UNFAVORABLE: SB0926 – "End-of-Life Option Act"

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As a pharmacist, I took an oath and promised to consider the welfare of humanity and relief of suffering my primary concerns. People with terminal illnesses certainly do suffer… as do their families. I have seen this in my 25+ years as a clinical pharmacist, and I do understand why some might think this "option" is a good idea. However, despite trying to rename it, ending your own life is still suicide regardless of the amount of life you are predicted to have remaining. There are numerous issues with this bill, and legalizing assisted suicide is not health care, nor is it good public policy.

Overview

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Pharmacy practice gone awry

This deadly prescription is not a simple bottle of pills.[1] DDMA-Ph is now the recommended concoction.[2] The amounts and the equivalence in tablets are:

- Digoxin 100,000 mcg → 0.25mcg tablets = # 400 tablets (cardiac medication)
- Diazepam 1,000 mg → 10mg tablets = # 100 tablets (benzodiazepine)
- Morphine 15,000 mg → 30mg tablets = # 500 tablets (opiate)
- Amitriptyline 8,000 mg → 100mg tablets = # 80 tablets (tricyclic antidepressant)
- Phenobarbital 5,000 mg → 100mg tablets = # 50 tablets (sedative/anti-seizure med)

Crushing up over 1,100 tablets is not something that a neighborhood pharmacy would have the time to do. Plus, the tablets have inert ingredients that increase the volume of the final powder mixture. Therefore, only a special pharmacy that can order bulk powders of the ingredients would be able to fill the prescription. Patients aren't likely to live near the few pharmacies in the state who might agree to compound these. How far will they have to drive to get this cocktail? Or will they receive the poison in the mail? Will it have the appropriate warning labels required for hazardous medications with ingestion,

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9270985/
[2] https://www.aadm.org/courses/pharmacology

contact, airborne, and disposal precautions? Furthermore, no identification of the patient or their agent is required upon delivery, so accountability is limited.

If the patient or a family member calls their regular pharmacist whom they know and trust with questions about the drugs used, that pharmacist would be in a tough position to counsel them. Their job is to be a health care professional and to avoid harming patients. What would they have to say? Let's imagine this counseling session…

Caregiver: *My mom wants to know about the end-of-life drugs. What can you tell us about it?*
Pharmacist: *Well, Ms. Doe, here's what I know.*

- *It is a massive overdose and an experimental procedure.*
- *It must be stored in a secure location because inhaling the vapor or touching the powder could be very harmful to family or pets.*
- *It will likely cause nausea and vomiting, so you need anti-nausea medications 30-60 min before the overdose.*
- *It can cause severe burning sensations in your mouth so sucking on a popsicle or icy sorbet to numb your mouth is recommended.*
- *The powder will need to be mixed with 2 ounces of water or clear apple juice; keep shaking or stirring to prevent settling and missing taking all of the overdose.*
- *The concoction must be consumed within 2 minutes, or you risk falling asleep before finishing the whole overdose.*
- *You could generally expect to die within hours of consuming it, but it is not guaranteed. Some patients take several days to die, and some survive the overdose.*
- *If you are obese or younger than 55, have gut issues, trouble swallowing, aversion to bitter tastes, brain cancer, substance use disorder, or medication tolerances, you are at higher risk of the overdose not killing you.*
- *If you do not die in a short period of time, the side effects you could experience include nausea, vomiting, seizures, arrhythmias, and coma.*

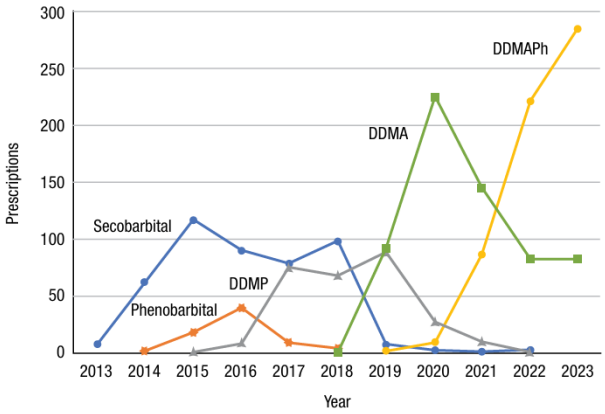
Definitely, this is pharmacy practice gone awry.

Illegal human experimentation

In my role as a clinical pharmacist, I coordinate drug studies at my hospital and serve on our Institutional Review Board (IRB), which reviews all protocols to make sure that they meet Good Clinical Practice (GCP) guidelines established by the Food & Drug Administration (FDA). The primary job of the IRB is reviewing the Informed Consent forms to make sure patients will be fully notified and aware of the risks and benefits of participation in the study, that the information provided to them is in writing, and that they have signed the consent form before any experimentation takes place. Additionally, the lack of oversight from clinicians is appalling. No medical provider is required to be in attendance at the ingestion. The side effects being reported – horrible taste, painful burning, nausea, vomiting, seizures, prolonged deaths (sometimes days) – are not benign. It is not always a peaceful passing, and some patients even survive the overdoses**.** And, this is limited data because no healthcare provider or witness is required to be there.

If we ever tried to treat patients with experimental drug regimens -- which is exactly what these concoctions are, and they change year-to-year as the figure shows[3] – and with so little informed consent or concern for our patients' wellbeing, the FDA would shut us down for violation of GCPs and not properly protecting our patients… and they would be right to do so!

Figure: Medication used in DWDA ingestions, 2013-2023



Vulnerable populations at risk

Maryland is a Total Cost of Care state with Centers for Medicare and Medicaid Services (CMS) and 30% of Marylanders are on Medicare or Medicaid. Hospitals have a fixed amount of revenue for the year and therefore, there are major incentives to cut costs. According to Derek Humphry, the founder of the Hemlock Society, which is now called Compassion & Choices, he stated that "economics, not the quest for broadened individual liberties or increased autonomy, will drive assisted suicide to the plateau of acceptable practice."[4] To paraphrase him, a dead patient is the cheapest patient. What does that mean

[3] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf
[4] Humphry, Derek and Mary Clement. *Freedom to Die*, St. Matin's Press (New York), 1998, p. 313.

to Maryland's vulnerable populations? The disabled, the elderly, the socioeconomically disadvantaged, minorities? What choice will they have? None. Those in power will make the choices for them. It is happening already to patients with non-CMS insurance.[5] People are being denied healthcare that could help them survive but are instead being offered assisted suicide as a medical "treatment" that their insurer will pay for. A choice that these patients did NOT request. This legislation will lead to an erosion of trust in the medical professions, especially in vulnerable populations.[6, 7]

It offends me

This legislation is offensive. Why? Life has infinite value. Assisted suicide, however, attacks that value by permitting some people in some circumstances to sometimes commit suicide. Human beings are relational, and no suicide happens in a vacuum. On average, one suicide affects an estimated 135 other lives.[8] Therefore, this legislation is offensive to me and to all human beings. Preventing that affront to all humans supersedes any individual's autonomy. Furthermore, what does this legislation say to those already suffering with suicidal ideation or past suicide attempts? How can we logically try to prevent suicide in 99.995% of people yet approve it for a tiny minority (0.005%, estimated n=300/6,000,000 Marylanders) and believe that it will not influence the rest of society? The fact is that is does influence more than just the very small number of people who might kill themselves with this "option." The next section will show that it has already begun…

Increased nonassisted suicide rates

This legislation will increase the suicide rate.[9, 10] The latest CDC data indicates that there were 608 suicides in Maryland in 2021 (up from 585 in 2020), for an age-adjusted rate of 9.5 per 100,000.[11] While this is less than the national average, shouldn't our efforts be to reduce the number of suicides even further, not promote it? If you doubt that passage of these bills will encourage nonassisted suicides, consider what Drs. Jones and Paton found when they evaluated the rates of suicide in the first four states that legalized assisted suicide compared to twenty-five states with suicide data that have not. If

[5] Callister, T Brian. "7 important reasons to oppose physician-assisted suicide." Updated 4/27/21. https://www.rgj.com/story/opinion/voices/2021/04/27/7-important-reasons-oppose-physician-assisted-suicide-callister/7261231002/
[6] https://globalnews.ca/news/9052672/canada-euthanasia-laws-disabled/
[7] https://www.theguardian.com/world/2022/may/11/canada-cases-right-to-die-laws
[8] Cerel et al. How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior. 2019; 49:529-534. https://doi.org/10.1111/sltb.12450
[9] Jones, D. Euthanasia, assisted suicide, and suicide rates in Europe. JEMH. 2022, volume 11. https://jemh.ca/issues/open/documents/JEMH%20article%20EAS%20and%20suicide%20rates%20in%20Europe%20-%20copy-edited%20final.pdf
[10] https://doi.org/10.1192/bjo.2022.71
[11] https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

assisted suicide were to be beneficial, you would expect to find a reduction in total suicides and a delay in those that do occur, since patients will feel that they have more control over their life… and their deaths. On the contrary, there was a significant (6.3%) increase in total suicides and no reduction in the rates of nonassisted suicides. "*The introduction of physician-assisted suicide seemingly induces more self-inflicted deaths than it inhibits*" (emphasis added).[12] If the anticipated increase in suicides of 6.3% from passage of this legislation is included, then an additional 39 all-cause suicides (excluding assisted ones, however, due to falsified death certificates) will occur with a new total of 647 suicides. Is this the "medical care" we want to provide to Marylanders?

Opening Pandora's box

Proponents have demonstrated that they will not stop with this legislation. This is only the outside of Pandora's box, and if we allow it to be opened, it will lead to all types of problems. Not immediately, but, eventually, yes. The proof? Seven of eleven jurisdictions (64%) where assisted suicide has been legalized have proposed and/or passed legislation to remove "barriers" [currently called "safeguards" in this legislation].[13, 14]

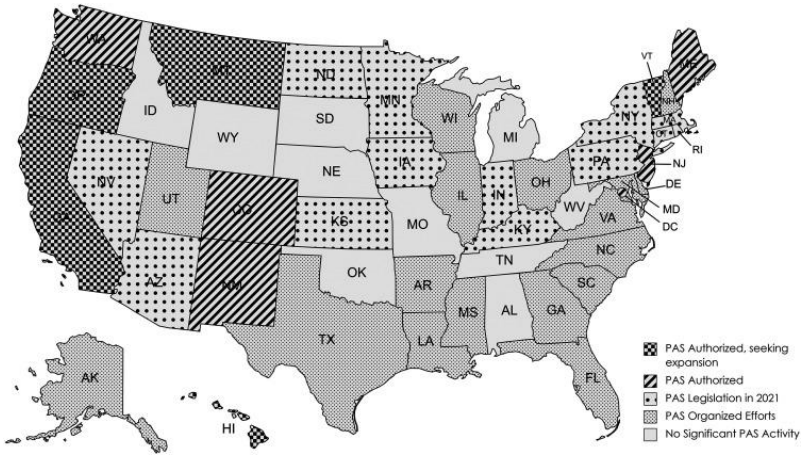
- Oregon (legalized in 1998) – first change took 21 years: 2019 - waiver of waiting periods allowed; 2023 - removed residency requirements
- Vermont (2013) – after 9 years: 2022 - removed physical presence requirement for requests, prescribing doctor need never physically examine the patient in person, and removal of final 48-hr waiting period; 2023 - removed residency requirements
- California (2016) – after only 6 years, first change: 2022 - reduced waiting period to 48 hours
- Washington (2009) – took 14 years for first attempt to change: 2023 - allow NPs and PAs to be prescribers, reduce waiting period to 7 days, and mailing of lethal prescriptions. 2025 - proposed legislation to edit definitions in "informed consent" and amend waiting periods.
- Hawai'i (2019) – just four years to first change: 2023 - added Advance Practice RNs and NPs as prescribers, reduced waiting period to 5 days or waived altogether for some patients
- New Jersey (2019) – After 5 years: 2024 - reduce waiting period for certain patients
- Colorado (2016) – After 8 years: 2024 – allow NPs to prescribe, reduce waiting period to 7 days or waive it entirely for certain patients

If the legislative template is not working in Oregon, California, Vermont, Washington, Hawai'i, New Jersey, or Colorado, why propose the same legislation here? It is because the goal is to sway public opinion into accepting this offensive bill as a "reasonable choice." How long before current safeguards in

[12] Jones DA and Paton D. How does legalization of physician-assisted suicide affect rates of suicide? Southern Medical Journal. 2015;108:599-604. https://pubmed.ncbi.nlm.nih.gov/26437189/
[13] https://www.compassionandchoices.org/in-your-state/
[14] https://compassionandchoices.org/state-advocacy/past-legislative-session-results/

the bill are re-labeled as “obstacles and barriers” and removed in Maryland? As the saying goes, the way to boil a frog is to slowly increase the temperature, and it will not notice the danger until it’s too late.

Status of Assisted Suicide (2021)[15]



Public opinion vs. flawed legislation

When people are asked generally about the topic, this seems like a compassionate thing. Why would we not want to ease someone’s suffering? But here’s the thing – we already can. Maryland has outstanding palliative and hospice care, but many are not even aware of what it is or how it can help. Plus, what public opinion poll questions do NOT mention are the serious issues in the bill:

- redefines the term “suicide” and prohibits stating truthfully what these actions are
- falsification of death certificates is mandated by deeming this a death of “natural causes”
- it gives the doctor writing the prescription broad legal immunity which means no accountability for their actions
- records are protected from discovery and subpoena
- no state residency requirements
- no long-term relationship is required to exist between the prescribing doctor and patient
- there is no requirement to notify next of kin
- no witnesses are required when the overdose is taken
- no routine audits, investigations, or supervision by an independent safety monitoring board

Contrary to what you may hear, not everyone thinks this is a good idea. In 2024, in Maryland this legislation died in committee. [There was a hiatus of pushing this legislation from 2020-2022 due to trying to save lives during the COVID pandemic.] In 2019, of the 13 states that considered assisted suicide legislation, only 2 passed it. That means 11 rejected it, including Maryland. Utah even passed legislation to definitively make it illegal.

[15] https://doi.org/10.1177%2F00243639211058966

Autonomy?

This bill is not really about offering "a choice" or autonomy. I have heard proponents say they have a right to die. That is true, and patients already have that option now and without this legislation. There is no requirement for anyone to continue medical care that they do not want. As for attempting to control the date or time of death, that already lies within their hands as well. The vast majority (> 70%) of the fraction of people who killed themselves in 2023 (in Oregon and Washington) using assisted suicide were cancer and ALS (Lou Gehrig's disease) patients. They don't need permission from the government – or a firearm or starvation – to end their lives. They already have access to powerful drugs in their medicine cabinets, and in amounts that would allow them to commit suicide peacefully. Opiates and benzodiazepines especially when combined with alcohol, can produce respiratory depression and death – most of the time within a few hours. The person falls asleep and never wakes up.

Therefore, if the minority of people who might make use of this already have the right to die, the right to commit suicide (it's not illegal, after all), and have access to the drugs to do so, why the need for this bill? The true goal of this bill is to change public opinion about assisted suicide… through government approval of it and physicians and pharmacists legitimizing it by participation. And, eventually, autonomy and choices will be denied to those who do not agree with this "option," and it will become an unspoken expectation for them to terminate their own life to prevent being a burden to others.[16, 17]

Summary

Let's build a society that treasures life, not terminates it. Please don't fall for the euphemisms of "end-of-life options," "medical aid-in-dying," or "death with dignity" that proponents are attempting to use to mask the truth. This is assisted suicide, and it is poor public policy and bad medicine. I urge you to vote "unfavorable" on this bill. Thank you.

[16] https://doi.org/10.3389%2Ffpsyt.2020.532817

[17] Coelho R, Maher J, Gaind KS, Lemmens T. The realities of Medical Assistance in Dying in Canada. Palliative and Supportive Care. 2023;21(5):871-878. doi:10.1017/S1478951523001025