



**Written Testimony of Catherine Glenn Foster, M.A., J.D.
President and CEO, Americans United for Life
In Opposition to Senate Bill No. 845
Submitted to the Judicial Proceedings Committee
March 7, 2023**

Dear Chair Smith, Vice-Chair Waldstreicher, and Members of the Committee:

My Name is Catherine Glenn Foster, and I serve as President and CEO at Americans United for Life (“AUL”). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides on end-of-life issues,¹ tracks state bioethics legislation,² and regularly testifies on pro-life legislation in Congress and the states.³ Courts have cited AUL briefs, including the Supreme Court decision in *Washington v. Glucksberg*,⁴ which ruled the federal Due Process Clause does not recognize suicide assistance as a fundamental right, and the Massachusetts Supreme Judicial Court’s recent decision in *Kligler v. Attorney General*, which ruled there is no fundamental right to assisted suicide under the state constitution.⁵ I have litigated end-of-life cases and published scholarship on assisted suicide.⁶ Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

Thank you for the opportunity to testify against Senate Bill No. 845 (“bill”). It is in my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and coercion, the bill’s “safeguard” provisions fail to adequately protect

¹ *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE (last visited Feb. 13, 2023), <https://aul.org/law-and-policy/>.

² *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE (last visited Feb. 13, 2023), <https://aul.org/law-and-policy/state-legislation-tracker/>.

³ See, e.g., *Revoking Your Rights: The Ongoing Crisis in Abortion Care Access Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life); *What’s Next: The Threat to Individual Freedoms in a Post-Roe World Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life).

⁴ 521 U.S. 702, 774 n.13 (1997) (citing Brief for Members of the New York and Washington State Legislatures as *Amicus Curiae*).

⁵ 491 Mass. 38, 40 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical and Dental Associations).

⁶ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51 (2018).

vulnerable end-of-life patients, and the bill erodes the integrity and ethics of the medical profession.

I. *Suicide by Physician Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion*

Individuals living in poverty, the elderly, and those living with disabilities are already exposed to greater risks of abuse, neglect, and coercion. Maryland should be protecting these vulnerable citizens rather than subjecting them to further abuse under S.B. 845.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management. State reports show that patients seek assisted suicide because of the challenges they face living with severe illnesses or disabilities. In 2021, only 26.9% of Oregon patients and 46.0% of Washington patients cited “[i]nadequate pain control, or concern about it” as a reason for choosing suicide by physician.⁷ “[T]he main drivers [of those contemplating suicide by physician] are depression, hopelessness, and fear of loss of autonomy and control. . . .”⁸ Physicians should be helping their patients cope with these feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, physicians are instead encouraging their patients to take their own lives, which opens the door to real abuse.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states with approved suicide by physician, including a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.⁹ In Oregon and Washington, individuals have died by assisted suicide even though they were not terminal ill and did not have the capacity to consent.¹⁰ Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.¹¹ Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms such as written and witnessed requests from patients, attending and consulting physician

⁷ OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13 (Feb. 28, 2022); WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).

⁸ 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/>.

⁹ 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.).

¹⁰ *See* Disability Rights Education & Defense Fund, *Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DREDF, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_edn1 (last visited Mar. 2, 2023).

¹¹ *See Id.*

compliance forms, pharmacy dispensing forms, after-death reporting forms, and death certificates.¹²

There have been similar instances of abuse and coercion in Maryland even though assisted suicide is illegal in the state. In 2014, it was reported that a Maryland doctor had participated in assisted suicide deaths of *non-terminally ill* Maryland residents, three of which had clinical depression.¹³ The state never charged or prosecuted the doctor even though he was involved in 15 assisted suicides in Maryland.¹⁴ These examples from Oregon, Washington, and Maryland, evidence the wide-spread abuse physicians subject their vulnerable end-of-life patients to when assisting in their deaths.

Notably, the Alzheimer’s Association recently terminated its relationship with a prominent assisted-suicide advocacy group, Compassion and Choices.¹⁵ Accordingly, the Alzheimer’s Association issued a press release stating, that Compassion & Choices’ “values are inconsistent with those of the Association. We deeply regret our mistake and have begun the termination of the relationship”¹⁶ The Alzheimer’s Association clarified that it “stands behind people living with Alzheimer’s, their care partners and their health care providers as they navigate treatment and care choices throughout the continuum of the disease. *Research supports a palliative care approach as the highest quality of end-of-life care for individuals with advanced dementia.*”¹⁷

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected the practice of assisted suicide, advocacy groups continue to promote the legalization of physician-assisted suicide. This has led to a “suicide contagion,” or the Werther Effect.¹⁸ Empirical evidence shows that media

¹² Richard Doerflinger, *Lethal Non-Compliance with Washington’s “Death with Dignity Act”*, CHARLOTTE LOZIER INST. (Dec. 20, 2022), <https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/>.

¹³ See Scott Dance, *Maryland Strips Doctor of License for Assisting in Six Suicides*, BALTIMORE SUN (Dec. 30, 2014), <https://www.baltimoresun.com/health/bs-hs-suicide-doctor-20141230-story.html>; See also End-of-Life Option Act (Richard E. Israel and Roger “Pip Moyer Act): Hearing on S.B. 701 Before the S. Comm. on Judicial Proceedings, 2020 Leg., 442nd Sess. (Md. 2020) (written statement of the Legislative Action Committee for the Maryland Psychiatric Society).

¹⁴ *Id.*

¹⁵ Wesley J. Smith, *Alzheimer’s Association Terminates Partnership with Assisted-Suicide Advocacy Group*, NAT’L REV. (Jan. 30, 2023), <https://www.nationalreview.com/corner/alzheimers-association-terminates-partnership-with-assisted-suicide-advocacy-group/>.

¹⁶ *Id.*

¹⁷ *Id.* (emphasis added).

¹⁸ 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/>.

coverage of suicide inspires others to commit suicide as well.¹⁹ Studies have also demonstrated that legalizing suicide by physician in certain states has led to a *rise in overall suicide rates*—assisted and unassisted—in those states.²⁰ After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.²¹ Unfortunately, these effects are even greater for individuals older than 65, which has seen a 14.5% increase in overall suicide rates for that demographic.²² As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.²³

Legalizing suicide by physician is neither “compassionate” nor an appropriate solution for those who may suffer from depression or loss of hope at the end of their lives. S.B. 845 targets these vulnerable individuals and communicates the message that their lives are not worth living. However, individuals living in poverty, the elderly, and those living with disabilities, are indeed worthy of life and are entitled to equal protection under the law, which is why this Committee should reject this bill.

II. *The Bill’s Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although this bill includes so-called “safeguard” provisions, in effect, these protections cannot adequately protect vulnerable end-of-life patients. For example, the bill only requires a physician to refer a patient to a mental health professional for an assessment “if, in the medical opinion of the attending physician or the consulting physician, an individual may be suffering from a condition that is causing impaired judgment or otherwise does not have the capacity to make medical decisions” Yet, even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.²⁴ In Oregon in 2021, for example, assisted suicide physicians prescribed lethal drugs to 383 patients yet only referred two of these patients for counseling—*approximately 0.5% of patients*.²⁵ Further, as of 2021,

¹⁹ See *id.*; see also S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOLOG. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RES. 137 (2004).

²⁰ 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/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf>; see also David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CENTRE (2022), <https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf>.

²¹ *Id.*

²² *Id.*

²³ 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/> (suicide prevention experts criticizing a billboard stating, “My Life My Death My Choice,” which provided a website address, as “irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal”).

²⁴ Glenn Foster, *supra* note 6, at 54.

²⁵ OR. PUB. HEALTH DIV., *supra* note 7, at 8.

Oregon data shows that the median duration of an assisted suicide patient-physician relationship was only five weeks.²⁶ Therefore, if this bill is passed, the likelihood of a Maryland physician referring an end-of life patient to a mental health professional is extremely low, especially when they may have only known the patient for less than five weeks.

The bill also fails to define “impaired judgment,” which means that even if the patient is suffering from depression, that in and of itself does not preclude the patient from being prescribed and utilizing life-ending medication. This is concerning given that scholarship shows “[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms.”²⁷ “[A]round 25–50% of patients who have made requests for assisted suicide showed signs of depression and 2–10% of patients who have received physician-assisted suicide were depressed.”²⁸ These patients’ “desire for hastened death is significantly associated with a diagnosis of major depression.”²⁹ Their psychiatric disability also may impair decision-making, “such as the decision to end one’s life.”³⁰

Moreover, on the off chance that a Maryland physician refers a patient for a mental health assessment, the bill has no requirement that the patient and mental health professional meet more than once. One study has shown, “[o]nly 6% of psychiatrists were very confident that *in a single evaluation* they could assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.”³¹ Nevertheless, under this bill, an individual suffering from depression can be deemed competent to take their own life after only one consultation with a psychologist or psychiatrist. For these reasons, it is difficult to argue that these “safeguards” will allow physicians and mental health professionals to accurately assess an individual’s mental health.

Lastly, the bill assumes that physicians can make the correct diagnosis that a patient has a terminal illness that “will produce a patient’s death within six months.” This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating a patient’s terminal illness life expectancy. As the National Council on Disability notes, “[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months.

²⁶ *Id.* at 13.

²⁷ Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT’L J. L. & PSYCHIATRY 461, 461 (2013).

²⁸ *Id.* at 466; *see also* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Physicians’ Aid in Dying: Cross Sectional Survey*, 337 BMJ 1682 (2008) (finding 25% of surveyed Oregon patients who had requested lethal medication had clinical depression and the “[statute] may not adequately protect all mentally ill patients”).

²⁹ *Id.*

³⁰ *Id.*

³¹ Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996). (emphasis added).

It is common for medical prognoses of a short life expectancy to be wrong.”³² Likewise, “[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival.”³³

Shockingly, studies have shown “experts put the [misdiagnosis] rate at around 40%,”³⁴ and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an “error”³⁵ 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 of their diagnosis.³⁶ Nicholas Christakis, a Harvard professor of sociology and medicine, agreed “doctors often get terminality wrong in determining eligibility for hospice care.”³⁷ In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness, or had a longer life expectancy than six-months.

In sum, the bill’s purported “safeguards” fail to protect vulnerable end-of-life patients, leaving them susceptible to coercion and abuse at the hands of physicians and mental health professionals. H.B. 845 does not give end-of-life patients “control over their deaths,” as some proponents of the bill may argue. Instead, the bill gives physicians the ability to prematurely end their patients’ lives, which directly violates physicians’ Hippocratic Oath “to do no harm.”

III. Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession and Allows for Physicians to Experiment with Lethal Drugs on End-of-Life Patients

Prohibitions on suicide by physician protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, 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.”³⁸ Despite these ethical obligations, physicians are using experimental lethal drugs when assisting in suicide. There is no standardized drug nor required dosage for assisted suicide. “Of course, there is no federally approved drug for which the primary indication is the cessation of the

³² NAT’L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).

³³ *Id.* at 22.

³⁴ 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>.

³⁵ See, e.g., Malcom Curtis, *Doctor Acquitted for Aiding Senior’s Suicide*, THE LOCAL (Apr. 24, 2014), <https://www.thelocal.ch/20140424/swiss-doctor-acquitted-for-aiding-seniors-suicide> (reporting the doctor was not held accountable for his negligence).

³⁶ Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), <http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/>.

³⁷ See *id.*

³⁸ 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).

mental or physical suffering by the termination of life.”³⁹ The Food and Drug Act regulates pharmaceuticals at the federal level and requires “that both ‘safety’ and ‘efficacy’ of a drug for its intended purpose (its ‘indication’) be demonstrated in order to approve the drug for distribution and marketing to the public.”⁴⁰ Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.⁴¹ Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.⁴² As the U.S. Food and Drug Administration (“FDA”) notes on its website, “[c]ompounded drugs are not FDA-approved. *This means that FDA does not review these drugs to evaluate their safety, effectiveness, or quality before they reach patients.*”⁴³ This means physicians have experimented their lethal drug compounds on end-of-life patients with “no government-approved clinical drug trial, and no Institutional Review Board oversight when they prescribed the concoction to patients.”⁴⁴ Notably, the bill is silent as to what drugs doctors must use and there are no safeguards preventing doctors from using experimental lethal drug compounds directly on patients.

Ultimately, S.B. 845 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. Thus, the bill opens the door for physicians to be forced to violate their conscience rights⁴⁵ and medical ethics, such as the Hippocratic Oath, and increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits.

³⁹ Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POLL. & CIV. RTS. L. REV. 323, 339 (2006).

⁴⁰ *Id.* at 340.

⁴¹ Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429–430 (2017).

⁴² See Robert Wood et al., *Attending Physicians Packet*, END OF LIFE WASH. 1, 7 (Apr. 11, 2022), https://endoflifewa.org/wp-content/uploads/2022/04/EOLWA-AP-Packet_4.11.22.pdf (describing suicide doctors’ experiments with different lethal drug compounds).

⁴³ *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), <https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies> (emphasis added).

⁴⁴ Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, THE ATL. (Jan. 22, 2019), <https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/>.

⁴⁵ *Cf. Christian Med. & Dental Ass’ns v. Bonta*, No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022) (issuing a preliminary injunction against California’s requirement that doctors medically document a patient’s lethal drug request, which counts towards the two required drug requests, despite doctors’ conscientious objections to assisting a suicide); *Lacy v. Balderas*, No. 1:22-cv-953 (D.N.M. filed Dec. 14, 2022) (alleging New Mexico provisions that require doctors to tell patients of the availability of suicide assistance and refer for the practice infringe upon conscience rights).

Even the U.S. Supreme Court has acknowledged that “[t]he State also has an interest in protecting the integrity and ethics of the medical profession.”⁴⁶ In Justice Antonin Scalia’s dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, 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.’”⁴⁷ This bill directly contradicts with Maryland’s legitimate interest to protect the integrity and ethics of the medical profession and instead allows physicians to freely violate their ethical obligations, causing lethal harm to their patients with experimental drugs.

IV. *Conclusion*

The majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Since Oregon first legalized the practice in 1996 “about 200 assisted-suicide bills have failed in more than half the states.”⁴⁸ Likewise, this Committee should reject S.B. 845 and continue to uphold its duty to protect the lives of all its citizens—especially vulnerable people groups such as the ill, elderly, and disabled—and maintain the integrity and ethics of the medical profession.

Sincerely,



Catherine Glenn Foster
President and CEO
AMERICANS UNITED FOR LIFE

⁴⁶ *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

⁴⁷ *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

⁴⁸ Foster, *supra* note 6, at 53.