EXHIBIT 5
DATE 2/10/15
HB 328

February 10, 2015

To: Montana Senate Judiciary Committee

From: Thomas A. Warr, MD, FACP

Re: **HB 328**

I am in favor of HB 328.

Let me first state my qualifications: I have lived and practiced medicine in Great Falls, Montana since 1989. I am ABIM certified in internal medicine, medical oncology, hematology, and hospice/palliative medicine. I was medical director of Peace Hospice for 15 years. I have supervised or was directly involved with the deaths of nearly 5000 patients.

Assisted suicide (AS) is not needed. It is bad public policy. It stifles active effort at relief of suffering. AS is potentially hazardous to survivors of those who commit suicide. SB 202 is poorly written.

The hospice and palliative care movement was in response to unrelieved suffering, and frankly, to prevent requests for AS. Hospice care is supported by Medicare and all 3rd party payers. The field has expanded and has become a unique medical specialty. Hospice care will improve quality of life and sometimes even prolonged life (compared to traditional acute care).

Hospice care is the standard of care for the terminally ill, recognized as such by all major medical societies, by all major Judeo-Christian religious traditions, as well as Islam, and by the US Supreme Court. These same groups and organizations do not recognize AS valuable or necessary, and in fact, discourage AS in all position statements. If you ignore this body of wisdom, you do so at the public's peril.

AS is NOT a legitimate medical procedure, nor is it a rational alternative to hospice/palliative care.

Proponents of AS cite unusual and rare anecdotes that seem to demonstrate the failure of hospice/palliative care. Based on my experience, these anecdotes are so rare as to be irrelevant in a public policy forum.

Proponents of AS concede that physical pain and physical suffering can be relieved by hospice/palliative care, but that existential suffering is not. In my experience, hospice/palliative care can effectively relieve existential suffering, in the vast majority of situations.

When someone is not happy with their life, they have existential suffering. Brittany Maynard refused treatment for her aggressive brain tumor, and instead relocated to Oregon from California to take advantage of the state's Death With Dignity law. She suffered existentially, not physically.

But this notorious example is unusual – note how rare they are reported in the media. Medical research suggests most people suffering existentially commonly have poor social support, complain of loneliness, and have high levels of anxiety and depression. Proponents of AS support these patients desire to end their lives. Hospice/palliative care seeks to identify and define the sources of suffering and correct them. From a public policy standpoint, I feel we should strive to help these patients rather than kill them. What a poor reflection on a society that would rather kill this vulnerable population.

Hospice/palliative care is cost effective, compared to traditional acute care. Oregon demonstrated that AS is even more cost effective. As such, there is a risk that economic factors can coerce patients into AS.

But I see a bigger risk: the risk of biased physicians who support AS. How much effort will that physician take to relieve suffering, beyond prescribing a lethal dose of something? To a hammer, everything looks like a nail. To an AS promoting physician, all suffering looks like an opportunity to kill.

AS is too easy, just a prescription away from oblivion. AS is secretive, involves only one willing physician. The only challenge facing proponents of AS is societal acceptance that death is better than life.

Hospice care is not easy. It involves a multidisciplinary team of certified and dedicated professionals, always striving to do better. It is done in the open, with standards of care, review boards, and order sets. For hospice, suffering is a call to action: more work, effort, compassion, and loving care.

Suicide, including AS leaves a legacy of guilt and unresolved grieving. There is risk that other family members may also consider suicide as an option when facing adversity. These facts are denied by proponents of AS. The sequelae of assisted suicide in the patient's survivors are unknown.

After a hospice patient dies, bereavement and grief counsellors will attend to their survivors, children included. Evaluations from survivors routinely praise hospice care.

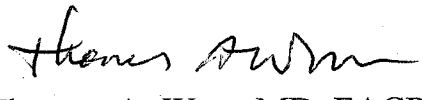
Opponents of AS are an unfunded and disorganized group who wish to prevent a societal catastrophe. I was told that AS supporters enjoy more money for lobbying than any other special interest in Montana, and that most of this money is from out of state.

Proponents of AS cite personal freedom (patient autonomy): Freedom to do as they wish with their lives, to be free of conventional moral and ethical constraints. How can we argue against that? Do we let people kill themselves if that's what they want? Should our society condone this, despite considerable evidence that there is no justification?

Hospice has always been about the value of life, quality of life, and living. Hospice would have you live until you die. AS has always been about supporting a patient's desire to die. What a stark contrast. Who, in their right mind would support AS, especially from a public policy standpoint?

Finally, there is great ambiguity in the law about assisted suicide. It should not stand as is. I believe that assisted suicide should not be legal.

I urge you to vote "YES" to HB 328.



Thomas A. Warr, MD, FACP

Clinic Cancer Care

3000 15th Avenue South

Great Falls, MT 59405