



GEORGETOWN UNIVERSITY

The Kennedy Institute of Ethics

Professor John Keown  
Senior Research Scholar  
MA (Cambridge) DPhil (Oxford) PhD (Cambridge) DCL (Oxford)

TEL: (202) 687-8099  
FAX: (202) 687-8089  
ijk2@georgetown.edu

20 February 2020

### The “End of Life Option” Bill

Maryland legislators should reject the “End of Life Option” Bill, for two main reasons.

1. The bright-line prohibition in the criminal law and in professional medical ethics on the intentional killing of patients, and on intentionally assisting patients to kill themselves, reflects a foundational ethical and legal principle: the inviolability of human life. That principle is grounded in a recognition that **everyone, regardless of illness, life-expectancy, age, disability, gender, race, religion or sexual orientation shares an intrinsic and ineliminable dignity and equality that makes it wrong for physicians intentionally to kill patients or help patients kill themselves.** (This does not mean patients’ lives must be preserved at all costs: it is proper for physicians to withhold or withdraw treatments which are futile or too burdensome or refused by patients, even if it is foreseen that death will come sooner.)

One of the several expert committees that have concluded that the prohibition on PAS and VE should be upheld was the eminent House of Lords Select Committee on Medical Ethics. It observed:

**That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.<sup>1</sup>**

By contrast, laws that permit PAS or VE are grounded on the notion that there are *two* categories of patient: those with lives ‘worth living’ and those who would be ‘better off dead’. Such laws invite fundamentally **discriminatory** judgments.

The superficially attractive argument that PAS or VE is required by respect for patient ‘choice’ is specious. Laws and proposed laws for PAS and/or VE do not allow them for *any* patient who autonomously wants them: they allow them only for *some* patients who want them (such as the ‘terminally ill’ or those ‘suffering unbearably’). So: PAS or VE are not fundamentally about choice but about the judgment that the requests of *some* patients should be granted because it is thought *by others* that they would be ‘better off dead’. No wonder that disability groups are at the forefront of opposition to PAS and VE. They see more clearly than many that any such judgment is discriminatory. And those with disabilities are not the only ones who would likely find themselves being judged to have lives less ‘worth living’ than others, or not ‘worth living’ at all. Other disadvantaged people, including those who cannot afford healthcare, would also be at heightened risk.

The judgments that would be permitted by the Bill are not only discriminatory; they are **arbitrary**.

---

<sup>1</sup> Report of the Select Committee on Medical Ethics (House of Lords, Paper 21-I of 1993-4) para 237.

- Why PAS only for those with a “terminal illness” (the Bill’s definition of which is vague)? Why not for those with MS, or ALS, or arthritis, especially when those with a “terminal illness” may not be suffering at all whereas those with a non-terminal condition may face many years of severe suffering? (The Bill does not require that the patient be suffering, and the two most common reasons for accessing PAS in Oregon are not suffering but “losing autonomy” and being “less able to engage in activities making life enjoyable”.<sup>2</sup>)
- Why lethal prescriptions but not lethal injections, especially if the patient is unable to self-administer the poison?
- Why a hastened death only for those who request it? Why not for those who may be suffering but who are (like those with dementia or severe learning disabilities) incapable of making a request?

**Supporters of proposals like the End of Life Option Bill have yet to produce cogent answers to any of these questions.** This Bill would, then, be merely a first step. Sooner or later, whether as a result of a legislative or a judicial decision recognizing that the proposed limitations are ‘discriminatory’ restrictions on the newly-established ‘right to die’, the law will be extended to allow VE and then euthanasia without request. The Dutch realized years ago, when they relaxed their laws, that it made no sense to permit PAS but not VE, or to limit them to the ‘terminally ill’. And since then the Dutch have, logically, extended their law to permit euthanasia for babies born with disabilities.

**2. Even if PAS or VE were defensible in principle, effective legal control would prove impossible.** Several expert committees that have considered the case for legalization, like the House of Lords Select Committee and the New York State Task Force on Life and the Law,<sup>3</sup> have rejected PAS and VE because of the risks of abuse, especially to vulnerable groups. How, for example, are doctors to *know* that a person (whom they may only just have met) is competent and that their request is truly voluntary, not the result of clinical depression or family pressure, or the fear of being a burden, or a misguided fear of dying in pain? This is especially so when patients can (as the vast majority do) access a hastened death without being examined by physicians with expertise in either psychiatry or palliative treatment.

Moreover, the evidence from those relatively few jurisdictions which allow PAS or VE reinforces concerns about effective control. The Netherlands legalized both over thirty-five years ago. Despite the legal requirement that physicians end life only at the request of the patient and that they report all cases, official Dutch surveys have disclosed that physicians have, with impunity, failed to report thousands of cases, and have given lethal injections to thousands of patients without request. The law allows even purely mental suffering as a ground for PAS and VE, and in 2016 the government supported further relaxation of the law to allow assisted suicide for even healthy elderly folk with a “completed life”.<sup>4</sup>

The evidence from Oregon, where no comprehensive surveys like those in the Netherlands have been carried out, is far more limited and is certainly insufficient to substantiate any claim that its law has

---

<sup>2</sup>See Oregon Health Authority, ‘Death with Dignity Act: 2018 Data Summary’, Table 1.  
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21>.

<sup>3</sup> New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York, NYSTF: 1994)

<sup>4</sup> See John Keown, *Euthanasia, Ethics and Public Policy* (Cambridge University Press, 2<sup>nd</sup> edition 2018), ch. 17.

provided effective control. We simply do not know how many physicians have practised PAS outside the law, or how reliable the reports filed by physicians with the Oregon Health Authority have been. As the analysis of the Oregon statute by Professor Alexander Capron, the leading health lawyer, rightly concluded, **the Oregon law's safeguards are "largely illusory"**.<sup>5</sup>

Moreover, Oregon's minimal ex post 'review' procedure is weaker even than that in the Netherlands, and both jurisdictions rely on self-reporting by physicians. Which physician is going to report that he or she has broken the law? And one Oregon study, which found that some patients accessed lethal drugs under the Act even though they were depressed, concluded: "the current practice of the Death with Dignity Act may fail to protect some patients whose choices are influenced by depression from receiving a prescription for a lethal drug."<sup>6</sup> This is hardly surprising, given that ordinary physicians lack expertise in diagnosing and treating depression. The End of Life Option Bill is modelled on the Oregon Act and suffers from similar, serious flaws. It is not surprising that such Bills have been repeatedly rejected elsewhere.

The real challenge facing Maryland, from which legalizing PAS would be a dangerous distraction, is to provide quality end-of-life care and social support to all, especially the poor, the disabled and the marginalized.<sup>7</sup>

A handwritten signature in black ink, appearing to read 'John L.' with a stylized, cursive script.

---

<sup>5</sup> Alexander M Capron, "Legalizing Physician-Aided Death" (1996) 5 (1) *Cambridge Quarterly of Health Care Ethics* 10.

<sup>6</sup> Linda Ganzini et al, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross-sectional survey" (2008) 337 *British Medical Journal* a1682.

<sup>7</sup> I write this note in my personal capacity, not on behalf of the Kennedy Institute or Georgetown University. Three of my books which explore the issues are: Euthanasia Examined (Cambridge University Press, 1995); Debating Euthanasia (with Emily Jackson; Hart Publishing, 2012); Euthanasia, Ethics and Public Policy (Cambridge University Press, 2<sup>nd</sup> edition 2018).