**Testimony of Douglas W Heinrichs M.D. -- Favorable**
**Regarding SB0443/HB0403 -- The End-of-Life Option Act**
**(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)**
**February 2024**

I am Dr. Douglas Heinrichs, a psychiatrist who has practiced in Maryland for over 40 years. I am a member of the Maryland Psychiatric Society (MPS) legislative committee, but I am speaking here as a private individual. I strongly support this bill and wish to make three points as a psychiatrist.

***Maryland psychiatrists and physicians nationwide support aid in dying.***

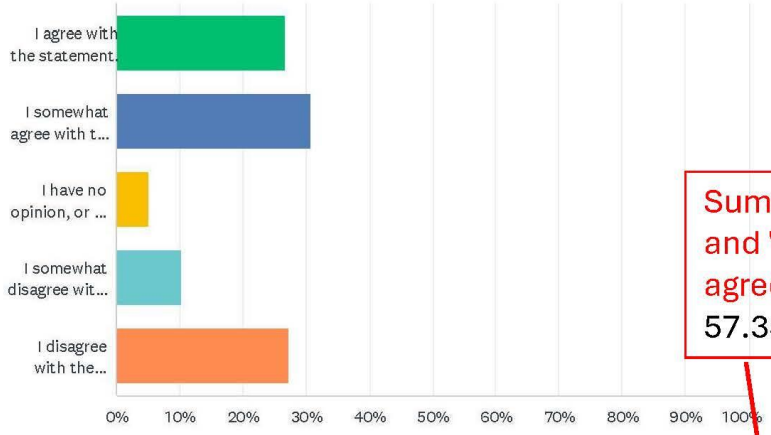
In a 2022 poll that the MPS leadership chose not to make public, MPS members were asked if physicians should be allowed to prescribe lethal medication to competent patients with a terminal condition. 57% agreed or somewhat agreed, while 37.5% disagreed or somewhat disagreed. (See page 2 insert) This is in keeping with the many polls of psychiatrists and other physicians nationally that have found that most physicians support medical aid in dying. The opposition of the MPS is out of step with its membership and the medical profession in general.

***It is unreasonable to require psychiatric evaluation of everyone seeking aid in dying.***

Two studies where mandatory evaluations by mental health professionals were required -- the University of California San Francisco and the state of Hawaii -- with a combined sample of 261 patients, found no patients who lacked capacity due to a psychiatric condition that impaired decision-making. (Bell BK, et al. 2022; Goodyear B. 2024) Both studies concluded that mandatory evaluations by mental health professionals should not be required unless the attending physician's evaluation raises a concern. Requiring such an assessment when mental health resources are so severely stretched is wasteful, and the inevitable delay would be an extreme burden for those seeking aid in dying, as well as being demeaning to a person with no past or present indication of mental illness, as if her mere request raises questions about her sanity.

MPS Survey

# 57% of 176 Psychiatrists who Responded "Agree" or "Somewhat Agree" that "Physicians should be allowed to prescribe lethal medication to these patients."*




Sum of "agree" and "somewhat agree" equals 57.38%

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| I agree with the statement. | 26.70% | 47 |
| I somewhat agree with the statement, more than I disagree. | 30.68% | 54 |
| I have no opinion, or do not lean in either direction. | 5.11% | 9 |
| I somewhat disagree with the statement, more than I agree. | 10.23% | 18 |
| I disagree with the statement. | 27.27% | 48 |
| TOTAL | | 176 |

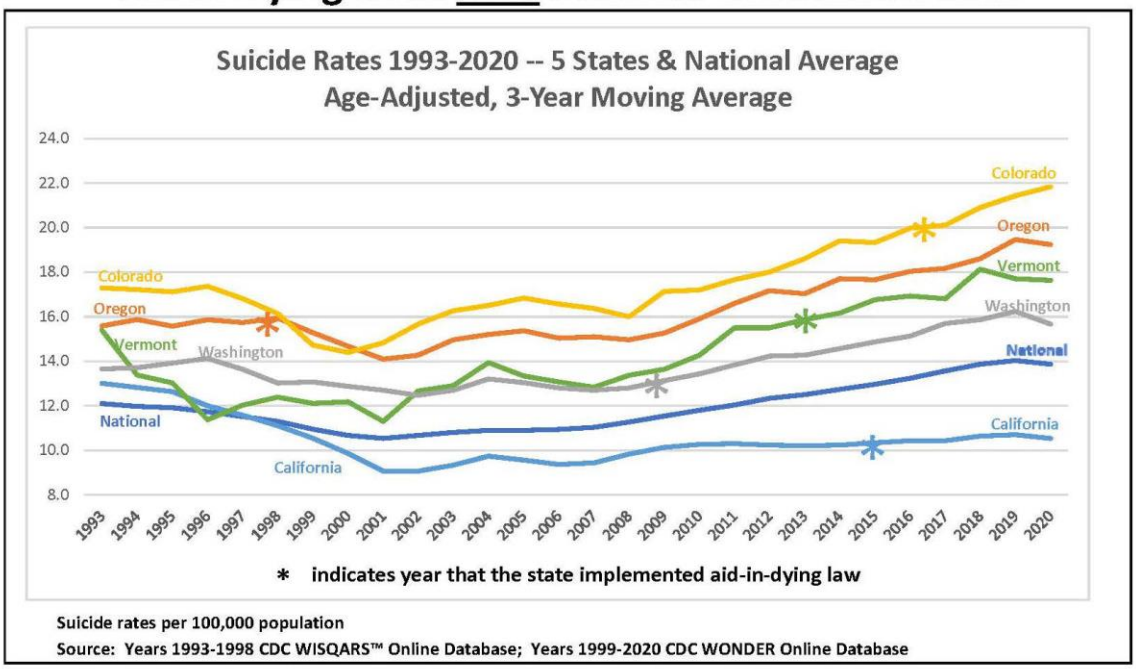
Sum of "disagree" and "somewhat disagree" equals 37.5%

* Question pertains to a competent person with a terminal condition who has significant pain, suffering and/or functional deterioration, despite adequate treatment. Terminal condition means an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life–sustaining procedures, there can be no recovery.

***Aid in dying does not lead to increases in copycat suicides.***

The data from states where it has been available indicate otherwise. No changes in the pattern of suicide rates are seen that correspond to the introduction of aid in dying legislation. States with higher rates of suicide than the national average had higher rates before the introduction of aid in dying legislation in those states. (See graph below.) This should be no surprise. The motivational structure for suicide and for aid in dying are totally different. Typically, people committing suicide choose, for whatever reason, to end their life when it would otherwise be continuing. People seeking aid in dying would love to keep living. It is their disease that is killing them. They are only seeking control over the process to maximize their dignity and minimize their suffering and that of their loved ones.

**Aid in Dying Does NOT Increase the Suicide Rate**



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Commentary

# Mandatory Mental Capacity Evaluations for Patients Requesting Medical Aid in Dying: Are They Necessary?

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## ABSTRACT

Medical aid in dying is now legally authorized in 11 jurisdictions within the United States of America. The State of Hawaii is the only jurisdiction in which mental capacity evaluations are mandatory for all patients who request medical aid in dying. Previous research and the results of the author's evaluations of 161 patients who requested medical aid in dying in the State of Hawaii between January 2019 and December 2023 support the conclusion that mental capacity evaluations should not be legally mandated for all patients who request medical aid in dying.

**Keywords:** Medical aid in dying; Mental capacity; Mandatory mental capacity evaluations

## DESCRIPTION

A total of 11 jurisdictions within the United States of America currently allow medical aid in dying. Eligibility in all jurisdictions requires a patient to be a terminally ill adult with a prognosis of six months or less (hospice eligible), and to have the mental capacity to make an informed medical decision.

In April 2018, the State of Hawaii became the eighth jurisdiction in the USA to legalize medical aid in dying. In addition to evaluation by an attending and consulting provider, every patient requesting medical aid in dying in Hawaii must undergo a mental capacity evaluation performed by a licensed psychiatrist, psychologist, or clinical social worker.

The State of Hawaii is currently the only jurisdiction in which a mental capacity evaluation is mandatory. In all other jurisdictions, referrals for capacity evaluations are made at the discretion of the attending provider. Such referrals are rarely found to be necessary. Only 5.6% of 991 patients in Oregon who ingested legally prescribed lethal medication were sent for psychiatric evaluation to assess competence [1]. Similarly, a review of trends in Oregon and Washington found that only 4% of 3,368 patients were referred for mental health consultation [2]. And in a sample of patients in Washington and Oregon with ALS, only 2.7% required psychiatric consultation [3].

Other studies have not found significant relationships between the presence of mental health symptoms and end-of life medical decisions [4-7].

The largest body of research on patients who participate in medical aid in dying has been done by Dr. Linda Ganzini of Oregon Health and Science University and her associates. Their research indicates that mental disorders are not present in the majority of patients who request medical aid in dying [8,9]. Based on her experiences in Oregon, Ganzini has concluded that while all patients requesting medical aid in dying should be carefully screened for depression, requiring a psychiatric consultation in every case is burdensome, unnecessary and possibly unworkable [10].

Overall, the research findings seem consistent with the legal principles described by Grisso and Appelbaum, who emphasized that courts across the USA have made it consistently clear that the presence of mental illness, mental retardation, or dementia alone does not render a person incompetent, and that a patient may be psychotic, seriously depressed, or in a moderately advanced stage of dementia, yet still be found competent to make some or all decisions [11].

Between January 2019 and December 2023, the author conducted a total of 161 mental capacity evaluations for terminally ill patients who had requested medical aid in dying in the State of Hawaii. Evaluations consisted of a review of relevant medical records, a mental status examination, and a detailed clinical interview, which included a screening for symptoms of major depressive disorder and an assessment of decisional capacity based on the principles outlined by Grisso and

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Appelbaum [11], and subsequently incorporated into handbooks developed jointly by the American Bar Association and the American Psychological Association [12,13]. The principles involve the assessment of four functional abilities: The ability to understand information relevant to the decision; the ability to appreciate the significance of the information and the probable consequences of the available options; the ability to use reasoning to weigh the potential risks and benefits of the options; and the ability to communicate a voluntary decision. A checklist was developed to assist in the assessment of these abilities in medical aid in dying patients.

Consistent with the findings of the patients' attending providers, the author found that the vast majority of patients clearly had the mental capacity to request medical aid in dying. Only four of the 161 patients (2.48%) lacked the necessary decisional capacity, all because of rapid deterioration in cognitive functioning subsequent to the attending provider's initial visit. A total of 15 of the 161 patients (9.32%) were found to have a mental disorder (either a depressive disorder or adjustment disorder) at the time of the evaluation. In all cases the disorder was mild, and in no case was the disorder severe enough to impair decisional capacity. Mental health treatment was recommended as deemed necessary and appropriate for these patients. Another ten patients acknowledged a remote history of mental disorder that was not evident at the time of the evaluation.

Several conclusions can be drawn from the data reviewed above. First, a request for medical aid in dying should not be equated with the presence of a mental disorder. Second, mental disorders are found to be present in a minority of patients who request medical aid in dying. Third, even when a mental disorder is present, decisional capacity is rarely impaired. These conclusions strongly support the assertion that mental capacity evaluations are not clinically necessary for the great majority of patients who request medical aid in dying.

It thus seems reasonable to argue that mental capacity evaluations should not be legally mandated for all patients who request medical aid in dying. Referrals for such evaluations can be made at the discretion of the attending provider, consistent with the process that providers customarily follow when assessing patient's decisional capacity for other medical procedures. Patients who request medical aid in dying should be carefully screened by their attending and consulting providers for the possible presence of any mental disorders that might affect decisional capacity. Terminally ill patients should not, however, be required to undergo a potentially costly, time-consuming, and burdensome evaluation by a mental health specialist unless the attending or consulting provider finds that there is a clear reason to do so.

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