Americans United for Life

Written Testimony of Catie Kelley
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In Opposition to H. 5219
Submitted to the House Committee on Judiciary
February 11, 2025

Dear Chair Craven, First Vice Chair McEntee, Second Vice Chair Knight, 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] Our vision at AUL is to strive for a world where everyone is welcomed in life and protected in law.

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

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 7, 2024). 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 Jan. 27, 2025). *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Jan. 28, 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*).

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]

Thank you for the opportunity to testify against H. 5219. It is my legal opinion that the bill places already-vulnerable persons at greater risk of abuse and coercion, the bill's "safeguards" fail to adequately protect vulnerable end-of-life patients, and the bill erodes the integrity and ethics of the medical profession.

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

Individuals in Rhode Island who live in poverty, the elderly, and those living with disabilities are exposed to greater risks of abuse, neglect, and coercion, as well as underreporting of such harms. This becomes even more true when these individuals face potentially terminal diagnoses and require end-of-life (or palliative) care. As a study in the Journal of Palliative Medicine notes, "[p]atients at the end of life, by nature of their clinical and social circumstances, are at higher risk for elder abuse."[6]

Rhode Island should protect these vulnerable citizens rather than subjecting them to additional abuse and lethal medication that ends their lives under H.5219. If enacted, not only would the bill perpetuate false narratives about assisted suicide, but it would also promote ableism and ageism by disproportionately offering individuals with disabilities and the elderly death-on-demand instead of treatment options and true end-of-life care.

Contrary to the prevailing cultural narrative, the vast majority of patients facing potentially terminal diagnoses do not consider suicide by physician for pain management reasons. Instead, it's been reported that 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.[7]

Rather, the top five reasons for choosing assisted suicide in both Oregon and Washington are:

1. Being less able to engage in activities making life enjoyable (88.8% in Oregon, 83.0% in Washington);
2. Losing autonomy (86.3% in Oregon, 83.0% in Washington);
3. Loss of dignity (61.9% in Oregon, 69.0% in Washington);
4. Being a burden on family, friends/caregivers (46.4% in Oregon, 59.0% in Washington); and

[5] 491 Mass. 38, 40 n.3 (2022) (citing Brief *Amicus Curiae* of Christian Medical and Dental Associations).
[6] K. Maya Jayawardena, *Elder Abuse at End of Life*, 9 JOURNAL OF PALLIATIVE MEDICINE (Jan. 23, 2006).
[7] 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).

5. Losing control of bodily functions (44.6% in Oregon, 49.0% in Washington).[8]

Physicians should ensure that their patients receive the best palliative care and help them cope with feelings of hopelessness and depression after receiving a difficult diagnosis.

Yet, in states that have legalized assisted suicide, such as Oregon and Washington, vulnerable patients are encouraged to take their own lives, opening the door to real abuse, and creating barriers for access to mental health services and true end-of-life care, especially for the elderly and individuals with disabilities.

Many professionals in the bioethics, legal, and medical fields have recognized abuses and failures in states which have decriminalized suicide by physician. These include: (1) a lack of reporting and accountability, (2) coercion, and (3) failure to ensure the competency of the requesting patient.[9]

One board certified internal medicine and hospitalist reported in 2020 that two of his patients with "serious illness [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."[10] Another woman in California was denied coverage for chemotherapy, but her insurance "offered to pay for physician assisted suicide after California passed a law allowing the measure."[11]

Even worse, 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 (one "psychologist deemed [a patient with dementia] competent while still noting that her 'choices may be influenced by her family's wishes and her daughter… may be somewhat coercive'").[12]

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[8] *Id.*

[9] 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.).

[10] 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 (last visited Jan. 28, 2025).

[11] 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.

[12] *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 Jan. 28, 2025).

Some individuals seeking assisted suicide are *never* referred to mental health professionals despite having medical histories of depression and suicide attempts.[13] Furthermore, physicians in states with legalized physician-assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[14]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected physician-assisted suicide, advocacy groups continue to promote its legalization, seeking to normalize a practice that ultimately results in the disproportionate deaths of individuals in poverty, individuals with disabilities, and the elderly.

Widespread calls to normalize physician-assisted suicide has led to a "suicide contagion," or the Werther Effect.[15] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[16] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[17]

One study found that legalizing suicide by physician in certain states led to a *rise in overall suicide rates*—assisted and unassisted—in those states.[18] After accounting for demographic, socioeconomic, and other state-specific factors, suicide by physician is associated with a 6.3% increase in *overall* suicide rates (assisted and "unassisted").[19]

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[13] *See id.*

[14] Richard Doerflinger, *Lethal Non-Compliance with Washington's "Death with Dignity Act"*, CHARLOTTE LOZIER INST. (Dec. 20, 2022), https://lozierinstitute.org/lethal-non-compliance-with-washingtons-death-with-dignity-act/.

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

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

[17] *See* 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").

[18] *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.

[19] *See id.* at 601.

And for individuals older than 65, this study found a 14.5% increase in overall suicide rates.[20]

Legalizing suicide by physician is neither "compassionate" nor an appropriate solution for those who may suffer from depression or loss of hope at the end of their lives. H. 5219 effectively 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.[21] But these individuals are worthy of life, access to true palliative care, and treatment options, and are entitled to equal protection under the law. So, the Committee should reject this bill.

II. H. 5219's Supposed Safeguards Are Ineffective to Adequately Protect Vulnerable Patients

Although the bill includes so-called "safeguards," these provisions cannot adequately protect vulnerable end-of-life patients. For example, under §§ 23.4.15-2(1)–(2) and 23.4.15-3(8), a physician is not required to (1) evaluate a patient for depression or other mental health conditions, including suicidal ideation or (2) refer a patient to a pyschiatrist.[22] In fact, the physician's determination of a patient's decision-making capabilities rests on the patient's medical history, current medical condition, and a *physical* examination.

But this requirement does not include a basic evaluation of a patient's current *mental* health state and whether they may be suffering from depression or anxiety that is commonly co-morbid with chronic and end-of-life illnesses.

Nor is the physician even required to practice in the area relating to the patient's terminal condition. Under § 23.4.15-2(1), a "treating or consulting relationship" between a patient and physician could involve a patient with a specific illness that requires a speciality physician, but a practicing physician in *any* speciality, even one with *no* experience in that patient's illness or condition could prescribe lethal drugs to a patient. This means that a primary care practitioner could prescribe lethal drugs based on a patient's cancer diagnosis or a gynecologist could prescribe lethal drugs based on a kidney failure diagnosis.

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[20] *Id.* at 603.

[21] Physician assisted suicide is rife with discrimination. *See, e.g.*, *United Spinal Association v. State of California*, No. 2:23-cv-3107 (C.D. Cal. filed Apr. 25, 2023) (case challenging California's physician assisted suicide law as unlawful for discriminating against persons with disabilities); *see also* Carolyn McDonnell, *A Time to Choose: Suicide Assistance or Suicide Prevnetion?*, 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 (stating that physician assisted suicide "creates a 'two-tiered system for measuring the worth of human life'" where "[t]he young and vital who become suicidal would receive suicide prevention. . . . At the same time, the suicides of the debilitated, sick, and disabled, and people with extended mental anguish . . . would be shrugged off as merely a matter of choice").

[22] H. 5219, Gen. Leg. Assemb., Reg. Sess. (R.I. 2025).

To illustrate H. 5219's inherent inconsistency with the standards of care for terminally ill patients, turn to the Annals of Internal Medicine, *Best Practices in Caring for Seriously Ill Patients*. Instead of offering or suggesting physician-assisted suicide as an option, "[a]ll physicians should seek training on the general knowledge and skills needed to provide primary PC (palliative care) for patients in routine practice," which includes, "[q]uality PC provided by an interdisciplinary team that address physical, emotional, social, spiritual, and existential aspects of suffering and aims to promote quality of life, hope, and dignity for all seriously ill patients."[23]

"Clinicians and health care organizations should implement practices that routinely assess and track seriously ill patients' needs for specialist PC (palliative care) so they can make timely referrals for high-quality management of symptoms and psychological, spiritual, and existential suffering should these be necessary."[24]

In fact, under the true standard of care for treating seriously ill patients, individuals who wish to preemptively end their lives should be immediately evaluated for suicidal ideation and depression:

> Further, "[s]eriously ill patients with active suicidal ideation, *including those requesting hastened death*, often fear unmanageable symptoms or loss of control. Such requests *should prompt an immediate assessment for suicidality* while addressing concerns about the end of life"[25] (emphasis added). And because depression "is not uncommon in seriously ill patients," "[p]hysicians should therefore have a low threshold for assessment and treatment" as "[i]t can be difficult to differentiate depression from preparatory grief."[26]

And the "American College of Physicians ("ACOP"), which is committed to improving care for patients approaching the end of life, does not support MAID (medical aid in dying) – a euphemistic term for assisted suicide.

"Instead, the guidelines suggest that requests for MAID prompt discussion to understand the underlying reasons for the request."[27] The American College of Physicians' Ethics Manual also provides that physicians caring for patients near end of life "should partner with colleagues from social work, chaplaincy, and other fields to meet psychosocial, spiritual, and other needs of dying patients and their families."[28]

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[23] Bernacki, Rachelle, MD, Annals of Internal Medicine, *Best Practices in Caring for Seriously Ill Patients*, at 1, (July 9, 2024), https://medicine.vumc.org/sites/default/files/2024-08/Bernacki-%20ITC%20best-practices-in-caring-for-seriously-ill-patients%20-%20AIM%202024.pdf.
[24] *See id.* at 2.
[25] *See id.* at 10.
[26] *See id.*
[27] *See id.* at 13.
[28] American College of Physicians, Annals of Internal Medicine, *Ethics Manual: Seventh Edition*, (Jan. 15, 2019).

ACOP defines physician-assisted suicide to "occur[] when a physician provides a medical means of death, usually a prescription for a lethal amount of medication that the patient takes on his or her own."[29] And the "College does not support the legalization of physician-assisted suicide or euthanasia. After much consideration, the College concluded that making physician-assisted suicide legal raised serious ethical, clinical, and social concerns."[30]

ACOP advises that "[s]ome patients who request assisted suicide may be depressed or have uncontrolled pain."[31] ACOP also uses Oregon as an example, citing that "losing autonomy or dignity and inability to engage in enjoyable life activities have been cited as concerns in most physician-assisted suicide cases. These concerns are less amenable to the physician's help, although physicians should be sensitive to these aspects of suffering."[32]

H. 5219, as a result, can never satisfy the standard of care for treating the needs of end-of-life or seriously ill patients. And H. 5219 pushes all clinical and ethical responsibility for truly evaluating or considering the vulnerable patient's mental capacity entirely onto a "psychiatrist, psychologist, or clinical social worker…for confirmation that the patient [i]s capable and d[oes] not have impaired judgment."[33]

Even then, a mental health professional is not required to evaluate, offer treatment, or actually treat a vulnerable patient for depression, suicidal ideation, grief, anxiety, or any other mental health condition that could likely impact a patient's decision to request lethal drugs.[34] The mental health professional must only "confirm[ ] that the patient … did not have impaired judgment."[35]

This is patently absurd, exceedingly dangerous, and will result in the disproportionate, preemptive deaths of vulnerable patients suffering from depression and suicidal ideation that are commonly co-morbid with chronic, end-of-life illnesses and conditions.

H. 5219 will always fail to meet the standard of care for treating seriously ill and/or end-of-life patients by permitting a treating physician to skip or ignore evaluating, treating, and addressing a vulnerable patient for depression and suicidality simply because that vulnerable patient seeks to end their life.[36]

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[29] *See id.*
[30] *See id.*
[31] *See id.*
[32] *See id.*
[33] *See* H. 5219 at § 23-4.15-3(8).
[34] *See id.*
[35] *See id.*
[36] *See* Bernacki, *supra* note 23.

Despite H. 5219's mental health referral option, mental health counseling referrals for patients considering assisted suicide are exceedingly rare.[37] To illustrate, in Oregon in 2022, physicians prescribed lethal drugs to 431 patients requesting physician-assisted suicide, yet only referred *three* of these 431 patients for mental health counseling—equating to *approximately 0.7% of patients*.[38]

This figure, compared to the 24% of adults in Oregon who have reported a diagnosis of depression, and the 16.5% of adults over 65 in Oregon who have reported a diagnosis of depression, also shows the inadequacy of statutory safeguards for screening patients seeking physician-assisted suicide suffering from depression.[39]

In Rhode Island, 21.7% of adults have reported a depression diagnosis, and 15.0% of adults over 65 reported a depression diagnosis at some point in their lives.[40] H. 5219 does not adequately protect Rhode Island's citizens suffering from depression from seeking physician-assisted suicide when facing a potentially terminal diagnosis.

In addition to H. 5219's deviation from the standards of care for end-of-life management, the bill fails to account for hidden or masked depression or other mental health conditions. As one study on depression notes, "[d]epression in older people is commonly hidden," and:

> Estimates of the prevalence of depression in older people vary but may be as high as 20%. Poor mental health is often co-morbid with long-term, chronic physical illness such as diabetes, coronary heart disease, stroke, and Parkinson's disease, all of which are more common in later life. Depression reduces quality of life and increases the risk of suicide. Depression also increases use of health and social care, including use of unscheduled care.[41]

The individuals most likely seeking physician-assisted suicide for chronic and/or terminal diagnoses are even more likely to be suffering from depression that is co-morbid with those very diagnoses and illnesses (depression "is not uncommon in seriously ill patients"[42]).

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[37] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 7, at 14.
[38] *Id.* at 9.
[39] United Health Foundation, America's Health Rankings, *Depression in Oregon*, https://www.americashealthrankings.org/explore/measures/Depression_a/OR (last visited, Feb. 11, 2025).
[40] United Health Foundation, America's Health Rankings, *Depression in Rhode Island* https://www.americashealthrankings.org/explore/measures/Depression_a/RI#measure-trend-summary, (last visited Feb. 11, 2025).
[41] Overend, Karen, *Revealing hidden depression in older people: a qualitative study within a randomized controlled trial*, (Oct. 19, 2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4617777/.
[42] *See* Bernacki, *supra* note 23.

H. 5219's reliance on physicians to refer a vulnerable patient to a mental health professional based on a *physical* exam and *past* medical history for mere "confirmation" of decision-making capability without any evaluation or treatment cannot be seriously treated as a safeguard. This is especially true as vulnerable, chronically ill and end-of-life patients are more likely to be depressed and older people are more likely to be experiencing hidden depression

Indeed, "older people are an important 'under-served' group, increasingly affected by economic deprivation, social isolation, and loneliness."[43] And, as one study on the failure to recognize depression in primary care settings notes: "[s]tudies conducted in primary care settings suggest that only about 50% of depressed patients are recognized."[44] And another study found that "less than 50% of depressed patients were recognized by attending physicians" in "older (age > 65 years) medical inpatients."[45]

The author of this study even argues that "[c]linicians and health care systems need to be held more accountable for outcomes of depression."[46] Yet, H. 5219 provides *no* accountability to healthcare providers to recognize, let alone refer for evaluation and treatment, depression or other mental health conditions associated with chronic diseases or potentially terminal diagnoses in vulnerable persons.

What's more, the median duration of an assisted suicide patient-physician relationship *is only five weeks*, as shown by 2022 Oregon data.[47] The short duration of these relationships raises serious concerns as to whether a physician can accurately determine the mental capacity of the patient. Accordingly, if the bill is passed, the likelihood of a Rhode Island physician referring an end-of life patient for a mental health evaluation is extremely low, especially when the physician 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."[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

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[43] *See id.*

[44] Egede, Leonard, *Failure to Recognize Depression in Primary Care: Issues and Challenges*, (March 17, 2007), https://pmc.ncbi.nlm.nih.gov/articles/PMC1852925/ (last visited, Jan. 28, 2025).

[45] *See id.*

[46] *See id.*

[47] *Id.* at 14.

[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

a diagnosis of major depression."[50] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[51]

Moreover, on the off chance that a Rhode Island physician refers a patient to a mental health professional for confirmation of decision-making capability, H. 5219 has no requirement that the patient and mental health professional meet more than once. In § 23.4.15-3(8), the licensed mental health professional must only make a "evaluation…for confirmation that the patient was capable." This means that a licensed mental health professional need only meet with the patient one time before that patient can be deemed competent to end their own life. This raises serious informed consent issues because healthcare professionals have limited abilities to diagnose mental health issues when evaluating referred patients considering assisted suicide.

As one study shows, "[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."[52] For these reasons, it is difficult to argue that any of these alleged "safeguards" will allow medical providers, or mental health professionals to accurately assess an individual's mental health and whether they have the requisite "capacity" to end their lives.

Last, H. 5219 assumes that physicians can correctly diagnose a patient with a "terminal condition," but requires physicians to admit to patients that "the patient's life expectancy is an estimate based on the physician's best medical judgment and not a guarantee of the actual time remaining in the patient's life, and that the patient could live longer than the time predicted."[53] H. 5219 only requires a six-month prognosis—even though physicians must tell patients that the patient could live longer than that six-month prognosis—and a patient could in fact live well past those six months. But the patient can obtain lethal drugs so long as a doctor says the patient will die in six months or less.

This fails as a safeguard as well because, as the bill acknowledges, doctors have difficulty accurately dating the life expectancy of a terminally ill patient. 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."[54] Likewise,

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patients who had requested lethal medication had clinical depression and the "[statute] may not adequately protect all mentally ill patients").

[50] *Id.*

[51] *Id.*

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

[53] *See* H. 5219 at § 23-4.15-3(6)(ii).

[54] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).

"[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[55]

In *Best Practices in Caring for Seriously Ill Patients*, the physician authors explain that "prognostication is challenging," "[i]t is important to explain to patients that estimating prognosis is an approximate, inexact, and iterative process," and "[a]s the patient advances in the trajectory of serious illness, their prognosis is likely to change depending on treatment, treatment response, new illnesses, and other factors."[56]

Shockingly, "experts put the [misdiagnosis] rate at around 40%,"[57] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an "error"[58] which resulted in the individual's premature death. Prognoses can be made in error as well, with one study showing at least 17% of patients were misinformed of their prognosis.[59] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[60] In effect, H. 5219 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, but for a physician's errant prognosis.

In sum, these purported "safeguards" fail to protect vulnerable end-of-life patients. The bill leaves patients susceptible to coercion and abuse by family members and caregivers, does not—and cannot—ensure patients have given their informed consent to die through medicalized suicide. H. 5219 does not give end-of-life patients "control over their deaths," as some proponents of the bill may argue. Instead, the bill gives physicians 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 by Authorizing Prescriptions of Experimental, Unapproved Lethal Drugs

Prohibitions on physician-assisted suicide protect the integrity and ethics of medical professionals, including their obligation to serve patients as healers, to "keep

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[55] *Id.* at 22.
[56] *See supra* note 18 at 3.
[57] 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.
[58] *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).
[59] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[60] *See id.*

the sick from harm and injustice," and to "refrain from giving anybody a deadly drug if asked for it, nor make a suggestion to this effect."[61]

Despite these ethical obligations, physicians use *experimental* lethal drugs when assisting in suicide. "[T]here is no federally approved drug for which the primary indication is the cessation of the mental or physical suffering by the termination of life."[62]

The Food and Drug Act regulates pharmaceuticals at the federal level and requires "that both 'safety' and 'efficacy' of a drug for its intended purpose (its 'indication') be demonstrated in order to approve the drug for distribution and marketing to the public."[63] Assisted suicide medication can never meet the safety or efficacy requirements for treating mental or physical ailments, because it treats an individual's health condition with a lethal drug overdose.

Nor is there any way for patients to self-report whether the lethal drugs actually result in a "peaceful" death—and thus no way for physicians or the U.S. Food and Drug Administration ("FDA") to test the alleged "safety and efficacy" of these medications.[64] Around 2016, doctors offering assisted suicide mediation began mixing experimental drug compounds at lethal dosages to assist suicides in vulnerable patients.[65]

But "[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*."[66] So, physicians have experimented on vulnerable patients with lethal drug compounds despite "no government-approved clinical drug trial, and no Institutional Review Board oversight."[67]

Under § 23-4.15-2(6)(v), the health care provider must inform the patient of the "potential risks associated with taking the mediations to be prescribed" and the "probably result of taking the medications to be prescribed." Yet the bill does not

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[61] 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).
[62] Steven H. Aden, *You Can Go Your Own Way: Exploring the Relationship Between Personal and Political Autonomy in Gonzales v. Oregon*, 15 TEMP. POLL. & CIV. RTS. L. REV. 323, 339 (2006).
[63] *Id.* at 340.
[64] *See id.*
[65] *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).
[66] *Compounding Laws and Policies*, U.S. FOOD & DRUG ADMIN (Sept. 10, 2020), https://www.fda.gov/drugs/human-drug-compounding/compounding-laws-and-policies (emphasis added).
[67] 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/.

require that the physician inform the patient that such medication is *experimental* and not approved by the FDA.

H. 5219 directly contradicts Rhode Island'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. 5219 harms the medical profession, physicians, and people who may be struggling to process the shock and grief associated with a potentially terminal diagnosis. The bill increases the risk that patients will be coerced or pressured into prematurely ending their lives when offered suicide by physician as a viable treatment option.

IV. Conclusion

Physician-assisted suicide is not healthcare, and H.5219 is inherently inconsistent with the standards of care for physicians to provide treatments for seriously ill patients or necessary mental health evaluations. Instead, it acts as a limited exception to homicide liability under state law and authorizes physicians to use experimental drugs directly upon patients without FDA approval or clinical trials.

Accordingly, the majority of states prohibit physician-assisted suicide and impose criminal penalties on anyone who helps another person commit suicide. Since Oregon first legalized the practice in 1996 more than "200 assisted-suicide bill have failed in more than half the states."[68]

Likewise, the Committee should reject H. 5219 and continue to uphold its duty to protect the lives of all its people—especially vulnerable people groups such as individuals suffering chronic physical and mental illnesses, the elderly, and individuals with disabilities—and maintain the integrity and ethics of the medical profession.

Sincerely,

Catie Kelley
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AMERICANS UNITED FOR LIFE

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