



**Written Testimony of Katie Glenn
Government Affairs Counsel, Americans United for Life
Against Senate Bill 701, the Richard E. Israel and Roger “Pip” Moyer Act
Submitted to the Maryland Senate Judicial Proceedings Committee
February 28, 2020**

Dear Chairman Smith and Members of the Committee:

I serve as Government Affairs Counsel of Americans United for Life (AUL), America’s original and most active organization advocating for life-affirming support and protections for the most vulnerable members of our communities. Established in 1971, AUL has dedicated nearly 50 years to advocating for everyone to be welcomed in life and protected in law. In my practice I specialize in life- and health-related legislation, and I am testifying as an expert in constitutional law generally and in the constitutionality of end of life-related laws specifically. I appreciate the opportunity to provide testimony against Senate Bill 701, the Richard E. Israel and Roger “Pip” Moyer Act, which would legalize suicide by medical means in Maryland.

I have thoroughly reviewed Senate Bill 701 (“the Act”) and it is my opinion that the Act goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable persons at greater risk, and fails to protect the integrity and ethics of the medical profession.

Suicide by Physician Places Already-Vulnerable Persons at Greater Risk

Maryland has a responsibility to protect vulnerable persons—including people living in poverty, elder adults, and those living with disabilities—from abuse, neglect, and coercion. Considering the risk posed to these vulnerable individuals, legalizing assisted suicide can be considered neither a “compassionate” nor an appropriate solution for those who may suffer depression or loss of hope at what may be the end of life.

Indeed, contrary to the prevailing cultural narrative, the reason why people consider seeking assistance in their suicide is neither pain nor fear of pain. In the last 15 years, pain and fear of pain have never been in the top five reasons cited by those seeking assisted suicide in Oregon;¹ the latest data from

¹ Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2018 DATA SUMMARY (Feb. 15, 2019) [hereinafter OREGON 2018 DATA SUMMARY], <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf>.

Washington State reveal the same concerns.² As bioethicist Ezekiel Emanuel has noted, “the main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . . In this light, assisted suicide looks less like a good death in the face of unrelenting pain and more like plain old suicide.”³

Emanuel is not alone. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved prescription suicide, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.⁴ The most vulnerable among us—such as the poor, the elderly, the terminally ill, the disabled, and the depressed—are equally worthy of life and even more in need of equal protection under the law, and state prohibitions on promoting or enabling suicide reflect and reinforce the well-supported policy “that the lives of the terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy.”⁵ Speaking to this disparate treatment, Dr. Kevin Fitzpatrick wrote, “When non-disabled people say they despair of their future, suicide prevention is the default service we must provide. Disabled people, by contrast, feel the seductive, easy arm of the few, supposedly trusted medical professionals, around their shoulder; someone who says ‘Well, you’ve done enough. No-one could blame you.’”⁶

There has been discussion of a “suicide contagion,” or the Werther Effect.⁷ Empirical evidence shows media coverage of suicide inspires others to commit suicide as well.⁸ One study, which incorporated assisted-suicide statistics, demonstrated that legalizing assisted suicide in certain states has led to a rise in overall suicide rates—assisted and unassisted—in those states.⁹ The study’s key findings show that after accounting for demographic, socioeconomic, and other state-specific factors, physician-assisted suicide is

² Wash. State Dept. of Health Disease Control and Health Statistics Div., WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (Mar. 2018) [hereinafter WASHINGTON 2018 REPORT], <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>.

³ Ezekiel J. Emanuel, *Four Myths About Doctor-Assisted Suicide*, N.Y. Times (Oct. 27, 2012), <https://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/>.

⁴ José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that “laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted.”); see also WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a “burden” on family members, raising the concern that patients were pushed to suicide.).

⁵ *Glucksberg*, 521 U.S. at 731–32.

⁶ Kevin Fitzpatrick, *Assisted Suicide for Disabled People – Democracy in Britain?*, Euthanasia Prevention Coalition blog, June 23, 2015, available at <http://alexschadenberg.blogspot.com/2015/06/assisted-suicide-for-disabled-people.html>.

⁷ See, e.g., Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOVERNMENT (May 17, 2018), <https://www.openaccessgovernment.org/the-werther-effect/42915/>. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. See, e.g., Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), <http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/>.

⁸ See *id.*; see also S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RES. 137 (2004).

⁹ See David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 (2015) <https://pdfs.semanticscholar.org/6df3/55333ceccc41b361da6dc996d90a17b96e9c.pdf>.

associated with a 6.3% increase in overall suicide rates.¹⁰ These effects are even greater for individuals older than 65 years of age—14% increase.¹¹ And so suicide prevention experts have criticized assisted-suicide advertising campaigns, writing that a billboard proclaiming “My Life My Death My Choice,” which provided a website address, was “irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal.”¹²

The Supposed Safeguards Are Ineffective in Practice

Despite the so-called “safeguards,” opening the door for suicide by physician also opens the door to real abuse. For example, SB 701 requires that there are two witnesses to the request for life-ending medication, but only one must be a disinterested party, at least in theory. There is no requirement that the second witness be completely disinterested, meaning an heir and his best friend, roommate, or significant other would satisfy the two-witness requirement, easily circumventing the alleged safeguard designed to protect the patient from pressure, coercion, or abuse.

Additionally, the Act’s mental health assessment requirement is practically nonexistent. The patient is referred to counseling for a mental health assessment only if the physician believes the individual “may be suffering from a condition that is causing impaired judgment or otherwise does not have the capacity to make medical decisions.” Then, the patient is provided the medication if the counseling physician “determines that the patient is not suffering a psychiatric or psychological condition including, but not limited to, depression, that is causing impaired judgment.”

This safeguard is ineffective for two reasons. First, the Act fails to define “impaired judgment” at all. This means that even if individual is suffering from depression, that in and of itself might not preclude the individual from being prescribed and utilizing life-ending medication. Second, there is no requirement that the counselling involve meeting more than once. As the most recent statistics from Oregon show, only 3 of the 168 patients who died from ingesting end-of-life drugs in 2018 were ever referred for a psychiatric evaluation.¹³ Similarly, in Washington, only 10 of the 251 individuals who died in 2018 were referred for a psychiatric evaluation.¹⁴ One study from Oregon found that “[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.”¹⁵ This is problematic because the Act only requires the provider making this determination be a “licensed psychiatrist or psychologist” not the primary care physician or a physician with a prior relationship with the individual who has an

¹⁰ *Id.*

¹¹ *Id.*

¹² See Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, Celebrate Life, Jan-Feb 2015, available at <https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/>.

¹³ OREGON 2018 DATA SUMMARY, *supra* note 1.

¹⁴ WASHINGTON 2018 REPORT, *supra* note 2.

¹⁵ Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, Am. J. Psychiatry 157:4, 595 (2000) <https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.157.4.595>.

understanding of his or her history and needs. For these reasons, it is difficult to argue this “safeguard” in SB 701 will accurately assess an individual’s mental health.

In addition, the Act assumes the physicians are able to make the correct diagnosis that a patient is has an incurable and irreversible disease which will “result in death within six months.” But this fails as a safeguard as terminality is not easy to predict. Current studies have shown “experts put the [misdiagnosis] rate at around 40%,”¹⁶ and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an “error”¹⁷ which resulted in the individual’s death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed.¹⁸ Nicholas Christakis, a Harvard professor of sociology and medicine, agreed “doctors often get terminality wrong in determining eligibility for hospice care,”¹⁹ and Arthur Caplan, the director of the Center for Bioethics at the University of Pennsylvania, considers a six month requirement arbitrary.²⁰ Even the Oregon Health Authority admitted, “[t]he question is: should the disease be allowed to take its course, *absent further treatment*, is the patient likely to die within six months? . . . [Y]ou could also argue that even if the treatment [or] medication could actually cure the disease, *and the patient cannot pay for the treatment*, then the disease remains incurable.”²¹

Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on physician-enabled suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as to the principles articulated in the Hippocratic Oath to “keep the sick from harm and injustice” and to “refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect.”²² Likewise, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of life. The AMA states that “permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.”²³ In fact, the

¹⁶ Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VeryWell Health (Aug. 2, 2018), <https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481>

¹⁷ See, e.g., Malcom Curtis, *Doctor Acquitted for Aiding Senior’s Suicide*, The Local, Apr. 24, 2014 (reporting the doctor was not held accountable for his negligence).

¹⁸ Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly, Jan. 13, 2009, <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>.

¹⁹ See *id.*

²⁰ See *id.*

²¹ Fabian Stahle, *Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model*, Jan. 2018 (emphasis added), available at <https://www.masscitizensforlife.org/oregon-health-authority-reveals-hidden-problems-with-the-oregon-assisted-suicide-model>.

²² The Supreme Court has recognized the enduring value of the Hippocratic Oath: “[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . . [W]ith the end of antiquity . . . [t]he Oath ‘became the nucleus of all medical ethics’ and ‘was applauded as the embodiment of truth’” *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

²³ AMA CODE OF MEDICAL ETHICS OP. 5.7 (Physician-Assisted Suicide), <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-5.pdf>.

AMA states the physician must “aggressively respond to the needs of the patients” and “respect patient autonomy [and] provide appropriate comfort care and adequate pain control.”²⁴ And in June of 2019, the AMA reaffirmed its position against suicide by physician by a vote of 65-35.²⁵

Furthermore, SB 701 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. It opens the door for physicians to be forced to violate medical ethics, such as the Hippocratic Oath to “do no harm,” as well as their moral convictions or religious beliefs against taking one’s own life or assisting another to end her life. Even though the Act includes language stating that a physician may “refuse to participate” in suicide by physician, it does require that the physician provide a referral to a physician who will act on the request. Many healthcare providers find referral a violation of their moral, ethical, or religious beliefs because they still feel complicit in the ultimate act. SB 701 as currently written insufficiently protects the conscience rights of Maryland healthcare providers.

The U.S. Supreme Court has stated “[t]he State also has an interest in protecting the integrity and ethics of the medical profession.”²⁶ In Justice Antonin Scalia’s dissent to another Supreme Court case involving a ban on the use of controlled substances for physician-assisted suicide, he pointed out: “Virtually every relevant source of authoritative meaning confirms that the phrase ‘legitimate medical purpose’ does not include intentionally assisting suicide. ‘Medicine’ refers to ‘[t]he science and art dealing with the prevention, cure, or alleviation of disease’ [T]he AMA has determined that ‘[p]hysician-assisted suicide is fundamentally incompatible with the physician’s role as healer.’”²⁷

The Majority of States Affirmatively Prohibit Medical Suicide

Currently, the majority of states—at least 37 states—prohibit assisted suicide and impose criminal penalties on anyone who helps another person end his or her life. And since Oregon first legalized the practice in 1996, “about 200 assisted-suicide bills have failed in more than half the states.”²⁸ In *Washington v. Glucksberg*, the United States Supreme Court summed up the consensus of the states: “In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States’ assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States’ commitment to the protection and preservation of all human life.”²⁹

This longstanding consensus among the vast majority of states is unsurprising when one considers, as the Court did, that “opposition to and condemnation of suicide—and, therefore, of assisting suicide—

²⁴ *Id.*

²⁵ Steven Ertelt, AMA Votes to Retain Longstanding Opposition to Assisted Suicide, LIFESITENEWS.COM (June 10, 2019), <https://www.lifenews.com/2019/06/10/ama-votes-to-retain-longstanding-opposition-to-assisted-suicide>

²⁶ *Glucksberg*, 521 U.S. at 731.

²⁷ *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

²⁸ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUMAN LIFE REV. 51, 53 (2018).

²⁹ 521 U.S. 702, 710 (1997).

are consistent and enduring themes of our philosophical, legal and cultural heritages.”³⁰ Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide in the U.S. Constitution, finding instead that there exists for the states “an ‘unqualified interest in the preservation of human life[,]’ . . . in preventing suicide, and in studying, identifying, and treating its causes.”³¹

Thus, Maryland should reject Senate Bill 701 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable individuals such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession. Thank you.

Sincerely,

A handwritten signature in dark ink, appearing to read "Katie Glenn", with a stylized, cursive script.

Katie Glenn, Esq.
Government Affairs Counsel
Americans United for Life

³⁰ *Id.* at 711.

³¹ *Id.* at 729–30.