Written Testimony of Emily Hoegler
Policy Counsel, Americans United for Life
In Opposition to House Bill 7760
Submitted to the House Judiciary Committee
April 30, 2026

Dear Chairwoman Hagan McEntee and Members of the Committee:

My name is Emily Hoegler, 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 Judicial Court's recent decision in *Kligler v. Attorney General*, which ruled there is no fundamental right to assisted suicide under a state constitution.[5]

Thank you for the opportunity to testify against House Bill 7760 ("H.B. 7760" or "bill"). It is my legal opinion that the bill places already-vulnerable persons at greater risk of

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[1] *Pro-Life Model Legislation and Guides*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/ (last visited Feb. 3, 2026). 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 Feb. 3, 2026); *Defending Life: State Legislation Tracker*, AMS. UNITED FOR LIFE, https://aul.org/law-and-policy/state-legislation-tracker/ (last visited Feb. 3, 2026).

[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).

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. Assisted Suicide 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. 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 lethal medication. If enacted, not only would H.B. 7760 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. 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, vulnerable patients are encouraged to take their own lives. This opens the door to real abuse and creates barriers for access to mental health services and true end-of-life care, especially for the elderly and individuals with disabilities.

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[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).
[8] *Id*.

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 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] Likewise, multiple patients suffering with anorexia in California were prescribed assisted suicide by their doctor rather than life-saving care and psychological treatments.[13]

Some individuals seeking assisted suicide are *never* referred to mental health professionals despite having medical histories of depression and suicide attempts. [14] Furthermore, physicians in states with legalized assisted suicide have routinely failed to submit legally required forms, blatantly violating the law of that state.[15]

Even though health organizations and professionals in the medical, legal, and bioethics fields have rejected assisted suicide, advocacy groups continue to promote its

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[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 Feb. 3, 2026).

[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 Feb. 3, 2026).

[13] Jennifer Brown, *Denver Doctor Helped Patients with Severe Anorexia Obtain Aid-in-Dying Medication, Spurring National Ethics Debate*, Colorado Sun (Mar. 14, 2022), https://coloradosun.com/2022/03/14/denver-doctor-gaudiani-aid-in-dying-aneroexia-patients/.

[14] *See* Disability Rights Education & Defense Fund, *supra* note 12.

[15] 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/.

legalization, seeking to normalize a practice that ultimately results in the disproportionate deaths of individuals in poverty, individuals with disabilities, and the elderly.

II. Legalizing Assisted Suicide Increases the Rates of Non-Assisted Suicide.

Widespread calls to normalize assisted suicide has led to a "suicide contagion," or the Werther Effect.[16] Empirical evidence shows that media coverage of suicide inspires others to commit suicide as well.[17] As a result, suicide prevention experts have criticized suicide by physician advertising campaigns.[18]

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.[19] 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").[20] And for individuals older than 65, this study found a 14.5% increase in overall suicide rates.[21]

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.B. 7760 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.[22] But these individuals are worthy of life, access to true palliative care, and

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[16] *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/.

[17] *See* Moody, *supra* note 16; *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).

[18] *See* Nancy Valko, *A Tale of Two Suicides: Brittany Maynard and My Daughter*, CELEBRATE LIFE, (Jan-Feb 2015), 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").

[19] *See* David Albert Jones & David Paton, *How Does Legalization of Assisted Suicide Affect Rates of Suicide*, 108 S. MED. J. 10 599, 599-600 (2015); *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.

[20] *See* Jones & David Paton, *supra* note 19, at 601.

[21] *Id*. at 603.

[22] 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 assisted suicide law as unlawful for discriminating against persons with disabilities); *see also* 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 (stating that 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

treatment options, and are entitled to equal protection under the law. Therefore, the Committee should reject this bill.

III. H.B. 7760 Does not Contain Safeguards to Adequately Protect Vulnerable Patients

While addressing the technical safeguards within H.B. 7760 is necessary for a thorough legal analysis, doing so does not resolve the fundamental ethical and social risks outlined in the sections above. Even a bill with more rigorous procedural requirements and safeguards would still operate within a framework that devalues the lives of the vulnerable and ignores the broader "suicide contagion" effect. However, a close examination of the bill's internal structure reveals that its purported protections are largely illusory. The following analysis of the bill's "safeguards" demonstrates that H.B. 7760 is not only philosophically flawed but also procedurally dangerous.

A. The bill does not require clinical evaluation, diagnosis, or treatment for possible psychiatric or psychological disorders or depression.

The safeguards in this bill are insufficient because they fail to require an evaluation for psychiatric disorders, such as depression, that can impair a patient's judgment. Under the current requirements, two physicians are only tasked with certifying that a patient is "capable" and does not have "impaired judgment," but the bill's definition of these terms is dangerously narrow. It defines a patient without "impaired judgment" simply as someone who can "sufficiently understand or appreciate the relevant facts" of an informed decision. This means a physician only verifies that a patient understands what is being said, not whether the patient is suffering from a mental illness that is driving their suicidality.

And even though a health care provider must make a determination that a patient is "capable," of making an informed decision, this requirement does not include a basic evaluation of a patient's current *mental* health state and an initial determination of whether they may be suffering from depression or anxiety that is commonly co-morbid with chronic and end-of-life illnesses. Indeed, "mental capability" is only defined as "the ability to make and communicate an informed decision." Accordingly, the bill ignores the patient's actual psychological state in favor of a mere communication standard.

To further illustrate H.B. 7760'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 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

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debilitated, sick, and disabled, and people with extended mental anguish . . . would be shrugged off as merely a matter of choice").

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] 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]

Likewise, 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] H.B. 7760, as a result, can never satisfy the standard of care for treating the needs of end-of-life or seriously ill patients.

B. The bill's mental health referral requirement is insufficient.

The proposed legislation places the entire burden of clinical and ethical oversight on the prescribing physician, creating a system that lacks specialized mental health protections. Under H.B. 7760, the responsibility to assess a patient's mental capacity and judgment falls to a physician rather than a mental health professional. While the bill allows a physician to refer a patient to a psychiatrist, psychologist, or clinical social worker, this referral is entirely discretionary. Critically, any such referral is restricted to the limited purpose of determining whether the patient's judgment is "impaired"—a term the bill defines narrowly as the mere ability to "understand or appreciate the relevant facts" of the decision. This means the

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[23] Rachelle Bernacki, 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 (emphasis added).
[26] *See id.*
[27] *See id*. at 13.
[28] AMERICAN COLLEGE OF PHYSICIANS, ANNALS OF INTERNAL MEDICINE, *Ethics Manual: Seventh Edition*, (Jan. 15, 2019).

referral is designed only to verify that the patient comprehends the doctor, not to determine whether the patient is suffering from a mental illness that is driving their suicidality.

Furthermore, the bill fails to mandate any form of therapeutic intervention. Even if a patient is referred to a mental health professional, neither the physician nor the specialist is required to assess or offer treatment for depression, anxiety, grief, or suicidal ideation—conditions that frequently influence a patient's desire to end his or her life. Instead of providing care, the professionals' roles are narrowed to facilitating the assisted suicide process. This lack of oversight is compounded by the fact that the bill does not require a sustained relationship or multiple consultations; a mental health professional can approve a patient for assisted suicide after only a single meeting, leaving underlying psychological distress unaddressed

This is 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.B. 7760 will always fail to meet the standard of care for treating seriously ill and/or end-of-life patients by permitting a health care provider 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.[29]

Moreover, despite H.B. 7760's provision allowing a physician to refer a patient for a psychological evaluation to determine whether the patient's judgment is impaired, current data shows that mental health counseling referrals for patients considering assisted suicide are exceedingly rare.[30] To illustrate, in Oregon in 2022, physicians prescribed lethal drugs to 431 patients requesting assisted suicide, yet only referred *three* of these 431 patients for mental health counseling—equating to *approximately 0.7% of patients*.[31]

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 assisted suicide suffering from depression.[32]

In Rhode Island, 24,9% of adults have reported a depression diagnosis,[33] and 14.1% of adults over 65 reported a depression diagnosis at some point in their lives.[34] H.B. 7760

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[29] *See* Bernacki, *supra* note 23.
[30] *See, e.g.*, OR. PUB. HEALTH DIV., *supra* note 7, at 14.
[31] *Id*. at 9.
[32] *Depression in Oregon*, AM.'S HEALTH RANKINGS, https://www.americashealthrankings.org/explore/measures/Depression_a/OR (last visited April 28, 2026).
[33] *Depression in Rhode Island,* AM.'S HEALTH RANKINGS, https://www.americashealthrankings.org/explore/measures/Depression_a/RI (last visited April 28, 2026).
[34] *Depression – Age 65+ in Rhode Island,* AM.'S HEALTH RANKINGS, https://www.americashealthrankings.org/explore/measures/depression_sr/depression_sr_75k/RI (last visited April 28, 2026).

does not adequately protect Rhode Island' citizens suffering from depression from seeking assisted suicide when facing a potentially terminal diagnosis.

C. The bill fails to account for hidden or masked depression, which is common in older patients and patients facing possible end-of-life diagnoses.

In addition to H.B. 7760'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:

> [e]stimates 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.[35]

The individuals most likely seeking 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.")[36]

H.B. 7760's contains no provisions requiring a patient to be screened or offered treatment for mental health issues. This is especially concerning 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."[37] And, as one study notes: "[s]tudies conducted in primary care settings suggest that only about 50% of depressed patients are recognized."[38] And another study found that "less than 50% of depressed patients were recognized by attending physicians" in "older (age > 65 years) medical inpatients."[39] The author of this study even argues that "[c]linicians and health care systems need to be held more accountable for outcomes of depression."[40] 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."[41] Yet, H.B. 7760 exempts physicians from making any inquiries into the patient's mental health at all.

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[35] Karen Overend et al., *Revealing hidden depression in older people: a qualitative study within a randomized controlled trial*, 19 BMC FAM. PRACT. 142 (Oct. 19, 2015).
[36] *See* Bernacki, *supra* note 23.
[37] *See id.*
[38] Leonard Egede et al., *Failure to Recognize Depression in Primary Care: Issues and Challenges*, 22 J. GEN INTERN MED. 3 (March 17, 2007).
[39] *See id.*
[40] *See id.*
[41] Linda Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Assisted Suicide,* 153 AM. J. PSYCHIATRY 1469 (1996) (emphasis added).

The lack of counseling referrals for vulnerable end-of-life patients is also gravely concerning. Scholarship shows "[a] high proportion of patients who request assisted suicide are suffering from depression or present depressive symptoms."[42] "[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 assisted suicide were depressed."[43] These patients' "desire for hastened death is significantly associated with a diagnosis of major depression."[44] Their psychiatric disability also may impair decision-making, "such as the decision to end one's life."[45]

The proposed legislation fundamentally fails to protect vulnerable patients by ignoring the high prevalence of hidden or masked depression among the elderly and those facing end-of-life diagnoses.

D. The bill incorrectly assumes that physicians' prognoses are accurate.

Last, H.B. 7760 assumes that physicians can correctly diagnose a patient with a "terminal condition." This fails as a safeguard as well because even licensed physicians 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."[46] Likewise, "[t]here is no requirement that the doctors consider the likely impact of medical treatment, counseling, and other supports on survival."[47]

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."[48]

Shockingly, "experts put the [misdiagnosis] rate at around 40%,"[49] and there have been cases reported where, despite the lack of underlying symptoms, the doctor made an

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[42] Jonathan Y. Tsou, *Depression and Suicide Are Natural Kinds: Implications for Assisted Suicide*, 36 INT'L J. L. & PSYCHIATRY 461, 461 (2013).
[43] *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").
[44] Tsou, *supra* note 42, at 466.
[45] *Id*.
[46] NAT'L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS, BIOETHICS AND DISABILITY SERIES 21 (2019).
[47] *Id*. at 22.
[48] Bernacki, *supra* note 23, at 3.
[49] 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.

"error"[50] 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.[51] Nicholas Christakis, a Harvard professor of sociology and medicine, agreed "doctors often get terminality wrong in determining eligibility for hospice care."[52]

In effect, H.B. 7760 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.

IV. Conclusion

Assisted suicide is not healthcare, and H.B. 7760 is inherently inconsistent with the standards of care for physicians to provide treatments for seriously ill patients or necessary mental health treatments. Because of this, the Committee should reject H.B. 7760.

Sincerely,

Emily Hoegler
Policy Counsel
AMERICANS UNITED FOR LIFE

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[50] *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).
[51] Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY (Jan. 13, 2009), http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.
[52] *See id.*