to be prescribed with medication to hasten their deaths.

A main concern that the opposition to this bill raises stems from their concern that this bill has the potential to target vulnerable populations. We see that you sponsored bill H.622, An Act eliminating racial and ethnic health disparities in the Commonwealth and we want to ensure you that An Act relative to end of life options will only empower patients, not discriminate against them. A patient could be prescribed this medication only if they are terminally ill, with a prognosis of 6 months or less to live, and have been deemed mentally and physically capable of self-administering the drug.

Representative Kafka stated that the cost of implementing this law is uncertain since it has never reached the Ways and Means Committee. However, speaking strictly on government spending, medical aid in dying is significantly cheaper than palliative care and end-of-life care. If this bill is passed, it is of utmost importance that it safeguards vulnerable populations, such as the poor and the disabled, and those who do not wish to use this medication so it is not just seen as a “cheaper solution” or a way to avoid expensive end-of-life care costs.

That being said, passing this bill will not have a significant impact on government spending nor will it be expensive for the Commonwealth. In literature on legislation like this bill, in other states, and their effectiveness, spending and cost are rarely mentioned. When cost to implement this legislation is mentioned, the details only indicate that there will not be a noticeable difference in overall spending. The goal of this bill is for medical aid in dying drugs to be treated the same way as any other prescription: insurance companies can elect whether or not to cover the medication. In 2017, in Oregon, 99.1% of patients who were prescribed with the medication had it covered by their insurance, both private insurance and Medicare or Medicaid.

In Oregon, the startup and maintenance costs of this legislation included: establishing administrative rules and policies, setting up the reporting and data system, preparing forms and instructions, establishing and convening advisory committees, conducting data analysis, preparing reports, answering media questions, setting up and posting documents on the web and consulting with the Department of Justice. Most of the fiscal cost of this bill will be to keep records and provide data to the public about the number of people who are prescribed with the medication, who take the medication and the demographics of those people in annual reports.

Chairman Sánchez, I urge you to make this bill a priority and vote it out of committee favorably so terminally ill patients in the Commonwealth can maintain their autonomy when their deaths are unavoidable. Thank you.
Letter to the Legislator

Our names are Javier Mendez and Marlee Nork and we are students at Brandeis University, residing in Waltham. We study public health and health policy and, through our studies, we have become passionate about medical aid in dying. We believe that everybody should have the freedom to choose how they die, when death becomes imminent and unavoidable. Many terminally ill patients suffer, psychologically, from no longer having a sense of control over their bodies or their outcomes – their deaths are guaranteed and there is nothing they can do to stop them. An Act relative to end of life options (H.1194/S.1225) allows terminally ill patients in Massachusetts, with prognoses of 6 months or less to live, to be prescribed a medication they will self-administer to hasten their deaths. Patients must be deemed physically and mentally capable by two physicians and a mental health expert. Each patient must file an oral and written request within 15 days of each other and two people must witness the written request: one of whom cannot be entitled to the patient’s inheritance. Currently the bill is in the Joint Committee on Public Health and we are writing to urge you to vote it favorably out of committee.

A main concern from the opposition stems from their fear that this bill will be used to target vulnerable populations and those with disabilities. The language in this bill ensures that there is no possible way for people who do not meet the eligibility criteria to be prescribed this medication. If the patient is not terminally ill with a prognosis of 6 months or less to live, or deemed both mentally and physically capable of self-administering the drug, by their physician, consulting physician and a mental health professional, they will not be prescribed the medication. The opposition also maintains that family members of those with disabilities will seek this treatment as a cheaper option. However, only the patients can request the medication and coercion is an offense punishable by jail time and/or a fine.

Six other states – Oregon, California, Colorado, Washington, Virginia, and Montana – have similar laws in place and research has shown that many of those who have been prescribed with such medication opted not to take it. Just the sense of control they gained over their outcome, when death was the ultimate and only certainty, improved their quality of life greatly by allowing them to maintain their autonomy. Additionally, they were also able to die painlessly at home, in a familiar and comfortable environment, rather than in a hospital bed.

We see that you supported bill S.2211, An Act furthering health empowerment and affordability by leveraging transformative health care, illustrating your commitment to diverse and fair healthcare. Please vote An Act relative to end of life options favorably out of the Joint Committee on Public Health so terminally ill patients can reap the benefits of diverse and fair healthcare.

Excerpts from Campaign Journals

Javier

Opposition to Medical Aid in Dying Senate Hearing

One of the most interesting events that we were able to attend this semester was one led by those opposed to the bill. The State House hosted an event where medical professionals opposed to the medical aid in dying bill were able to present testimonies on why the practice should not be allowed in Massachusetts. We attended this meeting in order to get a better understanding of the arguments that are made by opponents, and to build up any possible counter arguments that could be made.

While the attendance at this event was rather small the presentation made by the opponents was large, having over 20 doctors and physicians standing on the grand staircase, representing a united force in fighting against medical aid in dying. The testimonies that were made did highlight some of the important ethical issues that arise with this practice, however, the claims that were made by these professionals seemed to be based largely off assumptions of recorded data and patients’ motives for seeking the prescription.

This event was extremely beneficial to our research on how opponents viewed the bill and for how the public responds to hearing testimonies which could come from either side. It was unfortunate that we were unable to make any concrete connections with some of the doctors who were so strongly against the bill, and an interview with someone from the other side could have been beneficial to us in other assignments in which we constructed our own brief testimonial.

Marlee

Meeting with Representative Louis L. Kafka and staffer Mark Hogan

We met with Representative Kafka and Mark for about a half hour and asked more questions about the specifics of the bill, addressing the opposition and Dr. Roger Kligler’s lawsuit against the Commonwealth for his right to die, and how that was impacting the passing of the bill. They spoke to the common argument by the opposition that this bill will be used as a means to discriminate against those with disabilities. Specifically, they stated that they had met with disability advocacy groups and tightened the language of the bill to make it so they were comfortable with the language used. They added that they addressed all of the substantive concerns by the opposition when drafting the final bill for this session and that, this late in the session, the remaining opposition comes from those morally against the bill, and it would be much harder to persuade them to support it. This meeting was very informative because it dispelled the legitimacy of the
opposition and counterarguments raised at the aid in dying opposition event. It also allowed us to narrow and refine our elevator pitch to address the opposition that did not stem from a fundamental disagreement with the bill.

■ Update
As of June 13, 2018, the bill has been sent to study. See H.4600.

For more information

View the bill:
malegislature.gov/Bills/190/H1194

Death With Dignity
deathwithdignity.org