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Health and Government Operations Committee
Room 241
House Office Building
Annapolis, Maryland 21401

Dear Honorable Health and Government Operations Committee Member:

My name is Holly Ryerson Dahlman, MD, FACP. I am a graduate of the Johns Hopkins University School of Medicine and trained in internal medicine at the Johns Hopkins Hospital. I am CEO, owner, and lead physician of Green Spring Internal Medicine, a small independent primary care practice in Lutherville. I am writing to oppose HB933.

Health insurance companies have profited handsomely by not spending money on healthcare. Significant obstacles to patient care already exist in the form of prior-authorizations and denials. Here in Maryland, the Total Cost of Care Model began in 2019, a model which incentivizes hospitals to lower healthcare costs. Accountable Care Organization (ACO) models throughout Maryland are also incentivizing physician practice groups to achieve shared savings in healthcare. In other words, practices like mine are given a yearly bonus when we have reduced costs across a population of patients.

Life-saving care is often expensive. This is not the time for the low-cost death option! To permit medically-prescribed death would be to open the way to an entirely unmanageable set of financial conflicts of interest for insurance companies, hospitals, and medical practices. What will be the priority in healthcare: profitability or people?

To cast this issue as "compassion and choices" is deceptive. What is being debated is a prescription for death. The medical profession is full of compassionate doctors who offer choices to our patients every day. In primary care, we help our patients throughout their lives, even to the end. "MAID" (or "Medical
Aid in Dying") deceives the public as a term since help is already available for terminally ill patients, including home-based and inpatient hospice care. Surveys of public or professional support should not use this misleading terminology. History has shown us that the majority is not always right.

Personal autonomy must be weighed against other medical ethics such as beneficence, non malevolence, and social justice. One's own autonomy should not come at the expense of another person or group of people. The following individuals would be at greatest risk of harm if physician assisted suicide were to be legalized in Maryland: people unable to afford healthcare or medication, elders believing they are a burden, those wanting to avoid health costs in order to leave an inheritance, the lonely, the chronically ill, patients with weary caregivers, and people

living with disability. Members of the American Geriatrics Society, when surveyed, were concerned that those with low health literacy would be particularly at risk.

The "Right to Die" is tied to this legislation. It is false to imply that this form of autonomy depends upon legalizing physician-assisted suicide (PAS). Autonomy already exists in the rights of patients to decline medical treatment or to discontinue it. For physicians and healthcare teams to stand out of the way of the natural dying process is fundamentally and unalterably ethically different than to act with the intent to prescribe death. Physicians should not prescribe death, especially in situations where there is lack of accountability and anonymity which opens the door to abuses and renders the study of potential harms of PAS nearly impossible. Most physicians in states where prescription for death has been legalized have refused to participate.

Professional physician organizations oppose PAS. I am a member of the American College of Physicians (ACP), the largest organization of internal medicine doctors in the United States, representing over 160,000 physicians. The ACP opposes physician-assisted suicide. I have attached our ethics paper on this topic.

This is no time for Maryland to legalize medically-prescribed death. It is ironic that there is a push to enable physicians to do this at a time when our great State of Maryland is reeling from opioid overdose death and suicide epidemics, both of which preceded but have worsened during COVID times. The desire to end life is often a symptom of severe mental illness. As my clinical experience has also taught me, the wish to die may be transient. The influence of PAS crosses state lines, and the "guardrails" are not strong enough in this legislation.

Terminal illness remains difficult to define precisely. Patients whom I thought would die within months have lived for years. Some conditions such as Parkinson's disease or MS have been used to push the case for physician-assisted suicide. Yet, degenerative conditions have a long disease trajectory. In other countries where PAS was legalized, euthanasia has followed. At which point would terminal illness or even personal consent be cast aside as requirements? One should look to Europe and Canada for modern examples.

What is good, or beneficent, at the end of life is to provide high-quality, patient-centered care. Hospice care should be available for all Marylanders. We need to continue to improve the systems which help terminally ill patients and their families in the settings of their preference. In my practice, we have increasingly supported patients at the end of life with the help of home hospice. Hospice care needs ongoing investment to improve access and quality. This includes the need to study symptom management in terminal illness. Better hospice care should dissolve all demand for physician-assisted suicide by providing assurance to our society that physicians and other healthcare workers will labor to relieve suffering while shaping treatment plans around patient goals.

In summary:

- Because of financial conflicts of interest in healthcare, we must not allow the low-cost death option to be legalized in the State of Maryland.
- Compassionate care centered on patient goals at the end of life already exists, within the limits of what is beneficial and not harmful. Surveys should NOT mislead the public.
- Personal autonomy needs limits. Prescribed death threatens vulnerable populations.

*The "Right to Die" does not depend upon the existence of PAS.

- Amidst an opioid overdose epidemic, this is not the time to release dangerous drugs into society.

•Amidst a suicide epidemic, this is not the time to signal ending one's own life as a favorable option.

•Standing out of the way of the natural dying process is ethically distinct from actively prescribing or administering death.

*Most physicians in states where PAS has been legalized have refused to participate. Lack of accountability opens the way for abuse and prevents adequate evaluation of impact.

*The American College of Physicians opposes physician-assisted suicide.

*Defining terminal illness is inexact.

• Voluntary physician-assisted suicide opens the door to euthanasia, including involuntary euthanasia.

*Hospice care makes physician-assisted suicide unnecessary.

What is just, what is good, what avoids wrong, what is safe, and what is wise must be at the forefront of every consideration in healthcare. Though other states have legalized physician-assisted suicide, this would not be good for Maryland. Please do not vote in favor of this dangerous bill!

Professional regards,

Holly Ryerson Dahlman, MD, FACP
CEO, Owner, Physician
Green Spring Internal Medicine, LLC