February 20, 2020

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

RE: Oppose – SB 701: End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act)

Dear Chairman Smith and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) is a state medical organization whose physician members specialize in the diagnosis, treatment, and prevention of mental illnesses including substance use disorders. Formed more than sixty years ago to support the needs of psychiatrists and their patients, MPS works to ensure available, accessible and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branch of the American Psychiatric Association covering the state of Maryland excluding the D.C. suburbs, MPS represents over 700 psychiatrists as well as physicians currently in psychiatric training.

MPS opposes Senate Bill 701: End-of-Life Option Act (SB 701). Since this bill was first introduced in 2015, MPS has extensively deliberated the legislation within the organization through several listserv discussions, a member survey, and a four hour pro-con debate sponsored jointly with the Maryland somatic physician's organization, Med Chi. In addition to reviewing the legislation each year, MPS has considered information contained in the American Psychiatric Association's (APA's) resource document on assisted suicide and other literature as cited in the footnotes to this testimony.

MPS recognizes that this is a divisive issue and that some of our members disagree with the organization's position. Those members have been encouraged to contact their elected officials to contribute their thoughts and we welcome consideration of both sides of this serious policy.

MPS maintains its opposition to SB 701 based on three general areas of concern.

1. Suicide Contagion

Promotion of this bill, and assisted suicide laws generally, transmit a dangerous message to vulnerable Maryland citizens. According to the Centers for Disease Control (CDC), at

any given point in time 4% of people are experiencing suicidal thoughts. One-sixth of those individuals will attempt suicide (1.4 million Americans), and 3% will die.[1] Translated into Maryland numbers, this means that 242,000 people are presently thinking of killing themselves, 40,333 will attempt suicide, and 1210 will die.

Suicide clusters and contagion are well established phenomena with documented connections to media coverage and publicity.[2] The CDC and the World Health Organization both promulgate guidelines for the media coverage of high profiles suicides.[3] These guidelines advise against the portrayal of self-destruction as a "brave," or "romantic," and discourage reports which idealize suicidal behavior. They also caution against explicit discussion of suicide methods. These recommendations were developed in part due to a study which demonstrated that deaths by helium asphyxiation increased by more than 400% in New York following publication of the book Final Exit in 1991.[4]

Proponents of assisted suicide laws violate these public health recommendations when they describe self-destruction as a "graceful" or "beautiful" expression of personal autonomy.[5] To date there have been no well-designed studies to clarify the relationship, if any, between adoption of assisted suicide laws and states rates of un-assisted suicide. However, following the highly publicized death of Brittany Maynard in 2014 the number of assisted deaths by lethal medication in Oregon nearly doubled, from 71 in 2013 to 132 in 2015. In a letter to the Colorado Springs *Gazette*, Dr. Will Johnston documented the

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[1] Shreiber, J, and L Culpepper. 2020. "Suicidal Ideation and Behavior in Adults." Up-to-Date, January.

[2] Blasco-Fontecilla, Hilario. "On Suicide Clusters: More than Contagion." The Australian and New Zealand Journal of Psychiatry 47, no. 5 (May 2013): 490–91.

[3] Carmichael, Victoria, and Rob Whitley. "Media Coverage of Robin Williams' Suicide in the United States: A Contributor to Contagion?" PLOS ONE 14, no. 5 (May 9, 2019): e0216543.

[4] Marzuk PM, Tardiff K, Hirsch CS, Leon AC, Stajic M, Hartwell N, Portera L (1993) Increase in suicide by asphyxiation in New York city after the publication of Final Exit. N Engl J Med 329:1508–1510.

[5]. Death with Dignity National Center. Stories. - Accessed February 2, 2020.

case of a young man who was inspired to research suicide methods online after being impressed by, and admiring, Brittany Maynard's suicide video.[6]

Here in Maryland, two people with serious mental illness have sought psychiatric help to die on the basis of their mental illness. One was a resident of the Maryland state hospital system and made a request for lethal medication on the day the 2019 bill failed in the Senate.[7] Another was a resident of the Eastern Shore with schizophrenia who contacted several forensic psychiatrists for a capacity assessment in order to apply for euthanasia in Switzerland.[8]

Adoption of this law carries serious implications for people with mental disorders who would demand equality under the law. People with serious and treatment-resistant eating disorders could qualify, since qualification is based upon prognosis rather than diagnosis.

2. Safeguard Failures

MPS considers the statutory safeguards to be inadequate. Furthermore, the safeguards historically have been ignored without consequences to the negligent physicians.

Between 1998 and 2012, a total of 22 Oregon physicians were referred to the Board of Medical Examiners for non-compliance with the provisions of the Death with Dignity Act. None could be sanctioned due to the "good faith" protections of the law, even when required witness attestations were missing. No attempt has been made by Oregon, or any independent researchers, to document unreported cases in Oregon since the entry into force of the DWDA. The true reporting rate in Oregon is therefore unknown.[9]

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6. Johnson, Will. 2016 "Brittany Maynard's Story Sends the Wrong Message to Young People. - Accessed February 2, 2020.

7 Hanson, personal communication

8 Neghi and Crowley, personal communications

9 Lewis, Penney, and Isra Black. "Reporting and Scrutiny of Reported Cases in Four Jurisdictions Where Assisted Dying Is Lawful: A Review of the Evidence in the Netherlands, Belgium, Oregon and Switzerland." Med Law Int 13, no. 4 (2013): 221–39. - Accessed February 2, 2020

Similarly, in the first year of the Colorado law all prescribing physicians attested that they followed the law even when 42 cases were missing the consultant's evaluation, 22 had no written request, and nine of 69 cases were not reported at all by the physician.[10]

In 2016, the Des Moines Register investigated ten years of data in Washington and Oregon, and found that in 40% of cases the reports were missing key data. Failure to submit required reports, or to hold physicians accountable for reporting failure, is a substantial weakness of this legislation.[11] Even if all required documents were accounted for, there has been no study to date to confirm the accuracy and specificity of these statutory safeguards.

In Maryland, one physician was willing to violate our state's criminal prohibition. The late Dr. Lawrence Egbert admitted to participating in the assisted suicide deaths, by helium asphyxiation, of six non-terminally ill Maryland residents. Three of those patients had co-existing clinical depression. Dr. Egbert's actions were discovered purely by accident. Nonetheless, Dr. Egbert was never charged or prosecuted in Maryland. Dr. Egbert admitted in an interview with the Baltimore Sun that he had been involved in 15 suicides in Maryland and 300 nationwide.[12]

If Maryland is unwilling to enforce criminal prohibitions, the enforcement of statutory safeguards is even less likely. Connecticut's Division of Criminal Justice acknowledged that the statutory construction of their legislation would have prohibited prosecution for murder.[13]

3. Implications for the Practice of Psychiatry

This legislation has the potential to significantly complicate the practice of psychiatry in Maryland, for both the treating clinician and when functioning as an evaluator of

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[10] Colorado End-of-Life Options Act, Year One 2017 Data Summary. - Accessed February 2, 2020

[11] Munson, Kyle, and Jason Clayworth. 2016. "Suicide with a Helping Hand Worries Iowans on Both Sides of 'Right to Die.'" Des Moines Register, November 25, 2016.

[12] Dance, Scott. 2014. "Maryland Strips Doctor of License for Assisting in Six Suicides - Baltimore Sun." Baltimore Sun, December 30, 2014.

[13] Connecticut Division of Criminal Justice. Written Testimony Regarding HB7015. 2015. - Accessed February 4, 2020

decision-making capacity. This law would carve out a class of people who theoretically could be categorically exempt from emergency evaluation procedures or civil commitment. Given that some individuals live for more than one year after receiving a lethal prescription, and that capacity may deteriorate over that time, it is unclear whether a qualified patient who has lost capacity could be assessed and treated for mental illness under this law.

There is no provision to correct an error if lethal medication is given to a patient who has concealed his or her psychiatric history from a prescribing physician. A treating psychiatrist who discovers an error would have no legal means to take custody of or dispose of the medication given to a patient. There is no procedural mechanism to challenge a faulty or erroneous capacity assessment.

A psychiatrist charged with assessing capacity must also rule out the possibility of coercion. In order to do this, the evaluator must be at liberty to interview any individual with relevant information. Under this law, a coerced individual could refuse permission for the evaluator to speak with anyone who has knowledge of the coercion.

SB 701 allows the patient to ingest the medication at the time and place of his or her choosing. Thus, a participating facility could require an inpatient psychiatric unit to allow ingestion on the ward in violation of ward suicide prevention policies. This would be particularly detrimental on units designed for the treatment of eating disorders or in geriatric units, where it would be most likely to occur. People with mental illness also develop co-occurring serious medical conditions such as diabetes; since the law does not require the patient to accept any treatment, this condition would qualify as "terminal" if the individual refuses insulin.[14] California's health department regulations mandate that state psychiatric facilities must carry out assisted suicides within their units under certain conditions (9 CCR §4601).[15]

Conclusion

Several additional deficiencies have been identified by other opponent groups, and the Maryland Psychiatric Society endorses these concerns. These include:

1. No requirement for decisional capacity at the time of ingestion

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[14] Oregon Health Authority. 2018. Responses to Fabian Stahle. - Accessed February 4, 2020

[15] California. Petitions to the Superior Court and Access to the End of Life Option Act. 9 CCR §4601 (2016)

2. No requirement for an independent or law enforcement observer at the time of ingestion
3. No mechanism to detect a negligent, incompetent, or malicious prescriber
4. The risk to third parties in the home (depressed or mentally ill family members)
5. Detrimental psychological effects on the involved medical professional
6. No requirement for a doctor to notify a power of attorney or guardian that a prescription has been requested
7. Potential federal civil rights violations if the eligible person is institutionalized in a correctional facility or state hospital where prevention of suicide is an affirmative obligation.
8. The lack of mental health screening instruments validated in this population for this purpose
9. No mandatory reporting or whistleblower protection for healthcare providers aware of negligent or malicious prescribers

For all the reasons above, MPS asks the committee for an unfavorable report of SB 701. If you have any questions with regard to this testimony, please feel free to contact Dr. Annette Hanson at hanson1072@gmail.com.

Respectfully submitted,
The Legislative Action Committee for the Maryland Psychiatric Society

Extra References:

Anfang S et al. APA Resource Document on Physician Assisted Death. American Psychiatric Association 2017

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