

Todd Becker, LMSW

Regarding the End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

March 6, 2023

To Whom It May Concern:

My name is Todd Becker. I am a doctoral candidate in the University of Maryland School of Social Work where I study end-of-life care and am currently completing my dissertation on medical aid in dying. I write this testimony to express my full support of the End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).<sup>1</sup> My support stems from three distinct, yet interrelated, domains: my professional experience as a hospital social worker, my scholarly experience as a medical aid in dying researcher, and my personal experience as a fellow Marylander who wants not just to live—but also to die—in accordance with my values. Through my support, I join the 66% of Marylanders found to be in favor of medical aid in dying by Public Policy Polling in 2019.

Medical aid in dying offers an applied way through which law can make health care more equitable and socially just. Notwithstanding, much of what conditions the ultimate legality of the practice rests on interpretations of morals and ethics. Where this reliance can go wrong is when assumptions about medical aid in dying are conflated with other mechanisms of self-actualized death, most notably suicide. Leading medical, psychological, public health, and suicidological organizations have issued statements affirming that medical aid in dying is categorically different from suicide. The distinction is that, unlike those who die by suicide, for those pursuing medical aid in dying, death is both assured and imminent. That these individuals are likely to die within 6 months, regardless of the cause, is not questionable. In this way, when one's terminal illness has filled in the blanks for them pertaining to "who," "what," "where," "when," and "why" they will die, their ability to craft for themselves the "how" becomes all the more intimate and meaningful.

Such was the experience of Brittany Maynard, who publicly chronicled her process with medical aid in dying. In so doing, she recounted the dissonance of not recognizing the reflection staring back at her in the mirror due to the changes in her physical appearance prompted by her illness. She spoke of the trepidation of potentially forgetting to tell others that she loved them each day for fear that she would not get another opportunity. Most strikingly, she described that the "worst thing that could happen" would involve her terminal illness robbing her of her autonomy to live and die on her own terms through medical aid in dying. Throughout this process, she made clear that she loved her life and had no desire whatsoever to die but that her illness rendered death an inevitable and impending reality. Complicating this already-fraught situation was the fact that she, her husband, and her parents had to move from their native California to Oregon in order to access legal medical aid in dying. Moving an extended family across state lines is challenging in the best of circumstances and is not realistic for people of varying backgrounds. This recognition led to California's legalization in the year following Maynard's death. Even alongside legalization in nearby New Jersey and the District of Columbia, local disparities in equity and health care access can be counteracted by advancing legislation here in Maryland.

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<sup>1</sup> The views expressed in this testimony are my personal views and do not reflect the views of either the University of Maryland or the University of Maryland School of Social Work.

Longitudinal report data from U.S. environments where the practice is legal show that responsible implementation of medical aid in dying is feasible. Indeed, empirical studies have found a lack of widespread abuse of medical aid in dying, thereby combatting the commonly invoked boogeymen of slippery-slope and other arguments. These same reports show a growing divide between (a) the number of prescriptions written and (b) the number of deaths attributable to medical aid in dying. What we should deduce from this trend is that the relief that legalization offers to patients and families is not tied exclusively to death. Instead, awareness of the mere availability of a medical aid in dying option has been recognized for offering a psychological benefit to patients through restoring one's sense of control relinquished to their terminal illness. This recognition has led others to contend that the availability of medical aid in dying itself is palliative in nature, irrespective of whether or not it is ultimately used.

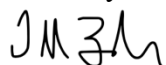
This same recognition is precisely why medical aid in dying—beyond its professional and scholarly importance—is personal to me. In full disclosure, I doubt that I myself would use medical aid in dying even if I qualified for it. Still, actively choosing not to use medical aid in dying is radically different from never having that choice in the first place. Getting to determine my own course of action in this regard would make a world of difference in improving my dying experience by reinvigorating my sense of agency, dignity, and personhood. These three factors are virtues that everyone should have at the end of life and that exist at the core of this policy.

Opponents have long asserted that providing quality hospice care would stem the impetus underlying medical-aid-in-dying requests by palliating symptoms and increasing comfort. Yet, these arguments fall flat when considering that the aforementioned longitudinal report data show that over 75% of those who use medical aid in dying are also enrolled in hospice care. Although most assuredly not a criticism of hospice care, this high proportion of overlap suggests that medical aid in dying may offer avenues of interest available outside of traditional hospice care.

Medical aid in dying's illegality does not nullify the desire to hasten one's death in the context of terminal illness. Research (my own included) shows that health care workers receive requests for medical aid in dying even in states where the practice remains illegal. The lack of availability traps patients in a cruel bind that discourages open and safe dialogue with their families and their health care teams—those who ostensibly warrant the clearest lines of communication—and, thus, perpetuates suffering. In certain cases, this restriction has led to some patients and families compassionately facilitating death independently. That this action occurs outside of a medical purview drastically threatens its safety and the psychosocial well-being of family, friends, and health care workers. This harrowing miscarriage of justice can be ameliorated by your action.

At 66%, Marylanders support medical aid in dying even more than the general American population, recently estimated by Pew Research Center to be 61%. Both of these proportions are expected to continue climbing. I, therefore, passionately call on Senate members to advance this policy pursuant to the stated interest of their constituents. Advancing this policy is the ethical and humane thing to do. Thank you in advance for your consideration of my testimony.

Sincerely,



Todd Becker, LMSW