Written Testimony of Jesse Southerland
Federal Policy Director, Americans United for Life
In Opposition to Senate Bill 280
Submitted to Education and Health Sub-Committee
January 23, 2024

Dear Chair Favola, and Members of the Committee:

My name is Jesse Southerland, and I serve as Federal Policy Director 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 280 ("S.B. 280"). It is my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited May 4, 2023). 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 Jan. 22, 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).

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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. Virginia should be protecting these vulnerable citizens rather than subjecting them to additional abuse under S.B. 280. 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, the Alzheimer's Association recently terminated its relationship with a prominent assisted-suicide advocacy group, Compassion & Choices.[12] 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 . . . ."[13] 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*."[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] Studies have demonstrated that legalizing suicide by physician in certain states has led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[17] After

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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 Mar. 2, 2023).

[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, *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/.

[13] *Id*.

[14] *Id*. (emphasis added).

[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).

[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

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. 280 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. 280'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 § 54.1-2999.1(C)(2), a physician is only required to refer a patient to a "capacity reviewer," if the provider is "uncertain as to whether he is capable of making an informed decision regarding consent to medical aid in dying." 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, even though the bill requires that the attending health care provider have a "practitioner-patient relationship" with the patient prior to the patient's request for lethal drugs, this phrase is left undefined. Thus, it is unclear what constitutes as a prior "practitioner-patient relationship" under the bill. This is problematic given the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[23] Accordingly, if the bill is passed, the likelihood of a Virginia physician or nurse practitioner referring an end-of life patient for an evaluation is extremely low, especially when the physician or nurse practitioner may have only known the patient for less than five weeks.

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.

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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 Virginia physician or nurse practitioner refers a patient for a mental health evaluation, the bill has no requirement that the patient and mental health professional meet more than once. In §54.1-2999.1 (C)(2), the bill merely states that the "provider shall refer the patient to a capacity reviewer for the purpose of determining whether the patient is a qualifying patient." This means that a psychologist or social worker 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 "capacity reviewer." For these reasons, it is difficult to argue that any of these alleged "safeguards" will allow physicians, nurse practitioners, or mental health professionals to accurately assess an individual's mental health and that they are "mentally capable."

Lastly, the bill assumes that physicians and nurse practitioners can make the correct diagnosis that a patient has a "terminal condition." Notably, the phrase "terminal condition" is left undefined in the bill.[29] Yet, under § 54.1-2999.1 (C)(1), the bill requires the attending health care provider to determine if the patient has a terminal condition. 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 as terminally ill will die within 6 months. It is common for medical

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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).
[29] Even though the bill uses the phrase "terminal condition" throughout the text, the bill does not define the phrase. However, the bill does include a definition for "terminal *disease*," although this phrase only appears in the definitions section of the bill.

prognoses of a short life expectancy to be wrong."[30] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[31]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[32] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[33] 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.[34] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[35] 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. 280 does not give end-of-life patients "control over their deaths," as some proponents of these bill may argue. Instead, the bill gives physicians and nurse practitioners 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."[36] 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."[37] 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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[30] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).
[31] *Id*. at 22.
[32] 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.
[33] *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).
[34] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[35] *See id.*
[36] 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).
[37] 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).

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demonstrated in order to approve the drug for distribution and marketing to the public."[38] 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.[39] Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.[40] 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*."[41] 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."[42]

Under § 54.1-2999.1 (C)(5), the bill only requires an attending health care provider to inform the patient of the risks with taking the lethal drugs, the risk that "more or less time may elapse between the time the patient takes" the drugs and their death, and the "risks and benefits of having another person present when the patient takes the [lethal drugs]." However, the bill does not require that the attending health care provider 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."[43] 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

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[38] *Id*. at 340.

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

[40] *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).

[41] *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).

[42] 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/.

[43] Washington v. Glucksberg, 521 U.S. 702, 731 (1997).

fundamentally incompatible with the physician's role as healer.'"[44] The bill directly contradicts Virginia's legitimate interest in protecting the integrity and ethics of the medical profession. Instead, the bill allows physicians and nurse practitioners to freely violate their ethical obligations and cause lethal harm to their patients through experimental drugs.

Consequently, S.B. 280 harms the medical profession, physicians, nurse practitioners, and people who may be struggling to process the shock of a difficult diagnosis. The bill opens the door for physicians and nurse practitioners 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."[45] Likewise, this Committee should reject S.B. 280 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,

Jesse Southerland
Federal Policy Director
AMERICANS UNITED FOR LIFE

[44] Gonzales v. Oregon, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).
[45] Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 53 (2018).