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The Honorable William C. Smith, Jr, Chair
The Honorable Jeff Waldstreicher, Vice Chair
2 East, Miller Senate Office Building
Annapolis, Maryland 21401

Testimony in Opposition to Senate Bill 0443: End-of-Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

Dear Chair Smith, Vice Chair Waldstreicher, and Honorable Members of the Judicial Proceedings Committee:

My name is Dr. Russell L. Margolis. I am a Board-Certified Psychiatrist, and Professor of Psychiatry and Neurology at the Johns Hopkins University School of Medicine, where I have evaluated and treated individuals with severe mental illness, and investigated the causes and consequences of mental illness, for over 30 years. The views expressed here are my own and do not necessarily reflect the policies or positions of the Johns Hopkins University or the Johns Hopkins Health System. I am a member of the Maryland Psychiatric Society, and my position agrees with that of both the Maryland Psychiatric Society and the Washington Psychiatric Society.

I am testifying in strong opposition to Senate Bill 0443, the End-of-Life Option Act.

1. Under the provisions of the Act, terminally ill individuals with treatable psychiatric disorders will inadvertently receive medical interventions that will lead to their death via assisted suicide.

A. Psychiatric disorders are common in people with terminal illnesses. Between 25 to 77% of individuals with terminal illnesses have treatable psychiatric disorders, including depression, anxiety, and delirium. The psychiatric disorders, rather than the underlying medical condition, are often the critical cause of suffering in these individuals. For instance, depression, especially in an older person, is often manifest not by overt sadness, but by overwhelming physical distress and pain. These conditions in the terminally ill respond to treatment, and the discovery of new, faster acting treatments, such as ketamine, psilocybin, and brain stimulation, makes detection of these conditions, even among those with days or weeks to live, imperative.

B. Physicians often do not detect psychiatric disorders in terminally ill individuals.

Unfortunately, the capacity of non-psychiatric physicians to detect psychiatric illness is limited. In a study of patients with terminal illness admitted to a palliative care unit, 2/3 had a diagnosable psychiatric condition, but 1/3 had not been identified or treated adequately prior to admission (Ita, 2003). My own early research similarly demonstrated that non-psychiatrists cannot reliably distinguish between depression and delirium on inpatient medical wards (Margolis, 1994). 25 years later, little has changed (AISalem, 2020).

C. The End-of-Life Option Act does not adequately address the problem of psychiatric illness in the terminally ill. Referral to a mental health professional is voluntary. In Oregon, with a similar voluntary system, only 3.3% of individuals requesting prescriptions to end their lives were referred for a mental health evaluation (Oregon Annual Report, 2021). The rate is similar in Canada. Further, in a misguided effort to preserve individual confidentiality, the Act does not require information from treating mental health professionals or family members. Failure to seek such information would be considered substandard care, if not outright malpractice, in any other situation in which an individual comes to medical attention for wanting to end their life. Finally, it is clear in the web pages of advocacy groups in favor of assisted suicide that if an individual's own physician cannot or will not provide a lethal prescription, help in finding such a doctor is available. That help seems likely to meet with success. In Oregon in 2021, 133 different physicians wrote lethal prescriptions, most for 1 or 2 individuals, but one physician wrote 47 such prescriptions. In the Netherlands, a specialized clinic has developed for assisted suicide.

D. Example. Some years ago, before effective treatment was developed for HIV/ AIDS, I treated an individual with advanced AIDS who was barely eating and drinking, had become incontinent, and was in psychological agony. I have no doubt that if a law like the proposed Act had existed at the time, he would have requested assisted suicide, and most physicians would have readily acquiesced. Fortunately, he was referred to psychiatric treatment, where it was clear that he was profoundly depressed. With assistance from his partner, he was eventually persuaded to accept a standard treatment for depression. His previous optimism, good humor, and will-to-live returned. Before he died from AIDS some months later, in a large public ceremony, in the presence of family, loved ones, and friends, he gratefully received a long-delayed award for his prominent humanitarian efforts.

The Act should therefore be opposed on the basis that many individuals requesting assistance to end their life have treatable but unrecognized psychiatric conditions which lead them to seek death. With appropriate psychiatric care, the quality of life for these people can immensely improve, allowing them to maintain a dignified and meaningful life.

2. The reasons for which people seek to end their suffering by death can and should be managed by other means.

In Oregon, when asked why they sought help to end their life, 90.9% feared losing autonomy, 90.2% feared loss of ability to engage in activities that make life enjoyable, 73% feared loss of dignity, 48.3% feared being a burden on others, and 43.7% feared loss of control of bodily functions, 27.5% feared pain, and 5% were concerned about the financial implications of continued treatment (Oregon Annual Report, 2021).

These fears can and should be addressed by progressive means—providing high quality palliative care, including psychological support, pain management, better health care and health care insurance, and examples of those who have lived meaningful lives despite impaired function (Dore ,

2022). A complicating factor, particularly in the setting of laws similar to the End-of-Life Option Act, is that physicians tend to underrate the quality of life of individuals with disabilities.

The role of medicine, and society, should be to instill hope and provide comfort, not to dodge social responsibilities. This is why almost all major disability rights groups oppose measures like the proposed Maryland Act.

3. Death as a solution to fear and despair becomes an accelerating self-fulfilling prophecy.

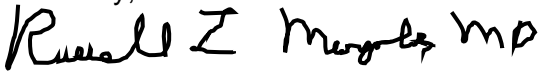
A. Increased rates of aided and non-aided suicide. In Oregon, the number of lethal prescriptions increased from 24 in the year after passage of the “Death with Dignity Act (DWDA)” in 1997, to 383 in 2021, the last year for which data is available. Similar increases have occurred in other countries. In the Netherlands, assisted-death accounts for ~4% of annual deaths, and in Canada, 3.3% of all deaths and rising (Frolic, 2022). Unlike the prediction of some advocates, typical deaths by suicide did not decrease, and if anything may have increased, as predicted by epidemiological analyses of the increased suicidality rates of those directly or indirectly exposed to the suicide (Maple, 2017). The effect is most detectable in marginalized and vulnerable populations. In Oregon, for instance, there has been a greater than 50% increase in suicide among elderly women since the enactment of the DWDA. The statement, by act of law, that assisted suicide is an option acknowledges that suicide is an acceptable life choice, plays into the fear of terminal illness, and increases the suicide rate.

B. Eligibility criteria for assisted suicide tend to become substantially less restrictive over time. The key eligibility criterion in most jurisdictions begins as “terminal illness with 6 month or less life expectancy”, or the equivalent, as in Maryland’s proposed Act. There is then pressure to broaden criteria: In Canada, within 7 years of the initial Medical Assistance in Dying (MAiD) legislation, the criterion requiring “foreseeable death” was removed, with the explicit goal of providing individuals with psychiatric disorders access to MAiD even if natural death is not imminent (Frolic, 2022). In the Netherlands, the initial broad criteria of “hopeless and unbearable suffering” also included such suffering consequent to psychiatric disorders. In a bill introduced to the Netherlands legislature, the emotion of having lived “a complete life” is under consideration as an additional eligibility criterion for assisted-death (Van Veen, 2022). Arguments that this will not occur in the United States are spurious; there are already examples in which assisted-suicide has been provided to individuals in their mid-30s with potentially treatable psychiatric disorders (eg, Guadiani, 2022).

C. The ultimate impact of assisted suicide is a shift in societal perspective in a very dangerous direction. As the use of assisted suicide increases, and the criteria for its use broaden, societies undergo a moral shift. Suicide become a reasonable option in the face of hardship, and pressure mounts on both the individuals facing the hardship, and the physicians caring for them, to take rapid and definitive action. The risk is that rather than seeking real solutions, which may be expensive and cumbersome, the pressure turns to assisted suicide, a fast and efficient solution. The health insurance system in the United States is a confounding factor; it is of concern that a single dose of lethal pills is likely much less expensive, from the standpoint of an insurer, than weeks or months of intense supportive care. And, as the evidence from Oregon is beginning to suggest, it is the most vulnerable in the population who will likely bare the brunt of this societal shift towards suicide as a solution for societal problems.

Conclusion: Assisted-death is a regressive policy, a “20th Century problem”, to paraphrase palliative care expert Matthew Dore. Maryland should be seeking progressive 21st Century solutions that provide hope, care, support, and quality of life, not discrimination, marginalization, and death.

Sincerely,

Handwritten signature of Russell L. Margolis, M.D. in black ink.

Russell L. Margolis, M.D.

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