G. Kevin Donovan, M.D., M.A.

SB 701 Testimony - Feb. 28,2020

Ladies and gentlemen, thank you for the opportunity to speak with you today about SB 701. This is not the first time that the Maryland assembly as considered such a bill nor is it the first time that I've spoken against it. I hope this body will share in the wisdom of its predecessors, and not allow this to become the law of the land. This is been a difficult issue for all concerned, and you will hear specific problems with the proposed bill - but not from me. I don't think tweaking the bill will solve the problems. I don't think there is a right way to do the wrong thing.

To be a lawmaker shares some of the features of being a physician: we have responsibilities to those individuals that we care for or represent, but we must always be cognizant that our actions will affect large segments of society as well. In your case, to pass a law is to set a societal standard for **all** those who will be affected by it. And make no mistake- this law will have repercussions for far more patients, far more people, than those few that it is intended for. You will be told the truth, that this law is intended as much as a comfort as it is a curative. In states such as Oregon, only a tiny minority of the people seek a lethal prescription, and many never actually use it. Today I want you to consider that much larger majority of your constituents, my patients, who have no declared need for such a law, no intention of ever using it, and a well-founded fear of it. You have heard and will hear, from representatives of the disabled who rightly fear this bill, but this fear and danger applies not just to them. They are just the canaries in the

coal mine. There is a frightening list of those who will be placed at risk: the physically disabled, the mentally disabled, the elderly, the unfriended, the indigent, those who have never had adequate access to the healthcare system and are afraid of being shut out of access near the end of their lives as well. I am a medical doctor and an ethicist, and now spend much of my professional time with those near the end-of-life. Many are now concerned, rightly concerned, about how laws such as this create a new category for persons - persons whose lives may be looked at as less valuable, less worthy of preserving even as those lives dwindle, whose quality-of-life may be judged by others by this new criteria as meriting an early exit. Imagine how these patients feel when faced with such a proposal? Too many want to live, but want to live better lives, not to end them. In the absence of adequate services to the disabled, healthcare to the indigent, or palliative care to those near the end-of-life, this bill is premature. It represents a failure of societal support to those most in need. Instead, it places them in a new category, those whom society would allow or even encourage to choose death. We've seen other cultures take this route, both in the past and currently. We have seen the justification for it easily expand the list for whom it is intended. This is inevitable. If we feel driven by compassion to end the lives of those who suffer, where should we draw the line? Where can we draw the line? If it is the most compassionate choice that our society has to offer, how can we deny it to those not immediately included in this bill? After all, people can suffer without being terminally ill. People can suffer psychological anguish without being in physical pain. Should this choice be limited? Soon the so-called safeguards will be recast as barriers, barriers to be overcome by a society and the legislature that has redefined death as something not just to be accepted in due time, but to be promoted ahead of its time. And it will be promoted for those who are not seeking it, who are

unable to seek it because of their psychological state, their dementia, or the fact that they are still children. These are not speculative problems. They are inherent in the justifications for such a bill, and they are being promoted already in Canada, which is only had such laws in the past four years, as well as Belgium and the Netherlands which have had them for decades.

Moreover, how can we struggle to reduce the number of suicides among our young people and our veterans, yet promote self killing for others? It doesn't work - it sends a mixed message, and that message has led to increased suicides elsewhere when such laws are instituted.

And last but not least, as a physician I would beg you not to distort the best practices of medicine, the trust relationship that we strive to build with our patients. Physicians are devoted to healing. Killing is not healing. Giving someone a deliberate lethal overdose is killing, not the practice of medicine. Even the notorious Dr. Kevorkian, a pathologist who typically only saw patients after their demise, did not seek to define euthanasia or assisted suicide as a medical act. He thought little independent clinics could be set up, and technicians taught how to do this. I would point out that physicians are not taught in medical school how to effectively prescribe a lethal overdose. I don't like Dr. Kevorkian's solution either, any more than most of you would want to work in such a clinic, especially if you're familiar with the concept of Soylent Green. If you would have an aversion to such a solution, I ask you to trust your instincts and your good sense. Changing the law to create a category for assisted suicides is unwise, unnecessary and ultimately uncontrollable. It fails to serve the greater good.

G. Kevin Donovan, MD, MA
Director,Pellegrino Center for Clinical Bioethics
Professor,Georgetown University Medical Center