Maryland Legislative Lobby for Life, Inc

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Speaking up for life since 1982

Unfavorable House Bill 403 Friday, February 16, 2024

End of Life Option Act House Health and Government Operations Committee
House Judiciary Committee

Delegate Pena-Melynak, Chair, Delegate Cullison, Vice-Chair HGO
Delegate Clippinger, Chair, Delegate Bartlett, Vice Chair, Jud.

Good afternoon. My name is Sheila Wharam, Secretary of MLLL speaking in opposition to HB 403 the End of Life Option Act

There are questions that anyone would have about this bill and how it would work. This is a bill about killing people and yet look at the definition of health care provider on page 4, lines 5-8

5 (G) "HEALTH CARE PROVIDER" MEANS AN INDIVIDUAL LICENSED **OR**
6 **CERTIFIED** UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH
7 CARE OR DISPENSE MEDICATION IN THE ORDINARY COURSE OF BUSINESS OR
8 PRACTICE OF A PROFESSION.

Certified to provide health care in Maryland includes certified nursing assistants, geriatric nursing assistants, certified medicine aides, student nurses, home health aides.

Then on page 4 lines 28-29 and page 5-lines 8-12:

Page 4
28 (N) "PALLIATIVE CARE" MEANS HEALTH CARE CENTERED ON A
29 TERMINALLY ILL INDIVIDUAL AND THE INDIVIDUAL'S FAMILY THAT:
8 (4) INCLUDES DISCUSSIONS BETWEEN THE INDIVIDUAL AND A
9 HEALTH CARE PROVIDER CONCERNING THE INDIVIDUAL'S GOALS FOR TREATMENT
10 AND APPROPRIATE TREATMENT OPTIONS AVAILABLE TO THE INDIVIDUAL,
11 INCLUDING HOSPICE CARE AND COMPREHENSIVE PAIN AND SYMPTOM
12 MANAGEMENT.

By its definition, this bill allows home health aides to advise terminally ill patients on symptom management and treatment options.
Then page 19-lines 2-7
SUBSECTION (B) OF THIS SECTION DOES NOT PROHIBIT:
3 (1) A HEALTH CARE PROVIDER FROM PARTICIPATING IN AID IN
4 DYING:
5 (I) WHILE ACTING OUTSIDE THE COURSE AND SCOPE OF THE
6 HEALTH CARE PROVIDER'S CAPACITY AS AN EMPLOYEE OR INDEPENDENT
7 CONTRACTOR OF THE SANCTIONING HEALTH CARE FACILITY;

Do we really want home health aides, CNAs, CMAs, student nurses, GNAs to participate in aid in dying? As it is "Licensed to provide health care" already has nurses and nurse practitioners included under the term "health care provider". How much of the health system do the sponsors want involved in killing patients?

The AMA said killing patients "would be difficult or impossible to control." This seems to validate that.

As Marylanders we should be proud that "in this land of pleasant living" we have one of the lowest suicide rates in the United States.

Out of all 50 states only 2 or 3 other states have as low a rate of suicide as Maryland (NJ, NY, MA, MD).

https://www.cdc.gov › suicide › suicide-rates-by-state.html Suicide Rates by State | Suicide Prevention | CDC

We should do nothing to change that.

But we know that suicide is contagious.

Media Coverage and Suicide Contagion [1.]
Reviewed by Psychology Today Staff

What are some factors of this contagion?

Among factors that the Center for Disease Control lists as provoking further suicides are-
-Family or loved one's history of suicide,
-Suicide cluster in the community,
-Easy access to lethal means of suicide among people at risk,
-Unsafe media portrayals of suicide,

all of which this proposed End of Life Option bill will create. https://www.cdc.gov/suicide/factors/index.html/

1. Today, the Maryland General Assembly, you as lawmakers, are presented with a bill to give a completely different body of people, all physicians, a path to kill their patients. One might assume that this second body, physicians, favors the new right?

This would be a mistaken assumption since the largest membership group of physicians in the US, the American Medical Association, voted 3 months ago (November 2023) that: "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."

At the same meeting the American Medical Association voted against changing the nomenclature of physician assisted suicide to the incorrect name Medical Aid in Dying, since what is going on is not medical aid.

Medical aid furthers health.

Medical aid is a doctor prescribing certain compounds in certain dose ranges to improve or maintain a patient's health or perhaps prescribing certain physical therapies or perhaps foods to eat or not eat to maintain or improve a patient's health. The physician keeps his* eye on the patient's health at every stage of the patient's life. Even when he cannot stop a disease he does not kill the patient.

This bill is about using poisons to kill people. Doctors are not trained as either poisoners or killers.

We ask you to respect the real-world experience of being a doctor and reject a bill that physician's themselves know opposes their care for patients, their role to cure sometimes, to relieve often, and to comfort always.

2. **The "Safeguards"** as window-dressing to slip the legislation in, sometimes called the sales pitch. They are a façade that will be removed one by one.

The course of suicide legislation in the US and around the world is that supposed limitations or safeguards on committing suicide get removed one after the other from laws that were passed by legislators.

In the US this reduction in safeguards is sometimes in response to lawsuits, for example those proudly brought by the group, Compassion and Choices,

Compassion & Choices Files Lawsuit Over New Jersey Residency Rule

This case follows our successes in Oregon and Vermont asserting that such requirements violate the U.S. Constitution. Our legal team has also taken recent action to protect California's law. Sep 29, 2023

No doubt Maryland will be the subject of Compassion and Choices lawsuit and can become a suicide destination site like Compassion and Choices Oregon client, Dr. Nicholas Gideonse has.

This will invalidate page 5, line 18 and page 10, lines 5-16 of this bill, residency requirements, and either cost the state money in defending the law or with a wink and a nod just have the state buckle under. Either way page 5 line 18 and page 10, lines 5-16 are not worth the ink they were written with.

Compassion and Choices "However, firsthand experience from doctors and patients, and decades of data, make it clear that the **residency restriction functions more as a barrier to access than as a safeguard.** https://www.compassionandchoices.org/legal-advocacy/residency-restrictions/

Sometimes state officials themselves throw out requirements of the law such as the Oregon Health Authority, who admitted in 2017, that they considered a person with diabetes who was not taking his insulin to be a terminally ill person who qualified to commit physician assisted suicide in Oregon.
(https://alexschadenberg.blogspot.com/2018/02/oregon-assisted-suicide-act-designed-to.html)

We have seen the Parliament in Canada expand suicide from those with "foreseeable death" to those "without a foreseeable time of death". March 17, 2021.

Due to Compassion and Choices in 2023 the snowball is going faster down the slope. We watched Oregon and Vermont drop their residency requirements for assisted suicide https://www.nbcnews.com/news/us-news/oregon-ends-residency-rule-medically-assisted-suicide-rcna21932 opening themselves up to suicide tourism. Oregon becomes America's first 'death tourism' destination for the terminally ill | Daily Mail Online

Compassion and Choices has filed a lawsuit to force New Jersey, which is the state with the lowest rate of suicide of all the 50 states, to open up their Physician Assisted Suicides to neighboring states. Perhaps they are worried that not enough New Jerseyites will want to kill themselves? In 2023 we saw Hawaii and Washington State open up their suicide providers to non-physicians.

A goal for many suicide acceptors is that there should be no law to stop suicide for any reason (see Switzerland [1.], Compassion and Choices [2.]), which would take legislators out of the picture.

Worldwide, this suicide acceptance has spread to the point that in February 2020 the federal court in Switzerland declared that anyone who wants to commit suicide, for any reason, may do so with the help of anyone. (February 26, 2020). https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/EN/2020/bvg20-012.html)

Apart from ethical objections and a loss of trust by patients wondering if their doctors will prescribe death for non-medical reasons, why would physicians want to get involved with this constantly shifting scenario?

3. Third, in the more than 20 years we have had "death with dignity" laws we have learned that an underlying premise and promise of these bills is quite incorrect. Proponents imply that this killing is peaceful, pain-free, and dignified. They are wrong.

One reason that the poisons used change so often, is that they don't work in a peaceful, dignified, or even, it is now known, pain-free way, so this is not a fast, peaceful way to die. One formula or another has been tried over the last twenty years and it turns out that whether taken orally as in this bill or injected into the circulatory system this is not quick or peaceful. (In lethal-injection-Belgium in 2022 nurses smothered a screaming 36 year old cancer patient to death with a pillow.)

Over the years the same drugs have been used for criminal lethal injections as for oral physician assisted suicide use and in injection in Canada and Europe which has death by injection.

Orally people choke and vomit even though they have taken anti-emetics as they swallow the bitter, burning, poisonous concoctions. Then, sedated, they do not necessarily lie quietly and quickly die.

The current medication recommended by the American Clinicians Academy on Medical Aid in Dying (ACAMAID) is DDMA-Ph (diazepam- Valium when used in therapeutic not poisonously high dosages), digoxin, morphine, 15 grams, about 100 times the therapeutic dose, amitriptyline-Elavil- when used in therapeutic, not poisonously high dosages, phenobarbital- Luminal).

Dr. Jonathan Treem of the University of Colorado Palliative Care explained the process of physician assisted suicide to a group of nurse practitioners in 2022. (JADPRO Live 2022, Jonathan Treem, MD, of the University of Colorado Palliative Care.)

"When counseling patients considering medical aid in dying, it is important to note that the medication must be consumed within 2 minutes of administration and has an unpleasant taste," said Dr. Treem, who noted that there have been no reported cases of patients remaining awake during the dying process.

(They are paralyzed. Could they tell you?)

The medications (poisons) are administered in large doses, with 1 gram of diazepam, (Valium, anywhere from 21/2 to 10 times the medical dose and all at once not in divided doses) and 15 grams of morphine (more than 100 times the medical dose). (Parentheses our emphasis)

He said: The medication typically causes patients to fall asleep within 2 minutes **to 2 hours**, and death occurs within **30 minutes to 8 hours**,".

(We know however from Oregon reports that it can take as long as **3 days** for PAS patients to die.)

"The onset of death can vary greatly, with some cases occurring as quickly as **30 minutes, while others may take up to 24 hours**. Just because someone is still alive, however, does not **necessarily** mean they are suffering, said Dr. Treem. (our emphasis. We do not know why at one point he says death in 8 hours and another point he says death in 24 hours.)

(The patients are sedated and mostly cannot move. That does not mean they cannot feel pain especially in these prolonged deaths.)

According to Dr. Treem, it is also important to counsel patients and their family members about what **they** may experience while **at the bedside** of a loved one during the dying process.

"Death is a process and not a sudden event as is commonly portrayed in media," he explained. "It can involve **muscle twitching, irregular breathing, and difficulty with secretions** (? **Is this the foaming at the mouth that is a sign of drowning? See Dr. Zivot below**), and it is important to let family members know that these symptoms are not

distressing for the patient, although they can be distressing for loved ones to witness."

(Parentheses ours. Can he know they are not distressing the patient?)

The question is are the patients suffering?

Dr. Joel Zivot is an anesthesiologist from Emory University Hospital in Atlanta who had been asked to look at the autopsy reports of more than 200 prisoners executed by lethal injection to see if the blood results showed whether there had been a sufficient dose of sodium thiopental. He found in 84% of the autopsies that the prisoners' lungs had been so damaged by the poisonous dose of pentobarbital while their hearts continued to beat that they were filled with fluid to twice the normal weight of lung tissue and the prisoners died drowning.

This seems like the cruel and unusual punishment forbidden by the Eighth Amendment to the US Constitution and the cruel penalty forbidden by Article 16 of the Maryland Declaration of Rights.

We urge you not to start Maryland, this land of pleasant living, on this path where ideologues will fight year after year to make any painful suicide for any reason the solution to any problem.

Thank you,

Sheila Wharam

Secretary, MLLL, Inc.

* Note: He, him or his is used here in the traditional sense which includes both men and women.

1.Zurich-Forch, 27 May 2022

Revised chapter 6.2.1. "Assisted suicide" in the medical-ethical guidelines "Management of dying and death" by the **Swiss Academy of Medical Science (SAMS**) now made statutory rule for medical doctors by the Swiss Medical Association (FMH) What is the impact on physician-supported assisted suicide made possible by DIGNITAS – To live with dignity – To die with dignity

Quote from SAMS' guidelines: "**Not ethically justifiable in accordance with these guidelines is the performance of assisted suicide in persons who are healthy.**"

Comment by DIGNITAS (Switzerland):

Ethics, also called moral philosophy, is about social, religious, or civil behaviour considered correct, especially that of a particular group, profession, or individual5 .

Morals is tied to personal worldviews (Weltanschauung).

The SAMS guideline is "medical[1]ethical", and it represents the personal view of some individuals of a private institution.

The guidelines are not medical evidence/science-based, and they are not in line with law and jurisdiction; SAMS (and FMH) ignore that **the Swiss Federal Supreme Court and European Court of Human Rights, also the German and Austrian Constitutional Courts, have declared the freedom of an individual to decide on time and manner of their own end in life as a human right. The right to a self-determined death is not limited to situations defined by external causes like serious or incurable illnesses, nor does it only apply in certain stages of life or illness. Rather, this right is guaranteed in all stages of a person's existence. The individual's decision to end their own life, based on how they personally define quality of life and a meaningful existence, eludes any evaluation on the basis of general values, religious dogmas, societal norms for dealing with life and death, or considerations of objective rationality.**

Compassion and Choices website mission statement:

We envision a society that …empowers everyone to choose end-of-life care that reflects their… beliefs.

2018

Conscience and Religious Freedom Division in U.S. Department of Health and Human Services **Office for Civil Rights** Sets a Dangerous Precedent

Formed in January, the new Conscience and Religious Freedom Division in the Department of Health and Human Services Office for Civil Rights threatens to undermine patient access to end-of-life options, with proposed regulations that would allow providers to impose their own religious beliefs on their patients and opponents to bring cases in support of those beliefs. While providers have the right to opt out of providing healthcare services they object to for reasons of conscience or religious freedom, this would allow a physician to withhold information about anything that they personally find unconscionable, including palliative care, voluntary stopping of eating and drinking, or **medical aid in dying**. Compassion & Choices submitted comments to the Federal Register **and launched an advocacy effort against these proposed regulations.** We will continue to fight against this major threat, which would impact people in every state.

The American Special Education System Helps Us Understand the Pitfalls Inherent in Assisted Suicide

Meghan Schrader

By Meghan Schrader

Meghan is an autistic person who is an instructor at E4 Texas - University of Texas (Austin) and an EPC-USA board member.

The coercion I experienced when I was enrolled in the Special Education system are what drives much of my staunch opposition to assisted suicide. It's my observation of the systemic oppression enabled by that system that makes me say, "no, assisted suicide is not a good idea" no matter what pro-euthanasia argument I'm confronted with.

When I talk about my experiences in the Special Education system, I am not comparing having a learning impairment to having cancer, and I am not saying, "Oh, well, I suffered so you have to do it too." I am not operating from a petty grudge along the lines of, "My Kindergarten teacher held my hand-crafted duck project up in front of the class and told them it was a bad duck because I didn't follow her directions correctly, and so you have to die a painful death."

What I mean is that there are instructive parallels between how the Special Education system works and the systemic oppression in the medical system, and that people in both systems engage in coercion of subjugated people. That makes assisted suicide unfair to subjugated people. In Special Education disputes about how to educate disabled children, school districts typically hold

most of the cards. School systems will fight tooth and nail to avoid paying for services for disabled kids, no matter how badly not having those services harms the child. Wealthy, privileged communities will happily build multi-million dollar playgrounds for predominately able-bodied children while loudly complaining about the money spent on accommodating disabled students, no matter what consequences students with disabilities experience as a result of not having those services. Similarly, it's clear that some government and private healthcare programs will fund lots of things for able-bodied people before taking care of disabled people's basic needs.

School systems have engaged in inordinate amounts of expensive legal maneuvering to force disabled students to stay in public schools where they are subjected to daily toxic stress so severe that it leads to serious physical and mental health problems, just as futile care impositions manipulate the medical system to force disabled people to die. What special education students often experience is a phenomenon that disability studies scholar Paul Longmore would call a "social death": The person metaphorically "dies" because systemic oppression constrains equal participation in the activities that anyone would want to engage in-education, jobs, community engagement, etc.

It's pretty much the same thing with utilitarian bioethics, Quality Adjusted Life Years, forced DNRs and "termination without request or consent" and euthanasia in some countries. There's a system that enables powerful people to bully disenfranchised persons. This systemic bullying of disabled people has seeped into pretty much all social institutions and drives much of our public discourse, making it easier for people in power to enact policies that literally kill disabled people.

Peter Singer is a professor at Princeton who tells disabled people to kill ourselves so that the money spent accommodating us can be sent to third world countries, and there's nothing we can do about it. Because of thinking like Singer's, doctors in states with futile care laws bully the families of dying and severely disabled people to withdraw life-sustaining care from a loved one, and there's nothing they can do about that, either. The doctors are in control, and no matter what emotional, financial, or physical consequences it has for the patient and her loved ones. Are disability rights activists really supposed to believe that doctors aren't going to try to force people to die by assisted suicide?

The Special Education and medical systems also share commonalities in respect to the varying motivations for why people decide to pursue careers in those systems. Now, just as some disabled people are fortunate to have access

to skilled and caring doctors, I did have some absolutely amazing teachers whose influence was critical in me accepting my disability, relying on my strengths and conscientiously working towards my goals. Those teachers loved me-they always had a hug for me, they valued my intelligence, they were more than happy to provide accommodations for my learning impairment. Similarly, many doctors are dedicated professionals who will do anything to care for their patients. But, not everyone goes into service professions out of love. Some special education teachers join that field because they like to be in charge of smaller, weaker people, just as some doctors go into the medical profession out of an arrogant desire to control sick people.

For instance, I once had a Special Education teacher who saw literally everything I did, even my smallest and most innocuous quirks, as "behavior." She would punish me for something as small as fidgeting in my chair or not looking at her in the eye. At one point during mud season there was a group of bullies who would come up to me on the playground and repeatedly push me into the mud. I remember her angrily helping me take off my soiled jacket and jeans, and articulating what was essentially a utilitarian philosophy about her job: "I have multiple students that I have to be responsible for, and now I have to spend my time helping you take off your clothes," she complained. This is essentially what some disabled people experience from nurses in hospitals-cleaning out bed pans is the nurses's job, but the nurse is annoyed that they actually have to do that.

Neither the Special Education system nor the medical system can be trusted to implement legal procedures in a way that is fair to disenfranchised people, and that makes assisted suicide an unjust social policy.

When I was growing up, I was fully aware that there were laws called Section 504 of the Rehabilitation Act, the Individuals with Disabilities Education Act, and the Americans with Disabilities Act. But, I also saw people blatantly violate those laws in spirit while using loopholes to essentially negate them. For instance, for whatever reason my high school Special Education team didn't care that I was an honors student; they were dead set on forcing me not to take college preparatory classes or exams, because "Special Education students don't go to college." When I did those things anyway, they made sure that I suffered as much as possible. For instance, in addition to multiple other things my high school guidance counselor did to make the college application process miserable for me, he insisted on proctoring one of my college entrance exams. Even though my accommodations proscribed at quiet environment for ADHD, he made sure to tap papers against his desk, run his printer, and create various other sources of noise. When I asked him to stop, he said, "I'm

only required to avoid unnecessary noise. I'm not making unnecessary noise. Other students have to deal with pencils scratching on paper and people breathing." The toxic stress of being obliged to have my test proctored by this man was really, really unfair to me, but there was nothing I could do about that; the law allowed schools to pick whichever proctors they wanted to give tests to students, and if the evil guidance counselor wanted to force me to sit alone in a room with him for hours so that he could do disparaging things to me during a college entrance exam, well, tough crap.

What I experienced was essentially the non-lethal equivalent of what happened to Roger Foley. The guy was denied accommodations that he needed to live on his own, was confined to a hospital, an then was put in a room alone with a bioethicist who urged him to ask to be killed. Similarly, Canadian law did not allow Alan Nichols family to protect him. In the Netherlands, an advanced request for euthanasia led to a woman being held down and euthanized when she was clearly saying "no." As a former Special Education student who was pressured to drop out of high school, I could see those scenarios coming, and that's why I've always taken the position on assisted suicide that I do now.

I am sympathetic to people who want to legalize assisted suicide because they've had a deeply traumatic experience or they have no firsthand knowledge of how it will affect some people. It is not ethical for right to die activists to exacerbate already violent and unpredictable mechanisms of oppression and injustice so that they can die with a glass of rose champagne in their hand. (Article link)

We live in a society where the able-bodied majority feels entitled to have what it wants at disabled people's expense, and assisted suicide is just a very extreme form of that trend. Assisted suicide puts disabled people in a position in which it isn't enough for us to be denied education and employment or endure various other forms of abuse, we also have to have our suicides turned into a "medical procedure" and maybe even be coerced into doing that so that the proponents can "chart their own end of life journeys." That's privileged arrogance.

Disabled opponents of assisted suicide are not asking the proponents to die alone and in agony; we are simply asking that they use and improve the other multiple other techniques available to treat pain and disability at the end of life. We are asking that they give up some of the control they'd like to have so that disabled people do not experience even more vicious forms of oppression then we already do. That doesn't seem like too much to ask to me.

Certified Medicine Aide Fact Sheet

- Admission to the CMA Training Program

A. All applicants for initial CMA training must hold a current, active, unencumbered Maryland nursing assistant certificate.
B. The candidate seeking initial admission must have:

1. Current employment and two (2) years full time work experience as a CNA in a facility licensed under 42CFR Part 483 et. seq. (e.g. an ICF/MR such as Rosewood) or
2. Current employment and one (1) year full time work experience as a GNA in a facility licensed in Maryland under COMAR 10.07.02 (e.g. a licensed nursing home), and,

C.Be recommended for the CMA Training Program by the Director of Nursing of the employing ICF/MR or licensed nursing home.

- Initial Certification

A. The initial CMA certification will be effective until the date of expiration of the CNA or CNA/GNA certificate regardless of when the initial CMA program was completed. This may be less than two (2) years for the initial CMA.
B. The individual may not practice as a medicine aide until the Board has certified the individual as a CMA and his/her name appears as a CMA on the Board's web page.

C. The CMA Training Program must notify the Board when the individual has completed the initial CMA training program. The Board will add the additional certification of medicine aide to the Board's data base at no additional cost.

D. Should the Board's online verification system not contain the CMA certification please contact the Board.

- When to Complete the Clinical Update

Regardless of when the CMA completed his/her initial CMA Training Program the CMA certificate is renewed at the same time as the CNA or CNA/GNA certificate(s) are renewed.

A. The CMA who is renewing his/her individual CNA, GNA and CMA certificate will need to complete the required CMA Clinical Update, no more than 90 days before

the expiration of his/her CNA/GNA/CMA certificate. For example, if the individual's CNA, GNA and CMA certificate expires September 28, 2008 the individual will need to complete a CMA Clinical Update sometime in July or August or September of 2008.

B. In addition, there is a thirty (30) day grace period beyond the date of the expiration of the certificate to renew. Therefore, the individual has an additional 30 days following the expiration of the certificate to obtain the Clinical Update.

C. If one fails to obtain the Clinical Update before the expiration of the grace period, the CMA will be required to repeat the entire 60 hour CMA Training Program.

- Admission requirements to the CMA Clinical Update

The CMA applicant must provide the CMA Training Program with the following information:

A. current, active, unencumbered Maryland CNA\GNA\CMA certificate per MBON web page.

B. In the licensed nursing home setting written verification from the employer or the CMA applicant affirming that the applicant has:

1. practiced as a CNA for at least 16 hours in the two (2) years immediately preceding admission to the CMA Clinical Update;
2. practice as a GNA for at least eight (8) hours in the preceding two (2) years; and
3. practice as a CMA for 100 hours in the two (2) years immediately preceding admission to the CMA Clinical Update.

C.In the state licensed ICF/MR written verification from the employer or the CMA applicant affirming that the applicant has:

1. practiced as a CNA for at least 16 hours in the two (2) years immediately preceding admission to the CMA Clinical Update.
2. practiced as a CMA for 100 hours in the two (2) years immediately preceding admission to the CMA Clinical Update.

D.Documentation of previous successful completion of an initial 60-hour CMA course training in Maryland.

- Where to Attend the CMA Clinical Update Training Program

The CMA may attend any Board approved Community College for the Clinical Update. The CMA is not required to return to the original school where he/she obtained the initial CMA training to take the Update Course.

- Expiration and Renewal of Certificate

A. The first renewal of the CMA certificate will be at the same time the CNA or CNA/GNA certificate expires regardless of when the initial CMA Training Program was completed. This may be less than two (2) years for the initial CMA.
B. After the first renewal, the CMA certificate will renew every two (2) years on the individual's birth year/birth month.

Example: If the initial CMA class was completed in January and the CNA certification expired in October of the same year, the CMA certification would also expire at the same time the CNA certification expires (October). In this instance, the Clinical Update would need to be completed between August 1st, and November 30th of that same year. The CMA Clinical Update may not be taken before August 1st and may not be taken after November 30th. If the Clinical Update is not completed by November 30th the entire 60 hour Medicine Aide Training Program must be repeated to retain the CMA certification.

C. When renewing the certification, be sure to check all appropriate certifications. Do not check certifications you are not eligible for

- Inactive/Non-Renewed Medicine Aide Certificate

When the CMA does not renew his/her CMA Certificate by failing to complete a renewal form and/or failing to complete the CMA Update in the appropriate time frame, the individual must complete the entire 60 hour CMA training program.

Nursing Assistant Certification

Nursing Assistant Certification

All nursing assistants must be certified in order to work. If there are any nursing assistants working in your facility who are not certified, they must **immediately** apply for certification.

The CNA certification is the basic level of certification. Any other certifications are in addition to the CNA certification. The CNA certification must be completed first or in conjunction with any additional certification.

The following are **additional certifications** that are specific to Federal law or State regulation. The additional certification will appear on the CNA certification card.

- **Geriatric Nursing Assistant (GNA)** – has passed the Geriatric Nursing Assistant examination and meets Federal requirements – **required** for all nursing assistants working in licensed comprehensive care facilities.

- **Certified Medicine Aide (CMA)** – meets state requirements – **required** to administer medications in a licensed comprehensive care facility. Only a GNA with one year of experience and who has completed an approved 60-hour medicine aide course taught in a community college are eligible to become a CMA.
- **Dialysis Technician** – Meets training requirements of the state – **required** to work in dialysis units in Maryland. Click here for more informing on becoming a Dialysis Technician.

GNA Registry

Federal law requires that a state maintain a GNA registry listing the status of GNA certification and those who have had disciplinary action taken against them.

The Board has a combined CNA certification database with the GNA registry. Information regarding GNA certification will be found on the Board's license verification web site. There is no cost for the registry. Renewals of certification are now handled by the Board.

GNA Testing

Examinations are offered through Credentia Nurse Aide Credentialing Services and the Maryland Geriatric Nursing Assistant Testing Service. Credentia notifies the Board of examination results. Those passing the examination will be provided a GNA certificate. A new certificate will be issued with the GNA initials at the next regular renewal. The GNA certification will appear on the online verification at the Board's web site under "License" in the top green title bar.

1. MDGNATS offered by the Credentia (phone: 888-204-6249) may be contacted directly to:
    - Obtain the Maryland Geriatric Nursing Assistant Candidate Handbook which explains the written and clinical testing process, including the 20 skills tested in Maryland;
    - Register for the examination: To download the application to register for the GNA Examination, please go to the Credentia website at https://credentia.com/test-takers/maryland Click on the "Create an Account" link under step 3 on the home page to create an account and submit a testing application.
    - Cancel a scheduled test session.

- Arranged special accommodations. (Instructions on the application)
- Change the candidate's current address or name prior to testing. Driver's License or 'Proof of Address Change' document is required on the day of the exam.
  Credentia may be reached at: 888-204-6249 to update your address.

2. CNA training programs **must** be approved by the Board of Nursing **prior to** accepting students. Students will not be permitted CNA certification if they complete a program that has not been approved by the Board and will not be eligible to take the GNA examination. A list of Board approved Nursing Assistant training programs is available on the Board's web page. Click here for information on how to become an approved CNA and or dialysis technician training program.

Training programs, which have not been approved by the Board of Nursing, **must immediately cease and desist** training candidates. The training program must submit all materials specified in the Regulations Governing Nursing Assistant Training Programs, COMAR 10.39.02. Interested parties may contact the Board at MBON.CNATrainingProgram@maryland.gov.

Renewal of CNA Certification

CNA certification is for a 2-year period following the date of the first renewal. Costs for renewal is $40 for the 2-year period.

The expiration date of certification for GNAs, Medicine Aides, and Home Health Aides match the CNA expiration date. There is no charge for the GNA or Medicine Aide certification. Those certificate holders that have initially been certified will be required to re-certify as the certification expires on the 28th day of the individual's birth month in an odd or even year. If the individual is born in an odd year the certificate will expire in an odd year. If the individual is born in an even year the individual will expire in an even year.

GNA Certification

The Board of Nursing is responsible for processing GNA certification and renewals, not the testing service. GNA certification will be indicated on the CNA certification. There is no cost for GNA certification or renewal if the individual meets the requirements for GNA certification. GNA certification will expire at the same time as CNA certification.

updated 1/30/2024

https://www.nursinglicensure.org/cna/maryland-nursing-assistant/

NA Training Requirements

In order to achieve the CNA, an individual may complete an approved nursing assistant program or equivalent training. Maryland not only permits but requires student nurses to hold CNA certification. Graduate nurses and international nurses may also apply.

Individuals who are pursuing nursing assistant training as an end goal will enroll in Board-approved programs. There is a list available on the website of the Board of Nursing (https://mbon.maryland.gov/Pages/nursing-assistant-certification.aspx).

Individuals who are attending nursing school may consult the same list to see what coursework they will need to complete before they are eligible for their CNA license. The Board has made a list of course titles by school; students will find both in-state and out-of-state schools listed. In many cases, the same courses will simultaneously fulfill training requirements for the GNA license – at least at in-state schools. Out-of-state courses do not provide students with the opportunity to get experience in a Maryland nursing home and are listed as “CNA status only”. (The individual may, however, qualify for GNA after graduation from nursing school.)

Click here to see Nurse Aide and other entry to nursing and health care programs in Maryland.

Individuals who have pursued military healthcare training can also consult the list to see which courses may qualify them for Maryland CNA credentialing. Those who received their training through the Department of the Air Force, for example, will need to document both ‘N. 1317 Fundamentals of Patient Care’ and ‘N. 1318 Basic Nursing Care’.

CNA Background Check Requirements

New CNAs must have criminal background checks. Fingerprints may be made electronically or manually. The Board notes that fingerprints that are taken electronically at Reistertown Plaza are processed quickly; other criminal justice centers may begin providing similar services in the future (http://www.mbon.org/Pages/nursing-assistant-certification.aspx).

Once the Board receives evidence that the prints have been made, the individual can receive a temporary license. A candidate can also be authorized to take the GNA examination at this stage (assuming other requirements have been met).

GNA Training and Examination Process

Individuals who are seeking GNA certification must complete approved nursing assistant programs that provide clinical experience in Maryland nursing homes. They must hold the CNA credential before they can be eligible for the GNA. Additionally, they must take and pass the National Nurse Aide Assessment Program (NNAAP) examination. (The NNAAP is used in more than 20 states; in most cases, it is required for the CNA credential.)

Click here to see Nurse Aide and other entry to nursing and health care programs in Maryland.

The NNAAP consists of two separate evaluations. In the skills evaluation, aides perform five nursing assistant duties. At least one of the tasks requires the candidate to take and record measurements; the measurement could be blood pressure, weight, or radial pulse (among others). Skills are randomly selected and may change from administration to administration.

The knowledge examination is multiple choice and may be administered in written or oral form. The oral examination includes 60 oral knowledge questions and ten questions that require basic reading ability. The candidate handbook includes a content outline and a reading self-assessment.

The NNAAP is administered by Pearson VUE. However, Maryland candidates do not register directly through Pearson. Instead, they go through the American Red Cross.

Candidates will need to document eligibility. Nursing students do not have to be currently enrolled to be certified as CNAs or GNAs. If they did not graduate, however, they need to apply for GNA within 12 months of the time that they complete the qualifying coursework. International nurses must document that they have been approved to take the NCLEX licensing examination for nurses; they do not have to have actually taken the exam.

The Red Cross will need to receive an application by the 15th day of the month in order to schedule the candidate for the next month's examination. Candidates generally receive their admission tickets about two weeks before examination day. Candidates who need to re-schedule are to do so a minimum of four days in advance. The American Red Cross can be reached at 866-257-6470.

Initially, a prospective GNA will register for both the knowledge and skills evaluations. A re-examination candidate, however, may register for just one. The fee is $105 for the full assessment. The skills examination costs $70; the knowledge examination, $35. A test taker who is employed by a nursing home can expect the facility to cover fees.

Test results are generally available the day of testing. Maryland candidates are allowed to attempt the exam up to four times without re-training. They must pass within 24 months.

Out-of-state CNAs Endorsement

Out-of-state CNAs can be endorsed into Maryland if their registry status is current and they are in good standing. The Board has provided a checklist for endorsement applicants (https://mbon.maryland.gov/Documents/cna-checklistforendorsement.pdf).

An out-of-state CNA who is not currently active on another state's registry will need to enroll in an approved course (https://mbon.maryland.gov/Documents/cna-endorsementinfo.pdf).

The Application Process

Some candidates will receive applications through their program (a school or nursing home). Others will need to request materials from the Board. Requests may be made by fax at 410-764-8042. Candidates may also mail or email their request (http://mbon.maryland.gov/Pages/nursing-assistant-certification.aspx). They will need to specify whether they want the initial or endorsement application. They are asked to provide address and telephone number when making their request.

Pearson VUE sends the Maryland Board names of successful examination candidates. Registration status can be verified online.

CMA Training

After two years of full-time CNA experience, or two years of full-time experience as a GNA in an appropriately licensed facility, an employed nurse aide may begin training as a Certified Medicine

Aide (CMA). The aide will need a recommendation from the director (http://mbon.maryland.gov/Pages/nursing-assistant-certification.aspx).

Additional Information

Nursing assistant certification information can be found on the site of the Maryland Board of Nursing (http://www.mbon.org/Pages/nursing-assistant-certification.aspx). Candidates may reach the certification agency at 410-585-1990 or 1-877-847-0626.