Senate Judicial Proceedings Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Honorable Senate Judicial Proceedings Committee Member,

I am writing today in opposition of House Bill 643 and Senate Bill 701, both of which are titled, An Act concerning the End of Life Options Act. I am a psychiatrist and medical ethicist on the faculty of Johns Hopkins School of Medicine. I want to explain to you why you should not legalize Physician Assisted Suicide in Maryland.

The 2300-year-old history of medical ethics is grounded in the core ethical foundations established at the dawn of medicine — the Hippocratic values "professed" by physicians as a covenant-based community of values. The Hippocratic Oath says: "I will give nobody a poison, nor counsel any others to do so." This is the root of the mighty tree from which the House of Medicine was built, this value persisting as societies and their demands have come and gone. To this day, the World Medical Association, the AMA and many other major medical organizations continue this ethical stance against physician-assisted suicide and euthanasia.

Legalizing assisted suicide empowers one class of human beings (ironically, physicians) to literally take the life of another. It turns suicide from a freedom into it right. No country has been able to constrain these practices to the extreme end of life and over time have inevitably expanded to euthanasia by injection and looser criteria for eligibility. Some did it rapidly, others, like Oregon, are now slowly beginning this inevitable drift.

In Oregon there is no way to distinguish between encouragement and coercion by those who "support" terminally-ill loved ones taking lethal drugs prescribed to cause death. There are no regulations to keep lethal prescriptions from being diverted. There is evidence of a contagious increase in ordinary suicide, subsequent to legalizing assisted suicide, as the message that "some suicides are OK" suffuses society.. New legislation is being pursued there now to move to more active euthanasia by injection and to make prognostic criteria for eligibility more vague. The law even allows patients whose conditions are not considered "terminal" to make themselves so, by choosing to refuse life-sustaining treatments — diabetics stopping their insulin, for example.

Canada, Belgium and the Netherlands went straight to euthanasia, which is vastly preferred in those countries to assisted suicide by prescription. In 2017 the rate of euthanasia in Canada increased by 1/3 between the first and second half of the year. In Ontario, it is unethical and illegal for physician conscientious objectors to refuse to refer a patient for possible euthanasia evaluation, if they won't provide it themselves.

In Belgium and the Netherlands, where these practices have evolved over 18 years, and 4% of all human deaths are by physicians' injections, the slope has slipped to include eligibility for those with nonterminal illnesses, psychiatric conditions, young children, and uncomfortable lifestyles. There are strong advocacy efforts, with governmental support, to de-medicalize the criteria for such procedures by allowing those who are "tired of living" or feeling that their life is "complete" to ask for euthanasia, with the hopes of developing a "suicide pill" that can be obtained without a medical evaluation or prescription — a high sanctification of autonomy. Organ donation by those seeking euthanasia is encouraged as a "virtue opportunity." The slippery slope is real.

The profound changes to a civilized society produced by such laws are unnecessary and undesirable. The suffering and disabled should have even more access to the very latest, state -of-the art palliative care, without it being economically or morally short-circuited by institutional killing promoted as a seductive virtue — referring to it as "dying with dignity" or self-determination. The so-called "choice" that is offered to the suffering to end their lives is a pseudo-choice, filtered through a physician's own values, or chosen because of narrowed choices in others ways--economics, social support, healthcare, etc. It is unjust, and therefore impossible, in a democratic society, to limit these procedures to some — like the terminally ill — but refuse it to others — like those with chronic physical and psychiatric disabilities. Yet, it signals that chronic disability and its sufferings might constitute a "life not worth living." It is an unfair and confusing public health message to designate one category of people who are helped to suicide, but others who are actively prevented from doing so with psychiatric care. Medicalizing suicide out-sources to the medical establishment the moral responsibility for a taboo about taking one's own life by suicide,

reducing the moral deterrence to suicide and lowering the threshold of acceptability for all suicide. It takes the protected and vital ethos of health care professionals away from their millennia-old Hippocratic commitment to be providers of comfort, hope, and healing, to become providers of death, not just supporters of the dying.

TEN REASONS TO OPPOSE SUCH LAWS:

1. They contradict public health messages to prevent suicide, which becomes forbidden for some, but not others.

2. These laws imply that illness, dependency & debilitation are lives not worth living. Bad message for the disabled.

3. There are always inadequate safeguards against coercion & diversion.

4. Everywhere this is law we see unequivocal slippery slopes to euthanasia, inclusion of mentally ill, linking to organ donation, etc. LEARN from the living laboratories of places where this is legal

5. Outsourcing suicide to physicians lowers barriers to suicide in general. Data shows effect of such laws on raising ordinary suicide rates.

6. Suicide is a freedom, not a right

7. The Hippocratic Oath and the subsequent history of medical ethics has consistently excluded killing in the House of Medicine, which is critical for patients' vulnerable trust that their physician will not administer death.

8. The U.S and world's major medical associations hold that assisted suicide is UNETHICAL: The AMA, the American Psychiatric Association, The World Medical Association, many others.

9. The state-of-the-art of palliative care is a profoundly effective way to provide "death with dignity," but is inadequately accessed

10. The patient doesn't really "choose"—the Dr. does-it comes down to the individual Dr.'s choice about who is eligible.

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