SUBJECT: **HB1328 End-of-Life Option Act**
(The Honorable Elijah E. Cummings and the Honorable Shane E. Pendergrass Act)

COMMITTEE: **Health and Government Operations,** The Honorable Joseline Peña-Melnyk, Chair
Judiciary, The Honorable Luke Clippinger, Chair

HEARING DATE: Monday, **March 3. 2025**

POSITION: **FAVORABLE**

My name is James Rogers. I write on behalf of my wife and myself. We live at Collington, a CCRC in Prince George's County, a community of seniors strongly supportive of the passage of this bill. Many of us have already experienced the deaths of our parents, siblings, spouses, even children, and have seen both relatively peaceful passings and horrendous deaths. Even those of us who would never consider using this option ourselves understand that it is a personal choice that each of us should be able to make for ourselves.

I would like to address some of the concerns that opponents of this bill have raised.

1. **Concern – are attending and consulting physicians capable of / qualified to assess mental capacity?**

   Fact – Healthcare providers are required by law and medical ethics to obtain a patient's informed consent to <u>any</u> proposed treatment or procedure. A healthcare provider must verify that the patient has the capacity to understand and make decisions. Thus, attending and consulting docs routinely make such assessments and are both qualified and have the ability and experience to do so.

   Fact – writing in the Psychiatric Times, *Ethical and Practical Issues for Psychiatrists,* in 2018, psychiatrists Drs. Dan Nguyen and Joel Yager, outline the requirements of the laws in jurisdiction where MAID is legal, including the requirement that "Two physicians must agree in the determination that the … criteria have been satisfied" including the requirement of mental competency. **They express <u>no concern</u> whatsoever that attending and consulting physicians are not qualified to make that kind of an assessment and that no concern that a mental health professional is not generally required to assess a patient's competency**.

   Fact – Of the 11 jurisdictions in which MAID is legal, Hawaii is the only one to mandate a mental capacity evaluation performed by a licensed psychiatrist, psychologist, or clinical social worker.

   Brian Goodyear, a clinical psychologist, is one of 18 providers who conducted the Hawaii required mental capacity evaluations. He recently reported on the 161 mental capacity evaluations for terminally ill patients who had requested medical aid in dying that he has conducted. (https://www.walshmedicalmedia.com/open-access/mandatory-mental-capacity-evaluations-for-patients-requesting-medical-aid-in-dying-are-they-necessary.pdf He says:

   > **Consistent with the findings of the patients' attending providers**, the author found that the vast majority of patients clearly had the mental capacity to request medical aid in dying.

   He concluded:

   > Patients who request medical aid in dying should be carefully screened by their attending and consulting providers for the possible presence of any mental disorders that might affect decisional capacity. **Terminally ill patients should not be required to undergo a potentially costly, time-consuming, and burdensome evaluation by a mental health specialist unless the attending or consulting provider finds that there is a clear reason to do so**.

2. **Concern - Safe storage of meds and suicidal grandchildren**

   Fact - In 25+ years of experience in Oregon and many additional years of experience in 10 other jurisdictions, there has **never been a single case reported of suicide by misappropriation of these meds.**

I assure you that, if there had been, the opposition would be trotting out the heart-rending story, often with distorted details.

Fact – Few grandchildren are suicidal, and those few who are looking for means to do so are looking in Grandpa's closet for his gun(s), not in Grandpa's medicine cabinet for his meds. Per Johns Hopkins Center for Gun Violence Solutions, there were 1,421 suicide deaths of children and teens by firearms in 2021. A study by Donna Ruch et al, *Characteristics and Precipitating Circumstances of Suicide Among Children Aged 5 to 11,* reported suicide by hanging or suffocation (78.4%) was the most frequent method, followed by firearms (18.7%). In every case where gun access was noted, the child obtained a firearm stored unsafely in the home.

Fact – **While few children and teens are suicidal,** sad to say**, many are addicted**. What they are looking for is not the regimen of lethal meds that must be taken under a strict protocol, but the **oxycodone**, **morphine, and other opioids** that the sickrooms of many terminally ill patients are full of.

3. **Concern - Safe disposal of unused meds**

Fact – The **bill requires** that unused meds be **disposed of "in a lawful manner"** and **DEA regulations cover the disposition of controlled substances**.

Fact – Experience shows that those who choose this option are overwhelmingly enrolled in hospice care (e.g., Oregon 91.4% in 2022, California 95.4% in 2022). **Maryland requires** a general **hospice** care program to establish a **written policy that outlines the procedures for the collection and disposal of a patient's unused prescription medication. (**§ 19-914, *Collection and disposal of unused prescription medication)*

Fact – if a patient dies without having taken the medications, those meds will be disposed of in the same way as the patient's other prescription drugs including their oxycodone and morphine.

4. **Concern – Doc shopping, patients being turned down by one doc, shopping for a physician who will deem them eligible; a few docs writing all the prescriptions.**

Fact – certainly doctors disagree about individual diagnoses, prognoses, capacity, etc. Isn't that why we are encouraged to get second opinions in serious situations? So, it is possible that someone deemed ineligible for whatever reason will seek a second opinion. But the chief reason that patients will doc shop is because their own doc is not willing to write such a prescription for any patient.

Fact – Many doctors work in **hospitals (particularly Catholic hospitals) where they are forbidden** to assist patients in this way.

Fact – **Many doctors in states where the option is legal are currently unwilling to participate**. In addition to those who don't believe the practice should be legal, most are unfamiliar with the law and its requirements. They are not willing to do the research to educate themselves on the legal aspects. They are not willing to do the research to educate themselves on the medical aspects. They are not willing to deal with the bureaucratic aspects and required reporting. They are not willing to spend the time to do the patient education that the law requires. They are worried about how they will get paid for the services that they provide.

Fact – **Over time, as the option becomes more widely known and understood by both patients and physicians, more patients will request it, more physicians will provide it.** In Oregon, in 2000, 39 patients completed the process to receive a prescription, 22 physicians wrote those prescriptions. 23 years later, in 2022, 146 physicians wrote 431 prescriptions; 78% of those physicians wrote only one or two prescriptions. In the state of Washington in 2022, 207 physicians wrote 452 prescriptions, which were dispensed by 68 different pharmacists. In California, in 2022, a total of 341 physicians prescribed 1,270 individuals aid-in-dying drugs.

Fact – We are aware of one California physician, who wrote 90 prescriptions in the first 5 years of the option being legal in California, as reported in a 2021 article in the Atlantic (https://www.theatlantic.com/health/archive/2021/03/aid-dying-lonny-shavelson/618139/).

> He would say that this had little to do with him and more to do with the fact that other doctors refused to perform assisted deaths, or were forbidden to do them by the hospitals and hospices where they worked. Sometimes, Shavelson told me, he got quiet phone calls from doctors at Catholic health systems. "I have a patient," the doctors would say. "Can you help?"

A 2016 article in KFF News about this same physician (https://kffhealthnews.org/news/a-new-sort-of-consultant-advising-doctors-patients-on-californias-aid-in-dying-law/) reported:

> Shavelson is adamant that this is "something that has to be done right." To him, that means starting every patient encounter with a one-word question: "Why?"
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> "In fact, it's the only initial approach that I think is acceptable. If somebody calls me and says, 'I want to take the medication,' my first question is, why? Let me talk to you about all the various alternatives and all the ways that we can think about this," he predicts he will say.
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> Shavelson worries that patients may seek aid-in-dying because they are in pain, so first, he would like all his patients to be enrolled in hospice care.
>
> "This can only work when you're sure that the patients have been given the best end-of-life care, which to me is most guaranteed by being a part of hospice or at least having a good palliative care physician. Then this is a rational decision. If you're doing it otherwise, it's because of lack of good care."

Isn't Dr. Shavelson exactly the kind of caring, careful, dedicated physician we all want engaging in this option and writing (or declining to write) these prescriptions?

In closing, let me say that I am a layperson with no professional expertise connected to the issue. However, my wife and I are strong believers in personal autonomy. My life, my death, my decisions.

We have downloaded the annual reports from each jurisdiction where it is legal; we have downloaded and read more than 100 academic studies and papers with data, research, and discussions of various aspects of Medical Aid in Dying and would be happy to share any of them with you. We would be more than happy to research and attempt to address any questions you have. Our email is rogers1515@aol.com.

We ask for your favorable report on HB1328. Thank you.