March 3, 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

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

Dear Chair Peña-Melnyk, Chairman Clippinger, and Honorable Members of the Committees:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

The MPS & WPS recognize that proponents of this bill have reasonable concerns about the wish to end suffering and may ethically favor legislation supporting personal autonomy and the privacy of the doctor-patient relationship. Our members have been encouraged to contact their elected officials to contribute their thoughts, and we welcome consideration of both sides of this serious policy.

The MPS & WPS oppose House Bill 933 (HB 933): End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

While we recognize that the law has statutory requirements, there is no mechanism to ensure adherence as written. Thus, the Health Department should adopt regulations to conduct random audits of the prescribing physician's records to ensure adherence with the law.

No standardized procedures exist for assessing both capacity and coercion in these specific circumstances in the primary care setting. While a standardized mental health assessment is not routinely required before most medical procedures, the provision of fatal care is unlike any existing treatment. Given the severe consequences of an erroneous outcome, the decision-making capacity for fatal care should require a more rigorous assessment.

Many serious medical conditions are known to cause a variety of capacity-impairing mental disorders, such as clinical depression, cognitive impairment, and delirium. Indeed, as many as 25% of patients diagnosed with terminal illnesses may suffer from clinical depression. Infection with the human immunodeficiency virus is often associated with increased rates of treatable mood disorders and dementia. Neurodegenerative diseases like Parkinson's disease and ALS (Lou Gehrig's disease) can also cause cognitive impairment and depression. A recent study showed that more than half of patients in hospice care exhibit unrecognized cognitive impairment, and these deficits are directly related to impaired decision-making capacity. Furthermore, a psychological screening tool that physicians could use is insufficient to detect all conditions that could cause impairment, nor does any existing screening tool have the ability to detect a patient who deliberately conceals his/her symptoms.

A full mental capacity evaluation is a complex and multifaceted process. A clinician who performs a capacity assessment must consider information from collateral sources such as family members or friends and must also review psychiatric treatment records if they exist. Yet, under this law, no provision exists for a clinician to access this information if the patient refuses to consent. This is a serious shortcoming given that a clinician would need to speak with a treating psychiatrist as part of any ordered assessment. Similarly, a treating psychiatrist could be barred from communicating potentially relevant information to the prescribing physician if the patient declines to consent to that communication.

This bill has implications for Maryland's involuntary treatment laws as well. The bill is unclear regarding whether a qualified patient who possesses a lethal prescription would be required to permanently surrender that medication already received if he meets civil commitment criteria because of mental illness. Maryland's civil commitment law is based upon dangerousness to self or others rather than decisional capacity. A civil commitment should require a re-evaluation of eligibility to receive a new prescription.

HB 933 also has implications for institutionalized patients in Maryland's prison and state hospital systems. Institutionalized patients are a protected class under the federal Civil Rights of Institutionalized Persons Act (CRIPA). Failure to intervene and protect these patients from suicide is commonly accepted as a civil rights violation under CRIPA as well as by established federal case law. A patient committed to a psychiatric facility retains the legal right to make medical decisions. This includes long-term patients residing in Maryland's public institutions with potentially terminal medical conditions. In fact, the Maryland Division of Corrections maintains a palliative care unit for terminally ill prisoners. Under the End-of-Life Options Act, the attending physician would be the individual who prescribes the fatal medication. For institutionalized psychiatric patients, this would require that the treating physician certify the diagnosis and prognosis of a terminal medical condition. In light of *Estelle v Gamble*, 42 U.S. 97 (1976), an institutional physician would be placed in a professional quandary between federal and state laws.

Finally, for the safety of the patient and the welfare of others present, lethal medication should be consumed in a controlled or monitored setting. Through regulation, we encourage the Maryland Department of Health to develop standards to provide the necessary protections.

To conclude, MPS and WPS recognize that this is an ethically complex issue affecting patients and colleagues struggling with desperate, painful situations. We know that reasonable people have strong convictions on both sides. Nevertheless, more must be done to ensure adequate protections are in place so we cannot support the bill as written.

For those reasons, MPS/WPS asks this committee for an unfavorable report on HB 933. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Joint Legislative Action Committee
of the Maryland Psychiatric Society and the Washington Psychiatric Society