Angela S. Guarda M.D.
Professor of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine
Director, Johns Hopkins Eating Disorders Program, Johns Hopkins Hospital
Meyer 101, 600 N. Wolfe Street, Baltimore, MD 22187

Monday, March 6, 2023

The Honorable Joseline A. Peña-Melnyk
Health & Government Operations Committee
Room 241 - House Office Building
Annapolis, MD 21401

The Honorable Luke Clippinger
Judiciary Committee
Room 101 - House Office Building
Annapolis, MD 21401
Dear Chair Peña-Melnyk, Chairman Clippinger, and Honorable Members of the Committees:

RE: Oppose – HB 933 "End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

I write in opposition to SB 845 or the Maryland 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. **Despite a high mortality rate, anorexia nervosa is a treatable, not a terminal illness**. Nearly every case can improve with expert psychiatric care and nutrition, and a majority achieves full recovery at 20-year follow up, including many who were severely ill. Importantly, **seasoned clinicians who treat anorexia nervosa cannot predict who will recover or when, and who will remain chronic, or succumb to their illness**.

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 who weighs 50 pounds, is in kidney failure with unstable vital signs, all resulting from their starved state, the attending physician, the community provider or 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 — especially when she refuses it. 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 persons with this disorder are ambivalent about accepting the treatment they need: nutrition. Additionally, capacity to make treatment decisions

is often impaired -- in one specific realm – in the ability to appreciate the seriousness of one's condition, to freely choose treatment, and to imagine the possibility of life without the disorder.

Patients with anorexia appear rational in all ways but one: they often lack the capacity to accept the curative treatment they need. How then can they have the capacity to accept physician assisted suicide?

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, other approaches, including harm reduction and palliative care, focus on improvements in quality of life, yet still foster hope in eventual recovery and motivation to reverse malnutrition. There should be no room however for prescribed suicide as a "treatment" for this condition.

In Colorado, where a similar bill is law, and despite reported safeguards against misuse, physician assisted suicide is taking place for patients with treatable anorexia nervosa. Dr Jennifer Gaudiani, the attending physician (a specialist in internal medicine) involved in these cases, recently published an article advocating for a diagnosis of "terminal anorexia" eligible for physician assisted suicide (referenced below) and 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 adequate treatment. The arguments presented in this paper, easily accessible electronically 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, the first instances of physician assisted suicide for a primary psychiatric diagnosis in the U.S., should be a wakeup call as they illustrate why safe application of this law is not possible.

Following news media attention to these cases, 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". Dr Gaudiani however 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 published a response to Gaudiani et al.'s article (see reference below) noting the dangers of a diagnosis called "terminal anorexia" and of physician assisted suicide in this population. In return I received several emails from patients thanking me and noting that they believed they would likely be dead today had physician assisted suicide been an option when in the depths of their illness.

I was also contacted by an ex-patient of Dr Gaudiani's who reported "I was told that, although I wasn't yet 30 years old at the time, **she would "make an exception" for me and "allow" me to die, if that was my choice. It didn't feel like my choice – I felt coerced....** I'm not sure how to describe it, but something inside me wouldn't let me take the MAID. I ate just enough to "not die" right away… I weaned off of the morphine, and all the other hospice drugs that kept me in such a fog…In those 18 months since, I moved…I have a job …that I love, a new puppy, and a great group of friends. I'm able to fuel my body to hike and do the things I love. I'm repairing my relationship with my family, and I have a great therapist who is helping me process all of

this…I want to thank you for being a voice for those of us who have been told we are beyond hope".

These words detail how easily a patient with extreme anorexia could feel seduced or coerced into accepting "aid-in-dying" as a solution to their 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 to facilitate their death.

Yours sincerely,

Angela Guarda M.D.
Director, Eating Disorders Program, Johns Hopkins Hospital
Stephen and Jean Robinson Professor of Eating Disorders
Professor of Psychiatry and Behavioral Sciences, Johns Hopkins School of Medicine

References:

Guarda AS, Hanson A, Mehler P, Westmoreland P. Terminal anorexia is a dangerous term: it cannot, and should not, be defined, J Eat Disord 2022;10(1):79
https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-022-00599-6

Gaudiani JL, Bogetz A, Yager J. Terminal anorexia nervosa: three cases and proposed clinical characteristics. J Eat Disord. 2022;10(1):23.
https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-022-00548-3

Eddy KT, Tabri N, Thomas JJ, Murray HB, Keshaviah A, Hastings E, et al. Recovery from anorexia nervosa and bulimia nervosa at 22-year follow-up. J Clin Psychiatr. 2017;78(2):184–189. doi: 10.4088/JCP.15m10393. - DOI - PMC – PubMed