



March 6, 2023

Submitted Electronically via Federal Rulemaking Portal

Secretary Xavier Becerra
U.S. Department of Health and Human Services
Office for Civil Rights
Attn: Conscience NPRM (RIN 0945-AA18)
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Safeguarding the Rights of Conscience as Protected by Federal Statutes (RIN 0945-AA18)

Dear Secretary Becerra:

On behalf of Americans United for Life (“AUL”), I am writing in opposition to the Proposed Rule, “Safeguarding the Rights of Conscience as Protected by Federal Statutes,” 88 Fed. Reg. 820. AUL is the oldest and most active pro-life nonprofit advocacy organization in the country. Founded in 1971, before the Supreme Court’s decision in *Roe v. Wade*,¹ AUL has dedicated over fifty years to advocating for comprehensive legal protections for human life from conception until natural death. AUL attorneys are legal experts on constitutional law and bioethics, and regularly testify before state legislatures and Congress on abortion and end-of-life issues.² Supreme Court abortion opinions have cited AUL briefs and scholarship in bioethics decisions, including *Dobbs v. Jackson Women’s Health Organization*³ and *Washington v. Glucksberg*.⁴ The Massachusetts Supreme Judicial Court also cited AUL’s brief in *Kligler v. Attorney General* when ruling there is no fundamental right to assisted suicide under the state constitution.⁵

¹ 410 U.S. 113 (1973).

² 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).

³ 142 S. Ct. 2228, 2266 (2022) (citing Clarke D. Forsythe, ABUSE OF DISCRETION: THE INSIDE STORY OF *ROE V. WADE* 127, 141 (2012)).

⁴ 521 U.S. 702, 774 n.13 (1997) (citing Brief *Amicus Curiae* on behalf of Members of the New York and Washington State Legislatures 15, n.8).

⁵ 491 Mass. 38, 40 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical & Dental Associations).

AUL attorneys have comprehensively analyzed and prepared legal white papers and scholarship on the decision in *Dobbs v. Jackson Women’s Health Organization*⁶ and abortion litigation in a post-*Roe* world.⁷ AUL publishes a quarterly litigation report that tracks and evaluates bioethics litigation across the nation, including the ongoing assisted suicide conscience litigation in *Christian Medical & Dental Associations v. Bonta*⁸ and *Lacy v. Torres*.⁹

Based on AUL’s legal expertise, I urge the U.S. Department of Health and Human Services (“HHS”) to keep the 2019 Rule’s enforcement mechanism to protect conscience rights. Below, I elaborate how (I) federal conscience protections do not include an explicit private right of action, so it is essential that HHS robustly enforces statutes safeguarding conscientious objections to abortion and assisted suicide; (II) promoting suicide access violates the major questions doctrine and subverts Congress’ public policy stance of suicide prevention; (III) suicide assistance is not healthcare; (IV) valuing access to suicide assistance undercuts federal policies condemning disability discrimination; and (V) there has been a rise in attacks on the conscience rights of medical professionals who object to assisting a suicide. Section I’s discussion of the need for robust compliance measures responds to HHS’ request for information about the “scope and nature of the problems giving rise to the need for rulemaking.”¹⁰ The discussion of assisted suicide in sections II through V answers HHS’ request for comments on information and examples of discrimination against medical professionals and entities that object to assisted suicide.¹¹

Weakening compliance measures for abortion and suicide assistance conscience protections is arbitrary and capricious, is without a legal basis, is antithetical to federal suicide prevention and anti-discrimination policies, and undercuts Congress’ defense of conscientious objections to the taking of human life through abortion and suicide assistance. AUL urges HHS to defend conscience rights and abandon the Proposed Rule.

⁶ Carolyn McDonnell, *Dobbs v. Jackson Women’s Health Organization: The Overturn of Roe v. Wade*, AMS. UNITED FOR LIFE (July 5, 2022), <https://aul.org/wp-content/uploads/2022/07/Dobbs-v.-Jackson-Womens-Health-Organization-The-Overturn-of-Roe-v.-Wade.pdf>.

⁷ Carolyn McDonnell, *The Attorney General’s Playbook for a Post-Roe World*, AMS. UNITED FOR LIFE (June 28, 2022), <https://aul.org/wp-content/uploads/2022/06/AG-Playbook-for-a-Post-Roe-World.pdf>.

⁸ No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022) (issuing a preliminary injunction against California’s requirement that doctors must medically document a patient’s lethal drug request, which counts towards the two required drug requests, despite doctors’ conscientious objections to assisting a suicide).

⁹ No. 1:22-cv-953 (D.N.M. filed Dec. 14, 2022) (alleging conscience violations by New Mexico provisions that require doctors to tell patients of the availability of suicide assistance and refer for the practice, as well as prohibit medical organizations from conditioning membership based upon nonparticipation in suicide assistance).

¹⁰ Safeguarding the Rights of Conscience as Protected by Federal Statutes, 88 Fed. Reg. 820, 826 (proposed Jan. 5, 2023) (to be codified at 45 C.F.R. pt. 88).

¹¹ *Id.*

I. It Is Critical That HHS Robustly Ensures Compliance with Federal Laws Protecting Conscientious Objections to Taking Human Life Since an Explicit Private Right of Action Does Not Exist.

Abortion and physician-assisted suicide fundamentally raise objections to taking a human life. Without a recognized private right of action, is it critical that HHS robustly enforces statutes defending conscientious objections to killing another human being.

A. Abortion and Physician-Assisted Suicide Raise Grave Religious, Moral, and Ethical Questions About Ending a Human Life.

Taking a human life involves “a deeply personal decision” rooted not only in religion, but also in ethics and morality.¹² As Professor Mark Rienzi describes:

The decision whether or not to kill another human being—even where the killing is conducted or sanctioned by the government—is . . . [a] higher personal decision that implicates “the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life.”¹³

Due to the seriousness of forcing an individual to take a human life, the federal government has a rich tradition of protecting conscientious objections to military conscription,¹⁴ capital punishment,¹⁵ and, at issue here, abortion¹⁶ and assisted suicide.¹⁷ Fundamentally, conscientious objections to abortion and assisted suicide are refusals to violate human dignity and take a life, which is why HHS must strengthen conscience protections, not weaken them.

Notably, conscientious objections are from the perspective of the objector. It is immaterial how a state defines the “practice” of assisted suicide¹⁸ or whether it disagrees that abortion is a procedure that takes the life of a separate, unique, human

¹² Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 EMORY L. REV. 121, 175 (2012).

¹³ *Id.* at 128 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992), *overruled by Dobbs*, 142 S. Ct. 2228; *Lawrence v. Texas*, 539 U.S. 558, 574 (2003) (citation omitted)).

¹⁴ *See, e.g.*, *United States v. Seeger*, 380 U.S. 163, 166 (1965) (holding a Vietnam War draft exemption for religious conscientious objectors applied to Daniel Seeger, an agnostic who objected based upon “a purely ethical creed”); *Welsh v. United States*, 398 U.S. 333, 341, 344 (1970) (exempting Elliott Welsh under the same conscience exemption, even though he had “struck the word ‘religious’ entirely” on his conscientious objector application, because the statute protected conscientious objections “spurred by deeply held moral, ethical, or religious beliefs”).

¹⁵ *See, e.g.*, 18 U.S.C. § 3597(b) (protecting prison employees’ religious and moral conscience rights against forced participation in capital punishment).

¹⁶ *See, e.g.*, Church Amendments, 42 U.S.C. § 300a-7.

¹⁷ *See, e.g.*, Affordable Care Act, 42 U.S.C. § 18113.

¹⁸ *See, e.g.*, OR. REV. STAT. § 127.885(5)(d)(B)(ii) to (iii) (1995) (defining “participate” narrowly, so that it excludes the provision of suicide assistance information and patient referrals).

being.¹⁹ As the Supreme Court recognized in *Thomas v. Review Board of the Indiana Employment Security Division*, “religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection.”²⁰ The Court also stated that it should not delve into the reasonableness of a conscientious objector’s beliefs:

We see . . . [the objector] drew a line, and it is not for us to say that the line he drew was an unreasonable one. Courts should not undertake to dissect religious beliefs because the believer admits that he is “struggling” with his position or because his beliefs are not articulated with the clarity and precision that a more sophisticated person might employ.²¹

Under statutory law, such as the Religious Freedom Restoration Act, the Supreme Court likewise has not delved into the rationality of an objector’s belief, but, rather, limited its analysis to whether the belief is sincerely held.²² In this regard, conscientious objections are from the perspective of the objector. Consistent with Congress’ decision to protect refusals to take a human life, HHS should vigorously enforce federal conscience laws.

B. Without Recognition of an Implied Private Right of Action, HHS’ Office for Civil Rights Must Retain Sufficient Tools to Ensure Compliance with Conscience Laws.

Many Americans associate civil rights laws not only with anti-discrimination provisions, but also the most indispensable form of self-help compared to beseeching an agency for aid: the private right of action. While private rights of action are generally ubiquitous,²³ especially in waiving federal sovereign immunity,²⁴ these provisions are distressingly absent in the existing panoply of laws protecting conscience rights. Nowhere in the Church Amendments;²⁵ Coates-Snowe

¹⁹ See, e.g., CAL. CONST. art. I, § 1.1 (amended 2022) (viewing abortion as a “fundamental right”).

²⁰ 450 U.S. 707, 714 (1981).

²¹ *Id.* at 715.

²² *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014) (applying the Religious Freedom Restoration Act to the sincerely held religious beliefs of a closely held for-profit corporation that objected to the Affordable Care Act’s mandate that employers provide insurance coverage for contraception).

²³ See, e.g., 42 U.S.C. §§ 2000e-5(f); *id.* 2000e-16(c); *id.* § 12188 (describing private rights of action for aggrieved individuals under Title VII and the American Disabilities Act, respectively).

²⁴ See, e.g., 28 U.S.C. §§ 1346(a), 1491(a)(1) (waiving sovereign immunity under the Tucker Act); 28 U.S.C. §§ 1346(b), 2680 (waiving sovereign immunity under the Federal Tort Claims Act).

²⁵ 42 U.S.C. § 300a-7 (protecting conscience rights related to, e.g., abortion and sterilization).

Amendment;²⁶ Medicare;²⁷ Medicaid;²⁸ Weldon Amendment;²⁹ or Affordable Care Act³⁰—all which address convictions against funding, performance, or assistance of morally objectionable procedures such as abortion and suicide assistance—does Congress explicitly articulate a right of action for infringements on one’s conscience rights.

As HHS has previously noted, this lack of remedy entails troubling consequences.³¹ In *Cenzon-DeCarlo v. Mt. Sinai Hospital*, for example, a federal district court, the Second Circuit, and New York state courts all found no implied cause of action under the Church Amendments, even when a physician was forced to participate in an abortion against her conscientious objections.³²

The federal judiciary has a long practice of disfavoring implied rights of action.³³ Consequently, without an implied right of action, conscience protections are, at best, limited by the Office for Civil Rights’ (“OCR”) limited resources; and at worst, meaningless without a more direct means to ensure compliance. If plaintiffs must exclusively rely on OCR for recourse for the foreseeable future,³⁴ HHS must institute robust measures to ensure compliance with federal conscience laws. This includes HHS’ duty to anticipate emerging threats to conscience rights, especially in abortion³⁵ and, discussed below, physician-assisted suicide.

II. Under the Major Questions Doctrine, HHS Does Not Have the Authority to Promote Suicide Access or Subvert Congress’ Policy Stance of Suicide Prevention.

In the Proposed Rule, HHS expresses concern with “the balance Congress struck between safeguarding conscience rights and protecting access to health care

²⁶ 42 U.S.C. § 238n (safeguarding conscience rights against abortion provision, training, referral, or accreditation).

²⁷ 42 U.S.C. § 1395w-22(j)(3)(A)—(B) (exempting moral or religious objections to counseling or referral).

²⁸ 42 U.S.C. § 1396u-2(b)(3)(A)—(B) (same).

²⁹ See, e.g., Consolidated Appropriations Act, 2022, Pub. L. No. 117-103, div. H, tit. V, § 507(d)(1), 136 Stat. 49, 496 (2022) (describing one of several subsequent appropriations to HHS that protects health care entities that do not provide, pay for, provide coverage of, or refer for abortions).

³⁰ 42 U.S.C. §§ 18023, 18081(b)(5)(A), 18113 (safeguarding conscience rights for healthcare providers who object to abortion, physician-assisted suicide, euthanasia, or mercy killing).

³¹ Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23,170, 23,178 (2018) (codified at 45 C.F.R. pt. 88).

³² 626 F.3d 695, 698–99 (2d Cir. 2010); 962 N.Y.S.2d 845 (N.Y. Sup. Ct. 2010), *aff’d*, 957 N.Y.S.2d 256 (N.Y. App. Div. 2012).

³³ See, e.g., *Egbert v. Boule*, 142 S. Ct. 1793, 1802–05 (2022).

³⁴ The latest Congressional actions on conscience protections, the *Conscience Protection Act of 2021*, S.B. 401, 117th Cong. (2021) and its House equivalent with the same name, H.R. 6060, 117th Cong. (2021) were referred to committees but did not leave there.

³⁵ See, e.g., CAL. CONST. art. I, § 1.1 (devising abortion as a “fundamental right”); MICH. CONST. art. I, § 28 (amended 2022) (same); MINN. STAT. § 145.409 (2023) (same).

access.”³⁶ HHS properly recognizes that “[s]ome doctors, nurses, and hospitals . . . object for religious or moral reasons to providing or referring for . . . assisted suicide, among other procedures. Respecting such objections honors liberty and human dignity. It also redounds to the benefit of the medical profession.”³⁷ However, HHS alleges that it must weigh conscientious objections against access to suicide assistance as a purported healthcare service, because “[o]ur health care systems must effectively deliver services . . . to all who need them in order to protect patients’ health and dignity.”³⁸ This contention is flawed because HHS does not have the authority to promote suicide assistance, which is against Congress’ policy stance of suicide prevention.

A. HHS Cannot Promote Suicide Access Under the Major Questions Doctrine.

There is no federal right or interest in assisted suicide. The Supreme Court rejected the notion that the Due Process Clause protects suicide assistance in *Washington v. Glucksberg*,³⁹ and held the Equal Protection Clause does not extend to suicide assistance in *Vacco v. Quill*.⁴⁰ Likewise, there is no federal statute decriminalizing suicide assistance.⁴¹

Yet in balancing suicide access against conscience rights, HHS purports there is a federal public policy stance of suicide access. There is no such policy, and under the major questions doctrine, HHS *must* have *explicit* authority from Congress to promote assisted suicide. The major questions doctrine “refers to an identifiable body of law that has developed over a series of significant cases all addressing a particular and recurring problem: agencies asserting highly consequential power beyond what Congress could reasonably be understood to have granted.”⁴² As the Court recognized, “there are ‘extraordinary cases’ that call for a different approach—cases in which the ‘history and the breadth of the authority that [the agency] has asserted,’ and the ‘economic and political significance’ of that assertion, provide a ‘reason to hesitate before concluding that Congress’ meant to confer such authority.’”⁴³

Just as the Court “f[oun]d it ‘highly unlikely that Congress would leave’ to ‘agency discretion’ the decision of how much coal-based generation there should be over the coming decades” in *West Virginia v. Environmental Protection Agency*,⁴⁴ it is equally unlikely that Congress authorizes HHS to promote a national suicide

³⁶ Safeguarding the Rights of Conscience as Protected by Federal Statutes, 88 Fed. Reg. at 820.

³⁷ *Id.* at 826.

³⁸ *Id.*

³⁹ 521 U.S. at 706.

⁴⁰ 521 U.S. 793, 797 (1997).

⁴¹ In fact, Congress has broadly prohibited the use of federal funds for assisted suicide. Assisted Suicide Funding Restriction Act, 42 U.S.C. §§ 14401 to 14408.

⁴² *West Virginia v. Env’t Prot. Agency*, 142 S. Ct. 2587, 2609 (2022).

⁴³ *Id.* at 2605 (citation omitted) (alteration in original).

⁴⁴ *Id.* at 2596.

assistance policy through conscience protections. Assisted suicide is a highly contentious issue. Federal law says nothing about decriminalizing suicide assistance, but rather, has an explicit stance of suicide prevention. Accordingly, under the major questions doctrine, HHS must show that Congress has delegated the authority to promote assisted suicide, but it cannot.

B. Congress Has an Explicit Public Policy Stance of Suicide Prevention, Not Suicide Assistance.

The United States has a robust public policy of suicide prevention.⁴⁵ The Centers for Disease Control and Prevention (“CDC”) recognizes that “[s]uicide is a serious public health problem . . . [and] is a leading cause of death in the United States.”⁴⁶ “Suicide and suicide attempts cause serious emotional, physical, and economic impacts” in suicide survivors, loved ones, and the community.⁴⁷ According to the CDC, “[t]he financial toll of suicide on society is also costly. In 2019, suicide and nonfatal self-harm cost the nation nearly \$490 billion in medical costs, work loss costs, value of statistical life, and quality of life costs.”⁴⁸

Assisted suicide exacerbates suicide rates. According to recent scholarship published by the Anscombe Bioethics Centre, when a jurisdiction introduces assisted suicide, the “[r]ates of non-assisted suicide also increase, in some cases significantly.”⁴⁹ The research examined assisted suicide scholarship and found “[t]here is no evidence that legalisation of EAS [euthanasia or assisted suicide] would have a beneficial effect on suicide prevention.”⁵⁰ In fact, legalization of assisted suicide undermines suicide prevention policies:

There is robust evidence, taken from different jurisdictions and using a variety of statistical methods, that the total number of self-initiated deaths rises significantly where EAS is legally available, and strong evidence that this has a greater impact on older women. There is some evidence, less robust but by some measures statistically significant, that deaths by non-assisted suicide also increase. There is no evidence of a reduction in non-assisted suicide.⁵¹

⁴⁵ *Suicide Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 19, 2022), <https://www.cdc.gov/suicide/index.html>.

⁴⁶ *Facts About Suicide*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 24, 2022), <https://www.cdc.gov/suicide/facts/index.html>.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ David Albert Jones, *Suicide Prevention: Does Legalising Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CTR. 1, 2 (2022), <https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf>.

⁵⁰ *Id.* at 9.

⁵¹ *Id.*

In this regard, by promoting access to suicide assistance, HHS is subverting public policies that prevent suicide.

HHS also is undercutting Congress' decision to limit the harmful effects of suicide assistance. The Supreme Court has recognized there is no constitutional right to suicide assistance.⁵² Similarly, nothing in federal law creates a right to suicide assistance or otherwise decriminalizes the practice. Rather, Congress has sought to decrease the harmful effects of assisted suicide. In the Assisted Suicide Funding Restriction Act, Congress broadly prohibits the federal funding of suicide assistance, recognizing the Act's purpose is "to continue current Federal policy by providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide . . . of any individual."⁵³ In turn, Congress has restricted the federal funding of suicide assistance in health care programs, certain grant programs, advocacy programs, funds appropriated to the District of Columbia, and a catch-all prohibition that "no funds appropriated by the Congress shall be used to provide, procure, furnish, or fund any item, good, benefit, activity, or service, furnished or performed for the purpose of causing, or assisting in causing, the suicide . . . of any individual."⁵⁴

Similarly, Congress robustly defends the conscientious objections of medical professionals who oppose assisting a suicide. At issue here is Section 1553, which prohibits discrimination against "an individual or institutional health care entity . . . on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing."⁵⁵ The provision broadly applies to "[t]he Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act . . . or any health plan created under this Act . . ."⁵⁶ Section 1553 clearly shows Congress' decision to prioritize conscientious objections to taking a human life over suicide access. HHS does not have the authority to reweigh these interests and devalue congressional safeguards for conscience rights.

III. Suicide Assistance Is Not Healthcare.

In balancing suicide access against conscience rights, HHS also erroneously considers suicide assistance as healthcare. Yet, assisted suicide acts as a limited exception to homicide liability under state laws, and allows physicians to use

⁵² *Washington*, 521 U.S. at 706, 710–719 (holding nothing in "our Nation's history, legal traditions, and practices" give rise to a due process right to assisted suicide); *Vacco*, 521 U.S. at 797, 801–808 (finding New York's assisted suicide ban was different in causation and intent from refusal of life-sustaining medical treatment and, thus, did not violate the Equal Protection Clause).

⁵³ 42 U.S.C. § 14401(b).

⁵⁴ *Id.* §§ 14402 to 14405, 14407.

⁵⁵ *Id.* § 18113(a).

⁵⁶ *Id.*

experimental drugs directly upon patients without FDA approval nor clinical trials. Accordingly, HHS should not weigh access to suicide assistance against the conscientious objections of medical professionals who are opposed to assisting a suicide.

A. Assisted Suicide Acts as a Narrow Exception to Homicide Laws.

Today the legality of assisted suicide depends on state law. There is no right to assisted suicide under the United States Constitution.⁵⁷ Multiple state courts similarly have rejected the argument that their respective state constitution creates a “right” to assisted suicide.⁵⁸ As the Supreme Court found in *Washington v. Glucksberg*, “[i]n 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.”⁵⁹ Only nine states and the District of Columbia have legalized assisted suicide through statute and they “have done so only through considered legislative action” and with so-called patient safeguards.⁶⁰ Notably, these statutes do not change the underlying criminal prohibition on assisted suicide; they “simply . . . carve out an exception for one profession [*i.e.*, physicians] to assist in suicides.”⁶¹ Rather, these laws merely create a legal fiction that “[a]ctions taken in accordance [with the assisted suicide laws] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law,” but do not decriminalize assisted suicide in all circumstances.⁶²

One state, Montana, succumbed to litigation activism that sought to legalize assisted suicide. In *Baxter v. State*, the Montana Supreme Court declined to recognize a patient’s right to assisted suicide, but nevertheless held physicians may raise a statutory “consent” defense against homicide charges in assisted suicide cases.⁶³ Unfortunately, Montana has absolutely no safeguards against coercion and abuse because the state supreme court permitted assisted suicide through judicial activism. Nevertheless, the Montana judiciary decriminalized assisted suicide as a narrow exception to Montana’s homicide laws.

Ten jurisdictions have decriminalized assisted suicide through legislation: California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, New Mexico,

⁵⁷ *Washington*, 521 U.S. at 706; *Vacco*, 521 U.S. at 797.

⁵⁸ *Myers v. Schneiderman*, 85 N.E. 3d 57, 65 (N.Y. 2017) (citing cases); *see also Kligler*, 491 Mass. at 40 (declining to concoct a state constitutional right to assisted suicide).

⁵⁹ 521 U.S. at 710 (citing *Cruzan*, 497 U.S. at 280).

⁶⁰ *Myers*, 85 N.E. 3d at 65.

⁶¹ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 53 (2018).

⁶² OR. REV. STAT. § 127.880 (1995).

⁶³ 354 Mont. 234, 239, 251 (Mont. 2009).

Oregon, Vermont, and Washington.⁶⁴ Assisted suicide protocol in these jurisdictions depends on the statute. These statutes generally include heightened informed consent protections for patients, including:

- Residency requirements;
- Determination by both an attending physician and consulting physician that the patient suffers from a terminal disease;
- At least two individuals must witness the patient’s medication request, and there are restrictions on who may qualify as a witness, including an exclusion on the patient’s attending physician from acting as a witness;
- Physician-provided informed consent disclosures, including the patient’s medical diagnosis, potential risks of the lethal drug, and feasible alternatives to assisted suicide;
- In limited instances, referral of the patient for counseling;
- Both an oral and written drug request;
- Reiteration of the oral request after a reflection period after the initial oral request;
- Physician documentation of information in the patient’s medical record, including the patient’s diagnosis and medication requests.⁶⁵

If suicide doctors do not follow these requirements, then they may be subject to homicide charges, civil liability, or professional sanctions. Accordingly, states criminally prohibit assisted suicide, but a minority of jurisdictions have decriminalized physician-assisted suicide in limited circumstances as a legal fiction that the practice is not “suicide,” or, in the case of Montana, allowed a consent defense to homicide charges for assisted suicide. Thus, suicide assistance is not healthcare, but a narrow legal exception to homicide liability.

B. Suicide Doctors Use Experimental Drugs Directly on Patients without FDA Approval or Clinical Trials.

Assisted suicide is not healthcare because there is no standardized drug or dosage for ending a patient’s life. “Of course, there is no federally approved drug for which the primary indication is the cessation of mental or physical suffering by the termination of life.”⁶⁶ Federally, the Food and Drug Act regulates pharmaceuticals and requires “that both ‘safety’ and ‘efficacy’ of a drug for its intended purpose (its

⁶⁴ CAL. HEALTH & SAFETY CODE §§ 443 to 443.9 (2016); COLO. REV. STAT. §§ 25-48-101 to 25-48-123 (2016); D.C. CODE §§ 7-661.01 to 7-661.16 (2017); HAW. REV. STAT. §§ 327L-1 to 327L-25 (2019); ME. STAT. tit. 22 § 2140 (2019); N.J. STAT. §§ 26:16-1 to 26:16-20 (2019); N.M. STAT. ANN. §§ 24-7C-1 to 24-7C-8 (2021); OR. REV. STAT. §§ 127.800 to 127.897 (2017); VT. STAT. Ann. tit. 18 §§ 5281 to 5293 (2013); WASH. REV. CODE §§ 70.245.010 to 70.245.903 (2009).

⁶⁵ As the first jurisdiction to decriminalize physician-assisted suicide in the United States, Oregon’s law provides a model for other states contemplating suicide assistance. *See* OR. REV. STAT. §§ 127.800 to 127.897.

⁶⁶ 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).

‘indication’) be demonstrated in order to approve the drug for distribution and marketing to the public.”⁶⁷ Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Since states that have legalized suicide assistance do not provide guidelines for assisted suicide drug composition or dosages, suicide doctors have experimented with the dosage and composition of these lethal drugs. Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.⁶⁸ Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.⁶⁹ 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.”⁷⁰ As *The Atlantic* reported in 2019, “[n]o medical association oversees aid in dying, and no government committee helps fund the research. In states where the practice is legal, state governments provide guidance about which patients qualify, but say nothing about which drugs to prescribe.”⁷¹ As a result, assisted suicide proponents have experimented their lethal drugs 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.”⁷² Accordingly, assisted suicide uses experimental drugs without patient safeguards. This is not healthcare.

In sum, HHS cannot consider assisted suicide as healthcare. Legally, physician-assisted suicide is a legal fiction that acts as a limited exception to criminal liability, but assisted suicide is otherwise homicide. Suicide doctors are using experimental lethal drugs directly on patients without clinical trials or oversight by an institutional review board for the protection of human subjects. HHS cannot devise assisted suicide as “healthcare,” and use suicide access to devalue conscience rights.

IV. Assisted Suicide is Ableist and is Contrary to Federal Policies Preventing Disability Discrimination.

By weighing suicide access against conscience rights, HHS is furthering ableist policies that discriminate against persons with disabilities. In his executive order, *Advancing Racial Equity and Support for Underserved Communities Through the*

⁶⁷ *Id.* at 340.

⁶⁸ Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & BIOSCIS. 424, 429–430 (2017).

⁶⁹ 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).

⁷⁰ *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), <https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies>.

⁷¹ 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/>.

⁷² *Id.*

Federal Government, President Biden recognized that “[e]qual opportunity is the bedrock of American democracy, and our diversity is one of our country’s greatest strengths.”⁷³ Accordingly, President Biden directed that it is “the policy of [his] Administration that the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality.”⁷⁴ The executive order identifies that persons with disabilities “belong to underserved communities that have been denied such [equitable] treatment.”⁷⁵ Yet, assisted suicide is rampant with disability discrimination and undercuts President Biden’s policy stance of furthering equity for persons with disabilities.

A fundamental problem with assisted suicide, and its perceived compassion to “aid” patients in dying is that “the desire to die arises out of serious illnesses or disabilities.”⁷⁶ This creates “a two-tiered system for measuring the worth of human life” according to bioethicist Wesley J. Smith.⁷⁷ In this stratified system:

The young and vital who become suicidal would receive suicide prevention—and the concomitant message that their lives are worth living. At the same time, the suicides of the debilitated, sick, and disabled, and people with extended mental anguish—the “hopelessly ill”—would be shrugged off as merely a matter of choice. Such a value system would not only reflect a distorted value about the worth of human life but also send a lethal message to the weak and infirm that their lives are not worth living.⁷⁸

The National Council on Disability echoes Smith, noting that under legalized assisted suicide, “people’s lives, particularly those of people with disabilities, will be ended without their fully informed and free consent, through mistakes, abuse, insufficient knowledge, and the unjust lack of better options.”⁷⁹ Although states have tried to place safeguards into statutes, “[n]o safeguards have ever been enacted or proposed that can prevent this outcome.”⁸⁰

State reports show that patients seek assisted suicide not for pain management, but because of the challenges of living with severe illnesses or disabilities. In 2021, only 26.9% of Oregon patients and 46.0% of Washington patients cited “[i]nadequate pain control, or concern about it” as a reason for choosing assisted

⁷³ Exec. Order No. 13,985, 86 Fed. Reg. 7009, 7009 (Jan. 20, 2021).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ WESLEY J. SMITH, *CULTURE OF DEATH: THE AGE OF “DO HARM” MEDICINE* 117 (2d ed. 2016).

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ NAT’L COUNCIL ON DISABILITY, *THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES* 14–15 (2019).

⁸⁰ *Id.* at 15.

suicide.⁸¹ Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Losing autonomy (93.3% in Oregon, 85.0% in Washington);
- Less able to engage in activities making life enjoyable (92.0% in Oregon, 85.0% in Washington);
- Loss of dignity (68.1% in Oregon, 73.0% in Washington);
- Burden on family, friends/caregivers (54.2% in Oregon, 56.0% in Washington);
- Losing control of bodily functions (47.1% in Oregon, 50.0% in Washington).⁸²

Data shows that Oregon patients historically have ranked pain lower than the autonomy and dignity categories.⁸³ These lamentably are “psychological issues that are all-too-familiar to the disability community.”⁸⁴

In other words, patients usually do not seek assisted suicide for pain management. Rather, they seek assisted suicide because of disability and quality of life concerns, under the perception that “a patient is deprived of dignity when he is made to feel dependent and helpless as the end of life approaches.”⁸⁵ Accordingly, assisted suicide is rampant with ableism and discrimination because it lethally judges patients’ quality of life based upon their terminal illnesses and disabilities. If HHS promotes access to suicide assistance, then it is undercutting federal policies to promote equity for persons with disabilities.

V. Section 1553 Assisted Suicide Conscience Protections Are Essential Because There Has Been a Rise in Conscience Threats and States Inadequately Protect Conscientious Objectors.

As HHS recognized in the 2019 Rule, medical professionals have raised conscience concerns regarding assisted suicide in recent years.⁸⁶ For example, “[w]hen the Vermont Department of Health construed Act 39 to require all health care professionals to counsel for assisted suicide, individual health care professionals and associations of religious health care providers sued Vermont, alleging a violation of their conscience rights” in *Vermont Alliance for Ethical Health Care, Inc. v. Hoser*.⁸⁷ Similarly, “the family of a California cancer patient sued UCSF Medical Center for alleged elder abuse because the cancer patient died after the oncologists on staff

⁸¹ OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13 (Feb. 28, 2022); WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).

⁸² *Id.*

⁸³ OR. PUB. HEALTH DIV., *supra* note 81, at 13.

⁸⁴ NAT’L COUNCIL ON DISABILITY, *supra* note 79, at 37.

⁸⁵ Aden, *supra* note 66, at 324.

⁸⁶ Protecting Statutory Conscience Rights in Health Care, 84 Fed. Reg. at 23,177.

⁸⁷ *Id.* (citing Complaint, *Vt. All. for Ethical Health Care, Inc. v. Hoser*, No. 5:16-cv-205 (D. Vt. Apr. 5, 2017) (dismissed by consent agreement)).

declined to participate in assisted suicide, but before she could obtain a new physician.”⁸⁸

Part of the problem is that states have increasingly decriminalized physician-assisted suicide but have not implemented proper conscience safeguards. Ten jurisdictions have decriminalized assisted suicide through legislation. These jurisdictions include conscience protections for objecting to “participate” in suicide assistance.⁸⁹ Some jurisdictions, however, have narrowly defined “participate” so it excludes the provision of suicide assistance information and referrals upon a patient’s request.⁹⁰ This means that these statutes do not protect medical professionals who conscientiously object to providing suicide information or referring for the practice from discrimination by professional organizations or associations, or from health care providers. In addition to excluding the provision of suicide information from the definition of “participate,” Maine has created a right for patients to receive assisted suicide information, which may raise conscience issues for medical professionals who conscientiously object to providing suicide information.⁹¹

Two states, California and New Mexico, are undergoing litigation because they have limited the definition of “participate,” but imposed affirmative duties on medical professionals to assist a suicide. California amended its End of Life Option Act in 2019, recognizing that “[a] health care provider who objects for reasons of conscience, morality, or ethics to participate under this part shall not be required to participate.”⁹² Yet, even if a healthcare professional conscientiously objects, “the provider shall . . . document the individual’s date of request . . . in the medical record.”⁹³ This medical documentation counts as the first of the two required requests that the patient must make to receive a lethal drug prescription.⁹⁴ Consequently, state law requires medical professionals to assist a suicide even if they conscientiously object. A district court has issued a preliminary injunction against the medical documentation requirement on free speech grounds in *Christian Medical & Dental Associations v. Bonta*.⁹⁵

⁸⁸ *Id.* (citation omitted).

⁸⁹ CAL. HEALTH & SAFETY CODE § 443.14(e); COLO. REV. STAT. § 25-48-117; D.C. CODE § 7-661.10; HAW. REV. STAT. § 327L-19; ME. STAT. tit. 22 § 2140(21) to (22); N.J. STAT. § 26:16-17; N.M. STAT. ANN. § 24-7C-7; OR. REV. STAT. § 127.885; VT. STAT. Ann. tit. 18 §§ 5285 to 5286; WASH. REV. CODE § 70.245.190.

⁹⁰ D.C. CODE § 7-661.10(e)(4) to (5); HAW. REV. STAT. § 327L-19(e)(2) to (3); ME. STAT. tit. 22 § 2140(22)(G)(2)(e)(1); N.J. STAT. § 26:16-3; OR. REV. STAT. § 127.885(5)(d)(B)(ii) to (iii); WASH. REV. CODE § 70.245.190(2)(d)(ii)(B) to (C).

⁹¹ ME. STAT. tit. 22 § 2140(3).

⁹² CAL. HEALTH & SAFETY CODE § 443.14(e)(2).

⁹³ *Id.*

⁹⁴ *Id.* § 443.3(a) (“An oral request documented in an individual’s medical record shall not be disregarded by an attending physician solely because it was received by a prior attending physician or an attending physician who chose not to participate.”).

⁹⁵ No. 5:22-cv-335.

Under New Mexico’s assisted suicide law, even if a doctor conscientiously objects to assisting a suicide, he or she must tell a patient of the availability of suicide assistance,⁹⁶ and refer a patient for the practice.⁹⁷ New Mexico law also prohibits medical associations from revoking or denying membership to medical professionals that engage in assisted suicide, even if the medical association conditions its membership upon not participating in suicide assistance based on conscience grounds.⁹⁸ A complaint and motion for a preliminary injunction have been filed in *Lacy v. Torres*, challenging these provisions of New Mexico’s assisted suicide law.⁹⁹

Montana is the only jurisdiction that has decriminalized assisted suicide through judicial activism. In *Baxter v. State*, the Montana Supreme Court devised a statutory “consent” defense to homicide charges for physician-assisted suicide.¹⁰⁰ Unlike the other jurisdictions that have decriminalized assisted suicide, there are no statutory provisions safeguards for conscientious objections to assisting a suicide in Montana.¹⁰¹ Consequently, Montana physicians rely upon Section 1553 to protect their conscientious objections to assisting in the taking of human life.

In sum, state laws protect conscience rights to a lesser degree than Section 1553. In some instances, such as in New Mexico and California, states laws have affirmatively required doctors to assist suicide, thus violating conscience rights. Montana does not recognize any conscience protections for healthcare professionals or entities that object to assisting a suicide. Accordingly, it is imperative that HHS ensures compliance with Section 1553 and safeguards conscientious objections to taking human life.

VI. Conclusion

Abortion and assisted suicide implicate grave questions regarding the taking of a human life. For the reasons discussed above, AUL urges HHS to retain the 2019 Rule, including:

- Definitions of terms, including “[a]ssist in the performance,”¹⁰² which is especially critical as states limit the definition of the “practice” of assisted suicide;
- Explanation of the application and requirements of federal conscience anti-discrimination laws;¹⁰³

⁹⁶ N.M. STAT. ANN. § 24-7C-6.

⁹⁷ *Id.* § 24-7C-7(C).

⁹⁸ *Id.* § 24-7C-7(B).

⁹⁹ No. 1:22-cv-953.

¹⁰⁰ 354 Mont. at 239, 251.

¹⁰¹ Rienzi, *supra* note 12, at 146–147 (arguing that “the [Montana] conscience protection applicable to withdrawing treatment suggests a willingness to protect objectors in a related context,” but there is no “express protection” for conscientiously objecting to assisting a suicide).

¹⁰² 45 C.F.R. § 88.2 (2019).

¹⁰³ *Id.* § 88.3.

- Requirements of assurance and certification of compliance;¹⁰⁴
- Compliance requirements to aid investigations of alleged conscience violations;¹⁰⁵
- Detailed explanation of OCR’s authority to ensure compliance with federal conscience anti-discrimination laws;¹⁰⁶
- Rule of construction “in favor of a broad protection of the free exercise of religious beliefs and moral convictions,” which is consistent with Congress’ public policy stance of protecting conscientious objections to taking human life.¹⁰⁷

Accordingly, HHS should abandon the Proposed Rule, and retain the 2019 Rule. HHS does not have the authority to undermine Congress’ decision to protect conscientious objections to taking a human life.

Sincerely,

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AMERICANS UNITED FOR LIFE

¹⁰⁴ *Id.* § 88.4.

¹⁰⁵ *Id.* § 88.6.

¹⁰⁶ *Id.* § 88.7.

¹⁰⁷ *Id.* § 88.9.