OPPOSITION TO SB 701
A MONUMENT TO THE DOCTRINE OF UNINTENDED CONSEQUENCES

Michael P. May, Esq.
606 Baltimore Ave.,Suite 204
Towson, MD 21204
443-725-5484
Mike@mpmaylaw.com

For yet another year, well-intentioned legislators have attempted to make physician assisted suicide the law in Maryland, joining other states who have passed similar legislation, with disastrous consequences. This year's bill continues that tragic and heartbreaking effort. Decades ago, Archbishop Fulton J. Sheen wrote *Life Is Worth Living*. Somehow our society has regressed, rejecting that fundamental precept, notwithstanding the hallowed words of our Declaration of Independence: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness." The bill additionally ignores the United Nations Universal Dclaration of Human Rights: "Everyone has the right to life, liberty and security of person."

The bill implies that suicide may be chosen by people of sound mind. Of course, no one can agree on the meaning of the term "sound mind." Extremely busy physicians, many trained in specialties other than psychiatry, somehow must decide if a person who wishes to commit suicide possesses a so-called sound mind in rejecting the fundamental human instinct of self-preservation. If the physician suspects an unsound mind, whatever that means, or the consulting physician has the same suspicion, one or both may refer the individual to a mental health professional, not necessarily even a physician, to determine if the patient's suicide desire is rational. The bill does not provide the health care providers with any guidance.

Similarly, this year's bill attempts to guard against coercion or undue influence. The doctor must talk to the patient alone – unless the patient needs an interpreter. The doctor receives no guidance as to what questions to ask to discern coercion or undue influence. Indeed, the bills provide no guidance on how to distinguish coercion or undue influence from a mere conversation about assisted suicide. In the final analysis, a doctor's determination as to whether a patient seeks to commit suicide as a result of coercion or undue influence amounts to the physician's best guess.

To add to the conundrum, patients considering or requesting physician assisted suicide would naturally seek out a physician whose opinion favors assisted suicide. Indeed, states with assisted suicide laws already on their books have only a small percentage of physicians who engage in the practice. The greatest majority try to help their patients, not kill them. Thus, the doctor ostensibly screening for coercion or undue influence has a predisposition to find that neither exist, notwithstanding the fact that generally the doctor knows nothing of the patient's family dynamics. To put matters another way, no patient would tell the doctor that a friend or a family member forced, bullied, tricked or coerced him or her into requesting the pills that will cause death, not even immediately, but sometimes days after ingesting them. The screening therefore becomes a cynical illusion designed to foster, support and promote suicide.

The bill discriminates between persons with terminal illnesses who only have a few months to live and those with lifelong illnesses and no idea how long they will live. Only the former are "entitled"to commit suicide – if their prognosis is that they will die within 6 months, although no doctor has a crystal ball to enable him or her accurately to predict when the patient would actually die of natural causes.

Oregon, a "pioneer"in the assisted suicide movement, allows people with depression to end their lives through assisted suicide. That, of course, undermines agencies offering support to people

with depression.

In reality, it is impossible to determine how long someone will live or to predict how a particular person will respond to a terminal illness. Thus, a doctor could prescribe life ending poison for a person, only to have the person live beyond the six-month window and ingest the suicide pills later. The current bill makes that a distinct possibility. In Oregon, there have been lapses of almost 3 years between the time the patient received the poison and the time the patient took it.

Insurance companies could deny access to expensive medical treatment while covering suicide options. Already, the current bills effectively invalidate incontestability provisions in life insurance policies, a clear violation of the Contracts Clause of the United States Constitution. Moreover, insurance companies have a fiduciary relationship to their shareholders or, in the case of mutual companies, to their policyholders. One could certainly make the argument that fulfilling that fiduciary obligation requires the companies to save money by denying access to certain treatments while effectively encouraging suicide by telling the patient or policyholder that the company will pay for suicide but not for treatment. After all, that would save the company money, and that sort of phenomenon has already surfaced in Oregon.

In Maryland, hospitals generally receive reimbursement, not on a per patient basis, but on a lump-sum formula. They therefore must budget resources. That scenario raises the question of whether hospitals with limited resources would provide quality care to a patient who is not expected to live or would begin to limit end-of-life options offered to terminal patients.

The bill eviscerates, indeed contradicts, the concept of health care. Doctors must preserve lives. Facilitating death at a patient's own hand hardly accomplishes that. Instead, it undermines any trust between the doctor and the patient who can no longer be sure that the doctor is helping him or her to live or die. On the other hand, if the doctor does not offer a suicide option to a terminally ill patient, the doctor could be maligned for allegedly prolonging a patient's pain. The doctor has a choice – between the devil and the deep blue sea.

There additionally appears to be a persistent correlation between assisted suicide and divorce. Judge Gorsuch writes that in each year except 2000, as his Winter 2004 article in the Wisconsin Law Review notes, "Divorced persons have represented over 24% of all assisted suicides in Oregon, well in excess of their representation in the population of all deaths due to similar underlying illnesses." He also noted that over time, Oregon physicians became increasingly unlikely to refer their patients for psychiatric or psychological consultation before providing them with an imprimatur to kill themselves.

Statistics tend to show that in the United States, the duration of the physician-patient relationship and assisted suicide cases is exceedingly short. Thus, the doctor vetting, and eventually approving, a patient for assisted suicide does not know the patient well and may not know the patient's family at all. Sadly, the bill practically guarantees that will be the case because assisting patients to kill themselves remains anathema to most physicians.

Gorsuch writes of the cases of "Helen"and Ms. Chaney in Oregon. Helen was a breast cancer

patient in her mid 80s. Both her regular physician and a second doctor refused to help her kill herself. Her husband then called Compassion in Dying. That organization's medical director spoke to her and later explained that she was "frustrated and crying because she felt powerless." She was neither bedridden or in great pain. In fact, she enjoyed aerobic exercises until 2 weeks before contacting Compassion in Dying. She was also still performing housework. The organization recommended a physician to Helen, and that doctor referred her to a specialist of some kind, as well as to a psychiatrist who saw her only once. She got the lethal prescription. Her family told a newspaper reporter that Helen was worried that further care would threaten her financial assets.

Ms. Cheney, an 85-year-old widow, went to the doctor with her daughter who was a retired nurse. The daughter thought that the initial physician was dismissive, so she and her mother got another referral for a doctor within the same HMO, Kaiser Permanente. The second doctor referred Ms. Cheney to a psychiatrist who found that she "did not seem to be explicitly pushing for assisted suicide and that she lacked the very high level of capacity to weigh options about it." She accepted that assessment, but the daughter became angry. The HMO then suggested a 2nd psychiatric evaluation and agreed to pay for it. The 2nd mental health professional, a psychologist according to Judge Gorsuch, found that the daughter might have been "somewhat coercive" but that Ms. Cheney was competent to make the decision to kill herself. She then received the lethal prescription, and the drugs were placed under her daughter's care. Eventually she went to a nursing home temporarily to give her daughter a break. When she returned home, she said that something had to be done about her declining health and that she did not want to go back to the nursing home. She said she wanted to use the pills in her daughter's custody. Her daughter consented, and Ms. Cheney took the pills and died.

Of course, both stories are heartbreaking. People died needlessly – at their own hands. Moreover, one necessarily wanders what would have happened had family members urged against the request to die? What would have happened if the family members had offered care? Should patients be permitted to shop around for doctors who will go along with the desire to commit suicide? What if the HMO had not referred Ms. Cheney to a 2nd doctor? What if Compassion in Dying had not referred Helen to one of its stable of physicians chosen to help people kill themselves?

The bill guarantees a horrifically discriminatory and disproportionate effect on the elderly, African-Americans, the poor and the disabled. In fact, things are so bad in Holland that many old people insist on written contracts assuring against involuntary euthanasia before they will admit themselves. One necessarily wonders if Oregon's extremely homogeneous population, roughly 90% white, made it a pioneer. The *Detroit Free Press*, in 1994, found that while 53% of whites sampled in Michigan could envision assistance in committing suicide, only 22% of African-Americans could.

The *New England Journal of Medicine* reported that female, African-American, elderly and Hispanic cancer patients are all less likely than similarly situated non-minorities to receive adequate pain-relieving treatment that might obviate or eliminate a patient's perceived need to resort to suicide. In 1994, the Journal reports, minority cancer patients were 3 times less likely than non-minority patients to receive adequate palliative care. Only 48% of African-Americans received medicines designed to slow the progress of AIDS, compared to 63% of whites. Only 58% of African-American patients received treatments for preventing AIDS -related pneumonia while 82% of whites

got the treatment.

Clearly this year's bill will, once again, have a highly disparate, disproportionate and deleterious effect on the most vulnerable members of our society: our poor, our elderly and our minorities. Certainly no enlightened legislative body, much less the members of the committees, can countenance, much less promote, such horrific carnage.

The bill contradicts our most fundamental values. It also starts to propel us, as a society, down that proverbial slippery slope to the day when the government decides that a person's life no longer has meaning, no longer has inherent value, that the person can no longer make a contribution, that the person is a liability, an albatross, that the person must therefore die.

Almost three centuries ago, Goethe wrote *The Sorrows of Young Werther*. The protagonist, devastated by unrequited love, killed himself. The book became an instant phenomenon. It sparked an appalling rash of copy cat suicides. So many occurred that some jurisdictions forbade the wearing of blue coats and yellow pants, as Werther did in the book, because so many young people were killing themselves.

The current bill permits adults to decide to kill themselves under certain circumstances with the assistance of a physician. The age of majority in this state is 18. Can anyone say that an 18-year-old has reached full emotional development? Is the 18-year-old immune from influences that would not affect someone older or more mature? Could an 18-year-old engage in a copy cat suicide?

One must also ask why the bill mandates that the death certificates of those who would engage in physician assisted suicide should attribute their deaths to the underlying condition that purportedly formed the basis of the request. That requirement implicitly acknowledges that a doctor's assisting a patient to commit suicide is wrong. If helping people kill themselves were right, if obtaining medications, actually poisons, to kill oneself were right, there would be no reason to avoid the truth, that a person died at his or her own hand with the assistance of a physician who took an oath to care for people, not kill them.

Under no circumstances should this committee permit the bill it is considering to emerge from committee, a Leviathan rising from the sea, destroying people and ultimately destroying a society founded on life, liberty and the pursuit of happiness.

Michael P. May
February 20, 2020