Oppose HB1328

End-of-Life Option Act

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Thank you, Delegates, for your service to our community. I am Nancy Weisman. I've lived in Maryland for over 30 years where I practice clinical psychology.

Here are four reasons why I believe this bill must not pass:

1) It has nothing to do with Choice or Autonomy

2) It endangers Public Health and Safety

3) It corrupts Medicine and endangers patients

4) It erodes Trust both public, in the institution of Medicine, and private, in the doctor-patient relationship

5) If the broader community insists on legalizing euthanasia/assisted death, let it be administered through the courts and the police who are qualified to distinguish between suicide and murder.

This is not about Choice and Autonomy.

Children under ten have taken their own lives - much to grief of their parents, neighbors, and all feeling people. Legislation to permit dispensing a drug lethal cocktail accomplishes nothing. Virtually every home already has in the medicine cabinet and household products to end a life. All cancer and hospice patients have in their possession lethal amounts of opioids. This bill has nothing to do with the "right to choose" but everything to do with the "right to recruit accomplices" - and that is an invitation to social disaster.

This bill endangers Public Health and Safety.

Public Health and Safety are endangered when doctors are licensed to kill. It is a policy of socially sanctioned killing by the historically most trusted profession

- medicine: within medical channels, by means of medical decisions, facilitated by health professionals. Such a policy destroys a critical social and psychological barrier against killing.

The rapid and sustained increase in suicide, at ever younger ages, as well as murder-suicides and mass killings are surely related to our degraded respect for human life.

Corrupts Medicine and Endangers Patients. It is incoherent to charge doctors with both healing and terminating lives. From the time of Hippocrates, "Western medicine has regarded the killing of patients, even on request, as a profound violation of the deepest meaning of the medical profession." (JAMA 1988)

Proponents say this is a benefit, a benefit not related to physical pain, but to psychological pain. However, there are treatments for the psychological distress of terminal illness. Dr. William Breitbart in New York, Annette Stanton in California and many others have psychotherapy programs that are designed to alleviate just that distress and help patients find renewed meaning and purpose at the end of life.

This bill denies the possibility of renewal and growth. Instead, it affirms the existence of "a life is unworthy of life." This legislation is based on the belief that suicide is a rational response to terminal illness and should therefore be supported by our laws.

This notion of a "life unworthy of life" presents a very real threat to people with disabilities. Who can decide that for another? Can there be objective criteria? What expertise qualifies doctors to make such a judgement?

In Austin, Texas, Michael Hickson was 46 years old with "substantial verbal, cognitive and mobility limitations. … (the) medical team decided not to treat his Covid complications …in a recorded conversation with Mr. Hickson's wife, a physician stated that because the patient could not walk or talk, he had no quality of life. Since treating (him) would not change his functional status or quality of

life, the team decided to withdraw care and nutritional support. Mr. Hickson died several days later." When Mr. Hickson's wife asked the doctor if he was "ok with killing?" He replied, "We don't call it killing," (M. Morris, Death by Ableism, NEJM, 2023.). The same scenario unfolded for Megan Morris' Uncle David, whose quality of life was deemed insufficient to warrant treatment, despite family wishes and intense support.

This is the benefit we must not deny others?

This bill restricts supported suicide to terminally ill adults with a projected 6 months to live who ask for lethal drugs. In Europe, with a longer history of "assisted suicide," adults and children with chronic or psychiatric illness, voluntarily or involuntarily, are all eligible for euthanasia. Why withhold the benefit? Why permit the suffering to continue? Examples:

In Belgium. an 11 year with cystic fibrosis, a chronic condition, was put to death by parental request and medical consent; two years after the child's death, treatment for CF was available (WashingtonPost, 2017).

In Ireland, a technician came to remove the ventilator of filmmaker and ALS patient, Simon Fitzmaurice - *against his wishes*. They believed in the "therapeutic imperative:" ending suffering even if it required killing the patient. How could they deny him the benefit? "Don't you know it's only going to worse? Why would you want to live?" They asked him. Only great and sustained effort on the part of Fitzmaurice and his family saved his life - allowing him to complete 2 more film among many other, even more worthwhile, things. (It's Not Dark Yet. 2017)

Two other examples, one from Washington State, one from Minnesota: <u>"Will you forgive me for saving you?</u> (Terry McGowan, NEJM) The doctor saved a toddler, beaten in her home - twice. The baby's mother and grandmother were happy and grateful, but the doctor worried, "Did I save you for a good life? Are you glad I did?" The doctor asks herself if she should have let the baby die rather than go back to a bad home. She confuses the province of Child Protective Services with medicine. She confuses fixing a problem with ending a life.

"We didn't save his life - we did better." (C. Winebrenner, Washington Post/Kevin MD 2/2017) A man was found without a pulse and brought into the ER. After an hour, his pulse is restored. Rather than stabilize him and send him up to the ICU, the doctor in charge called in his family, wife and grown daughter, and declared, "His life of holding hands, his life of living is gone," though there were no signs of brain death. Yet the doctor firmly admonished the family to stop treatment and let him die rather than face the uncertainty of recovery.

Is this what we want doctors thinking about when an injured patient shows up in the Emergency Department?

Contrast that to NY Marathon doctor, Theodore Strange, who responded to a stranger's call for help and restored an unconscious woman's pulse - more than once - sending her off in an ambulance. She lived, recovered, and calls him every December to thank him for another Christmas.

Erodes Trust, both public and private. In the words of four prominent physician-ethicists:

"If the moral center collapses, if physicians become killers or are even licensed to kill, the profession - and, therewith, each physician - will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty.

"We call on fellow physicians to say that we will not deliberately kill. We must also say to each of our fellow physicians that we will not tolerate killing of patients...we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing." Willard Gaylin,MD, Leon Kass,MD. Edward Pellegrino,MD, Mark Siegler, MD. Doctors must not kill. JAMA, 1988.

If the people of Maryland insist on legalizing "assisted suicide" or euthanasia, let them take it to the courts and the police to do the killing. Let the police distinguish between coercion and free choice, murder or suicide.