MARYLAND PSYCHIATRIC SOCIETY

February 8, 2024

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

RE: Oppose - Senate Bill 443: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass 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 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, this organization 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 a district branch of the American Psychiatric Association covering the state of Maryland, MPS represents more than 700 psychiatrists and physicians currently in psychiatric training.

The MPS recognizes 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 opposes Senate Bill 443 (HB 403): 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 audits of the prescribing physician's records to ensure adherence with the law. **We strongly recommend a review of all cases by the Suicide Mortality Review Board.** We realize that some do not consider the ingestion of a legally prescribed medication to be Physician Assisted Suicide (PAS) and prefer the terminology Medical Assistance in Dying (MAID); however, we believe that the intentional ingestion of a substance that causes death would meet the definition of suicide and thus could be reviewed by the Suicide Mortality Review Board.

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. Only a trained clinician expert in diagnosing mental health disorders could discern if these are clinical symptoms requiring treatment by conducting a comprehensive psychiatric evaluation.

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 requested 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. Under this bill there would be no way to stop the process if a patient obtains lethal medication through deception or by concealing their current psychiatric care. There should be a process analogous to our extreme risk protection order law to confiscate the medication.

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.

SB443/HB403 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.

Furthermore, doctors working in state psychiatric hospitals may be forced to participate due to legislation passed in the 2023 session. House Bill 121, "Mental Health - Treatment Plans for Individuals in Facilities and Resident Grievance System" modified Health-General 10-706 to allow patients to seek a treatment mandate from an administrative law judge. If the patient is found to be qualified under HB433, the judge could order a treating psychiatrist to write a lethal prescription for their patient.

For the safety of the patient and the welfare of others present, lethal medication should be consumed in a controlled or monitored setting. Prescription of lethal drugs puts another means to accidental and intentional injuries in homes where there may not be close monitoring of the prescribed medication. This has happened in another jurisdiction. Through regulation, we encourage the Maryland Department of Health to develop standards to provide the necessary protections.

While there are academic arguments against "slippery slope" fears in certain situations, when it comes to legally prescribed lethal medications in certain countries and jurisdictions, there has been an extension of this practice to include clinical situations that are not imminently life threatening. There are examples in some jurisdictions of this practice extending to those with mental health issues and without life threatening medical conditions. We are very concerned that this legislation could increase the number of people choosing to die rather than continuing to seek treatment for their treatable psychiatric and medical conditions. If this legislation were to be passed, it would be important to specify clearly that this law should never be extended to include clinical situations that are not clearly documented to reflect a medical condition expected to imminently cause death.

To conclude, MPS recognizes 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 asks this committee for an unfavorable report on SB443/HB 403.

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