HB1328
Opposed
Mary Hand
Bethesda, MD

Patients who would elect the end-of-life option would be placing an undue burden on their physicians and other health care providers who can already assist them with proven, time-honored palliative and hospice care that our health care system can offer that should be available for everyone.

Based on experience from other countries that have legalized this, e.g., Canada, the Netherlands, Switzerland, there will be future amendments for other health care providers, like nurse practitioners and physician assistants to prescribe the medication, and to extend the “option” to patients with other chronic conditions.

No matter how many protections, this is not the right way to go for Maryland, the home of such revered institutions as the National Institutes of Health, Walter Reed National Military Medical Center, and Johns Hopkins, among others.

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While End-of-Life Option Act's proponents may believe that passing this proposed legislation gives a dying patient autonomy, from my perspective as registered nurse for 50 years, the repercussions if this Bill were to pass, would constrain the autonomy of Maryland physicians and health care providers, including nurses, to have the freedom to practice according to their professional and ethical practice standards, and their racial, ethnic, and cultural backgrounds that reflect their practice. The legalization of aid in dying also undermines the currently available, sanctioned end-of-life modalities of palliative care and hospice.

Medical doctors would be asked to provide a prescription for a lethal dose of drugs to terminal patients who want to die on their terms, even though there are currently available sanctioned, palliative and hospice care modalities. The American Medical Association has retained its opposition to assisted suicide reaffirming that the legalization of physician-assisted-suicide is fundamentally incompatible with the physician's role as a healer[1]. The American College of Physicians (ACP) currently opposes legalization of physician-assisted suicide due to considerable practice, policy, and other concerns.[2]
(HB 1328 refutes the term physician-assisted suicide but employs its misleading term "aid in dying" whereby a physician prescribes medication to a qualified individual that the qualified individual may self-administer to bring about the qualified individual's death.)

Any disclaimers do not supersede professional and ethical standards of nursing practice[3,4] nor are they credible when they are part of this concerning legislation. Though <u>not</u> specifically called out in the bill, <u>*nurses*</u> are included under: "Health care provider (which) means an individual licensed or certified under the health occupations article to provide health care or dispense medication in the ordinary course of business or practice of a profession" (page 4, line 6). There are administrative, documentation, and educational requirements for the attending and consulting physicians for which they would inevitably need to enlist assistance from their clinical staff, notably nurses, with whom they work interdependently. This could include the physician's requirements for administrative documentation, informing the patient about the feasible alternatives and health care treatment options, facilitating referrals to consulting physicians, and submitting to the pharmacist, "by any means authorized by law," the prescription for the lethal potion, and for the drugs to counter the poison's immediate noxious effects. Nurses would be unwittingly complicit if they get pulled into these tasks. Though the bill indicates participation is voluntary, the reality of most clinical settings where aid in dying would be employed is that the patient care work among team members is busy. Doing tasks that are part of this proposed legislation may sneak up on allied health care providers. Nurses and their colleagues may become insensitive or hardened to the implications of their actions as being part of the steps leading to a patient's self-induced death.

This extends to nurses who may be with patients at the end of their lives in the home or hospital, including hospice (one of the settings mentioned in the bill). According to the American Nurses Association position paper on the nurses' role when a patient requests medical-aid-in-dying[2], the delivery of high-quality, compassionate, holistic, and patient-centered care, including end-of-life care is central to nursing practice.

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The nurse should never abandon or refuse to provide comfort and safety measures to the patient who has chosen medical-aid-in-dying though the nurse may inform their employer of their "conscience-based objection to being so involved so they can be appropriately assigned." The statement acknowledges a patient may request that a nurse be present when the patient ingests the lethal cocktail but if elected to do so, nurses "should understand their boundaries." The Nursing Code of Ethics stresses that nurses, "should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and *may not act with the sole intent to end life*."[3] Hospice nurses may find themselves in a conundrum between not being an agent to care of a patient whose sole intent is to end his life versus not abandoning the patient and family. There are anecdotal reports of hospice nurses leaving their jobs in states that have passed physician-assisted suicide.

Further, the end-of-life-option does not ensure a smooth, predictable day of death. [4] A guidebook by a medical-aid-in-dying doctor recommends that "a skilled clinician, most commonly a nurse" be present because of the complexities of handling the lethal potion, patient anxiety, the need to support the patient with the potion's side effects, and a range of times of death. Children and pets should not be around as they could be harmed/killed by contact with the poisonous potion.[5]

Patients now can gain control of the last stage of their lives and can be reassured that our available hospice system can monitor their last days and hours and ensure comfort and care for themselves and their families.[7-9] Palliative care and hospice care as sanctioned treatment modalities need to be deployed more[10], especially in minority communities and the underserved. There are documented racial and ethnic disparities in palliative and hospice care, which should be a clarion call for more inclusive policies.[11]

The ever-changing death concoction used for patients to kill themselves is tantamount to experimentation with these individuals on their deathbed, with a range of noxious and unpredictable side effects (as noted). Our government has left behind its shameful days of drug experimentation with vulnerable groups, a sensitivity which I recall in my 50 years of nursing practice.[12] As a nurse, I want the best evidence-based medical care for all patients and their families, meaning sanctioned pain relief and comfort care interventions, not voodoo medicine for dying patients.

I urge you to vote against this legislation that would upend the excellence in the many medical/health care institutions for which Maryland is renowned, that are working to ultimately safeguard patients and their families, so patients receive the best standard of care at all stages of life, including this last sacred stage.

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