Research Brief
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Knee on the Neck: Assisted Suicide and the African-American Experience in Maryland

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KEY TAKEAWAYS
Adopting physician-assisted suicide (PAS) in Maryland raises the concerning prospect that the inequalities that deny equal care to black Marylanders could also lead to directly hastening their deaths.
PAS in Maryland will empower the small number of doctors with the least principled objections to prescribing toxic medication, and potentially those most prone to racial prejudice and animus.
PAS would exacerbate invidious racial disparities; perpetuate internalized black inferiority; and undermine the unique role of pastors and churches to anchor self-worth at the end of life, to the detriment of black lives and dignity.

Executive Summary

Despite advances over the past generation, African-Americans in Maryland continue to face unacceptable inequalities in health care. Health decisions made on their behalf, and sometimes even made by African-Americans themselves, reflect both conscious and unconscious discrimination that values the lives of persons of color less than that of other racial groups.

The possibility of physician-assisted suicide (PAS) in Maryland raises the concerning prospect that the inequalities that deny equal care to black Marylanders could also lead to directly hastening their deaths. Despite the best intentions of the medical establishment, the health care system would be able not merely to withhold equal care, but also to unequally authorize death itself—to put its knee on the neck—of Maryland African-Americans facing difficult and life-threatening medical circumstances.

African-Americans have good reason to be suspicious of physicians evaluating their lives fairly.

In their powerful analysis "Lessons for Physician-Assisted Suicide from the African-American Experience," Georgetown University professors King and Wolf clearly

state why African-Americans should have reasonable reservations about physicians deciding or influencing when they should die:

> Not only have African-Americans experienced disrespect for their autonomy, they have suffered injustice in medicine as well as in the broader society. As a group, blacks have been abused, neglected, and exploited. They have reason to believe that their lives are not valued in the same way as whites, and in their encounters with the health care system they frequently perceive that they are treated differently solely because of their race. African-Americans have reason to be suspicious of physicians and rightly worry about giving them too much authority.

In addition to "blacks' distrust of physicians, medical institutions, and the health care system generally," King and Wolf note, African-Americans as a group are distinct from other Americans in terms of stronger religious commitment and "cultural characteristics like trusting families more than physicians."[1] Discriminatory treatment by hospitals under Jim Crow, eugenics-based sterilization campaigns, and numerous damaging prejudices by the government show how much reason there is for these suspicions, which are reinforced by the widespread financial incentives – both public and private – to discontinue care of expensive or impoverished payments by any means necessary.

African-Americans in Maryland suffer persistent inequality in health care treatment and outcomes

Despite improvement in other areas, African-Americans in Maryland continue to face persistent inequities—whether by design or systemic neglect—which continue to affect care. In a number of areas, racial disparities have grown worse, not better, over the last decade. Here are just a few out of many facts that could be cited to exemplify this sad truth.

- For all forms of cancer, the Maryland cancer mortality rate for black persons is higher than that of white persons. This is true despite the fact that black persons are less likely than white persons to contract cancer in the first place. In the latest available data (2018), the black cancer mortality rate was 16 percentage points higher than the white mortality rate, and the race differential in cancer mortality had increased over the past five years.[2] Terminal cancer prognosis is one of the most common conditions cited to justify PAS.

- The Maryland mortality rate for black infants in the first year of life (9.8 per 1,000) was 2.6 times higher than that of white infants (3.7 per 1,000) and 1.8 times higher than that of Hispanic infants (5.3 per 1,000), according to the most recent data from the Maryland Department of Health.[3]

- The March of Dimes reports: "The preterm birth rate among babies born to Black birthing people is 1.4x higher than the rate among all other babies." The 2024

March of Dimes Report Card for the State of Maternal and Infant Health gives Maryland a grade of C-minus, largely due to the high disparity in perinatal health care outcomes for black births.

- Pregnancy-related deaths (maternal mortality) among black mothers in Maryland is twice as high as among white mothers, according to the latest (2022) Maryland Maternal Mortality Review. The Review comments that this difference "illustrat[es] the persistent racial disparity in these rates in Maryland."

- The proportion of black persons among physicians in Maryland (12.2%) is 2.5 times less than the proportion of black persons in the Maryland population (30%).[4] This large disparity reenforces suspicion of systemic racial discrimination among health care providers.

- Nationally, over half (52%) of black U.S. adults report that "racism is a major problem in U.S. healthcare," per the Kaiser Family Foundation's most recent (2024) Survey on Racism, Discrimination and Health.[5] To the question, "How much of the time do you think you can trust doctors and other health care providers to do what is right for you or your community?" almost one in three black persons (32%) responded "never" or "only some of the time." This level of distrust of doctors is gradated by skin tone, from 25% of black persons with a light or very light skin tone to 36% of those with a dark or very dark skin tone.[6]

PAS perpetuates the false and destructive myth of racial inferiority that has historically diminished black self-worth.

African-Americans' self-assessment of their own human worth has often been diminished, and would be diminished further through PAS, by invidious racial stereotypes. King and Wolf write:

> The myth of white superiority persists and has profoundly affected both whites and blacks. As Professor Charles Lawrence notes, "We do not recognize the ways in which our [shared] cultural experience has influenced our beliefs about race or the occasions on which those beliefs affect our actions. "Stereotypes that capture and reflect negative attitudes towards African-Americans flourish and become embedded in the culture to the point where they may not be consciously noticed. . . . Feelings of inferiority and unworthiness are among the psychic injuries inflicted on blacks. As a result, in addition to all the disadvantages that blacks suffer, they carry the additional burden of not always appreciating their own worth as human beings. As Herbert Nickens points out, "such stigma is never far from consciousness for minorities and is one of the lenses through which life is perceived."[7]

Despite the best intentions of all concerned, the decisions of black patients to die rather than continue their life in difficult circumstances would inescapably often be made through the lens of supposed inferiority.

PAS exacerbates racial disparities by empowering the few, potentially most racist, doctors willing to prescribe death.

In states that have legalized PAS, very few doctors have been willing to prescribe death for their patients. The cautionary example of Oregon, the first state to enact PAS laws, is instructive on this point. Despite being legal, the vast majority of physicians in Oregon are either unwilling or unable to facilitate patients' deaths. In 2022, of Oregon's 13,000 active physicians, only 146 (one-hundredth of one percent) actually wrote death prescriptions. Just one fifth of that number (22%; 32 doctors) accounted for three-fifths (60%) of the death prescriptions. A single doctor wrote 51 death prescriptions, 12% of the total.[8]

This concentration of PAS practice in just a small number of physicians reflects the principled opposition of most physicians to PAS - evidenced by the American Medical Association's opposition to PAS and the Maryland Medical Association's refusal to support the law in Maryland.

If the Maryland experience is like that of Oregon, the implementation of PAS will exacerbate the racial disparities presented above. Rather than benefitting end-of-life health care generally, and despite most physicians' desire to help their patients irrespective of race, the opportunities for fatal racial discrimination are immense. PAS in Maryland will empower the small number of doctors with the least principled objections to prescribing toxic medication, and potentially those most prone to racial prejudice and animus.

There is nothing random about which doctors will prescribe death, it's those willing that *some* group of people should die. Whether that group is defined by physical condition, psychological health, age, wealth, – or race – the result is the same. All suicide prescriptions carry the same lack of protection for the most vulnerable. If there are any sufficiently racist doctors, they will naturally become suicide prescribers – selecting, and perhaps even encouraging Black patients to receive a death prescription.

PAS pushes aside black pastors and churches in favor of doctors and hospitals

Faith in God pervades the lives of black Americans more strongly than any other racial group. Medical professionals, on the other hand, are less religious than most groups of Americans, and tend to be far less religious than black Americans. Black Americans' faith that they have been uniquely created and loved by God and are each vested with infinite value, sustains their dignity and self-worth in an adverse social context that can often suggest otherwise.

When black Marylanders are faced with difficult health decisions about the value of life, a state-instituted PAS program inevitably places a hand on the scale against the influence of pastors and family who share the patient's values and in favor of the views of physicians who do not. Belief that life is worth living in the face of suffering is already difficult when there is no choice. When presented with a suggestion, recommendation or prescription for death from a medical figure, trained to see the suffering person primarily as a "patient" or "case," such a belief is even more difficult. This in turn, undermines the influence of contrary spiritual pleas from pastors and family who see the suffering person as a beloved child of God.

New York 1990s: PAS rejected due to "extraordinary risks" for stigmatized minorities

In response to an early debate over PAS, Governor Mario Cuomo of New York empaneled a Task Force on Life and the Law ("Task Force"), composed of distinguished medical and ethical authorities in that state, to study the issue in the early 1990s. After extensive consideration of the arguments for and against PAS, the Task Force issued a final book-length report in 1997 which offered several reasons that PAS would not constitute sound social policy.

The Task Force concluded that "we can do far more to benefit [terminally ill] patients by improving pain relief and palliative care than by changing to law to make it easier to commit suicide or to obtain a lethal injection."[9] Instead of PAS, in 1998 New York amended laws to facilitate greater use of medication to control pain and improve palliative care, which remains the policy in that state to this day.

The Task Force members unanimously concluded that

> legalizing assisted suicide and euthanasia would pose profound risks to many patients. … No matter how carefully any guidelines for PAS are framed, the practice will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society.

Thus the

> practices [of PAS and euthanasia] would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would be most severe for those whose autonomy and well-being are already compromised by … membership in a stigmatized social group.[10]

"The risks of legalizing assisted suicide and euthanasia for these individuals," they added, "in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary." [11]

The reasons given by New York—a progressive state with similar norms and culture to those of Maryland—for foregoing PAS were not ideological or religious, but recognized the practical and operational obstacles to ensuring that a PAS policy was administered fairly and effectively. The Task Force noted, for example, the,

> impossibility of developing effective regulation. Clinical safeguards proposed to prevent abuse and errors are unlikely to be realized in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behavior to prevent mistake and abuse.

CONCLUSION

The potential damage from PAS due to racial disparities is smaller in New York, where African-Americans make up only 18% of the population, than in Maryland, where nearly a third (32% by the most recent census) of the population is black and the proportion is growing. African-Americans in Maryland already face large and persistent disparities in health care treatment and outcomes.

Reflection and analysis yield good reasons to believe that PAS would not relieve, but exacerbate, these invidious racial disparities; perpetuate internalized black inferiority; and undermine the unique role of pastors and churches to anchor self-worth at the end of life, to the detriment of black lives and dignity. Whatever more recent decisions New York may have made about PAS, they were right to reject it in the 1990s due to unacceptable risks for their black citizens. The state of Maryland would also be right, prudent and wise to reject PAS—to refuse to place the knee of unfair death on the neck of its black population--on the same grounds today.

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ENDNOTES:

[1] Patricia A. King and Leslie E. Wolf, "Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience," *Minn. L. Rev.* 82 (1997): 1023.
[2] 2021 Cancer Data, reporting on surveillance from the federal Centers for Disease Control (CDC), by the Maryland Department of Health, available at https://health.maryland.gov/phpa/cancer/Documents/2021%20CRF%20Cancer%20Report_FINAL.pdf
[3] Maryland Vital Statistics Report released July 2023, available at https://health.maryland.gov/vsa/Documents/Reports%20and%20Data/Infant%20Mortality/InfantMortalityAnnualReport_2021_Final.pdf
[4] See https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard .
[5] Reported at https://www.kff.org/health-information-trust/racism-discrimination-health-views-on-racism-and-trust-in-institutions/
[6] See https://www.kff.org/health-information-trust/racism-discrimination-health-views-on-racism-and-trust-in-institutions/#8007c4bb-82f8-4d81-b216-e7e94b4310f4, Figures 2 and 8.
[7] King and Wolf, "Empowering and Protecting Patients," 1024.
[8] Oregon Department of Health, "Oregon Death With Dignity Act Data Summary 2024", p. 11, available at https://www.oregon.gov/OHA/PH/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/index.aspx
[9] New York State Task Force on Life and the Law, *When Death Is Sought*, ix.
[10] New York State Task Force on Life and the Law, *When Death Is Sought*, xii.
[11] New York State Task Force on Life and the Law, *When Death Is Sought : Assisted Suicide and Euthanasia in the Medical Context* (New York, N.Y. : New York State Task Force on Life and the Law, 2000), vii–viii, http://archive.org/details/whendeathissough0000newy_h9k5.