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The Honorable William C. Smith, Jr.
Judicial Proceedings Committee
2 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Oppose - Senate Bill 443/House Bill 403: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Chairman Smith, Chairwoman Pena-Melnyk and Honorable Members of the Committees:

I write in opposition to SB 443/HB 403 or the Maryland physician assisted suicide bill. This bill cannot be safely implemented and will lead to unnecessary premature deaths. I am a Professor of Psychiatry at the Johns Hopkins School of Medicine and have directed the Johns Hopkins Eating Disorders Program for over 25 years. I treat patients with severe and extreme anorexia nervosa, a population at high risk under the proposed law. Anorexia nervosa is not a terminal illness. Nearly every case can improve with expert psychiatric and nutritional care, and a majority achieves full recovery at 20-year follow up. ***Importantly, seasoned clinicians who treat anorexia cannot predict who will recover or when, and who will remain chronic, or succumb to their illness.*** Proponents of this bill argue that there are safeguards against its misuse, however in Colorado where a bill similar to SB 443/HB 403 is law, physician assisted suicide has already been applied to individuals with anorexia nervosa.

Patients with anorexia nervosa are often in the care of general practitioners and general psychiatrists. Most doctors — psychiatrists included, can diagnose anorexia but have no training to treat it. Faced with a patient in intensive care with extreme starvation who weighs 50 pounds and refuses nutrition, the attending physician, the community provider, even the palliative care specialist -- may judge the patient terminal because they are unaware of, and don't know how to get her, the treatment she needs. And the starved patient could be influenced to view "aid in dying" as the best way out of an intolerable situation or believe her family would be better off without her emotionally and financially as the care of anorexia nervosa is extremely costly.

Anorexia nervosa is challenging to treat because the disorder renders patients ambivalent about accepting care, unable to freely choose treatment or to imagine life without their disorder. ***Patients can appear rational but often lack capacity to accept the medication they most need - food. How then can they have the capacity to accept a lethal medication?***

When a patient's life is at risk, involuntary treatment provided by an expert behavioral inpatient specialty program, can be lifesaving, and when effective is often met with gratitude by patients.

When such treatment is inaccessible, or when involuntary treatment has failed, approaches, including harm reduction and palliative care, focus on improvements in quality of life, whilst still fostering hope in eventual recovery and motivation to reverse malnutrition. ***There should be no room for prescribed suicide as a "less restrictive treatment option" for anorexia nervosa -- yet despite reported safeguards against misuse, physician assisted suicide is already taking place in Colorado for patients with a primary diagnosis of anorexia nervosa.***

Dr Jennifer Gaudiani, the attending physician (a private practitioner and specialist in internal medicine) and Dr Joel Yager a prominent psychiatrist have proposed a diagnosis of "terminal anorexia" which they argue is eligible for physician assisted suicide. In a published article (referenced below), Dr Guadiani described her participation in prescribing lethal medication for two patients in their 30s with anorexia nervosa, neither of whom, based on the information provided had failed an adequate trial of intensive treatment. The arguments presented in this paper, and in subsequent news articles easily accessible to the public, risk fueling demand for physician assisted suicide amongst demoralized patients and their families grappling with this serious yet treatable condition. These deaths, represent the first instances of physician assisted suicide for a primary psychiatric diagnosis in the U.S., and should be a wakeup call -- they illustrate why safe application of this law is not possible.

Following news media attention, Compassionate & Choices issued a statement that "This law does not, and was never intended to apply to a person whose only diagnosis is anorexia nervosa" however Dr Gaudiani retains an active license, not only in Colorado, but in multiple U.S. states including Maryland, where she can assess and treat patients remotely by telemedicine.

I have been contacted by several patients who believe they would be dead today had physician assisted suicide been offered to them as an option in the depths of their illness. One of these, an ex-patient of Dr Gaudiani's, said she was prescribed lethal medication when severely ill although she never did take it. She details how confused and despairing her thinking was at that time and how she felt coerced into accepting aid in dying as a solution to her suffering.

I urge you to oppose the Maryland aid-in-dying or assisted suicide bill because there's too much room for error. It risks endangering the most vulnerable, not only the 0.5-1% with anorexia nervosa but by extension the one in five Americans who suffer from a treatable mental condition that affects their ability to visualize a better day. Our job as psychiatrists is to help patients cope, improve their quality of life and heal, not facilitate their death.

Recent news from Canada halting the decision to expand physician assisted suicide to mental illnesses should give us further pause. We are all subject to unconscious bias, physicians included and the majority of prescriptions for physician assisted suicides in the U.S. are written by few self-selected physician advocates of "death with dignity".

I respectfully request you vote against SB443/HB 403.
Yours sincerely,

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References:

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