Americans United for Life

Written Testimony of Catie Kelley
Policy Counsel, Americans United for Life
In Opposition to House Bill 140
Submitted to the Senate Executive Committee
April 9, 2025

Dear Chair Sokola, Vice Chair Townsend, and Members of the Committee:

My name is Catie Kelley, and I serve as Policy Counsel at Americans United for Life ("AUL"). Established in 1971, AUL is a national law and policy nonprofit organization with a specialization in abortion, end-of-life issues, and bioethics law. AUL publishes pro-life model legislation and policy guides,[1] tracks state bioethics legislation,[2] and regularly testifies on pro-life legislation in Congress and the states.[3] Courts have cited AUL briefs, including the Supreme Court decision in *Washington v. Glucksberg*,[4] which ruled the federal Due Process Clause does not recognize suicide assistance as a fundamental right, and the Massachusetts Supreme Judicial Court's recent decision in *Kligler v. Attorney General*, which ruled there is no fundamental right to assisted suicide under the state constitution.[5] Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

I write to urge your opposition of House Bill 140 ("H.B. 140" or "bill").[6] For the past ten years, Delaware has consistently rejected bills seeking to legalize physician-assisted

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Apr. 9, 2025). AUL is the original drafter of many of the hundreds of pro-life bills enacted in the States in recent years. *See* Olga Khazan, *Planning the End of Abortion*, ATLANTIC (July 16, 2020), www.theatlantic.com/politics/archive/2015/07/what-pro-life-activists-really-want/398297/ ("State legislatures have enacted a slew of abortion restrictions in recent years. Americans United for Life wrote most of them."); *see also* Anne Ryman & Matt Wynn, *For Anti-Abortion Activists, Success of 'Heartbeat' Bills was 10 Years in the Making*, CTR. PUB. INTEGRITY (Jun. 20, 2019), https://publicintegrity.org/politics/state-politics/copy-paste-legislate/for-anti-abortion-activists-success-of-heartbeat-bills-was-10-years-in-the-making/ ("The *USA TODAY/Arizona Republic* analysis found Americans United for Life was behind the bulk of the more than 400 copycat [anti-]abortion bills introduced in 41 states.").

[2] *State Spotlight*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-spotlight/ (last visited Apr. 9, 2025).

[3] *See, e.g.*, *Revoking Your Rights: The Ongoing Crisis in Abortion Care Access Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life); *What's Next: The Threat to Individual Freedoms in a Post-Roe World Before the H. Comm. on the Judiciary*, 117th Cong. (2022) (testimony of Catherine Glenn Foster, President & CEO, Americans United for Life).

[4] 521 U.S. 702, 774 n.13 (1997) (citing Brief for Members of the New York and Washington State Legislatures as *Amicus Curiae*).

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

[6] AUL has provided written and in-person testimony against similar bills during the 2023 and 2024 legislative sessions.

suicide. Along with residents of Delaware, I strongly affirm AUL's opposition to H.B. 140 for the following reasons: 1) the bill places already-vulnerable persons at greater risk of abuse and coercion, 2) the bill's "safeguards" fail to adequately protect vulnerable end-of-life patients, and 3) the bill erodes the integrity and ethics of the medical profession.

I. Physician-Assisted Suicide Targets Already-Vulnerable Persons and Puts Them at Greater Risk of Abuse and Coercion

Today, you have the opportunity to protect individuals living in poverty, the elderly, and those living with disabilities, from dangerous death-on-demand policies. Physician-assisted suicide laws promote both ableism and agism,[7] which is why all national disability rights organizations that have taken a position on assisted suicide have opposed it.[8] This includes national, recognized groups like the American Association of People with Disabilities, the National Council on Disability, the Disability Rights Education and Defense Fund, the United Spinal Association, and many more.[9]

As the National Council on Disability notes in a 2019 report, "[t]he idea that hastened death is a pathway to dignity for people facing physical decline reveals the public's extreme disparagement of functional limitations and a perception that 'dignity' is not possible for people who rely on supports, technology, or caregivers to be independent or alive."[10] "These types of misperceptions and misunderstandings are rooted in disability prejudice, and in the context of assisted suicide laws and policies, they create a deadly mix that poses multifaceted risks and dangers to people with disabilities as well as people in other vulnerable constituencies," such as the elderly, and people who have chronic or progressive conditions.[11] Accordingly, assisted suicide "creates 'a two-tiered system for measuring the worth of human life.'"[12] "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 . . . would be shrugged off as merely a matter of choice."[13] This kind of value system perpetuates discriminatory treatment of vulnerable persons.

Not only do physician-assisted suicide laws disparately impact people with disabilities and the elderly, but they also subject vulnerable communities to greater risks of abuse, neglect, and coercion. In states that have decriminalized physician-assisted suicide, there are a myriad of abuses that occur, including a lack of required reporting, coercion of

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[7] *See* Carolyn McDonnell, *A Time to Choose: Suicide Assistance or Suicide Prevention?*, AMS. UNITED FOR LIFE (May 2023), https://aul.org/wp-content/uploads/2023/04/2023-05-A-Time-to-Choose-Suicide-Assistance-or-Suicide-Prevention-Web.pdf.
[8] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 15 (2019).
[9] *Disability Groups Opposed to Assisted Suicide Laws*, NOT DEAD YET, https://notdeadyet.org/disability-groups-opposed-to-assisted-suicide-laws/ (last visited Apr. 9, 2025).
[10] *Supra* note 8, at 15.
[11] *Id*. at 16.
[12] McDonnell, *supra* note 7, at 14-15 (quoting 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/).
[13] *Id*. at 15.

patients, and failure to ensure the competency of patients seeking assisted suicide.[14] In Oregon and Washington, individuals have died by assisted suicide even though they were not terminally ill and did not have the capacity to consent.[15] Some individuals seeking assisted suicide were never even referred to mental health professionals despite having medical histories of depression and suicide attempts.[16] In Colorado, physicians have prescribed assisted suicide drugs to women who were struggling with eating disorders.[17] One doctor reported in 2020 that two of his patients with "serious illness[es] [who] would not be terminal with treatment" were referred for treatment to California and Oregon, but both "patients were denied care from their insurance companies and instead offered the end-of life option.[18] These examples from California, Colorado, Oregon, and Washington—four of the eleven jurisdictions that have legalized death-on-demand—evidence the wide-spread abuse vulnerable patients face when considering to engage in assisted suicide.

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, activist groups continue to promote its legalization. This has led to a "suicide contagion," or the Werther Effect.[19] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[20] One study demonstrates that legalizing suicide by physician in certain states has led to a *rise*

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[14] José Pereira, *Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls*, 18 CURRENT ONCOLOGY e38 (2011) (Finding that "laws and safeguards are regularly ignored and transgressed in all the jurisdictions and that transgressions are not prosecuted."); *see also* WASHINGTON 2018 REPORT (In 2018, 51% of patients who requested a lethal dose of medicine in Washington did so, at least in part, because they did not want to be a "burden" on family members, raising the concern that patients were pushed to suicide.).

[15] *See* Disability Rights Education & Defense Fund, *Some Oregon and Washington State Assisted Suicide Abuses and Complications*, DREDF, https://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/#_edn1 (last visited Apr. 9, 2025).

[16] *See Id*.

[17] *Denver Doctor Helped Patients with Severe Anorexia Obtain Aid-In-Dying Medication, Spurring National Ethics Debate*, CO. SUN (Mar. 14, 2022), https://coloradosun.com/2022/03/14/denver-doctor-gaudiani-aid-in-dying-aneroexia-patients/, *see also* Chelsea Roff, et al, *Assisted Dying Laws Around the World: Proposed UK Assisted Dying Bill Fails the Public Safety Test*, BMJ (Oct. 30, 2024), https://www.bmj.com/content/387/bmj.q2385/rr.

[18] Danielle Zoellner, *The Case Against Medical Aid in Dying: Insurance Firms, Doctors and Hollywood Among Those Accused of Pushing 'Assisted Suicide'*, INDEPENDENT (Oct. 22, 2020), https://www.the-independent.com/news/world/americas/medical-aid-in-dying-assisted-suicide-opposition-right-to-die-b1186312.html; *see also* Allie Sanchez, *Insurer Offers to Pay for Assisted Suicide but Not Chemotherapy*, INSURANCE BUSINESS MAGAZINE (Oct. 21, 2016), https://www.insurancebusinessmag.com/us/news/breaking-news/insurer-offers-to-pay-for-assisted-suicide-but-not-chemotherapy-39441.aspx.

[19] *See, e.g.,* Vivien Kogler & Alexander Noyon, *The Werther Effect—About the Handling of Suicide in the Media*, OPEN ACCESS GOV'T (May 17, 2018), https://www.openaccessgovernment.org/the-werther-effect/42915/. There is, however and more positively, a converse Papageno Effect whereby media attention surrounding people with suicidal ideation who choose not to commit suicide inspires others to follow suit. *See, e.g.*, Alexa Moody, *The Two Effects: Werther vs Papageno*, PLEASE LIVE (Jun. 5, 2015), http://www.pleaselive.org/blog/the-two-effects-werther-vs-papageno-alexa-moody/.

[20] *See id*.; *see also* S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. EPIDEMIOL. COMMUNITY HEALTH 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 ARCH. SUICIDE RSCH. 137 (2004).

in overall suicide rates—assisted and unassisted—in those states.[21] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in overall suicide rates.[22] Unfortunately, these effects are even greater for individuals older than 65, which has seen a 14.5% increase in overall suicide rates for that demographic.[23] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[24]

Suicide activists also continue to spread false narratives about death-on-demand policies, to the detriment of vulnerable communities. For example, contrary to the prevailing cultural narrative, patients are not considering assisted suicide for pain management reasons. According to recent data, only 31.3% of Oregon patients and 46.0% of Washington patients cited "[i]nadequate pain control" or just *concern* about inadequate pain control as a reason for choosing suicide by physician.[25] Rather, physicians reported that the top five reasons their patients requested assisted suicide in both Oregon and Washington were the following:

- Less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington).
- Losing autonomy (86.3% in Oregon, 83.0% in Washington).
- Loss of dignity (61.9% in Oregon, 69.0% in Washington).
- Burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington).
- Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[26]

These feelings "are all-too-familiar to the disability community,"[27] who may feel like a burden or less autonomous than someone who is able-bodied due to the misperceptions society places on them. However, rather than prescribing a lethal overdose to patients who are experiencing hopelessness and despair after receiving a difficult diagnosis, physicians should ensure that their patients are met with compassion and given the best treatment, palliative care, or pain management available that will improve their quality of life.

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[21] *See* David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (2015), https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf; *see also* David Albert Jones, *Suicide Prevention: Does Legalizing Assisted Suicide Make Things Better or Worse?*, ANSCOMBE BIOETHICS CENTRE (2022), https://bioethics.org.uk/media/mhrka5f3/suicide-prevention-does-legalising-assisted-suicide-make-things-better-or-worse-prof-david-albert-jones.pdf.

[22] Jones & Paton, *supra* note 21, at 601.

[23] *Id*. at 603.

[24] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, Jan-Feb 2015, available at https://www.clmagazine.org/topic/end-of-life/a-tale-of-two-suicides-brittany-maynard-and-my-daughter/ (suicide prevention experts criticizing a billboard stating, "My Life My Death My Choice," which provided a website address, as "irresponsible and downright dangerous; it is the equivalent of handing a gun to someone who is suicidal").

[25] OR. PUB. HEALTH DIV., OREGON DEATH WITH DIGNITY ACT: 2022 DATA SUMMARY 9, 14 (Mar. 8, 2023); WASH. DISEASE CONTROL & HEALTH STATS., 2022 DEATH WITH DIGNITY ACT REPORT 7 (June 2, 2023).

[26] *Id*.

[27] *Supra* note 8, at 37.

Furthermore, the legalization of physician-assisted suicide disincentivizes the medical field from developing and improving palliative care as well as treatment and care options for the chronically or terminally ill.[28] For example, after legalizing physician-assisted suicide, Washington, Montana, and Vermont fell "below the national average in hospice utilization rate."[29] In the end, "legalizing assisted suicide for *any* [person] will undermine healthcare for *everyone*."[30]

Legalizing suicide is neither "compassionate" nor an appropriate solution for those who may suffer from depression or loss of hope at the end of their lives. H.B. 140 targets these vulnerable individuals and communicates the message that their lives are not worth living simply because of their physical or mental disability, illness, or age. However, these individuals are worthy of life and are entitled to equal protection under the law, which is why you should reject H.B. 140.

II. H.B. 140's Supposed Safeguards Are Ineffective in Adequately Protecting Vulnerable Patients

Although the bill includes so-called "safeguards," in effect, these provisions cannot adequately protect vulnerable end-of-life patients.[31] For example, under § 2510C, the bill only requires a physician to refer a patient to a psychiatrist or psychologist for an evaluation if the physician believes that the patient may not have "decision-making capacity." Yet, even with the high rates of depression among patients considering assisted suicide, counseling referrals are astonishingly rare.[32] 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*.[33]

Additionally, even though the bill requires the attending physician or attending practice registered nurse ("nurse") to have "primary responsibility for the individual's terminal illness," the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[34] The short duration of these relationships raises serious concerns as to whether a physician or nurse can accurately determine the capacity of the patient. If this bill is passed, the likelihood of a Delaware physician or nurse

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[28] *See* Clarke D. Forsythe, *The Incentives and Disincentives Created by Legalizing Physician-Assisted Suicide*, 12 ST. JOHN'S J. LEGAL COMMENT. 680, 684, 687 (1996–1997).
[29] O. CARTER SNEAD, WHAT IT MEANS TO BE HUMAN: THE CASE FOR THE BODY IN PUBLIC BIOETHICS 263 (2020)
[30] Forsythe, *supra* note 22, at 687 (emphasis added).
[31] The text of the bill is inconsistent with its legislative findings. For example, in the preamble of the bill, it states "WHEREAS . . . a mental illness or mental condition is not a qualifying condition because it does not meet the definition of a terminal illness." The synopsis of the bill also misleadingly states that under the Act, neither a mental illness nor mental condition qualifies as a terminal illness. However, nowhere in the actual text of the bill does it state that mental illness or mental condition would not qualify as a terminal illness. It also should be noted that the bill's "whereas" clauses, *i.e.*, legislative findings, will not become law if the bill is enacted. Thus, if enacted, there is nothing in the law to prevent a person who has a mental illness from obtaining lethal drugs.
[32] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 8, at 14.
[33] *Id*. at 9.
[34] *Id.* at 14.

referring an end-of life patient for a psychological evaluation is extremely low, especially when the physician or nurse may have only known the patient for less than five weeks.

The lack of counseling referrals for vulnerable end-of-life patients is gravely concerning. Scholarship shows "[a] high proportion of patients who request physician-assisted suicide are suffering from depression or present depressive symptoms."[35] "[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."[36] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[37] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[38]

Even if a Delaware physician or nurse refers a patient to a mental health professional for an assessment, the bill has no requirement that the patient and mental health professional meet more than once. In fact, although the bill defines "counseling" as "1 or more consultations, as necessary, between a psychiatrist or psychologist and an individual for the purpose of determining if the individual has decision-making capacity," the word "counseling" is not used anywhere else in the text of the bill. Under § 2510C (a-b), a psychiatrist or psychologist just needs to communicate in writing to the referring physician or nurse that the patient has "decision-making capacity to make an informed decision" after an "evaluation."[39] Thus, patients who are believed to have impaired decision making, can still obtain lethal drugs even if they do not receive any professional counseling from a psychiatrist or psychologists to ensure their competency.

Further, the bill's legislative findings state that "a mental illness or mental health condition may be the reason that an individual does not have decision-making capacity." Yet, the bill does not include any language in its actual text that would prevent a patient suffering from a mental illness from obtaining lethal drugs. This raises serious informed consent issues. Even if a physician or nurse refers the patient to a mental health professional for an "evaluation," one study has shown, "[o]nly 6% of psychiatrists were very confident that *in a single evaluation* they could assess whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide."[40] Nevertheless, under this bill, an individual suffering from depression can be deemed competent to take their own life without any professional counseling and after only one "evaluation" with a psychologist or psychiatrist. For these reasons, it is difficult to argue that any of these alleged "safeguards"

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[35] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).
[36] *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").
[37] *Id*.
[38] *Id*.
[39] The term "evaluation" is left undefined.
[40] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996) (emphasis added).

will allow physicians, nurses, and mental health professionals to accurately assess an individual's mental health and their "decision-making capacity."

Lastly, the bill assumes that physicians can correctly diagnose a patient with a "terminal condition." Under § 2508C, the bill requires either a physician or nurse to determine if the patient has a terminal illness. This fails as a safeguard as well because terminality is not easy to predict, and doctors have difficulty accurately dating the life expectancy of a terminally ill patient. As the National Council on Disability notes, "[a]ssisted suicide laws assume that doctors can estimate whether or not a patient diagnosed as terminally ill will die within 6 months. It is common for medical prognoses of a short life expectancy to be wrong."[41] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[42]

Shockingly, studies have shown "experts put the [misdiagnosis] rate at around 40%,"[43] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[44] which resulted in the individual's death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their prognosis.[45] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[46] In effect, this bill will result in individuals dying of assisted suicide who either did not have a terminal illness or would have outlived a six months life expectancy.

In sum, the bill's purported "safeguards" fail to protect vulnerable end-of-life patients. The bill leaves patients susceptible to coercion and abuse by family members and caregivers and does not—and cannot—ensure patients have given their informed consent to die through medicalized suicide. H.B. 140 does not give end of life patients "control over their deaths," as some proponents of the bill may argue. Instead, the bill gives physicians and nurses the unfettered ability to prematurely end their patients' lives in direct violation of their Hippocratic Oath "to do no harm."

III. Suicide by Physician Erodes the Integrity and Ethics of the Medical Profession

Prohibitions on physician-assisted suicide protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor

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[41] *Supra* note 8, at 21.
[42] *Id*. at 22.
[43] Trisha Torrey, *How Common is Misdiagnosis or Missed Diagnosis?*, VERYWELL HEALTH (Aug. 2, 2018), https://www.verywellhealth.com/how-common-is-misdiagnosis-or-missed-diagnosis-2615481.
[44] *See, e.g.*, Malcom Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, THE LOCAL (Apr. 24, 2014), https://www.thelocal.ch/20140424/swiss-doctor-acquitted-for-aiding-seniors-suicide (reporting the doctor was not held accountable for his negligence).
[45] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[46] *See id.*

make a suggestion to this effect."[47] Despite these ethical obligations, physician-assisted suicide laws force physicians to prescribe drugs to their patients for the purpose of causing a lethal overdose, which directly violates their Hippocratic Oath "to do no harm."

Medical organizations have recognized the harms of assisted suicide and have disavowed its use. In November 2023, the American Medical Association (AMA) affirmed its opposition to assisted suicide and euthanasia.[48] The current policy will remain in place, which states,

> [e]uthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.[49]

The AMA also refused to change the term "assisted suicide" to the misleading and inaccurate euphemism, "medical aid in dying."[50]

Even the U.S. Supreme Court has acknowledged that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession."[51] In Justice Antonin Scalia's dissent to another Supreme Court case involving a ban on the use of controlled substances for suicide by physician, he pointed out: "[v]irtually every relevant source of authoritative meaning confirms that the phrase 'legitimate medical purpose' does not include intentionally assisting suicide. 'Medicine' refers to '[t]he science and art dealing with the prevention, cure, or alleviation of disease' . . . . [T]he AMA has determined that '[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"[52] The bill directly contradicts Delaware's legitimate interest in protecting the integrity and ethics of the medical profession. Instead, the bill allows physicians to freely violate their ethical obligations and cause lethal harm to their patients through experimental drugs.

Consequently, H.B. 140 harms the medical profession, physicians, and people who may be struggling to process the shock of a difficult diagnosis. The bill opens the door for physicians and nurses to be forced to violate medical ethics, such as the Hippocratic Oath,

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[47] The Supreme Court has recognized the enduring value of the Hippocratic Oath: "[The Hippocratic Oath] represents the apex of the development of strict ethical concepts in medicine, and its influence endures to this day. . . .[W]ith the end of antiquity . . . [t]he Oath 'became the nucleus of all medical ethics' and 'was applauded as the embodiment of truth'" *Roe v. Wade*, 410 U.S. 113, 131-132 (1973).

[48] Wesley J. Smith, *AMA Retains Policy Against Assisted Suicide*, NAT'L REV. (Nov. 13, 2023), https://www.nationalreview.com/corner/ama-retains-policy-against-assisted-suicide/.

[49] American Medical Association, *CEJA Report B – A-91 Decisions Near the End of Life*, https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/5.8%20Euthanasia%20--%20background%20reports.pdf (last visited Apr. 9, 2025).

[50] Smith, *supra* note 48.

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

[52] Gonzales v. Oregon, 546 U.S. 243, 285–86 (2006) (Scalia, J., dissenting) (third internal quotation citing *Glucksberg* 521 U.S. at 731).

and increases the risk that patients will be coerced or pressured into prematurely ending their lives when pitched with suicide by physician as a viable treatment option with alleged benefits.

IV. Conclusion

Physician-assisted suicide is not healthcare. Instead, it acts as a limited exception to homicide liability under state law and forces physicians to violate their ethical obligations to their patients. For these reasons, I urge you to reject H.B. 140 and continue to uphold its duty to protect the lives of all its citizens—especially its vulnerable communities—and maintain the integrity and ethics of the medical profession.

Sincerely,

Catie Kelley
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AMERICANS UNITED FOR LIFE