



A Time to Choose: Suicide Assistance or Suicide Prevention?

By Carolyn McDonnell, M.A., J.D.

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Introduction

“[W]e cannot allow suicide to be the solution to struggles and fears. . . . Too often in our society, we measure a person’s value based on their success, influence, ability to contribute to society, and freedom to choose their lifestyle. These ideas are badly flawed. Human dignity is an innate part of being human.”

Megan Gannon, Author of *Special Saints for Special People*¹



“But perhaps the most important question is not whether the rights of the few people who request assisted suicide and get it have been compromised, though that is a concern, but whether legalizing these individual assisted suicides has a broader social impact. Does it matter that a society accepts the disability-related reasons that people give for assisted suicide, declares the suicide rational and provides the lethal means to complete it neatly?”

Diane Coleman, President of *Not Dead Yet*²

Physician-assisted suicide is an attack upon human dignity. The United States has a robust public policy of suicide prevention.³ Yet, eleven states have carved out civil, criminal, and professional liability exemptions for homicide in the case of physician-assisted suicide. Suicide activists have pushed to deregulate the practice; Oregon now permits suicide tourism by out-of-state residents and Vermont authorizes telemedical suicide assistance. Assisted suicide threatens

vulnerable patients, poses grave informed consent issues, and blatantly discriminates against the elderly and persons with illnesses and disabilities. The practice undermines suicide prevention policies and increases the rates of non-assisted suicide. Congress and the states, however, have broad powers to protect human dignity at the end of life. This report provides a legal overview and resources for policymakers to combat the spread of physician-assisted suicide.

¹ Megan Gannon, Opinion, *Assisted Suicide Is a Threat to People With Disabilities Like Me*, NEWSWEEK (Mar. 1, 2023), <https://www.newsweek.com/assisted-suicide-threat-disabled-people-like-me-opinion-1784499>.
² *The Consequences of Legalized Assisted Suicide and Euthanasia: Hearing Before the Subcomm. on the Const., Civ. Rts. & Prop. Rts. of the S. Comm. on the Judiciary*, 109th Cong. 26 (2006) (statement of Diane Coleman, President, Not Dead Yet).
³ *Suicide Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 13, 2023), <https://www.cdc.gov/suicide/index.html>.

Terminology of Suicide Assistance



Before delving into the policy issues of suicide assistance, it is important to define certain end-of-life terms. “**Euthanasia**” involves the intentional killing of a patient out of a misguided sense of compassion for the patient’s condition, such as the patient’s age, disability, illness, or quality of life. “**Assisted suicide**” occurs when a person kills herself through the means or manner (e.g., lethal drug prescription or information about how to commit suicide) provided by another person. “**Physician-assisted suicide**” means a doctor provided the means for a patient to self-kill. In practice, the line between euthanasia and assisted suicide is muddled. As bioethicist John Keown writes, “[w]hat, for example, is the supposed difference between a doctor handing a lethal pill to a patient, placing the pill on the patient’s tongue and dropping it down the patient’s throat? Where does [physician-assisted suicide] end and [voluntary active euthanasia] begin?”⁴

Suicide activists often invoke euphemisms such as “**medical aid in dying**,” “**death with dignity**,” or “**assisted death**.” These terms are vague and, depending on the context, may broadly refer to euthanasia, assisted suicide, or other anti-life practices that threaten end-of-life patients.⁵ Part of this language problem is that there is a “radical notion of autonomy [in bioethics]” that views this type of suicide “as a matter of respecting personal autonomy and not

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engaging in non-maleficence by forcing people to stay alive.”⁶ Under this perspective, self-killing may be justified as a “rational suicide.”⁷ As discussed below, this anti-life logic raises serious discrimination concerns for the elderly and persons with illnesses or disabilities.

Some suicide activists try to parallel assisted suicide with other end-of-life scenarios. “**Withdrawal or refusal of life-sustaining medical treatment**” refers to a patient’s (or their surrogate’s) decision to remove or decline medical care that is critical to a patient’s ability to live. Such medical treatment includes mechanical

⁴ JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 18 (2d ed. 2018).

⁵ The Massachusetts Supreme Judicial Court recently rejected suicide activists’ attempt to use the euphemism “medical aid in dying,” noting it was “ambiguous” and “physician-assisted suicide” better described the practice. *Kligler v. Att’y Gen.*, 198 N.E.3d 1229, 1237 n.4 (Mass. 2022).

⁶ WESLEY J. SMITH, CULTURE OF DEATH: THE AGE OF “DO HARM” MEDICINE 106 (2d ed. 2016).

⁷ *Id.* at 106–108.

ventilation, chemotherapy, artificial nutrition and hydration, and other medical care that sustains the patient's life. The Supreme Court has found "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."⁸ Yet, the Court recognizes a distinction between withdrawal of care and physician-assisted suicide, which "comports with fundamental legal principles of causation and intent."⁹ As the Supreme Court discusses in *Vacco v. Quill*, "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."¹⁰

Assisted suicide also differs from palliative care. "**Palliative care**" is specialized medical care that provides pain and symptom relief for patients with serious illnesses.¹¹ In the end-of-

life context, palliative care may include high opioid doses that quicken a patient's death. The Supreme Court notes the legal contrast between palliative care and assisted suicide:

The same [intent and causation distinction] is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead."¹²

Thus, assisted suicide finds no legal parallel in palliative care or withdrawal or refusal of life-sustaining medical treatment.



⁸ *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

⁹ *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

¹⁰ *Id.*

¹¹ *Palliative Care*, MAYO CLINIC (Aug. 15, 2017), <https://www.mayoclinic.org/tests-procedures/palliative-care/about/pac-20384637>.

¹² *Vacco*, 521 U.S. at 802.

The Legal Status of Physician-Assisted Suicide



Assisted suicide has gained ground over the past thirty years through legislative and judicial activism. The pro-life movement and disability rights advocates, however, have held firm against these efforts, notably by preventing courts from concocting constitutional rights to suicide assistance and protecting the conscience rights of medical professionals.

Legalization and Requirements of Physician-Assisted Suicide

Today the legality of assisted suicide depends on state law. There is no right to assisted suicide under the United States Constitution.¹³ Multiple state courts similarly have rejected the argument that their respective state constitution creates a “right” to assisted suicide.¹⁴ 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.”¹⁵ 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 patient safeguards.¹⁶

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Notably, these statutes do not change the underlying restrictions on assisted suicide; they “simply . . . carve out an exception for one profession [i.e., physicians] to assist in suicides.”¹⁷

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 ho-

¹³ *Washington v. Glucksberg*, 521 U.S. 702, 706, 710–719 (1997) (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).

¹⁴ *Myers v. Schneiderman*, 85 N.E. 3d 57, 65 (N.Y. 2017) (citing cases); see also *Kligler*, 198 N.E.3d at 1237 (declining to concoct a state constitutional right to assisted suicide).

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

¹⁶ *Myers*, 85 N.E. 3d at 65.

¹⁷ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 HUM. LIFE REV. 51, 53 (2018).

micide charges in assisted suicide cases.¹⁸ Disastrously, Montana has absolutely no safeguards against coercion and abuse because the state supreme court permitted assisted suicide through judicial activism. Although Montana is the only state to permit a statutory consent defense to assisted suicide, activists have raised the same argument in other legal challenges.¹⁹

Ten jurisdictions have decriminalized assisted suicide through legislation: California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington.²⁰ 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.²¹

Additionally, these states prevent contracts, wills, insurance, or annuity policies from affecting a patient's ability to request lethal medication.²² Similarly, states often include clarifying language that the assisted suicide statute does not "authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."²³ As discussed below, these protections are not sufficient to



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

¹⁹ See, e.g., *Kligler*, 198 N.E.3d 1229.

²⁰ 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).

²¹ 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.

²² See, e.g., *id.* §§ 127.870(1), 127.875.

²³ See, e.g., *id.* § 127.880.



prevent coercion and abuse of vulnerable end-of-life patients.

There are some conscience and funding protections against assisted suicide. States that permit suicide assistance include protections for healthcare professionals who conscientiously object to taking a human life, and most jurisdictions extend these protections to healthcare institutions that prohibit employees from participating in assisted suicide on its premises.²⁴ The Affordable Care Act similarly prohibits discrimination against healthcare professionals or institutions that conscientiously object to assisting a suicide.²⁵ Congress also broadly prohibits the use of federal funds for assisted suicide.²⁶

Recent Suicide Activism

States are facing legislative and litigation threats from suicide activists. On the legislative side, states are facing bills that seek to decriminal-

ize the practice. In 2022, “[a]t least 12 states introduced bills that attempted to legalize physician-assisted suicide but all failed to pass, a reflection of the nationwide consensus that those who are sick deserve our care.”²⁷ States that have permitted suicide assistance are facing bills that would de-medicalize the practice and further abandon vulnerable patients to the harms of assisted suicide. In 2022, Vermont permitted the use of telemedicine within physician-assisted suicide and dropped the second reflection period that occurred between the informed consent process and when a physician could write a prescription.²⁸ California modified its assisted suicide statute in 2021, shortening the informed consent reflection period from 15 days to forty-eight hours.²⁹

On the litigation side, there has been a recent rise in assisted suicide litigation.³⁰ In March 2022, Oregon officials settled a lawsuit, agree-

²⁴ See, e.g., *id.* § 127.885.

²⁵ 42 U.S.C. § 18113.

²⁶ Assisted Suicide Funding Restriction Act of 1997, 42 U.S.C. §§ 14401 to 14408.

²⁷ Natalie M. Hejran, *2022 State Legislative Sessions Report*, AMS. UNITED FOR LIFE 4 (Oct. 11, 2022), <https://aul.org/wp-content/uploads/2022/10/AUL-2022-State-Legislative-Sessions-Report.pdf>.

²⁸ VT. STAT. ANN. tit. 18 § 5283.

²⁹ CAL. HEALTH & SAFETY CODE § 443.3(a).

³⁰ *Life Litigation Reports*, AMS. UNITED FOR LIFE (last visited Mar. 16, 2022), <https://aul.org/topics/life-litigation-reports/>.

ing to not enforce the state’s residency requirements laid out in *Gideonse v. Brown*.³¹ Regrettably, this means that Oregon is open for suicide tourism by out-of-state residents. Vermont just settled a similar challenge to its residency requirements in *Bluestein v. Scott*.³² In the settlement agreement, Vermont officials agreed to not enforce the residency requirements against Lynda Bluestein, a terminally ill woman from Connecticut. The Vermont Department of Health further agreed to support legislative repeal of the residency requirements as part of the settlement terms.

In *Shavelson v. Bonta*, suicide activists argued that federal disability rights laws require California’s End of Life Option Act to permit active euthanasia of persons with disabilities who cannot self-administer lethal drugs.³³ The District Court dismissed the case in December 2022 on procedural grounds but noted “the Court would dismiss the lawsuit on the merits. Setting aside the assistance prohibition would cross the sharp line drawn by the California Legislature between assisted suicide and euthanasia”³⁴ Suicide activists have appealed the ruling.

The Massachusetts Supreme Judicial Court decided *Kligler v. Attorney General* in December 2022, holding the state constitution does not protect assisted suicide, nor may doctors raise a consent defense to manslaughter charges.³⁵

Pro-life doctors have challenged California and New Mexico’s assisted suicide laws for alleged conscience rights infringements. Under California’s law, even if a doctor conscientiously objects to taking a human life, she still must medically document a patient’s lethal drug re-

States that have permitted suicide assistance are considering bills that would de-medicalize the practice and further abandon vulnerable patients to the harms of assisted suicide.

quest. This documentation counts as the first of the two required lethal drug requests, which means this doctor will still assist in a patient’s suicide. The district court granted a preliminary injunction in part against this California requirement in *Christian Medical & Dental Associations v. Bonta*.³⁶ In *Lacy v. Torrez*, pro-life doctors challenged New Mexico’s provisions that require a physician to tell patients of the availability of suicide assistance and refer for the practice. The plaintiffs also challenged the prohibition on 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. In response to the litigation, New Mexico amended its assisted suicide statute and expanded conscience protections. Accordingly, the plaintiffs voluntarily dismissed the litigation.³⁷

³¹ No. 3:21-cv-1568 (D. Or. dismissed Mar. 28, 2022).

³² No. 2:22-cv-160 (D. Vt. dismissed Mar. 14, 2023).

³³ No. 3:21-cv-6654 (N.D. Cal. Dec. 7, 2022).

³⁴ *Id.* at 2.

³⁵ *Kligler*, 198 N.E.3d at 1237.

³⁶ No. 5:22-cv-335 (C.D. Cal. Sept. 2, 2022).

³⁷ No. 1:22-cv-953 (D.N.M. dismissed Apr. 5, 2023).

Assisted Suicide “Safeguards” Cannot Protect Vulnerable Patients



Although assisted suicide statutes have included “safeguard” provisions, in effect, these protections cannot adequately protect vulnerable end-of-life patients. Assisted suicide uses experimental drugs, is coercive, and discriminates against the elderly and persons with illnesses or disabilities. These practices undermine the integrity of the medical profession and are contrary to a physician’s societal role as a healer.³⁸

Suicide Doctors Use Experimental Drugs on End-of-Life Patients

There is no standardized drug nor required dosage for assisted suicide. “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.”³⁹ Federally, the Food and Drug Act regulates pharmaceuticals and requires “that both ‘safety’ and ‘efficacy’ of a drug for its intended purpose (its ‘indi-

cation’) be demonstrated in order to approve the drug for distribution and marketing to the public.”⁴⁰ Lethal medication could never meet the safety or efficacy requirements for treating mental or physical ailments.

Around 2016, suicide doctors turned away from using short-acting barbiturates due to price gouging and supply issues.⁴¹ Consequently, suicide doctors began mixing experimental drug compounds at lethal dosages to assist suicides.⁴² 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.”⁴³ 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

³⁸ *Glucksberg*, 521 U.S. at 731 (discussing the State’s “interest in protecting the integrity and ethics of the medical profession”). Notably, the Alzheimer’s Association recently terminated its education partnership with Compassion & Choices, a leading assisted suicide activist organization, recognizing “[t]heir values are inconsistent with those of the Association,” which is “a patient advocacy group and evidence-based organization . . . [that] 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.” *Alzheimer’s Association Statement About Compassion & Choices*, ALZHEIMER’S ASS’N (Jan. 29, 2023), <https://www.alz.org/news/2023/alzheimers-association-statement>.

³⁹ 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).

⁴⁰ *Id.* at 340.

⁴¹ Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. L. & Bioscis. 424, 429–430 (2017).

⁴² 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).

⁴³ *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN. (Sept. 10, 2020), <https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies>.

These patients’ “desire for hastened death is significantly associated with a diagnosis of major depression.” Even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.

about which drugs to prescribe.”⁴⁴ In 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.”⁴⁵

The use of experimental drugs creates informed consent issues. Informed consent is a foundational principle of modern medicine, and “is a process by which the treating health care provider discloses appropriate information to a competent patient so that the patient may make a voluntary choice to accept or refuse treatment.”⁴⁶ Notably, a patient cannot agree to medical treatment unless she is “competent, adequately informed and not coerced” in giving informed consent.⁴⁷ Yet, as scholarship published in the *British Medical Bulletin* explains:

The experience of “assisted dying” may not be the “safe and comfortable” process promoted by campaigners, and patients must be properly informed of the realities of hastening death and the risk of distressing complications. In the case of assisted suicide, this includes difficulties ingesting the volume of lethal drugs, adverse reactions to such drugs once ingested, and chances of a prolonged dying which could take several hours.

In this regard, assisted suicide drugs raise serious informed consent issues regarding the experimental nature and attendant risks of the drug concoctions.

Assisted Suicide Safeguards Cannot Protect Patients from Coercion and Abuse

At both the medication request and time of ingestion stages, there are grave competency and informed consent concerns for assisted suicide patients. Scholarship shows “[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms.”⁴⁸ “[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.”⁴⁹ These patients’ “desire for hastened death is significantly associated with a diagnosis of major depression.”⁵⁰ Their psychiatric

⁴⁴ 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/>.

⁴⁵ *Id.*

⁴⁶ Christine S. Cocanour, *Informed Consent—It’s More Than a Signature on a Piece of Paper*, 214 AM. J. SURGERY 993, 993 (2017).

⁴⁷ *Id.*

⁴⁸ Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT’L J. L. & PSYCHIATRY 461, 461 (2013).

⁴⁹ *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”).

⁵⁰ *Id.*

disability also may impair decision-making, “such as the decision to end one’s life.”⁵¹

Even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.⁵² 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.⁵³ Even during counseling, psychiatrists have limited ability in diagnosing depression. One study shows that “[o]nly 6% of psychiatrists were very confident that in a single evaluation they could adequately assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide.”⁵⁴

Patients may engage in “doctor shopping,” where a patient will seek a different physician if a first physician refuses or denies prescribing lethal drugs to the patient.⁵⁵ More concerning is that, as of 2022, Oregon data shows that the median duration of an assisted suicide patient-physician relationship was only five weeks.⁵⁶ Doctor shopping raises serious concerns about a physician’s ability to diagnose depression in new patients.

All assisted suicide statutes require two witnesses to attest to a patient’s capacity at the time of the medication request. All jurisdictions but Vermont require that “one of the two witnesses must be unrelated to the patient and must not receive any benefits upon his or her death.”⁵⁷ In those jurisdictions, “no requirements are in place

Oregon data shows that the median duration of an assisted suicide patient-physician relationship was only five weeks.

for the second witness to be disinterested in any way—the two witnesses could be an heir and his cousin or an heir and his best friend.”⁵⁸ In this case, there are no requirements for witnesses to attest to the patient’s capacity at the medication request, nor are there safeguards against an heir or coercive family caregiver from being present when the patient requests medication.

Doctors also have difficulty in accurately dating terminal illness life expectancy. In the assisted suicide context, terminal illness “means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”⁵⁹ 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. Actually, it is common for medical prognoses of a short life expectancy to be wrong.”⁶⁰ Likewise, “[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival.”⁶¹

⁵¹ *Id.*

⁵² *Foster, supra* note 17, at 54.

⁵³ OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9 (Mar. 8, 2023).

⁵⁴ Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996).

⁵⁵ NAT’L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 27 (2019).

⁵⁶ OR. PUB. HEALTH DIV., *supra* note 53, at 14.

⁵⁷ *Foster, supra* note 17, at 53; see VT. STAT. ANN. tit. 18 § 5283(a)(4).

⁵⁸ *Id.*

⁵⁹ OR. REV. STAT. § 127.800(12).

⁶⁰ NAT’L COUNCIL ON DISABILITY, *supra* note 55, at 21.

⁶¹ *Id.* at 22.



Unfortunately, assisted suicide doctors do not provide oversight during the actual ingestion process. “[O]nce the prescription is written, there are no further protections. At no point does the law require [a physician or other healthcare provider] to be at the bedside. Nothing needs to be done to ensure that the patient is competent or to prevent coercion.”⁶² In California in 2021, a physician or health care worker only was present 43.0% of the time when the patient ingested the drugs.⁶³ In Oregon in 2022, excluding unknown data, the prescribing physician only was present when the patient ingested the lethal medication 24.4% of the time while a non-prescribing healthcare worker was present in 16.7% of cases.⁶⁴ Without a medical professional present, there is no medical oversight over the ingestion process or lethal outcome. This is concerning as there are no requirements that a disinterested person, or even anyone at all, witness the patient’s death or that the patient is the one ultimately taking these drugs.⁶⁵

Finally, states have inadequate reporting requirements. Oregon, for example, recognizes that it receives residency information from death certificates, but does not collect death certificates from non-residents that die out-of-state. Consequently, Oregon data “may not represent all [assisted suicide] deaths from out-of-state residents” that engaged in Oregon suicide tourism.⁶⁶ Generally, there is a “substantial lack of data, including both quantitative and qualitative data, on the medical and demographic profiles of people who have sought and used assisted suicide.”⁶⁷ The statistical data is solely based on forms filled out and filed by assisted suicide physicians and pharmacies that dispense the lethal drug cocktails.⁶⁸ “[D]octors are unlikely to report their own lack of compliance with the law . . . [and] the state has no way for the public, family members, or other healthcare professionals to report suspected problems, nor even a means of investigating mistakes and abuse.”⁶⁹

⁶² SMITH, *supra* note 6, at 130.

⁶³ CAL. DEP’T OF PUB. HEALTH, CALIFORNIA END OF LIFE OPTION ACT: 2021 DATA REPORT 8 (July 2022).

⁶⁴ OR. PUB. HEALTH DIV., *supra* note 53, at 14. These statistics show the issue of underreporting. Oregon recognizes that there is unknown data for whether a health care provider is present at the time of ingestion for 98 out of 278 reported drug ingestions, or 35.3% of patients. *Id.*

⁶⁵ Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 DISABILITY & HEALTH J. 16, 20 (2010); Foster, *supra* note 17, at 53.

⁶⁶ OR. PUB. HEALTH DIV., *supra* note 53, at 5.

⁶⁷ NAT’L COUNCIL ON DISABILITY, *supra* note 55, at 33.

⁶⁸ *Id.* at 34.

⁶⁹ *Id.*



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.

There also is a serious issue of missing documentation despite legal requirements for reporting. As a study from the Charlotte Lozier Institute details, in 2021, lethal drugs were dispensed to 400 patients under Washington’s “Death With Dignity Act,” but the state was missing legally required documentation of: “46 written and witnessed requests from patients[,] 35 attending physician compliance forms[,] 47 consulting physician compliance forms[,] 20 pharmacy dispensing forms, and] 39 after-death reporting forms.”⁷⁰ After noting missing data from other years, the report concludes, “[a]t the implementation level, then, the ‘Death with Dignity Act’ seems to be a system out of control—or out of the control of everyone except the physicians whose behavior it is supposed to regulate. When the safeguards are not enforced, they become meaningless.”⁷¹ In sum, assisted suicide “safeguards” inadequately protect patients against coercion and abuse.

Physician-Assisted Suicide Is Rife with Discrimination

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.”⁷² This creates “a two-tiered system for measuring the worth of human life” according to bioethicist Wesley J. Smith.⁷³ In this stratified system:

⁷⁰ Richard Doerflinger, *Lethal Non-Compliance With Washington’s “Death With Dignity Act,”* CHARLOTTE LOZIER INST. 1, 5 (Dec. 20, 2022), <https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/>.

⁷¹ *Id.* at 7.

⁷² SMITH, *supra* note 6, at 117.

⁷³ *Id.*

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.⁷⁴

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.”⁷⁵ Although states have tried to place safeguards into statutes, “[n]o safeguards have ever been enacted or proposed that can prevent this outcome.”⁷⁶

State reports show that patients seek assisted suicide not for pain management, but because of the challenges of living with severe illnesses or disabilities. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited either “inadequate pain control” or just concern about inadequate pain control as a reason for choosing assisted suicide.⁷⁷ Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

Accordingly, assisted suicide is rampant with ableism and discrimination because it lethally judges patients’ quality of life based upon their terminal illnesses and disabilities.

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 85.0% in Washington);
- Losing autonomy (86.3% in Oregon, 85.0% in Washington);
- Loss of dignity (61.9% in Oregon, 73.0% in Washington);
- Burden on family, friends/caregivers (46.4% in Oregon, 56.0% in Washington);
- Losing control of bodily functions (44.6% in Oregon, 50.0% in Washington).⁷⁸

Data shows that Oregon patients historically have ranked pain lower than the autonomy and dignity categories.⁷⁹ These lamentably are “psychological issues that are all-too-familiar to the disability community.”⁸⁰

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

⁷⁴ *Id.*

⁷⁵ NAT’L COUNCIL ON DISABILITY, *supra* note 55, at 14–15.

⁷⁶ *Id.* at 15.

⁷⁷ OR. PUB. HEALTH DIV., *supra* note 53, at 14; WASH. DISEASE CONTROL & HEALTH STATS., 2021 DEATH WITH DIGNITY ACT REPORT 11 (July 15, 2022).

⁷⁸ *Id.*

⁷⁹ OR. PUB. HEALTH DIV., *supra* note 53, at 14.

⁸⁰ NAT’L COUNCIL ON DISABILITY, *supra* note 55, at 37.



Increasing Suicide Access Undercuts Suicide Prevention Policies

end of life approaches.”⁸¹ Accordingly, assisted suicide is rampant with ableism and discrimination because it lethally judges patients’ quality of life based upon their terminal illnesses and disabilities.

The United States has a strong public policy of suicide prevention.⁸² 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.”⁸³ “Suicide and suicide attempts cause serious emotional, physical, and economic impacts” in suicide survivors, loved ones, and the community.⁸⁴ 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.”⁸⁵

Assisted suicide exacerbates suicide rates.⁸⁶ According to recent scholarship published by the Anscombe Bioethics Centre, when a juris-

Suicide and suicide attempts cause serious emotional, physical, and economic impacts in suicide survivors, loved ones, and the community.

diction introduces assisted suicide, the “[r]ates of non-assisted suicide also increase, in some cases significantly.”⁸⁷ 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.”⁸⁸ In fact, legalization of assisted suicide undermines suicide prevention policies:

There is robust evidence, taken from different jurisdictions and using a variety of

⁸¹ Aden, *supra* note 39, at 324.

⁸² *Suicide Prevention*, *supra* note 3.

⁸³ *Facts About Suicide*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 24, 2022), <https://www.cdc.gov/suicide/facts/index.html>.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ Part of the suicide contagion problem is that there is a “copycat” phenomenon, dubbed the ‘Werther Effect’ . . . whereby media reporting of suicides by celebrities and well-known figures leads to an increase in suicide deaths in the general population. This effect has been studied and re-confirmed across multiple time periods and geographic regions in recent decades.” Robert A. Fahey et al., *Tracking the Werther Effect on Social Media: Emotional Responses to Prominent Suicide Deaths on Twitter and Subsequent Increases in Suicide*, 219 Soc. Sci. & Med. 19, 19 (2018). In this regard, sensationalizing assisted suicide leads to lethal consequences.

⁸⁷ 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>.

⁸⁸ *Id.* at 9.

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.⁸⁹

Similarly, “[c]ontrolling for various socioeconomic factors, unobservable state and year effects, and state-specific linear trends,” research has demonstrated that assisted suicide legalization in U.S. jurisdictions is “associated with a 6.3% . . . increase in total suicides (including assisted suicides).”⁹⁰ However, in individuals over 65 years old, this increase was 14.5%.⁹¹ Consequently, expanding assisted suicide subverts suicide prevention policies.



⁸⁹ *Id.*

⁹⁰ David Albert Jones & David Paton, *How Does Legalization of Physician Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 599, 599, 601 (2015).

⁹¹ *Id.*

Congress' Powers to Protect End-of-Life Patients



Although the Supreme Court held there is no constitutional right to assisted suicide, the federal fight against suicide assistance is not over. As a first step, it is important for Congress to hold hearings to engage in fact finding and raise public awareness about assisted suicide.⁹² Facts raised during congressional hearings can bolster the defense of life-affirming laws or lead to prosecution of illicit behavior. During the 109th Congress, for example, the Senate Judiciary's Subcommittee on the Constitution, Civil Rights, and Property Rights held a hearing on the policy ramifications of legalizing assisted suicide.⁹³ Congress should consider hearings on these topics:

- Assisted suicide's ableism and discrimination against the elderly and persons with illnesses and disabilities.
- The improper use of lethal experimental drugs within physician-assisted suicide.
- Conscience concerns for doctors and pharmacists who religiously or morally

object to participating in the taking of a human life.⁹⁴

The Constitution also grants Congress the power to regulate and prohibit assisted suicide. For example, this report highlights the Commerce Clause, Spending Clause, Territorial Clause, Postal Clause, and the Fourteenth Amendment's Enforcement Provision.

The **Commerce Clause** authorizes Congress "[t]o regulate Commerce . . . among the several States."⁹⁵ Under the Commerce Clause, Congress may regulate (1) interstate commerce channels, (2) "the instrumentalities of interstate commerce, or persons or things in interstate commerce," and (3) "those activities having a substantial relation to interstate commerce."⁹⁶ Congress has used its commerce power to regulate drugs under the Federal Food, Drug, and Cosmetic Act⁹⁷ as well as the Controlled Substances Act.⁹⁸ Similarly, Congress could use the Commerce Clause to restrict the use of lethal experimental drugs in assisted suicide.⁹⁹

⁹² Although this report focuses on federal legislative strategies to combat assisted suicide, there is room for administrative actions as well. See Americans United for Life, Comment Letter on Proposed Rule on Safeguarding the Rights of Conscience as Protected by Federal Statutes (Mar. 6, 2023), <https://aui.org/wp-content/uploads/2023/03/AUL-Comment-Safeguarding-the-Rights-of-Conscience-as-Protected-by-Federal-Statutes-RIN-0945-AA18.pdf> (arguing for the U.S. Department of Health and Human Services to maintain robust compliance measures for federal anti-discrimination laws that protect conscientious objections to assisted suicide).

⁹³ *The Consequences of Legalized Assisted Suicide and Euthanasia*, *supra* note 2. See also *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Const. of the H. Comm. on the Judiciary*, 104th Cong. (1996).

⁹⁴ See Americans United for Life, Comment Letter on Proposed Rule, *supra* note 92 (detailing conscience issues raised in assisted suicide in the United States).

⁹⁵ U.S. CONST. art. I, § 8, cl. 3.

⁹⁶ *United States v. Lopez*, 514 U.S. 549, 558–559 (1995).

⁹⁷ 21 U.S.C. §§ 301 to 399i; see *United States v. Walsh*, 331 U.S. 432, 434 (1947) ("The Federal Food, Drug, and Cosmetic Act rests upon the constitutional power resident in Congress to regulate interstate commerce.").

⁹⁸ 21 U.S.C. §§ 801 to 971; see *Gonzales v. Raich*, 545 U.S. 1, 9 (2005) ("The CSA is a valid exercise of federal power [under the Commerce and Necessary and Proper Clauses] . . .").

⁹⁹ In *Gonzales v. Oregon*, the Supreme Court held unlawful the U.S. Attorney General's guidance that interpreted the Controlled Substances Act ("CSA"), and "declar[ed] that using controlled substances to assist suicide is not a legitimate medical practice and that dispensing or prescribing them for this purpose is unlawful under the CSA." 546 U.S. 243, 249, 275 (2006). Notably, *Gonzales v. Oregon* raised administrative law questions, not issues of Congress' Commerce Clause power. In other words, Congress retains its full constitutional authority to legislate on the assisted suicide issue.



The **Spending Clause** grants Congress the general power to spend “for the common Defence [sic] and general Welfare of the United States.”¹⁰⁰ Congress is limited in its exercise of the Spending Clause by five factors: 1) the expenditure must promote “the general welfare”; 2) any conditions imposed through the spending power must not be ambiguous; 3) the conditions must reasonably relate to the purpose of the expenditure; 4) the legislation cannot violate any independent constitutional rights of the recipient; and 5) the conditions must not be unconstitutionally coercive.¹⁰¹ Under its spending power, Congress attached assisted suicide conscience protections to the Affordable Care Act¹⁰² as well as prohibited the use of federal funds for suicide assistance.¹⁰³ Congress could use its spending power to strengthen protections for medical professionals and institutions who conscientiously object to taking a human life.

The **Territorial Clause** recognizes that “Congress shall have Power to dispose of and make all needful Rules and Regulations respecting the Territory or other Property belonging to the United States.”¹⁰⁴ Congress used its territorial power to pass federal funding restrictions on suicide assistance within the District of Columbia.¹⁰⁵ Congress likewise could restrict the distribution of lethal experimental drugs for suicide assistance within Washington D.C. and other U.S. territories.

The **Postal Clause** gives Congress the constitutional power “[t]o establish Post Offices and post Roads”¹⁰⁶ and “[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Power[.]”¹⁰⁷ Congress could use its postal power to restrict the dangerous use of telemedicine within suicide assistance, which utilizes the mail system and couriers to send lethal experimental drugs to patients.¹⁰⁸

¹⁰⁰ U.S. CONST. art. I, § 8, cl. 1.

¹⁰¹ *South Dakota v. Dole*, 483 U.S. 203, 207–208, 211 (1987).

¹⁰² 42 U.S.C. § 18113.

¹⁰³ 42 U.S.C. §§ 14401 to 14408, 18113.

¹⁰⁴ U.S. CONST. art. IV, § 3, cl. 2.

¹⁰⁵ 42 U.S.C. § 14407.

¹⁰⁶ U.S. CONST. art. I, § 8, cl. 7.

¹⁰⁷ *Id.* art. I, § 8, cl. 18.

¹⁰⁸ *Cf.* 18 U.S.C. § 1461 (barring the use of the United States Postal Service for mailing abortion-inducing drugs, including chemical abortion pills); 18 U.S.C. § 1462 (applying same restrictions to common carriers).

The **Fourteenth Amendment’s Enforcement Provision**, which gives Congress the “power to enforce, by appropriate legislation, the provisions of [the Fourteenth Amendment].”¹⁰⁹ Specifically, Congress could enforce the Equal Protection Clause of the Fourteenth Amendment, which guarantees that “nor [shall a State] deny to any person within its jurisdiction the equal protection of the laws.”¹¹⁰ Congress has used Section 5 to protect persons from disability discrimination through the Americans with Disabilities Act.¹¹¹ Similarly, Congress could protect persons with disabilities against discrimination and assisted suicide abuse through the Fourteenth Amendment’s Enforcement Provision.

In sum, Congress has the constitutional authority to protect end-of-life patients. Under these powers, Congress should consider legislation that:

- Restricts the use of lethal drugs for physician-assisted suicide.
- Prohibits the mailing of lethal drugs by postal service or courier to protect patients against the threat of telemedical suicide assistance.
- Strengthens conscience protections for doctors and physicians who conscientiously object to taking a human life.

- Requires states to report assisted suicide statistics to the Centers for Disease Control and Prevention.
- Reaffirms Congress’ stance against assisted suicide.¹¹²
- Increases social welfare to support patients’ access to authentic end-of-life healthcare.

This list is not exhaustive. For more ideas, Americans United for Life offers state model legislation that we can adapt to the federal level.¹¹³ Americans United for Life also is available to consult on new bill ideas. Congress has the power to protect vulnerable end-of-life patients from the threat of suicide assistance, and faces a time for choosing to foster a nationwide culture of suicide assistance or suicide prevention.

Congress has the power to protect vulnerable persons from the threat of suicide assistance, and faces a time for choosing to foster a nationwide culture of suicide assistance or suicide prevention.

¹⁰⁹ U.S. CONST. amend. XIV, § 5.

¹¹⁰ *Id.* amend. XIV, § 1.

¹¹¹ 42 U.S.C. § 12101 to 12213; see *Tennessee v. Lane*, 541 U.S. 509, 533–534 (2004) (holding that the Americans with Disabilities Act’s “Title II, as it applies to the class of cases implicating the fundamental right of access to the courts, constitutes a valid exercise of Congress’ § 5 authority to enforce the guarantees of the Fourteenth Amendment”).

¹¹² See H.R. Con. Res. 68, 117th Cong. (2022) (“That it is the sense of Congress that the Federal Government should ensure that every person facing the end of their life has access to the best quality and comprehensive medical care, including palliative, in-home, or hospice care, tailored to their needs and that the Federal Government should not adopt or endorse policies or practices that support, encourage, or facilitate suicide or assisted suicide, whether by physicians or others.”); see also H.R. Con. Res. 79, 116th Cong. (2019) (same); H.R. Con. Res. 80, 115th Cong. (2017) (same).

¹¹³ *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE (last visited Mar. 16, 2023), <https://aul.org/law-and-policy/>.

States' Roles in Safeguarding Human Dignity at the End of Life



States are on the frontlines of the battle against assisted suicide and have broad powers to protect the health and safety of their residents. As the Supreme Court recognized in *Barsky v. Board of Regents of the University of the State of New York*:

It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health.¹¹⁴

Under these robust powers, states can refuse to recognize suicide as medicine, and protect patients from the harms of assisted suicide. This is important because states are facing threats from the suicide lobby. Pro-life states are defending patients against the effects of suicide tourism and judicial and legislative activism that seeks to decriminalize suicide assistance. In anti-life states that have permitted assisted suicide, there are attempts to de-medicalize the practice which would further place patients at risk of coercion

States are on the frontlines of the battle against assisted suicide and have broad powers to protect the health and safety of their residents.

and abuse. Americans United for Life tracks assisted suicide legislation¹¹⁵ and has drafted model legislation to assist states in combatting the spread of suicide activism.¹¹⁶ This report highlights four AUL model bills.

The *Suicide by Physician Ban Act*¹¹⁷ prohibits any person from advising, assisting, or encouraging a patient to commit suicide, nor provide suicide assistance. If a person violates the Act, then they may be subject to civil and criminal penalties, as well as professional sanctions. This legislation is ideal to strengthen pro-life protections against assisted suicide or to repeal and re-criminalize assisted suicide in states that have permitted the practice.

The *Joint Resolution Opposing Suicide by Physician*¹¹⁸ recognizes that the state legislature

¹¹⁴ 347 U.S. 442, 449 (1954).

¹¹⁵ *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE (last visited Mar. 16, 2023), <https://aul.org/law-and-policy/state-legislation-tracker/>.

¹¹⁶ *Pro-Life Model Legislation and Guides*, *supra* note 114.

¹¹⁷ *Suicide by Physician Ban Act*, AMS. UNITED FOR LIFE (2023), <https://aul.org/wp-content/uploads/2022/12/Assisted-Suicide-Ban-Act-9-2022.pdf>.

¹¹⁸ *Joint Resolution Opposing Suicide by Physician*, AMS. UNITED FOR LIFE (2023), <https://aul.org/wp-content/uploads/2023/01/Joint-Resolution-Opposing-Physician-Assisted-Suicide.pdf>.

opposes and condemns assisted suicide because it takes and devalues human life, hinders authentic life-affirming medicine, and compromises the integrity of the medical profession. The legislation strengthens a state’s public policy of suicide prevention, which is an important safeguard against suicide activism.

The *End-of-Life Dignity Declaration Act*¹¹⁹ declares that there is no right or “consent” defense to assisted suicide, nor is there anything in state law that otherwise legalizes, condones, or decriminalizes suicide assistance. The legislation protects pro-life states against judicial activism that seeks to decriminalize assisted suicide.

The *Suicide Coercion Prevention Act*¹²⁰ clarifies that individuals who assist a suicide may not inherit from the deceased patient, restricts insurance from covering lethal experimental drugs, imposes professional sanctions upon doctors assisting a suicide, and clarifies that assisted suicide is not a “natural death” even though some states claim it is. The legislation assists pro-life states in protecting its residents against



the threat of assisted suicide, especially through suicide tourism.

AUL’s state policy team is available to assist state policymakers in adapting this model legislation to each state, as well as consulting on end-of-life bills. States have expansive powers to protect vulnerable patients from assisted suicide.

¹¹⁹ *End-of-Life Dignity Declaration Act*, AMS. UNITED FOR LIFE (2023), <https://aul.org/wp-content/uploads/2023/01/End-of-Life-Dignity-Declaration-Act10235b922c303f3c2a2a0a1933c2d5c4f5c3730078e3c55ee910cb9bfd2f5146.pdf>.

¹²⁰ *Suicide Coercion Prevention Act*, AMS. UNITED FOR LIFE (2023), <https://aul.org/wp-content/uploads/2023/01/Suicide-Coercion-Prevention-Act-01-2023.pdf>.



Conclusion

Suicide activists are pushing radical legislation and litigation that threatens human life. Physician-assisted suicide exploits vulnerable patients and degrades the integrity of the medical profession. Congress and the States, however, have the authority to protect all persons vulnerable to suicide activists. Americans United for Life is committed to assisting advocates and lawmakers in advancing the human right to life through a robust culture of suicide prevention. We strive for the day when all are welcomed throughout life and protected in law.

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Americans
**United
for Life**

(202) 289-1478
life@aul.org