Bigger fight against assisted suicide in Maryland expected in 2016

By Erik Zygmont

ezygmont@CatholicReview.org

It never emerged from committee for a vote last year, but the push to legalize doctor-assisted suicide in Maryland is back, as proponents and opponents alike are gearing up for a battle over a bill that would allow terminal patients to obtain lethal doses of medication.

Per the text of last year's bill – which could be modified before or during the state's 2016 legislative session that starts Jan. 13 – an adult Maryland resident determined by his or her doctor and confirmed by a second doctor to have a terminal illness with a prognosis of death within six months may request lethal medication.

Notification of a family member is not required. The patient would pick up the drug – likely up to 100 individual pills of secobarbital – and ingest it at his or her discretion, with no requirement that a doctor be present.

Catholics and non-Catholics oppose assisted suicide for a variety of moral and practical reasons.

The Catholic Church opposes assisted suicide – which proponents prefer to call "death with dignity" or "aid in dying" – because it runs counter to the dignity and inherent worth of life, from conception to natural death.

Timeline on death

Many have noted the pitfalls of assigning a number to a terminal patient's remaining time.

"I can't predict how long somebody's going to live," admitted Dr. Sam Ross, who

began his medical career as a family physician before eventually becoming CEO of Bon Secours Baltimore Health System.

“We can’t even tell (exactly) when somebody’s going to have a baby,” Ross said, speaking at a discussion against assisted suicide hosted Nov. 16 by the Central Baptist Church of Baltimore.

Archbishop William E. Lori has spoken about the terminal diagnosis of his friend Monsignor Arthur F. Valenzano, 24th rector of the Basilica of the National Shrine of the Assumption of the Blessed Virgin Mary in Baltimore. He died Sept. 5, fighting his battle with leukemia far longer than doctors had predicted.

“He beat the odds,” Archbishop Lori told members of Bethel A.M.E. Church in Baltimore Nov. 8, when he preached there as a guest. The archbishop added that Monsignor Valenzano had made good use of his remaining time, managing to “touch a great number of people” and “bring them to Christ.”

According to Samantha Crane, legal director and director of public policy for the Autistic Self Advocacy Network, assisted suicide bills, including Maryland’s, are murky about what exactly constitutes a six-month prognosis. A patient, she said, might be deemed to die within six months with “ordinary” medical intervention, whereas that patient could survive much longer with “extraordinary” intervention. The most recent version of Maryland’s bill mentions no distinction, but simply requires an affirmation that the illness “will, more likely than not, result in death within six months.”

Quality of life, and depression

The terms “ordinary” and “extraordinary” can be subjective, Crane added.

A person who has never lived with a disability might see a ventilator or feeding tube as a deal-breaker, “and they’ll be making the decision without the input of people who have lived every day with such an intervention.”

The two terms also point to a larger issue regarding quality of life and who should determine it. While people with autism are not considered “terminal” due to autism alone, Crane said, many who suffer from it also have other conditions.

When one condition compounds a pre-existing condition or disability, “it is assumed that (the patient) has a lower quality of life” and, consequently, “they don’t receive the same quality of life-sustaining care that a person without a disability might expect,” said Crane, who testified against the bill last year.

A patient with a condition resulting in progressive mobility impairments, such as multiple sclerosis, could eventually need respiratory support.

“They can continue to live for many more years,” Crane said, noting that the bill does not address such situations, though it does offer a less expensive but lethal option for a population she says already experiences disparity in health care.

Opponents also note that the bill does not automatically require a screening for depression. It does require the patient’s doctor, and the second doctor who signs off on the request for lethal medication, to refer the patient for a competency evaluation if in their “medical opinion” he or she “may be suffering from a condition that is causing impaired judgment or is otherwise not competent.”

Anya Naegele, associate director of the Respect for Life branch of the Maryland Catholic Conference, argued that depression is such a condition and likely to be a factor in a patient’s decision-making. “Often, the news that you have six months to live – that could be a trigger for some depression or psychological problems,” she said.

Opponents of assisted suicide also wonder if its growing acceptance changes the way society views depression.

“When depression gives rise to a desire to end life, it’s not seen as depression,” Crane noted. “It’s seen as a rational choice to end life.”

Coercion and the almighty dollar

The bill requires that patients be “acting voluntarily and not being coerced to sign the written request” for lethal medication, but Elena Boisvert, an elder law attorney, says that she serves elderly people who have been coerced into signing something all the time.

She said that elderly people more often than not rely on others to help them make important decisions.

“When they visit me, they’re always accompanied by one family member,” Boisvert noted, adding that the influence that a son or daughter has on an elderly parent “can’t be analyzed, especially if it’s not a longstanding relationship between the doctor and patient.”

Legal assisted suicide, Boisvert said, could be “just another tool the (financial) abusers will use.”

Even absent the scheming – conscious or rationalized – of a family member, opponents argue that money will (and has) held undue influence in the decision to end a life.

“Lethal drugs are much, much cheaper than probably the majority of life-sustaining treatments for the majority of life-threatening illnesses,” Naegele said. “Patients have been denied these while being advised that they were covered for lethal medication.”

According to figures kept by the state of Oregon, the first state to legalize physician-assisted suicide in 1997, 27 of the 859 who have ended their lives by ingesting lethal medication cited “financial implications of treatment as an “end-of-life concern.”

Per the Maryland bill, statistics may be nonexistent. Death certificates will be recorded with the underlying condition, rather than the lethal medication, listed as the cause of death.

Also see:

O.J. Brigance leads opposition to assisted-suicide bill

Playing God Part 3: Do no harm? End-of-life ethics in a ‘death with dignity’ culture

For more information, visit stopassistedsuicidemd.org

TIMELINE

1992 – California voters reject legislation in favor of assisted suicide by 54 percent.

1994 – Oregon voters approve by 51 percent, but a legal battle delays enactment of the law. Washington voters reject by 51 percent.

1997 – Oregon becomes first state to legalize when voters reject measure to repeal assisted suicide by 60 percent.

1999 – Gov. Parris N. Glendening signs into law a bill banning assisted suicide in Maryland.

2008 – Washington voters approve by 58 percent.

2009 – Montana Supreme Court rules assisted suicide allowed under privacy and dignity provisions of state's constitution.

2012 – Massachusetts voters reject by 51 percent.

2013 – Vermont enacts through legislature.

2014 – Legalized through courts in New Mexico's Bernalillo County.

2015 – Twenty-eight state legislatures weigh assisted suicide bills. California enacts.

Sources: American Life League, Death with Dignity National Center, Compassion and Choices, Casebriefs