BILL:	House Bill 403 / Senate Bill 443
TITLE:	End-Of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).
COMMITTEE:	Health and Government Operations Committee and Judiciary Committee
DATE:	February 16, 2024 1:00 pm
WHO:	**Kristen Holt, Pharm.D., MPH**
POSITION:	**OPPOSE**

Committee Chairs, the Honorable Delegate Pena-Melnyk and Delegate Clippinger, and Committees,

As a Clinical Pharmacist with a background in Health Policy from Harvard School of Public Health, I thank you for the opportunity to comment on House Bill 403. I am grateful for your shared compassionate aspirations to alleviate the suffering of others with a terminal illness.

I request an **UNFAVORABLE vote on HB 403**.

HB 403 would allow a physician to prescribe a lethal medication for self-administration to a patient with a prognosis of a terminal diagnosis who is "more likely than not" to die within the next 6 months.

For medical colleagues, I provided in Appendix A and B the current lethal protocol from the American Clinicians Academy on Medical Aid in Dying which recommends for example 200 times the therapeutic dose of digoxin.[1] Unlike palliative use of opioids moments before passing to make a patient comfortable, this regimen intentionally overdoses an individual potentially months before expected demise.

With almost two decades of dedication to assuring the safe use of these medications, receiving a script like this is viscerally nauseating. I agree with the American Medical Association assessment.

> ***"Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life."***[2]

For the sake of clarity, I define "Physician Assisted Suicide" according to the AMA Code of Medical Ethics.

> *"'Physician-assisted suicide' occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)."*[2]

Objection #1: HB 403 "End of Life Option" is misleading and makes the demise difficult to track. The provisions of HB 403 are what the AMA definition above calls "physician-assisted suicide". The End-Of-Life Option Act claims that "actions taken in accordance with this subtitle do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide." (Page 16, line 17-19). For record keeping, this intentional demise "shall be deemed to be a death from natural causes, specifically as a result of the terminal illness…" (Page 15, line 31). In actuality, the cause of death is not the disease, which is the reason for the clinician's lethal intervention.

Objection #2: For a pharmacist who conscientiously objects, there is no explicit immunity from civil liability or employer ramifications, but only immunity from board disciplinary action. The American Society Of Health System Pharmacists (ASHP) recognizes the "right of pharmacists, as health care providers, and other pharmacy employees to decline to participate in therapies they consider to be

morally, religiously or ethically troubling."[3] While there are civil protections granted for participants in assisted suicide, there is no explicit civil protection for opting out. (Page 17, line 3-11). It is stated that health care provider participation is voluntary, but only mentions physicians may not be required by an employer to participate. (Page 19, line 17-21).

Objection #3: A mental health assessment of the patient should be required not contingent on a prescriber confirming impaired judgment. (Page 11, line 19-24). Suicide regardless of health status is considered by an individual when they feel trapped in an emotionally painful situation and see immediate death as the only alternative. It would be important to confirm a psychological or psychiatric evaluation as we would do for any person wishing to hasten their death.

Objection #4: HB 403 allows the lethal medication or regimen to be self-administered at the timing of the patient without supervision from a healthcare professional. Unlike life-saving prescription use, assisted suicide regimens are not vetted through a well-studied clinical trial process. Depending on the medication(s) used it could be distressing for the individual.[4] Moreover, the medication could be indefinitely in the patient's possession and could be accessible to others including minors for unintended use.

Objection #5: Misuse and unintended consequences are concerning. The maximum penalty of up to $10,000 or 10 years of imprisonment for forging a written request seems insufficient to deter fraud and abuse for example by a clinician or nursing home facility. There are no stipulations for individuals caught multiple times. (Page 20, line 8-20)

Objection #6: Prognostic timing of terminal illness accuracy can be quite variable. Depending on the disease, the clinician, and the prognostic models used, [5] the accuracy of timing terminal illness demise can be variable**.** The bill's second opinion requirement does help add some validation, however, it would be important to establish the highest standards around actuarial predicted models versus just clinician assessment.

Objection #7: Over the last decade in the US, suicide has increased substantially and this bill lends credence to self-harm as an acceptable option in Maryland.[6, 7] Rising suicide rates and associated suicide prevention efforts have taken the forefront in healthcare.[8] With good reason, it is the commitment of healthcare providers to reaffirm the courage and dignity of our patients with compassion and clinical excellence. This is particularly essential for those near the end of life.

Objection #8: Barriers to access will be contested in pursuit of equity. Between 2016-2021, just 5 years after signed into law, the Medical Assistance in Dying Program accounted for more than 3% of all deaths in Canada.[9] While first limited to adults with terminal illness, it has since broadened to any "ir-remediable" and "intolerable" condition. In March 2024, it is scheduled to expand to include the mentally ill, however officials are seeking a legislative extension for another 3 years.[10]

Objection #9: There are spiritual and ethical ramifications unquantified. Often discounted in public health discussions founded in materialism are considerations of spirituality. Day one of ethics class at Harvard School of Public Health, my professor announced he required us to discount discussions of God in class. A rockstar female ED physician in Boston, originally from Nigeria, retorted, "God is integral to the discussion. An afterlife completely changes the ethical equation." Pursuit of this kind of knowledge can potentially change outcomes in favor of full human flourishing.

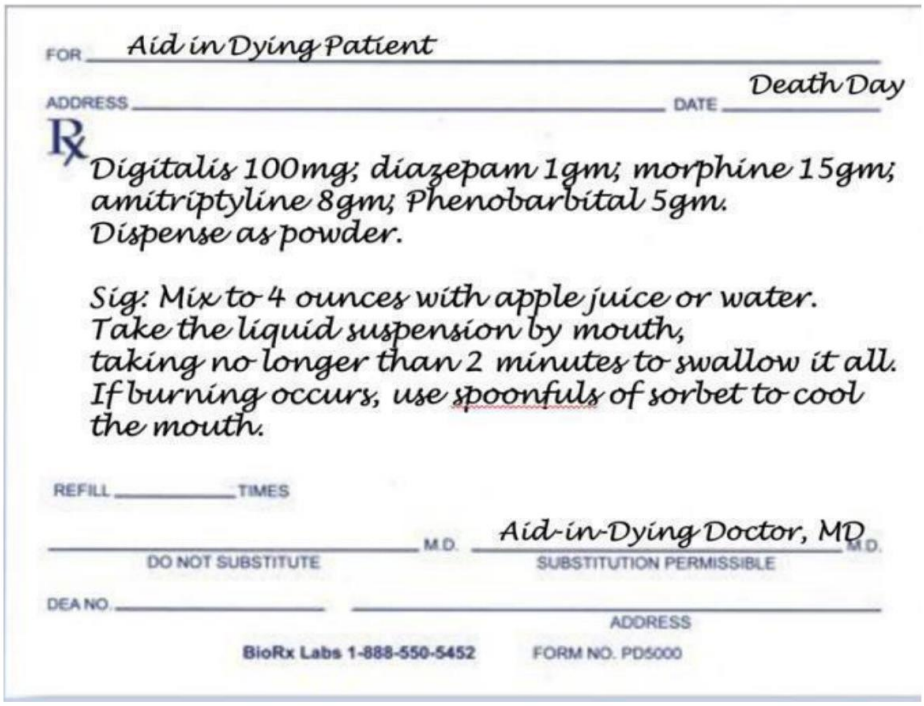
Thank you for taking these concerns into consideration and for an unfavorable report on HB 403.

Sincerely,

Kristen E. Holt, Pharm.D., MPH

Appendix A: Currently Recommended Aid-in-Dying Prescription

Figure 1. Prescription Recommended From [American Clinicians Academy on Medical Aid in Dying (acamaid.org).]


FOR Aid in Dying Patient

ADDRESS _____ DATE Death Day

℞ Digitalis 100mg; diazepam 1gm; morphine 15gm; amitriptyline 8gm; Phenobarbital 5gm. Dispense as powder.

Sig: Mix to 4 ounces with apple juice or water. Take the liquid suspension by mouth, taking no longer than 2 minutes to swallow it all. If burning occurs, use spoonfuls of sorbet to cool the mouth.

REFILL _____ TIMES

_____ M.D. DO NOT SUBSTITUTE

Aid-in-Dying Doctor, MD M.D. SUBSTITUTION PERMISSIBLE

DEA NO. _____ _____ ADDRESS

BioRx Labs 1-888-550-5452 FORM NO. PD5000

Step #1 Pre-medications for nausea/vomiting:
Ondansetron 8mg, Metoclopramide 20mg (10mg tabs, #2)
Sig: Take all three pills at least 30 minutes before proceeding to the next step.

Step #2: DDMAPh (At least 30 minutes after Step #1): Dispense as powder, in a 4 ounce bottle
Digoxin 100mg;
Diazepam 1gm;
Morphine 15gm;
Amitriptyline 8gm;
Phenobarbital 5gm.

Recommended Dose	Therapeutic Dose Range[11]	Above Max Dose
Digoxin 100 mg	0.25 mg - 0.5 mg once. Repeat 0.25 mg every 6 hours, max 1.5 mg in 24hr (loading). 0.125 mg to 0.25 mg once daily.	200 x single dose loading
		67 x daily dose loading
Diazepam 1 gm	Up to 40 mg / day in divided doses.	25 x daily dose
Morphine 15 gm	May give orally up to 30 mg every 4 hours as needed for severe, acute pain in hospitalized opioid naïve patients at low risk for respiratory depression (180 mg / day in divided doses)	500 x single dose opioid naïve
		83 x daily dose
Amitriptyline 8 gm	Initial dose max 50 mg / day. Titrate up over weeks to 100-300 mg/ day.	160 x daily dose initial
		27 x daily dose titrated
Phenobarbital 5 gm	Max 400 mg / day.	13 x daily dose

[1] American Clinicians Academy on Medical Aid in Dying. https://www.acamaid.org/pharmacologyinfoupdates/ Accessed February 5, 2024

[2] AMA. Code of Medical Ethics. Physician-Assisted Suicide. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide. Accessed February 5, 2024.

[3] ASHP Statement of Pharmacist's Decision-making on Assisted Suicide. Pharmacist's Right of Conscience and Patient's Right of Access to Therapy. American Society of Health System Pharmacists. https://www.ashp.org/-/media/assets/policy-guidelines/docs/statements/pharmacists-decision-making-assisted-suicide.ashx Accessed February 5, 2024. *(copy and paste into browser to view).*

[4] Jennie Dear. The Doctors Who Invented a New Way to Help People Die. The Atlantic. January 22, 2019. https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/

[5] UCSF. https://eprognosis.ucsf.edu/calculators.php. Accessed February 5, 2024.

[6] CDC. https://www.cdc.gov/suicide/suicide-data-statistics.html Accessed February 5, 2024.

[7] Preventing Suicide. CDC. https://www.cdc.gov/suicide/pdf/NCIPC-Suicide-FactSheet-508_FINAL.pdf Accessed February 5, 2024.

[8] The Joint Commission. National Patient Safety Goal for Suicide Prevention. https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf Accessed February 5, 2024.

[9] Rupa Subramanya. "Scheduled to Die: The Rise of Canada's Assisted Suicide Program" https://www.thefp.com/p/scheduled-to-die-the-rise-of-canadas October 11, 2022. Accessed February 5, 2024.

[10] Canada MAID Overview. https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html Accessed February 5, 2024.

[11] Lexicomp. https://online.lexi.com/lco/action/home Accessed February 5, 2024.