



June 1, 2026

Submitted Electronically via Federal Rulemaking Portal

The Honorable Robert F. Kennedy, Jr.
Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Request for Information Regarding “Medical Aid in Dying”
(MAID) (CMS-1851-P) (RIN 0938-AV78)**

Dear Secretary Kennedy,

On behalf of Americans United for Life (“AUL”), we are writing in response to your request for information regarding medical aid in dying (“MAID”), especially regarding “any issues that may arise when a Medicare hospice patient requests [assisted suicide].”¹ AUL is a national pro-life legal advocacy organization. Founded in 1971, AUL has committed over fifty years to protecting human life from conception to 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 Courts have cited AUL briefs, such as the Supreme Court in *Washington v. Glucksberg*,³ holding there is no federal due process right to assisted suicide, and the Massachusetts Supreme Judicial Court in *Kligler v. Attorney General*, ruling there is no fundamental right to assisted suicide under the state constitution.⁴ One

¹ Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements, 91 Fed. Reg. 17,338, 17,363 (proposed Apr. 6, 2026).

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).

³ 521 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).

⁴ 198 N.E.3d 1229, 1237 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical & Dental Associations).

of the authors of this comment has written a comprehensive policy paper on assisted suicide in the United States.⁵

Thank you for the opportunity to provide information on assisted suicide practices in the United States, which pose significant health and safety and informed consent concerns for hospice patients. Most individuals who die from assisted suicide in the United States are enrolled in hospice care: 92% according to Oregon’s 2025 data and 90% according to Washington’s 2024 data.⁶ Below, we provide the legal background of assisted suicide within the United States and discuss the legal and bioethical concerns for patient safety and informed consent. We then request that the Department of Health and Human Services (“HHS”) and Centers for Medicare & Medicaid Services (“CMS”) use “assisted suicide” terminology, not “MAID,” as the agencies further consider this issue to conform with statutory language. We further ask that HHS and CMS consider establishing assisted suicide reporting requirements on hospice programs to monitor discrimination against persons with disabilities and other vulnerable populations, as well as ensure compliance with the Assisted Suicide Funding Restriction Act.⁷

I. A Minority of U.S. Jurisdictions Permit Assisted Suicide, Which Raises Significant Ethical, Health and Safety, and Informed Consent Issues.

The legality of assisted suicide depends on state law. In total, only fourteen jurisdictions have legalized assisted suicide. Twelve states—California, Colorado, Delaware, Hawaii, Illinois, Maine, New Jersey, New Mexico, New York, Oregon, Vermont, and Washington—and the District of Columbia have legalized assisted suicide through statute with purported patient safeguards.⁸ 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

⁵ 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>.

⁶ Or. Pub. Health Div. *Oregon Death with Dignity Act: 2025 Data Summary (Oregon 2025 Report)*, Or. Pub. Health Div. 1, 9 (Apr. 1, 2026), https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/1e8579_25.pdf; *Disease Control & Health Stats., 2024 Death with Dignity (Washington 2024 Report)*, Wash. State Dep’t Health 1, 1 (July 2025), <https://doh.wa.gov/sites/default/files/2026-02/422-109-DeathWithDignityAct2024.pdf>.

⁷ 42 U.S.C. § 14402.

⁸ Cal. Health & Safety Code §§ 443 to 443.22 (2016); Colo. Rev. Stat. §§ 25-48-101 to 25-48-124 (2016); D.C. Code §§ 7-661.01 to 7-661.16 (2017); Del. Code Ann. tit. 16 §§ 2501C to 2513C (2026); Haw. Rev. Stat. §§ 327L-1 to 327L-25 (2023); 410 Ill. Comp. Stat. 22/1 to 22/999 (2026) (effective Sept. 12, 2026); Me. Stat. tit. 22 § 2140 (2025); N.J. Stat. Ann. §§ 26:16-1 to 26:16-20 (2019); N.M. Stat. Ann. §§ 24-7C-1 to 24-7C-8 (2023); N.Y. Pub. Health Law §§ 2899-D to 2899-S (2026) (effective Aug. 5, 2026); Or. Rev. Stat. §§ 127.800 to 127.897 (2023); Vt. Stat. Ann. tit. 18 §§ 5281 to 5293 (2023); Wash. Rev. Code §§ 70.245.010 to 70.245.903 (2023).

against homicide charges in assisted suicide cases.⁹ 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.

Assisted suicide protocol varies among the jurisdictions based on statute. These statutes generally include heightened informed consent protections for patients, including:

- Residency requirements;¹⁰
- Determination by both an attending medical practitioner and consulting practitioner 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 medical practitioner from acting as a witness;
- Medical-practitioner-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 that begins upon the initial oral request; and
- Prescriber documentation of information in the patient's medical record, including the patient's diagnosis and medication requests.¹¹

If prescribers of assisted suicide drugs do not follow these requirements, 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 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.

Ultimately, however, the decriminalization of suicide leads to serious ethical, health and safety, and informed consent issues. At both the medication request and

⁹ 224 P.3d 1211, 1215, 1222 (2009).

¹⁰ However, there is a concerning trend among states that have decriminalized assisted suicide to try and remove the residency requirement safeguard and/or allow the use of telemedicine for assisted suicide patients. As such, Oregon and Vermont have repealed their residency requirements. Vermont also permits the use of telemedicine for assisted suicide, *see* Vt. Stat. Ann. tit. 18 § 5283, and New York allows the use of telemedicine in limited circumstances, *see* N.Y. Pub. Health Law § 2899-F.

¹¹ As the first jurisdiction to decriminalize 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.

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.”¹² “[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.”¹³ These patients’ “desire for hastened death is significantly associated with a diagnosis of major depression.”¹⁴ Their psychiatric disability also may impair decision-making, “such as the decision to end one’s life.”¹⁵

Even with the high rates of depression in patients considering assisted suicide, counseling referrals are uncommon.¹⁶ In Oregon in 2025, for example, assisted suicide physicians prescribed lethal drugs to 637 patients yet only referred two of these patients for counseling—approximately 0.3% of patients.¹⁷ 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.”¹⁸

Patients may engage in “doctor shopping,” where a patient will seek a different medical practitioner if a first provider refuses or denies prescribing lethal drugs to the patient.¹⁹ More concerning is that, as of 2025, Oregon data shows that the median duration of an assisted suicide patient-physician relationship was only four weeks, with some ranging as little as zero weeks.²⁰ Doctor shopping raises serious concerns about a prescriber’s ability to diagnose depression in new patients.

Furthermore, while all assisted suicide statutes require two witnesses to attest to a patient’s capacity at the time of the medication request, this safeguard fails to protect a patient’s informed consent. Other than Vermont and New York, assisted suicide jurisdictions only require that “one of the two witnesses must be unrelated to

¹² Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Physician-Assisted Suicide*, 36 Int’l J. L. & Psychiatry 461, 461 (2013).

¹³ *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, Oct. 8, 2008, at 1, 3, 5 (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”).

¹⁴ Tsou, *supra* note 12, at 466.

¹⁵ *Id.*

¹⁶ Catherine Glenn Foster, *The Fatal Flaws of Assisted Suicide*, 44 Hum. Life Rev. 51, 54 (2018).

¹⁷ *Oregon 2025 Report*, *supra* note 6, at 10, 15.

¹⁸ Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 Am. J. Psychiatry 1469 (1996).

¹⁹ Nat’l Council on Disability, *The Danger of Assisted Suicide Laws*, Bioethics and Disability Series 27 (2019).

²⁰ *Oregon 2025 Report*, *supra* note 6, at 18.

the patient and must not receive any benefits upon his or her death.”²¹ In those jurisdictions, “no requirements are in place 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.”²² 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.

Prescribers 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.”²³ 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.”²⁴ Likewise, “[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival.”²⁵

Additionally, prescribers of assisted suicide drugs 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.”²⁶ In California in 2024, a physician or health care worker only was present 48% of the time when the patient ingested the drugs.²⁷ In Oregon in 2025, excluding unknown data, the prescribing physician only was present when the patient ingested the lethal medication 23.2% of the time while a non-prescribing healthcare worker was present in 20% of cases.²⁸ 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.²⁹

²¹ Foster, *supra* note 16, at 53; *see* Vt. Stat. Ann. tit. 18 § 5283(a)(4); *see* N.Y. Pub. Health Law § 2889-e(3)(b)

²² Foster, *supra* note 16, at 53.

²³ Or. Rev. Stat. § 127.800(12).

²⁴ Nat’l Council on Disability, *supra* note 19, at 21.

²⁵ *Id.* at 22.

²⁶ Wesley J. Smith, *Culture of Death: The Age of “Do Harm” Medicine* 130 (2d ed. 2016).

²⁷ *See California End of Life Option Act: 2024 Data Report*, Cal. Dep’t of Pub. Health 1, 10–11 (July 2025), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life_Option_Act_Report_2024.pdf.

²⁸ *Oregon 2025 Report*, *supra* note 6, at 17.

²⁹ Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 Disability & Health J. 16, 20 (2010); *see also* Foster, *supra* note 16, at 53.

In sum, assisted suicide “safeguards” inadequately protect patients against coercion and abuse, which is especially concerning for vulnerable populations like hospice patients.

II. There is No Federal Constitutional Right to Assisted Suicide and Congress Has Limited the Harmful Effects of Suicide Assistance.

The U.S. Constitution does not protect a right to assisted suicide.³⁰ In *Washington v. Glucksberg*, the U.S. Supreme Court held there is no due process right to assisted suicide, since the practice was not “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty.”³¹ The Court then determined Washington’s ban on assisted suicide passed rational basis review because the law rationally related to the state’s legitimate interests, which included the preservation of human life, prevention of suicide, maintenance of the integrity of the medical profession, protection of vulnerable groups such as persons with disabilities, and prevention of involuntary suicide and euthanasia.³²

In *Glucksberg*’s companion case, *Vacco v. Quill*, the Supreme Court determined New York’s assisted suicide ban did not involve a suspect classification between end-of-life individuals because the causation and intent were different in assisted suicide and refusal of life-sustaining medical treatment.³³ As the Court described, “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.”³⁴ The Supreme Court then incorporated its rational basis reasoning from *Glucksberg*, holding the state’s “valid and important public interests” were rationally related to the law.³⁵

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.”³⁶ In turn, Congress has restricted the federal funding of suicide assistance in health care programs—including Medicare hospice programs—certain grant programs, advocacy programs, funds appropriated

³⁰ State courts have similarly rejected the argument that their respective state constitution extends to a right to assisted suicide. *Myers v. Schneiderman*, 85 N.E. 3d 57, 65 (N.Y. 2017) (citing cases); see also *Kligler*, 198 N.E.3d at 1237.

³¹ 521 U.S. at 720–21, 728 (citations omitted).

³² *Id.* at 728–32, 735.

³³ 521 U.S. 793, 800–01 (1997).

³⁴ *Id.* at 801.

³⁵ *Id.* at 808–09.

³⁶ 42 U.S.C. § 14401(b).

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.”³⁷

Congress robustly defends the conscientious objections of medical professionals who oppose assisting suicide. Section 1553 of the Affordable Care Act 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.”³⁸ 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”³⁹ Accordingly, Congress has limited assisted suicide.

III. Assisted Suicide Prescribers Experiment with Lethal Drug Compounds Directly on End-of-Life Patients.

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.”⁴⁰ Federally, the Food and Drug Act regulates pharmaceuticals and requires “that both ‘safety’ and ‘efficacy’ of a drug for its intended purpose (its ‘indication’) be demonstrated in order to approve the drug for distribution and marketing to the public.”⁴¹ Assisted suicide drugs could never meet the safety or efficacy requirements for treating mental or physical ailments, since the drugs are lethal and do not treat the patient’s underlying condition, instead, killing the individual.

Since states that have legalized suicide assistance do not provide guidelines for assisted suicide drug composition or dosages, assisted suicide prescribers have experimented with the dosage and composition of these lethal drugs. Around 2016, assisted suicide prescribers turned away from using short-acting barbiturates due to price gouging and supply issues.⁴² Consequently, assisted suicide prescribers began

³⁷ *Id.* §§ 14402 to 14405, 14407.

³⁸ *Id.* § 18113(a).

³⁹ *Id.*

⁴⁰ 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).

⁴¹ *Id.* at 340.

⁴² Sean Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J.L. & BioScis. 424, 429–30 (2017).

mixing experimental drug compounds at lethal dosages to assist suicides.⁴³ As Oregon data shows, these drug compounds change year by year. Prescribers experimented with DDMP (diazepam, digoxin, morphine sulfate, and propranolol) between 2015 to 2022.⁴⁴ In 2025, 75% of assisted suicide prescriptions were DDMAPh (diazepam, digoxin, morphine sulfate, amitriptyline, and phenobarbital); 12% of prescriptions were DDMA (diazepam, digoxin, morphine sulfate, and amitriptyline), and 13% of prescriptions were a new lethal drug compound, DDHAPh (diazepam, digoxin, hydromorphone, amitriptyline, and phenobarbital).⁴⁵

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.”⁴⁶ State governments do not provide guidance about what drugs or dosages to prescribe for assisted suicide, and there is “no government-approved clinical drug trial, and no Institutional Review Board oversight when [assisted suicide practitioners] prescribed the concoction to patients.”⁴⁷ Consequently, assisted suicide uses experimental drugs without patient safeguards.

IV. Disability Discrimination Is a Defining Feature of Assisted Suicide.

Disability discrimination is a prevalent issue within assisted suicide. 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.”⁴⁸ This creates “a two-tiered system for measuring the worth of human life” according to bioethicist Wesley J. Smith.⁴⁹ 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

⁴³ See Robert Wood & Judy Kinney, *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 assisted suicide prescribers’ experiments with different lethal drug compounds).

⁴⁴ *Oregon 2025 Report*, *supra* note 6, at 10, 19.

⁴⁵ *Id.* at 10–11, 19.

⁴⁶ *Human Drug Compounding Laws*, U.S. Food & Drug Admin (Dec. 17, 2024), <https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies>.

⁴⁷ Jennie Dear, *The Doctors Who Invented a New Way to Help People Die*, Atlantic (Jan. 22, 2019), <https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/>.

⁴⁸ Smith, *supra* note 26, at 117.

⁴⁹ *Id.*

human life but also send a lethal message to the weak and infirm that their lives are not worth living.⁵⁰

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.”⁵¹ Although states have tried to place safeguards into statutes, “[n]o safeguards have ever been enacted or proposed that can prevent this outcome.”⁵²

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 2025, only 37.0% of Oregon patients and in 2024, 39.0% of Washington patients cited “[i]nadequate pain control, or concern about it” as a reason for choosing assisted suicide.⁵³ Rather, the top five reasons for assisted suicide in both Oregon and Washington were the following:

- Losing autonomy (89.0% in Oregon, 83.0% in Washington);
- Less able to engage in activities making life enjoyable (89.0% in Oregon, 83.0% in Washington);
- Loss of dignity (65.0% in Oregon, 49.0% in Washington);
- Burden on family, friends/caregivers (39.8% in Oregon, 43.0% in Washington); and
- Losing control of bodily functions (53.0% in Oregon, 45.0% in Washington).⁵⁴

Data shows that Oregon patients historically have ranked pain lower than the autonomy and dignity categories.⁵⁵ These lamentably are “psychological issues that are all-too-familiar to the disability community.”⁵⁶

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.”⁵⁷ Accordingly, assisted suicide is rampant with ableism and discrimination because it lethally judges patients’ quality of life based upon their terminal illnesses and disabilities.

⁵⁰ *Id.*

⁵¹ Nat’l Council on Disability, *supra* note 19, at 14–15.

⁵² *Id.* at 15.

⁵³ *Oregon 2025 Report*, *supra* note 6, at 16; *Washington 2024 Report*, *supra* note 6, at 8.

⁵⁴ *Id.*

⁵⁵ *Oregon 2025 Report*, *supra* note 6, at 16.

⁵⁶ Nat’l Council on Disability, *supra* note 19, at 37.

⁵⁷ Aden, *supra* note 40, at 324.

V. Assisted Suicide Practices Undercut Suicide Prevention Policies.

The United States has a robust public policy of suicide prevention.⁵⁸ 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.⁵⁹ In 2023 alone, over 49,000 people died by suicide and 1.5 million people attempted suicide.⁶⁰ “Suicide and suicide attempts cause serious emotional, physical, and economic impacts” in suicide survivors, loved ones, and the community.⁶¹ According to the CDC, “[t]he financial toll of suicide on society is also costly. In 2020, suicide and nonfatal self-harm cost the nation over \$500 billion in medical costs, work loss costs, value of statistical life, and quality of life costs.”⁶²

Assisted suicide exacerbates suicide rates. According to 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.”⁶³ 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.”⁶⁴ 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.⁶⁵

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

⁵⁸ *Suicide Prevention*, Ctrs. for Disease Control & Prevention, <https://www.cdc.gov/suicide/index.html> (last visited June 1, 2026).

⁵⁹ *Facts About Suicide*, Ctrs. for Disease Control & Prevention (Mar. 26, 2025), <https://www.cdc.gov/suicide/facts/index.html>.

⁶⁰ *Suicide Data and Statistics*, Ctrs. for Disease Control & Prevention (Mar. 26, 2025), <https://www.cdc.gov/suicide/facts/data.html>.

⁶¹ *Facts About Suicide*, *supra* note 59.

⁶² *Id.*

⁶³ David Albert Jones, *Suicide Prevention: Does Legalising Assisted Suicide Make Things Better or Worse?*, *Anscombe Bioethics Ctr.* 1, 2 (2022), *quoted in* McDonnell, *supra* note 5, at 16; *see also* Anne M. Doherty et al., *Investigating the Relationship Between Euthanasia and/or Assisted Suicide and Rates of Non-Assisted Suicide: Systematic Review*, *BJPsych Open*, May 3, 2022, at 1.

⁶⁴ Jones, *supra* note 63, at 9, *quoted in* McDonnell, *supra* note 5, at 16.

⁶⁵ *Id.*, *quoted in* McDonnell, *supra* note 5, at 16–17.

6.3% . . . increase in total suicides (including assisted suicides).”⁶⁶ However, in individuals over 65 years old, this increase was 14.5%.⁶⁷ Consequently, expanding assisted suicide subverts suicide prevention policies.

VI. State Assisted Suicide Reporting Requirements Are Insufficient and Prescribers Often Do Not Comply with the Reporting Laws.

In states that have decriminalized assisted suicide, there is a myriad of abuses that occur, including a lack of required reporting. Prescribers in assisted suicide states have routinely failed to submit legally required forms that purportedly illustrate patients’ informed consent, blatantly violating the law.⁶⁸ Washington’s assisted suicide data highlights this concerning trend. For example, the state’s 2024 data shows that for the 655 assisted suicide patients, providers failed to provide the following documents to the state:

- 75 written and witnessed requests from patients;
- 63 attending medical provider compliance forms;
- 76 consulting medical provider compliance forms;
- 14 pharmacy dispensing forms; and
- 65 after-death reporting forms.⁶⁹

These forms are critical because they document that the patient voluntarily requested the lethal medication, that the patient’s request for the drugs was informed, that the patient was counseled on alternatives to assisted suicide, that the patient had a terminal illness with a six-month prognosis, and that the patient does not have a psychiatric or psychological disorder that would impair their decision making.⁷⁰ Despite the necessity of these forms being filed with the state to help document patients’ informed consent, numerous providers fail to comply each year, as evidenced by Washington’s assisted suicide data.

Notably, these providers are not held accountable for their egregious noncompliance. A report from the Patients Rights Action Fund and Disability Rights Education & Defense Fund highlights this problem, noting that:

No one is held accountable for failing to report assisting in a suicide, and there is no investigation to see if they have done so. Oregon officials have admitted this problem: “We cannot determine whether physician

⁶⁶ David Albert Jones & David Paton, *How Does Legalization of Physician Assisted Suicide Affect Rates of Suicide*, 108 S. Med. J. 599, 599, 601 (2015).

⁶⁷ *Id.* at 599.

⁶⁸ Richard Doerflinger, *Lethal Non-Compliance with Washington’s “Death with Dignity Act”*, Charlotte Lozier Inst. 1, 4–7 (Dec. 20, 2022), <https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/>.

⁶⁹ See *Washington 2024 Report*, *supra* note 6, at 16.

⁷⁰ Doerflinger, *supra* note 68, at 1.

assisted suicide is being practiced outside the framework of the Death with Dignity Act.” The state has also acknowledged actually destroying the underlying data after each annual report.⁷¹

The lack of oversight over assisted suicide and prescribers of these drugs raises another area of concern: the growing disparity between lethal drug prescriptions and confirmed deaths of assisted suicide patients. Oregon’s 2025 data shows that while providers prescribed 637 lethal drug prescriptions, the ingestion status was unknown for 179 patients, *i.e.*, 28% of the prescribed lethal drugs were unaccounted for.⁷² This means that Oregon cannot confirm if these patients actually ingested the lethal drugs and thus has no idea if anyone else is in possession of the drugs. The complete lack of oversight over lethal assisted suicide drugs subjects the public to immense risk. As of 2023, there were at least two reported cases where relatives took sips of the assisted suicide drugs and barely survived.⁷³

VII. HHS and CMS Should Use “Assisted Suicide” Not “MAID” Terminology.

We request that HHS and CMS use “assisted suicide” when referring to the practice, not “medical aid in dying” or its abbreviation “MAID.” “MAID” terminology attempts to legitimize a practice that is illegal in most U.S. jurisdictions. It is euphemistic and obscures the fact that “MAID” is medical assistance to help an individual commit suicide, *i.e.*, “[t]he act of taking one’s own life.”⁷⁴ Although U.S. advocates use “MAID” to refer to assisted suicide, “MAID” also can mean euthanasia,⁷⁵ which is illegal in all U.S. jurisdictions. The American Medical Association has also rejected the use of “MAID” terminology and other similar phrases, noting that “[a]ttributing the term medical aid in dying to the practice of [physician-assisted suicide] is neither precise nor accurate and may contribute to the already existing confusion regarding the ethical scope of palliative and hospice care.”⁷⁶

Congress has used the more precise language, “assisted suicide, euthanasia, or mercy killing,” in both the Assisted Suicide Funding Restriction Act and Affordable

⁷¹ *A Primer on Assisted Suicide Laws* 1, 4 (Apr. 2017), <https://dredf.org/wp-content/uploads/2017/04/a-primer-on-assisted-suicide-laws.pdf>.

⁷² *Oregon 2025 Report*, *supra* note 6, at 8.

⁷³ Cassy Cooke, *A Man Accidentally Consumed Drugs Meant To Kill His Friend—And This Isn’t the First Time*, LiveAction (Oct. 17, 2023), <https://www.liveaction.org/news/assisted-suicide-drugs-accidentally-consumed>.

⁷⁴ *Suicide*, Black’s Law Dictionary (12th ed. 2024); *see also Assisted Suicide*, Black’s Law Dictionary (12th ed. 2024) (“The intentional act of providing a person with the medical means or the medical knowledge to commit suicide.”).

⁷⁵ *See Canada’s Medical Assistance in Dying (MAID) Law*, Gov’t Can. (July 31, 2024), <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>.

⁷⁶ Jeremy A. Lazarus, Am. Med. Assoc., *Report of the Council on Ethical and Judicial Affairs: Reconsidering the Terminology to Describe Physician Assisted Suicide* 2 (2023).

Care Act’s conscience protections.⁷⁷ We urge HHS and CMS to align its terminology with the statutory language. In fact, HHS previously did so in 2024 in its final rule, “Safeguarding the Rights of Conscience as Protected by Federal Statutes,” when it explicitly rejected the term “medical aid in dying,” and instead incorporated the Affordable Care Act’s terminology.⁷⁸

VIII. HHS and CMS Should Establish Federal Reporting Requirements for Hospice Programs Regarding Assisted Suicide.

HHS and CMS have the authority to authorize federal reporting requirements for hospice programs when it comes to assisted suicide. Under 42 U.S.C. § 1395x(dd)(2)(G), hospice programs must “meet[] such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.” 42 U.S.C. § 14402(d)(1)(A) restricts federal funding for assisted suicide within Medicare hospice programs.

Under this statutory authority, we request that HHS and CMS establish federal reporting requirements for hospice programs regarding assisted suicide. Federal reporting requirements will help provide the necessary oversight of hospice patients that receive suicide assistance, helping to monitor patient safety and welfare, including discrimination against persons with disabilities and complications from lethal experimental drug use on hospice patients. These federal reporting requirements also will enable HHS and CMS to ensure hospice programs comply with federal funding restrictions on assisted suicide. Hospice patients deserve such transparency.

IX. Conclusion.

Assisted suicide practices raise significant issues of disability discrimination, patient safety, and informed consent. We ask HHS and CMS to use “assisted suicide” terminology as it further considers this issue. We further urge HHS and CMS to implement assisted suicide reporting requirements on hospice programs to protect vulnerable populations, including persons with disabilities, and monitor compliance with the Assisted Suicide Funding Restriction Act.

⁷⁷ 42 U.S.C. § 14402; 42 U.S.C. § 18113.

⁷⁸ 89 Fed. Reg. 2,078, 2,093 (Jan. 11, 2024) (to be codified at 45 C.F.R. pt. 88).

Sincerely,

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