



**Written Testimony of Evangeline Bartz, Esq.
Corporate Counsel & Vice President of Operations, Americans United for Life
Opposing H.B. 399, the End-of-Life Option Act (Richard E. Israel and Roger “Pip” Mover Act)
Submitted to the Health and Government Operations and Judiciary Committees
February 15, 2019**

Dear Chair Pendergrass, Chair Clippinger, Vice Chair Pena-Melnyk, Vice Chair Atterbeary, and Honorable Members of the Committees:

My name is Evangeline Bartz, and I serve as Corporate Counsel & Vice-President of Operations at Americans United for Life (AUL). Established in 1971, Americans United for Life is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. Our vision at AUL is a nation where everyone is welcomed in life and protected in law. In my practice, I specialize in life-related legislation and constitutional law, and in the constitutionality of end-of-life laws specifically. I appreciate the opportunity to submit legal written testimony against Maryland H.B. 399, which would legalize physician-assisted suicide in Maryland.

I have thoroughly reviewed H.B. 399, and it is my opinion that the Act goes against the prevailing consensus that states have a duty to protect life, places already-vulnerable people groups at greater risk, and fails to protect the integrity and ethics of the medical profession.

The Majority of States Affirmatively Prohibit Physician-Assisted Suicide

Currently, the overwhelming majority of states—at least 39 states—affirmatively 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.”¹ 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.”²

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—

¹ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUMAN LIFE REV. 51, 53 (2018).

² 521 U.S. 702, 710 (1997).

are consistent and enduring themes of our philosophical, legal and cultural heritages.”³ Indeed, over twenty years ago, the Court in *Glucksberg* held there is no fundamental right to assisted suicide in the U.S. Constitution, and instead found 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.”⁴

Only by rejecting H.B. 399 can this Committee further Maryland’s important state interest in preserving human life and advance the State’s duty to protect the lives of its citizens, especially the lives of the most vulnerable groups in society.

Physician-Assisted Suicide Places Already-Vulnerable People Groups at Greater Risk

It is critical for Maryland to protect potentially vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and coercion. When considering the risks posed by assisted suicide to all of us, especially these vulnerable people groups, the availability of assisted suicide can be considered neither a compassionate nor an appropriate solution for those who may suffer at the end of life. Many in the bioethics, legal, and medical fields have raised significant questions regarding the existence of abuses and failures in jurisdictions that have approved physician-assisted suicide, which includes a lack of reporting and accountability, coercion, and failure to assure the competency of the requesting patient.⁵ Even the most vulnerable among us, such as the poor, the elderly, the terminally ill, the disabled, and the depressed, are worthy of life and of equal protection under the law, and state prohibitions on assisted 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.”⁶

Physician-Assisted Suicide Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on physician-assisted suicide also protect the integrity and ethics of the medical profession, including its obligation to serve its patients as healers, as well as 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.”⁷ And today, the American Medical

³ *Id.* at 711.

⁴ *Id.* at 729–30.

⁵ J. 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 WASH. STATE DEP’T OF HEALTH, WASHINGTON STATE DEATH WITH DIGNITY ACT REPORT (2018), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2017.pdf> (In 2017, 56% of patients who died after ingesting 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.).

⁶ *Glucksberg*, 521 U.S. at 731–32.

⁷ 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, 131–32 (1973).

Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of their 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.”⁸ In fact, the AMA emphasizes that physicians must “aggressively respond to the needs of the patients” and “respect patient autonomy [and] provide appropriate comfort care and adequate pain control.”⁹

In addition, the U.S. Supreme Court has stated, “[t]he State also has an interest in protecting the integrity and ethics of the medical profession.”¹⁰ 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.’”¹¹

“Safeguards” Do Not Always Work

Despite the so-called “safeguards,” opening the door for physician-assisted suicide also opens the door to real abuse. For example, H.B. 399 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 would satisfy the two-witness requirement, easily circumventing the alleged safeguard designed to protect the patient from pressure, coercion, or abuse.

One need only look to the Netherlands and Belgium to see how this plays out. A report commissioned by the Dutch government demonstrated that more than half of assisted suicide- and euthanasia-related deaths were involuntary in the year studied.¹² At least half of Dutch physicians actively suggest euthanasia to their patients.¹³ Another study showed that out of 1,265 nurses questioned, 120 of them (almost 10 percent) reported that their last patient was involuntarily euthanized.¹⁴ But only four percent of nurses involved in involuntary euthanasia reported that the patient had ever expressed his or

⁸AMA 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>.

⁹ *Id.*

¹⁰ *Glucksberg*, 521 U.S. at 731.

¹¹ *Gonzales v. Oregon*, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

¹²See W.J. Smith, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 118–19 (2003) (citing the Dutch government’s *Remmelink Report* documenting euthanasia results in the Netherlands).

¹³ See *id.* at 119 (citing R. Fenigsen, *Report of the Dutch Government Committee on Euthanasia*, 7 ISSUES LAW & MED. 239 (Nov. 1991); *Special Report from the Netherlands*, N.E.J.M. 1699-711 (1996)).

¹⁴ E. Inghelbrecht et al., *The Role of Nurses in Physician-Assisted Deaths in Belgium*, CAN. MED. ASSN. J. (June 15, 2010).

her wishes about euthanasia. Most of the patients euthanized without consent were over 80 years old, reaffirming the fact that assisted suicide and euthanasia quickly lead to elder abuse.

Another example of the unreliability of these “safeguards” is the requirement for mental health assessments. H.B. 399 requires the consulting physician refer the individual for a mental health assessment if he or she thinks the individual “may be suffering from a condition that is causing impaired judgment or otherwise does not have the capacity to make medical decisions.” However, as the most recent statistics from Oregon show, only five of the 143 patients who died from ingesting end-of-life drugs in 2017 were ever referred for a psychiatric evaluation.¹⁵ 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.”¹⁶ But without a requirement the mental health professional see the individual more than once, it is difficult to argue this “safeguard” in H.B. 399 will accurately assess an individual’s competency.

In conclusion, Maryland should reject physician-assisted suicide 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 by rejecting H.B. 399. Thank you.

For further information, please contact me or Catherine Glenn Foster, Esq., President & CEO of Americans United for Life and Maryland resident, at (202) 289-1478

Sincerely,



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Americans United for Life

¹⁵ Or. Health Auth. Pub. Health Div., OREGON DEATH WITH DIGNITY ACT 2017 DATA SUMMARY (Feb. 9, 2018) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf> (last visited Feb. 14, 2019).

¹⁶ 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>.