



**Opposition Statement HB933/SB845**  
Assisted Suicide/ 'End of Life Option Act'  
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**Position Statement**

On behalf of the Board of Directors of Maryland Right to Life, and medically vulnerable people across our state, we strongly oppose HB933/SB845 and the legalization of 'assisted suicide' also known as 'doctor-prescribed suicide'. By licensing doctors and other medical providers to prescribe lethal drugs to bring about a person's death, the state will be reducing the standard of medical care for all people with potentially disparate impact on the poor and underinsured.

This bill would put Maryland's most vulnerable populations at risk, including individuals with disabilities, those experiencing poverty, individuals in need of treatment for mental illness, our veterans, and those suffering from drug addiction.

The dangers presented to these populations and others far outweigh any perceived benefit being sold by the bill's out-of-state, well-funded proponents.

**Good Public Policy Serves the Many**

Legalizing assisted suicide will create great inequities in healthcare for Maryland residents. A *right to die* chosen by the wealthy few, will become a *duty to die* for many on public insurance. In Oregon, where this has been legal since 1994, nearly 70% of people who died from Assisted Suicide were Medicare or Medicaid patients, while only 30% had private insurance.

**Empirical Evidence of Risk**

We have the benefit of looking at two decades of history in Oregon to evaluate the credibility of the safeguards in this legislation. Unfortunately, substantially similar language in Oregon law has only wrought problems rather than protections.

The following illustrate immense problems with this legislation based on the data available to us, including:

- the failure to guarantee competence and mental health
- the lack of a required witness at the time of death
- the lack of a doctor-patient relationship and reality of doctor shopping
- the gravely flawed definition of terminal illness
- the reality of coercion and undue influence
- the reality of denial of wanted lifesaving care
- the indefinite requirement of self-administration
- the lack of specified data collected
- the mandate to falsify death certificates
- the casual standard to which doctors are held
- the failure of the state to be able to reasonably enforce violations of this policy and

- the stories of Michael Freeland, Helen X, Dr. Charles Bentz, Kate Cheney, Kathryn Judson, Mrs. Neill, Randy Stroup, Barbara Wagner, Barbara Houck, Patrick Matheny, and others experiencing firsthand the failures of safeguards in states with legal doctor-prescribed suicide.

In 2019 the proponents of the bill withdrew their support after state senators attached amendments that would have provided critical safeguards for patients. During the 2019 House of Delegates hearing on this bill, when asked about adding patient safeguards, Kim Callinan, CEO of **Compassion and Choices** (formerly the Hemlock Society and the organization advocating for this legislation), refused stating:

*“There are other states who currently have this legislation who are looking to remove some of the regulatory roadblocks.”*

## **FALLACY 1: “The Patient Must Be Competent/Have the Capacity to Make Medical Decisions”**

The capacity to make medical decisions and the requirement of a patient being a ‘qualified individual’ to request aid-in-dying, pose numerous problems. Though there is a requirement to possess “the capacity to make medical decisions”, substantial research and practical requirements of the legislation can offer no guarantee of competence or mental health.

### **Depression is a Normal Response to Terminal Diagnosis**

Research studying numerous cases of suicide has concluded a well-established psychological fact that nearly every terminally ill patient who desires death is suffering from a treatable mental disorder.<sup>1</sup> It is not uncommon for these patients to express depressive or suicidal thoughts, which may be a normal part of emotionally processing a severe diagnosis. Nonetheless, depression and suicidal ideation can be successfully treated and reversed. The worst response to a patient with suicidal thoughts is to affirm his or her worst fears of insignificance and of being a burden by helping that person end his or her life.

### **No Requirement of Assessment by Mental Health Professional**

Additionally despite language allowing the attending physician or consulting physician to refer a patient for a mental health professional assessment, there is absolutely no requirement that such action ever occurs in this bill. In practice, under the proposed language, if a mental health professional is given the opportunity to determine that a patient does suffer from a mental disorder or depression, if they also determine the person has decision-making ability, the individual can receive the lethal prescription.

Data from Oregon’s experience show only 4.9% of patients were referred for an evaluation in over 19 years of the practice.<sup>2</sup> In real numbers, that means 1,213 patients ended their lives through lethal prescriptions without being reviewed by a licensed mental health professional to ensure competency and clear decision making ability. This massive danger has resulted in documented cases reported in *The Oregonian* newspaper of patients suffering from depression and dementia receiving doctor-prescribed suicide.<sup>3</sup> One proponent of this legislation testified in the workgroup that patients with diagnosed depression are not disqualified from using this law in Oregon. Language in this legislation is not sufficient to protect patients.

<sup>1</sup> Barraclough, Bunch, Nelson, & Salisbury, *A Hundred Cases of Suicide: Clinical Aspect*, 125 BRIT. J. PSYCHIATRY 355, 356 (1976) and E. Robins, *THE FINAL MONTHS* 12 (1981).

<sup>2</sup> Oregon Public Health Division, *2017 Report on Oregon’s Death with Dignity Act*, released February 9, 2018. The annual reports are available online at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

<sup>3</sup> Erin Barnett, “A family struggle: Is Mom capable of choosing to die?” *Oregonian*, Oct. 17, 1999.

## Depression is Treatable

In Oregon, a patient by the name of **Michael Freeland** was diagnosed with lung cancer and received a lethal prescription under Oregon's law. Over a year after receiving his first prescription (clearly calling into doubt the validity of the 6-month lifespan diagnosis) he was admitted to a psychiatric treatment facility with depression and suicidal intent. After being treated and seeing great improvement, his caregivers ensured his 32 guns and all ammunition were removed from his home before Mr. Freeland could return home. However, his guardians knowingly allowed Mr. Freeland to keep the lethal prescription. Mr. Freeland's treating psychiatrist even submitted a letter to the court after his discharge indicating Mr. Freeland was not competent and was in need of a guardian. Fortunately after accidentally dialing a suicide prevention group when attempting to call an assisted suicide advocacy group, he was able to continue quality treatment for his depression and receive help in reconciling with his estranged daughter. He died naturally and in comfort almost two years after receiving a lethal prescription. Mr. Freeland released his medical records for public review.<sup>4</sup>

## Unattended Ingestion and Death

Because of the bill's lack of safeguards, there is serious concern as to whether a patient will still be competent at the time she or he actually ingests the lethal prescription. Patients prescribed a lethal prescription under this bill may not ingest it either for a period of time, or ever. 35.18% of patients prescribed a lethal prescription never take it (692 never ingested of 1,967 total prescriptions, 692 figure calculated from presentation of 1,275 patients who were reported having died from 1,967 lethal prescriptions written).<sup>5</sup> If a patient does not take the prescription, a lethal substance remains unmonitored and unregulated, potentially accessible to unintended recipients.

Additionally, the time reported between first request for death and actual ingestion is as little as 14 days to as high as 1,009 days (approaching 3 years).<sup>6</sup> Three years with a severe diagnosis can be one of dramatic changes. Aside from seriously challenging the definition of "terminal", it is unknown what changes to the patient's condition or life occurred in that time. Did the person's mental state deteriorate? Did the person's condition improve to no longer be considered terminal? Did caregivers tire of caring for a sick relative? Simply put, we don't, and will likely never know.

## Death Doctor Shopping

There is also no requirement in this legislation that the doctor has any notable relationship with the patient. Oregon's data show that 'doctor shopping' exists. A network of doctor-prescribed suicide proponents ensure that patients will receive lethal prescriptions<sup>7</sup>, even when their family doctor knows their desire for death is transient and could be alleviated. Oregon's data show that patients were prescribed fatal prescriptions after a duration of a "patient-physician relationship" of 0 weeks.<sup>8</sup> Clearly, the reality of a person searching for a willing physician after a family physician denying a request for suicide exists because of this bill's permissive allowance of it.

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<sup>4</sup> Patients Rights Council | N. Gregory Hamilton, MD and Catherine A. Hamilton, MA, "Competing Paradigms of Response to Assisted Suicide Requests in Oregon," *American Journal of Psychiatry*, June 2005, pp. 1060 - 1065.

<sup>5</sup> Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

<sup>6</sup> Ibid.

<sup>7</sup> Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.

<sup>8</sup> Oregon Public Health Division, *2017 Report on Oregon's Death with Dignity Act*, released February 9, 2018. The annual reports are available online at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

With regard to doctor shopping, **Compassion and Choices** openly admitted that they have worked with between 75% and 95% of all patients ending their lives in Oregon<sup>9</sup>, advertised their willingness to connect patients with willing doctors on their Washington chapter's website<sup>10</sup>, and promoted their referral program on their Vermont chapter's website<sup>11</sup>.

In Oregon, the story of '**Helen X**' clearly shows this. She had a history of breast cancer and was enrolled in hospice. She was using a wheelchair for two weeks and used oxygen when shortness of breath struck her. She reported no pain and was still doing aerobic exercises regularly. Her physician declined her request for a lethal prescription. A second physician she saw did the same due to feeling she was showing signs of depression. Her husband called Compassion and Choices and found a willing physician- Dr. Peter Reagan, a known advocate for doctor-prescribed suicide. Despite reporting surprise at her eagerness to die, Dr. Reagan nonetheless wrote the lethal prescription.<sup>12</sup>

Likewise, **Dr. Charles Bentz** diagnosed a malignant melanoma in an elderly man who had been under his care for 10 years. After the patient underwent radiation therapy, the radiation oncologist informed Dr. Bentz that the patient was depressed due to his diminished physical stamina. At about the same time, the patient completed his chemotherapy and requested a lethal prescription from his medical oncologist. The medical oncologist sought Dr. Bentz to be the required second physician, noting that secobarbital "works very well" and that the oncologist had used it many times. Dr. Bentz refused to agree citing the patient now had documented depression and needed appropriate therapy. The oncologist rather than reevaluating the effort to obtain a lethal prescription, found a willing second physician and did not refer the patient back to Dr. Bentz. Two weeks later, the patient ingested the lethal prescription and died.<sup>13</sup>

## **FALLACY 2: "The Patient Must Be Terminally Ill"**

Terminal illness is often difficult to predict. While physicians do their best to care for patients, there is a plethora of evidence that non-terminal patients have received lethal prescriptions. We are now seeing evidence from other states that lethal drugs may be prescribed for non-lethal and even mental health diagnoses, including depression or anorexia.

The aforementioned data indicating as long as 1009 days between first request for death and actual death indicates an obvious problem with the practicality of restricting this policy to only terminal patients.

### **Diabetes Can be Basis for Lethal Prescription**

Simply put, the definition of terminal in this legislation is overly broad. The definition does not preclude someone from ceasing treatment of an otherwise non-terminal condition in order to qualify. For instance, an insulin reliant diabetic could qualify under this bill. Whereas essentially no one would consider the condition terminal, a person with the condition could qualify if he or she ceases to

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<sup>9</sup> "FAQs." Compassion & Choices Oregon, n.d. Web. 12 Feb. 2016.

<<https://www.compassionandchoices.org/what-you-can-do/in-your-state/oregon/frequently-asked-questions/>>

<sup>10</sup> "Death with Dignity Act - End of Life Washington." End of Life Washington. End of Life Washington, n.d. Web. 12 Feb. 2016, Feb 2019. <<http://endoflifewa.org/dwd/>>

<sup>11</sup> "Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life." Talking to Your Doctor About Act 39, Patient Choice and Control at the End of Life (2014): Compassion & Choices Vermont. Web. <<https://www.compassionandchoices.org/userfiles/Talking-to-Your-Doctor-About-Act-39.pdf>>

<sup>12</sup> Patients Rights Council | Herbert Hendin and Kathleen Foley, "Physician-Assisted Suicide in Oregon: A Medical Perspective, *Michigan Law Review*, Vol. 106:1613 (June 2008), p. 1616.

<sup>13</sup> Patients Rights Council

administer the required insulin. In Oregon, patients with HIV/AIDS, multiple sclerosis, diabetes, viral hepatitis, and a number of other potentially non-terminal conditions ended their lives via this policy.<sup>14</sup>

### **FALLACY 3: “The Request Must Be Voluntary”**

While the bill states that the patient must request suicide voluntarily, the risk of coercion and undue influence is possible in several ways.

#### **Bill Authorizes Heir to Witness Request**

While the bill states that coercion and undue influence are prohibited, it simultaneously allows an heir to serve as a witness for a request for doctor-prescribed suicide. In fact, there is no language in this bill to prevent an heir from serving as a witness- under ‘Declaration of Witnesses’ in the “Maryland Request for Medication for Aid in Dying” form and explicitly authorized in the bill, language specifically allows an heir to be a witness who knows of his or her benefit from the patient’s death, and allows another person to benefit from the patient’s death providing that benefit is merely established after the written request. One of the two of these beneficiaries is allowed to be a relative by blood, marriage, or adoption.

Oregon data show that people regularly request doctor prescribed suicide due to the feeling that they are a burden on friends, family, and/or caregivers (43.7% of patients dying under this policy cited this reason since legalization of the policy).<sup>15</sup> It is unknown how many of these patients would have made a different decision with true compassion or with the absence of coercive pressure.

**Kate Cheney** was a woman diagnosed with terminal cancer and asked for a lethal prescription. Her doctor refused to write a prescription because of questions surrounding her competence due to dementia and referred her to a psychiatrist. The psychiatrist noted Kate Cheney’s short term memory loss and that her daughter seemed much more interested in doctor-prescribed suicide than Cheney did, going so far as noting that, “[Kate] does not seem to be explicitly pushing for this,” and that the patient lacked the, “very high capacity required to weigh options about assisted suicide.” While Kate Cheney seemed to accept the verdict, her daughter did not. A third effort done by Kate’s HMO determined she was capable of making the decision and authorized the writing of the prescription. Later, she went into a nursing home so her family could have a respite from caring for her. After returning home she proclaimed a desire to take the pills.<sup>16</sup> Kate Cheney, a patient with dementia, not only had a caregiver advocating for her death, but one willing to doctor shop until finding a willing doctor. Sadly, it was her own insurance coverage which helped authorize ending her life.

#### **Doctors May Pressure Patients**

The same pressure has been documented from health care providers as well. **Kathryn Judson’s** husband was gravely ill when brought to the doctor. To her shock, she overheard his doctor giving a sales pitch for doctor-prescribed suicide. “Think of what it will spare your wife, we need to think of

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<sup>14</sup> Oregon Public Health Division, *2017 Report on Oregon’s Death with Dignity Act*, released February 9, 2018. The annual reports are available online at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

<sup>15</sup> Ibid. The annual reports are available online at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>

<sup>16</sup> Patients Rights Council | Erin Barnett, “A family struggle: Is Mom capable of choosing to die?” *Oregonian*, October 17, 1999. | Herbert Hendin and Kathleen Foley, “Physician-Assisted Suicide in Oregon: A Medical Perspective,” *Michigan Law Review*, Vol. 106: 1613 (June 2008), p. 1624

her,” she noted the doctor said. They quickly changed physicians and Mrs. Judson’s husband lived another five years. Mrs. Judson was appalled by this treatment and feared leaving him alone with medical professionals again, remarking, “It’s not a good thing, wondering who you can trust in a hospital or clinic.”<sup>17</sup>

The same horror stories have already occurred in Vermont. **Mrs. Neill** was admitted to the Berlin Health and Rehab Center in Vermont for four months. Her daughter, Beth Neill, reports that her caregivers repeatedly reminded her of her ‘right’ to use Act 39 (Vermont’s doctor-prescribed suicide law), going so far as to say, “it is the law” and the patient could “off” herself at any time. The repeated, ceaseless discussions initiated by caregivers after Mrs. Neill expressed she was not interested, caused unwanted pressure on the patient. Interestingly, Mrs. Neill was in generally good health and had no terminal illness. The privilege of a strong, involved family and personal physician opposed to doctor-prescribed suicide helped her to resist the unwarranted pressure.<sup>18</sup>

### **Pain Basis for Only ¼ of Lethal Prescriptions**

Oregon’s data show only about 1 in 4 patients (25.8%) cite inadequate pain control or a concern about it. Despite the image of a patient suffering being the appeal to emotion behind support for this legislation, the evidence does not support it. Only 1 in 4 patients dying from fatal prescriptions cite this, and a notable proportion of these people may merely have been concerned about what may happen in the future, rather than experiencing any improperly controlled pain presently. In fact, this reason is not even in the top five reasons a patient asks for the lethal drugs.

### **Economic Pressure**

Realistically, coercion could arise out of a mere lack of affordable ‘feasible alternatives’. Although the bill requires that the patient be informed of “feasible alternatives and health care treatment options, including palliative care and hospice”, there is no such requirement that any of these alternatives be covered in insurance plans. This particularly hurts those in poverty and anyone without insurance or without enough insurance.

A striking example of coercion highlights precisely why we are opposed to the policy of doctor prescribed suicide generally. In Oregon, **Randy Stroup** and **Barbara Wagner** were each denied treatment they wanted and needed to survive by the Oregon Health Plan (Medicaid) and were informed in the same letter that they could instead “choose” doctor-prescribed suicide, which would be covered.<sup>19</sup> In a program designed to give true dignity to people in poverty through access to healthcare, the very opposite happens- wanted lifesaving treatment is denied because ending the lives of sick people is easier and cheaper than treating them.

**The mere legalization of doctor-prescribed suicide threatens the access to wanted healthcare of everyone in society.** There are surely many more people affected who didn’t have the courage to come forward. Just as this occurred with a public plan, the same can occur in state healthcare exchanges, and with any private insurance plan operating in the state. After all, private health insurance plans have the same, if not more, motivation for profit; eliminating the extent of coverage for treatment because there is a cheaper “option” can unquestionably occur right here in Maryland.

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<sup>17</sup> Patients Rights Council | Letter to editor, “Assisted Suicide? ‘I was afraid to leave my husband alone again with doctors and nurses” *Hawaii Free Press*, February 15, 2011.

<sup>18</sup> Patients Rights Council | “From the Netherlands to Vermont: Patients Under Pressure to Die - True Dignity.” *True Dignity*. True Dignity Vermont, 13 July 2015. Web. 15 Feb. 2016.  
<<http://www.truedignity.org/from-the-netherlands-to-vermont-patients-under-pressure-to-die/>>.

<sup>19</sup> Susan Donaldson James, “Death Drugs Cause Uproar in Oregon,” ABC News, Aug. 6, 2008, and Susan Harding and KATU web staff, “Letter noting assisted suicide raises questions,” July, 30, 2008.

#### **FALLACY 4: “The Patient Must Self-Administer”**

While the bill requires a person to self-administer the fatal drugs, many legal observers argue that this provision is one court challenge away from being overruled. For instance, the Oregon Attorney General’s office has stated that if there is a person with a particular disability which prevents the ability to swallow, the requirement in statute to self-administer is unconstitutionally discriminatory.<sup>20</sup> Realistically, this means lethal injection euthanasia is merely a court challenge away from being legal in Maryland, if this bill would pass.

During the 2019 House of Delegates hearing on this bill, Dr. Michael Strauss, the leading Physician promoting the bill, revealed the bill does permit others to administer the poison testifying:

*“The capsules- by either the patient or a family member – are pulled apart, the powder goes into about four to six ounces of a liquid and the patient ends up consuming the four to six ounces of liquid.” “A physician could be there or a family member could put the powder in a liquid.”*

There are already numerous stories of inappropriate “assistance” provided to patients’ suicide attempts. **Barbara Houck** was diagnosed with Amyotrophic Lateral Sclerosis (ALS or colloquially Lou Gehrig’s Disease). She immediately called Dr. Peter Rasmussen (an assisted suicide supporter) for a prescription which was written a few months later when Dr. Rasmussen thought she was closer to a terminal condition. He was present with her on the day of her death where he emptied the 90 capsules in her lethal prescription into a bowl of chocolate pudding and her two sons spoon fed it to her. She died about twelve hours after being fed because of illegal assistance.

**Patrick Matheny** was only 43 years old when contemplating doctor-prescribed suicide. He, too, had ALS. He set numerous arbitrary deadlines only to see them reached and extended. On March 10, 1999, Matheny tried to swallow the barbiturates mixed into a chocolate nutrition drink, sweetened with a sugar substitute. He reportedly had difficulty swallowing and the only person present — his brother-in-law Joe Hayes — had to “help” him die. Hayes did not disclose how he “helped” his father-in-law die, but he did state, “It doesn’t go smoothly for everyone...For Pat it was a huge problem. It would have not worked without help.”<sup>21</sup>

#### **FALLACY 5: “The State Will Punish Violations”**

There are numerous concerns about the ability of the state to adequately monitor and punish violations of this bill, if it would become law.

##### **Low Liability Standard**

The bill only holds a physician to a “good faith compliance” standard, rather than the higher “malpractice standard” applied to other health providers and to the same physicians in different medical circumstances. When dealing with a policy literally intending to cause death, physicians should be expected to uphold the highest professional standard. There are no do-overs when it comes to fatal prescriptions intended to cause death.

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<sup>20</sup> Letter from Oregon Deputy Attorney General David Schuman to State Senator Neil Bryant, March 15, 1999, “Oregon controversy: How assisted can suicide be?” *American Medical News*, April 12, 1999.

<sup>21</sup> Patients Rights Council | Erin Hoover Barnett, “Dilemma of assisted suicide: When?”, *Oregonian*, January 17, 1999 | Erin Hoover Barnett, “Man with ALS makes up his mind to die,” *Oregonian*, March 11, 2000.

### **Insufficient Reporting Requirement**

While there is a requirement for the Department of Health and Mental Hygiene to promulgate regulations to collect data, the bill is silent on what data must be collected. Data should be collected at least on the points currently collected by Oregon and featured in their annual report. Additionally, there must be means in place to enforce a reporting requirement, one significant reality missing in Oregon.

### **Falsification and Fraud**

Likewise, this bill would mandate, by statute, falsifications of death certificates. The bill mandates that death certificate for an individual using this option would be falsified to state that the individual died of “natural causes”. This prevents any ability to investigate a death or to monitor the frequency and circumstances involved in deaths under this policy. Therefore, when combined with a lack of specific points required in reporting, there could be absolutely no way to know the number of real suicides through this policy in Maryland.

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### **In Conclusion**

Because of the plethora of concerns with this legislation, Maryland Right to Life asks the committees to put patients before profit and support the concerns of people with disabilities, the underinsured and the medically vulnerable by issuing an unfavorable report on this bill.

There are simply too many grave concerns- each in and of itself significant enough to halt pursuing this policy- to correct with a simple amendment. The very policy is so innately flawed that it cannot be implemented as good public policy in Maryland.