MARYLAND PSYCHIATRIC SOCIETY

February 24, 2025

The Honorable Joseline A. Pena-Melnyk
Chair, Health Government and Operations Committee
241 Taylor House Office Building
Annapolis, Maryland 21401

Oppose: HB 1328: End–of–Life Option Act (The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act).

Dear Chairwoman Pena-Melnyk & Members of the Committee:

The Maryland Psychiatric Society (MPS) is 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, 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 branch of the American Psychiatric Association, MPS represents over 775 psychiatrists and physicians currently in psychiatric training.

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1. Implications for state facilities and state employed physicians

SB926/HB1328 poses a serious legal risk for any physician working in a state psychiatric facility. In Estelle v. Gamble, 42 U.S. 97 (1976), the United States Supreme Court held that state institutions cannot deny medical care to an individual solely because they are institutionalized. Furthermore, under Health-General §10–706 a patient in a state psychiatric facility may now obtain a change in their treatment plan through the patient grievance system. This means that a patient who wants to die may request an administrative hearing to demand lethal medication. A physician employed by the facility could receive an order to prescribe lethal medication for his or her patient. Refusal to do so could risk civil penalties for contempt. Doctors will undoubtedly choose to quit their jobs rather than risk this, and such a practice will have a chilling effect on the state's ability to hire physicians for these positions.

State employed physicians who choose to participate, and the facilities they work in, are also in legal jeopardy from this bill. 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. ***Thus, physicians in these facilities would be placed in conflict with state and federal law regardless of their decision to participate or not participate.***

This dilemma will also be an issue for the Division of Corrections and the physicians working in this system. The Maryland prison system has hundreds of prisoners serving life sentences and maintains a palliative care unit for terminally ill prisoners. Medical parole is almost never granted for these patients.

2. Effects on involuntary treatment laws

This bill does not require the patient to notify his or her family and loved ones. If a family member discovers the patient's suicidal intent and brings the patient to the hospital for an emergency psychiatric evaluation, it is unclear whether the patient could be certified for an involuntary admission or if they would be exempt as a matter of law. There would also no mechanism to legally confiscate, or require the patient to surrender, the prescription if they are opined to have lost decision-making capacity.

Presently an individual can only be civilly committed to a psychiatric facility if, among other factors, involuntary admission is a "least restrictive alternative" to outpatient care. In Colorado, a psychiatrist has been asked to opine whether assisted suicide was a "least restrictive alternative" to involuntary admission for a patient with anorexia nervosa. This is a particular concern for Maryland because our state has two prominent inpatient programs for the treatment of anorexia nervosa.

3. Limitations on capacity assessments

This bill does not require a capacity assessment by a licensed psychiatrist.

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 or 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.

At a minimum, physicians who prescribe lethal medication should be required to obtain certification to do so. The certification process should include training in the performance of a mental status examination, psychiatric review of symptoms, and cognitive assessments.

4. Efficacy and safety issues related to drugs used for assisted suicide

There is very little data about how many deaths from this method are actually smooth and painless and how many have botched and horrific outcomes. Evidence from jurisdictions where assisted suicide is legal reveals that some patients who ingest the prescribed lethal drugs experience distressing complications to include burning, nausea, vomiting and regurgitation, and prolonged time to death. In Oregon annual complication rates have been as high as 14.8% and patients are reported to have experienced difficulty swallowing or drug regurgitation, seizures, and have even regained consciousness after ingesting the lethal drugs. Of cases with available data in Oregon since 2001, time from drug ingestion to death has ranged from one minute—too short for the cause to have been oral ingestion—to 108 hours. In 2018, of the MAiD cases in Canada with available data, 50% were unsuccessful by 60 minutes and the clinician transitioned to euthanasia to kill the patient. In one published case report, a patient's brother also tasted the medication and required emergency medical care. ***This bill does not require any medical personnel to be present to ensure that the medication is not given to or ingested by an unauthorized person.***

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, the Maryland Psychiatric Society 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, the Maryland Psychiatric Society asks this committee for an unfavorable report on HB1328.If you have any questions regarding this testimony, please contact MPS lobbyist, Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society