



**Written Testimony in Support of HB858: Medical Aid in Dying,
Dr. Sonja Richmond, National Medical Director, Compassion & Choices and
Compassion & Choices Action Network
Committee on Health and Human Services, Subcommittee on Health
February 1, 2024 4:30 p.m. Eastern**

Dear Chair Hope and members of the House Committee on Health and Human Services,
Subcommittee on Health,

My name is Dr. Sonja Richmond and I am a Board-Certified Internist and Board-Certified Hospice Medical Director. I'm licensed to practice medicine in Virginia, Maryland and the District of Columbia. I attended the University of Virginia and The George Washington University School of Medicine for both medical school and residency. I also serve as National Medical Director for Compassion & Choices and Compassion & Choices Action Network. We are the nation's oldest and largest nonprofit organization working to improve care and expand options at life's end. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life.

Over my nearly two decades of caring for patients in the Greater D.C. area, I have become acutely aware of the challenges that both doctors and patients face. As a hospitalist and physician in long-term care centers, I observed the revolving door of frequent hospitalizations, numerous medications and procedures, and the patient's lack of voice in their own care/treatment. I've seen great suffering and poor quality of life.

I've also had the honor of serving as an advocate for my terminally ill patients, giving them a voice and honoring their wishes. I've been able to put my patients first and treat them as unique human beings, not as diseases or conditions. With that goal in mind, I've worked alongside colleagues in Washington D.C. providing medical aid in dying to terminally ill patients of sound mind who were able to request and ingest the medication of their own volition. Accompanying patients through the medical aid-in-dying process has been among the most profound and meaningful experiences I've had in my role as healer.

I've also had the unfortunate experience of having to deny patients medical aid in dying because it was not legal in Virginia or Maryland. That's why I'm here to urge you to pass HB858.

There is no need to speculate. Decades of data and experience from colleagues in 11 jurisdictions demonstrate that medical aid-in-dying laws work as designed. Most patients who opt for medical aid in dying are enrolled in hospice, suffering from terminal diseases where the trajectory toward death is predictable: end-stage cancers, neurodegenerative diseases and some heart and lung conditions. They have endured maximum tolerable treatment regimens and are hoping now simply for a peaceful death. Their disease is killing them and their end is inevitable.



I was pleased when my colleagues at the Medical Society of Virginia, acknowledging that members hold a range of views about medical aid in dying, moved to a neutral stance, allowing doctors and patients to make ethical decisions within the bounds of safety parameters. Because no one is obligated or mandated to participate in medical aid in dying, physicians, like the patients we care for, may act according to their own conscience.

Even the American Medical Association, in [Opinion 5.7 of the Code of Medical Ethics](#) confirmed that physicians may practice medical aid in dying without violating their professional obligations. I invite you to read the carefully crafted language of the Code which concludes that the pro and anti positions both embody moral insights and that neither can claim to be the one and only moral truth.

There is one important piece of misinformation that I'd like to clarify as someone who has seen health disparities up close. Medical aid in dying laws pose no threat to underserved communities, such as the Black community. Health and healthcare disparities are the result of long-term, deeply rooted systemic factors that cause Black patients to be less inclined to use hospice care and less inclined to participate in end-of-life planning.¹ They are more likely to receive aggressive treatment at the end of life and more likely to suffer.² Medical aid in dying laws will have no impact on this reality. In fact, if one looks at the data, Black patients are much less likely to choose medical aid in dying. Those most likely to opt for medical aid in dying are white, well educated and insured.³ The factors that contribute to health disparities are large and must be addressed. Denying dying patients access to a peaceful death will do nothing to address those disparities.

Thank you for considering this important legislation. As questions arise, please feel free to contact me. Medical aid in dying is a new concept for some, but many clinicians have decades of experience. Please let us provide accurate, data-driven and clinically-reliable information as you study and learn more.

Please pass HB858.

Thank you for your public service

Sonja Richmond, M.D.
Reston, VA

¹ Shi-Yi Wang, Sylvia H. Hsu, Melissa D. Aldridge, Emily Cherlin, and Elizabeth Bradley. Racial Differences in Health Care Transitions and Hospice Use at the End of Life. *Journal of Palliative Medicine*. Jun 2019.619-627. <http://doi.org/10.1089/jpm.2018.0436>

² Addressing Inequities in End-of-Life Planning and Care: Advancing Equity at Life's End. Available at: https://www.compassionandchoices.org/docs/default-source/default-document-library/research-scan-addressing-inequities-in-end-of-life-planning-and-care-final-1.6.22.pdf?sfvrsn=4c1f4085_1

³ Medical Aid-in-Dying Data Across Authorized States, 2023. Compassion & Choices. Available from: https://www.compassionandchoices.org/docs/default-source/default-document-library/final_maaid-utilization-report_1-24-2024.pdf?sfvrsn=5a81525d_2