Americans United for Life

Written Testimony of Danielle Pimentel
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In Opposition to Senate Bill 443
Submitted to Senate Judicial Proceedings Committee
February 8, 2024

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

My name is Danielle Pimentel, and I serve as Policy Counsel 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,[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] 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 443 ("S.B. 443"). It is my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and

[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 7, 2024). AUL is the original drafter of many of the hundreds of pro-life bills enacted in the States in recent years. *See* Olga Khazan, *Planning the End of Abortion*, ATLANTIC (July 16, 2020), www.theatlantic.com/politics/archive/2015/07/what-pro-life-activists-really-want/398297/ ("State legislatures have enacted a slew of abortion restrictions in recent years. Americans United for Life wrote most of them."); *see also* Anne Ryman & Matt Wynn, *For Anti-Abortion Activists, Success of 'Heartbeat' Bills was 10 Years in the Making*, CTR. PUB. INTEGRITY (Jun. 20, 2019), https://publicintegrity.org/politics/state-politics/copy-paste-legislate/for-anti-abortion-activists-success-of-heartbeat-bills-was-10-years-in-the-making/ ("The *USA TODAY/Arizona Republic* analysis found Americans United for Life was behind the bulk of the more than 400 copycat [anti-]abortion bills introduced in 41 states.").

[2] *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 6, 2024).

[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).

coercion, the bill's "safeguards" fail to adequately protect 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 additional abuse under S.B. 443. If enacted, not only would the bill perpetuate false narratives about assisted suicide and its impact on vulnerable persons, but it would also promote both ableism and ageism.

Contrary to the prevailing cultural narrative, patients are not considering suicide by physician for pain management reasons. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control" or just *concern* about inadequate pain control as a reason for choosing suicide by physician.[6] Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington).
- Losing autonomy (86.3% in Oregon, 83.0% in Washington).
- Loss of dignity (61.9% in Oregon, 69.0% in Washington).
- Burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington).
- Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[7]

Physicians should ensure that their patients receive the best palliative care and help them cope with feelings of hopelessness and depression after receiving a difficult diagnosis. Yet, in states that have legalized assisted suicide, vulnerable patients are being encouraged to take their own lives, which opens the door to real abuse, especially for the elderly and those with disabilities.

Many professionals in the bioethics, legal, and medical fields have acknowledged the existence of abuses and failures in states which have decriminalized suicide by physician. These include a lack of reporting and accountability, coercion, and failure to ensure the competency of the requesting patient.[8] In Oregon and Washington, individuals have died by assisted suicide even though they were not terminally ill and did not have the capacity to

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[6] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9, 14 (Mar. 8, 2023); WASH. DISEASE CONTROL & HEALTH STATS., 2022 DEATH WITH DIGNITY ACT REPORT 7 (June 2, 2023).

[7] *Id*.

[8] 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.).

consent.[9] Some individuals seeking assisted suicide were never referred to mental health professionals despite having medical histories of depression and suicide attempts.[10] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[11] These examples from Oregon and Washington evidence the wide-spread abuse vulnerable end-of-life patients face when considering to engage in assisted suicide.

Notably, in November 2023, the American Medical Association (AMA) affirmed its opposition to assisted suicide and euthanasia.[12] The current policy will remain in place, which states,

> [e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.[13]

The AMA also refused to change the term "assisted suicide" to the misleading and inaccurate euphemism, "medical aid in dying."[14]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, advocacy groups continue to promote its legalization. This has led to a "suicide contagion," or the Werther Effect.[15] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[16] One study demonstrates that legalizing suicide by physician in certain states has

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[9] *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 Feb. 7, 2024).
[10] *See Id*.
[11] 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/.
[12] Wesley J. Smith, *AMA Retains Policy Against Assisted Suicide*, NAT'L REV. (Nov. 13, 2023), https://www.nationalreview.com/corner/ama-retains-policy-against-assisted-suicide/.
[13] American Medical Association, *CEJA Report B – A-91 Decisions Near the End of Life*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/5.8%20Euthanasia%20--%20background%20reports.pdf (last visited Feb. 6, 2024).
[14] Smith, *supra* note 12.
[15] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOV'T (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/.
[16] *See id*.; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RSCH. 137 (2004).

led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[17] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[18] 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.[19] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[20]

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. 443 targets these vulnerable individuals and communicates the message that their lives are not worth living simply because of their physical or mental disability, illness, or age. However, these individuals are worthy of life and are entitled to equal protection under the law, which is why this Committee should reject this bill.

II. *S.B. 443's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients*

Although the bill includes so-called "safeguards," in effect, these provisions cannot adequately protect vulnerable end-of-life patients. For example, under § 5–6A–06, a physician is only required to refer a patient to a mental health professional, if the physician believes the "individual may be suffering from a condition that is causing impaired judgement or otherwise does not have the capacity to make medical decisions." Yet, counseling referrals for patients considering assisted suicide are astonishingly rare.[21] In Oregon in 2022, for example, assisted suicide physicians prescribed lethal drugs to 431 patients yet only referred three of these patients for counseling—*approximately 0.7% of patients*.[22]

Additionally, although the bill requires the attending physician to have "primary responsibility for the medical care" of the patient, the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[23] The short duration of these relationships raises serious concerns as to whether a physician can accurately determine the capacity of the patient. Accordingly, if the bill is passed, the

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[17] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (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.

[18] Jones & Paton, *supra* note 17, at 601.

[19] *Id*. at 603.

[20] *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").

[21] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 6, at 14.

[22] *Id*. at 9.

[23] *Id.* at 14.

likelihood of a Maryland physician referring an end-of life patient for an evaluation is extremely low, especially when the physician may have only known the patient for less than five weeks.

The lack of counseling referrals for vulnerable end-of-life patients is gravely concerning. Scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[24] "[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."[25] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[26] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[27]

Moreover, on the off chance that a Maryland physician refers a patient to a mental health professional for an assessment, the bill has no requirement that the patient and mental health professional meet more than once. In § 5–6A–01 (M), the bill defines "mental health professional assessment" as "one or more consultations between an individual and a licensed mental health professional." This means that a psychologist or psychiatrist just needs to meet with the patient once before that patient can be deemed competent to end their own life. This raises serious informed consent issues because healthcare professionals have limited abilities to diagnose mental health issues when evaluating referred patients considering assisted suicide. As 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."[28] Nevertheless, under the bill, an individual suffering from depression can be deemed competent to take their own life after one meeting with a mental health professional. For these reasons, it is difficult to argue that any of these alleged "safeguards" will allow medical providers, or mental health professionals to accurately assess an individual's mental health and whether they have the requisite "capacity."

Lastly, the bill assumes that physicians can correctly diagnose a patient with a "terminal condition." Under § 5–6A–04, the bill requires the attending physician to determine if the patient is a "qualified individual," *i.e.*, the individual has a terminal illness that will result in the 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 the life expectancy of a terminally ill patient. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed

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[24] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).
[25] *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").
[26] *Id*.
[27] *Id*.
[28] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996) (emphasis added).

as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[29] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[30]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[31] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[32] 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 prognosis.[33] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[34] In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness or would have outlived a six months life expectancy.

In sum, these purported "safeguards" fail to protect vulnerable end-of-life patients. The bill leaves patients susceptible to coercion and abuse by family members and caregivers, and does not—and cannot—ensure patients have given their informed consent to die through medicalized suicide. S.B. 443 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 unfettered ability to prematurely end their patients' lives in direct violation of their Hippocratic Oath "to do no harm."

III. *Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession*

Prohibitions on physician-assisted suicide 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."[35] 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. "[T]here is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[36] 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

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[29] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).
[30] *Id*. at 22.
[31] 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.
[32] *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).
[33] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[34] *See id.*
[35] 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).
[36] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POL. & CIV. RTS. L. REV. 323, 339 (2006).

demonstrated in order to approve the drug for distribution and marketing to the public."[37] Assisted suicide medication could never meet the safety or efficacy requirements for treating mental or physical ailments, because it is treating an individual's health condition with a lethal drug overdose.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.[38] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[39] 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*."[40] Consequently, 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."[41]

Under § 5–6A–04 (C), the bill only requires the attending physician to inform the patient of the risks with taking the lethal drugs and the "probable result of self-administering the medication to be prescribed for aid in dying." However, the bill does not require that the physician inform the patient that such medication is *experimental* and not approved by the FDA. Furthermore, the bill is silent as to what drugs doctors must use and there are absolutely no safeguards preventing doctors from using experimental lethal drug compounds directly on patients. This is one of the many informed consent issues in the bill because the patient may not understand that she is agreeing to an experimental overdose that is not FDA approved, has not undergone clinical drug trials, and has virtually no oversight from the government or medical institutions.

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."[42] 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: "[v]irtually 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.'"[43] The bill directly

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[37] *Id*. at 340.
[38] Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429– 430 (2017).
[39] *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).
[40] *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).
[41] 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/.
[42] Washington v. Glucksberg, 521 U.S. 702, 731 (1997).
[43] Gonzales v. Oregon, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

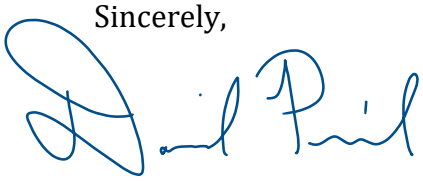
contradicts Maryland's legitimate interest in protecting the integrity and ethics of the medical profession. Instead, the bill allows physicians to freely violate their ethical obligations and cause lethal harm to their patients through experimental drugs.

Consequently, S.B. 443 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. The bill opens the door for physicians to be forced to violate 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.

IV. *Conclusion*

Physician-assisted suicide is not healthcare. Instead, it acts as a limited exception to homicide liability under state law and allows physicians to use experimental drugs directly upon patients without FDA approval nor clinical trials. Accordingly, 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 more than "200 assisted-suicide bill have failed in more than half the states."[44] Likewise, this Committee should reject S.B. 443 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,



Danielle Pimentel
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AMERICANS UNITED FOR LIFE

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