26-1001

United States Court of Appeals for the Third Circuit

SEAN CURRAN, et al.,

Plaintiffs-Appellants

v.

GOVERNOR OF DELAWARE, et al,

Defendants-Appellees

On Appeal from the United States District Court
for the District of Delaware
Civil Action No. 25-1475-GBW
Hon. Gregory B. Williams

BRIEF OF ALLIANCE DEFENDING FREEDOM, ET AL. AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS AND REVERSAL

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CORPORATE DISCLOSURE STATEMENT

Alliance Defending Freedom, Catholic Medical Association, Chayim Aruchim, Inc., Christ Medicus, Christian Medical & Dental Association, Concerned Women for America, Delaware Family Policy Council, Delaware Right to Life, Ethics and Religious Liberty Commission, National Association of Catholic Nurses, National Catholic Bioethics Center, National Catholic Partnership on Disability and the Rabbinical Alliance of America are non-profit corporations with no stock or parent corporations.

CatholicVote.org Legal Fund is a 501(c)(4) with no stock whose parent corporation is Fidelis Center for Law and Policy.

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INTEREST OF *AMICI CURIAE*[1]

Amici Alliance Defending Freedom, Catholic Medical Association, CatholicVote.org Legal Fund, Chayim Aruchim, Inc., Christ Medicus, Christian Medical & Dental Association, Concerned Women for America, Delaware Family Policy Council, Delaware Right to Life, Ethics and Religious Liberty Commission, National Association of Catholic Nurses, National Catholic Bioethics Center, National Catholic Partnership on Disability and the Rabbinical Alliance for America are medical, religious, ethical and legal non-profit organizations that support competent, compassionate and ethical health care for all individuals, including those with disabilities. Consequently, they are vehemently opposed to physician assisted suicide as it deprives vulnerable individuals of their fundamental right to life.

All parties have consented to the filing of this brief, pursuant to Federal Rule of Appellate Procedure 29(a)(2).

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), counsel for *Amici* represent that no counsel for a party authored this brief in whole or in part and that no person or entity, other than *Amici* or their counsel, made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

Delaware passed the End of Life Options Act ("EOLOA"), Del. Code Ann., tit. 16, § 2501C *et seq*., for the purpose of allowing a "terminally-ill-adult individual who has decision-making capacity . . . to request and self-administer medication to end their life in a humane and dignified manner." *Id.* at § 2501C(a). The EOLOA violates a core value of our democracy reflected in our founding documents—the right to life—by removing legal safeguards against medically assisted suicide. It erodes the role of government as protector of the right to life and instead makes it the enabler of an individual's desire to kill himself. This practice violates nearly 1,400 years of Anglo-American law which continuously criminalized assisted suicide and viewed suicide itself with disapproval either by criminalizing the practice or, as in modern times, discouraging it in various ways. The EOLOA violates Fourteenth Amendment substantive due process and procedural due process protections and should be struck down.

ARGUMENT

I. Life is a fundamental constitutional right that states have a solemn duty to protect under the Due Process Clause.

Understanding the meaning of the Due Process Clause necessarily involves an examination of our nation's history. "[T]he Due Process Clause

specially protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition' . . . and 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed." *Washington v. Glucksberg*, 521 U.S. 702, 720-21 (1997) (holding that there is no constitutional right to assisted suicide). Furthermore, "[t]he interpretation of the Constitution of the United States is necessarily influenced by the fact that its provisions are framed in the language of the English common law, and are to be read in the light of its history." *Smith v. Alabama*, 124 U.S. 465, 478 (1888). The right to life enshrined in the Constitution's Fourteenth Amendment Due Process Clause has long enjoyed robust support in our history and traditions, dating back even prior to the English common law.

A. Due Process and the right to life in the English common law

The Due Process Clause has its origins in the famous Magna Carta, originally issued in 1215 and codified in 1297: "(29) No freeman is to be . . . outlawed or exiled or *in any way ruined* . . . save by lawful judgement of his peers or by *the law of the land*. To no-one will we sell or deny of delay right or justice." Magna Carta, 1297, 25 Edw. 1, c. 9, § 29 (Eng.) (emphases added).

The great English expositor of the common law, Sir Edward Coke, when writing on this passage, explained that the words "by the law of the land" meant "without due process of law." 2 Edward Coke, *Institutes of the Laws of England* 50 (1642). Furthermore, he interpreted the words "in any way ruined/destroyed" as encompassing the right to life. "No man destroyed, etc. That is, fore-judged of life, or limb, disinherited, or put to torture, or death." *Id.* at 48. In describing the relationship between Magna Carta and the common law, he stated that the former was "to be holden for the common law, that is, the law common to all." *Id*. 526.

Sir William Blackstone, who was "a primary legal authority for 18th- and 19th-century American lawyers," *Glucksberg*, 521 U.S. at 712, affirmed that Magna Carta "contained *very few new grants*; but . . . was for the most part *declaratory of the principal grounds of the fundamental laws of England*. . . . all judgments contrary to it are declared void." 1 William Blackstone, *Commentaries on the Laws of England* *123-24 (1765) (emphases added). So, the rights guaranteed by Magna Carta predate it. The common law emerged in the 1100s. *Glucksberg*, 521 U.S. at 711 n.9.

Blackstone articulated three primary absolute rights, reflected in our Due Process formulation, which were guaranteed by Magna Carta and subsequent statutes: the right of personal security, the right of personal

liberty, and the right of property. 1 Blackstone, *supra*, at *125. Regarding personal security, he stated that it "consists in a person's legal and uninterrupted enjoyment of his life" which is "the immediate gift of God, a right *inherent by nature* in every individual." *Id.* (emphasis added).

Significantly, Blackstone affirmed that the primary purpose of government is to protect individuals' "absolute rights."

> For the principal aim of society is to protect individuals in the enjoyment of those absolute rights, which were vested in them by the immutable laws of nature . . . . And therefore the principal view of human laws is, or ought always to be, to explain, protect, and enforce such rights as are absolute.

Id. at *120-21.

The words of the commentators are reflected in the Declaration of Independence, which attests to the understanding in our legal tradition that the right to life is "self-evident" and "unalienable." The Declaration of Independence, para. 2 (U.S. 1776). These terms signify that the right did not originate in the state or in the individual person; individuals are "endowed by the Creator" with the right to life. The facts that "Governments are instituted among Men" to "secure these rights" and that King George III had utterly failed in his duty to protect the natural rights of the colonists provided the justification for the American Revolution. Therefore, these natural rights, including the right to life, are foundational to our form of government.

B. Suicide in the pre-common law and common law era

England initially adopted an ecclesiastical prohibition on suicide in 673 at the Council of Hereford, which was reaffirmed by King Edgar in 967. *Glucksberg*, 521 U.S. at 711 n.9. That prohibition was upheld in the common law up to and through the time of our nation's founding.

The early English commentator Henry de Bracton, writing in the 1200s, expounded on the law of suicide. "Just as a man may commit felony by slaying another so may he do so by slaying himself, the felony is said to be done to himself." 2 *Bracton on the Laws and Customs of England* 423 (G. Woodbine ed., Thorne trans., 1968-1977). A suicide committed during a felony to avoid arrest was punished by loss of all possessions, while a person who killed himself "in weariness of life or because he is unwilling to endure further bodily pain" would only forfeit movable goods. *Id*. at 424. Madmen "bereft of reason" would not be liable at all. *Id*.

In keeping with the view that life is a right given by God and nature, in sections of their works discussing homicide, both Coke and Blackstone affirmed that suicide was a felony at common law if the individual was of sound mind:

> *Felo de se* is a man or woman, which being *Compos mentis*, of sound memory, and of the age of discretion killeth himself . . . all the goods and chattels of the party so offending are forfeited. . . . If a man lose his memory by the rage of sickness

> or infirmity, or otherwise and kill himself while he is not compos mentis, he is not *Felo de se*: for as he cannot commit murder upon another, so in that case he cannot commit murder upon himself.

3 Coke, *Institutes* at 54 (1644). So, Coke agreed with Bracton that insanity was a defense but broke with him on the issue of forfeiture of lands, stating that the law only required forfeiture of goods and chattels. *Id*. at 55.

Blackstone affirmed the public nature of homicide, stating that suicide was a "violation of the laws of nature; of the moral as well as political rules of right" and which included "a breach of the public peace" and "threaten[ed] and endanger[ed] the subversion of all civil society." 4 Blackstone, *Commentaries* *176-77 (1769). Blackstone stated that, of all personal crimes, "the *most principal and important is the offence of taking away that life*, which is the immediate gift of the great creator; and which therefore *no man can be entitled to deprive himself* or another of." *Id*. at *177 (emphases added). He agreed that the guilty person forfeited goods and chattels only and offered deterrence as the reason for the harshness of the penalty: "hoping that his care for either his own reputation, or the welfare of his family, would be some motive to restrain him from so desperate and wicked an act." *Id.* at *190.

While acknowledging that there was some acceptance of suicide in Roman law when it was committed to alleviate personal suffering, *id*. at

*189, Blackstone affirmed that self-murder for any reason was an offense "among the highest, crimes" against God and the king, "who has an interest in the preservation of all his subjects." *Id*. Echoing Coke, he stated that a person must be "of years of discretion, and in his senses" for him to be adjudged guilty of suicide. *Id*. However, he clarified that the mere act of suicide, even if it resulted from "melancholy or hypochondriac fit," was not evidence of insanity any more than it would be in the case of any murder because criminal insanity required a man be "deprive[d] . . . of the capacity of discerning right from wrong." *Id*.

Finally, Blackstone confirmed that assisting a felony was itself a felony in the second degree if the accessory was not present for the fatal act. If the inciting individual was present and assisting, however, he would be guilty as a principal. 3 Blackstone, *Commentaries* at *35-37. Thus, assisting the felony of suicide was a felony under the common law.

C. Suicide in the American legal system

Prior to the American Revolution, the colonies were subject to the laws of England. *Ex parte Grossman*, 267 U.S. 87, 110 (1925). On the issue of suicide, the colonies largely adopted the common law. *Glucksberg*, 521 U.S at 712. The colonies of Providence Plantation (Rhode Island) and Virginia adopted the common law rule regarding forfeiture, with the latter

including lands. *Id*. at 712-13. The states eventually abolished the penalties of suicide in order to spare the survivors additional suffering, without legitimizing the practice itself. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 294 (1990) (Scalia, J., concurring).

Colonial and early state legislatures followed the common law rule that assisting a suicide was a crime. *Glucksberg*, 521 U.S. at 714. The earliest state to outlaw assisted suicide was New York, in 1828. *Id.* at 715. At the time of the adoption of the Fourteenth Amendment, assisting suicide was a criminal offense in twenty-one of the thirty-seven states and eighteen of the thirty ratifying states. *Cruzan*, 497 U.S. at 294-95. Most of the states that did not criminalize assisted suicide at the time of adoption came to recognize it as criminal in the fifty years following. *Id.* at 295. Prohibitions in assisted suicide spread to the western states in the late nineteenth and early twentieth centuries, based on the Field Model Penal Code drafted by a New York commission. *Glucksberg*, 521 U.S. at 715. In 1980, the Model Penal Code included a provision prohibiting assisting suicide, which resulted in many states enacting or revising their bans. *Id*. The drafters noted "the interests in the *sanctity of life* that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, *even though the act may be accomplished with the*

consent, or at the request, of the suicide victim." *Id*. at 716 n.12 (emphases added) (quoting the Model Penal Code Official Draft and Revised Comments 1980).

Significantly for assisted suicide laws in general and the Delaware law in particular, there was never an exception for assisted suicide for people near death, whether the individual was terminally ill or condemned to death for a crime. All were "under the protection of law equally as the lives of those who [were] in the full tide of life's enjoyment." *Id.* at 714-15 (citation omitted).

Suicide itself is no longer a criminal act in any state. Sean Sweeney, *Deadly Speech: Encouraging Suicide and Problematic Prosecutions*, 67 Case W. Rsrv. L. Rev. 941, 946 (2017). But assisted suicide is currently legal in only thirteen states (26%) and Washington, D.C.[2]

* * *

For nearly 1400 years, from England's first prohibition on suicide in 673 up to the present day, the vast weight of legal evidence has supported the view that life is a fundamental right inherent in nature and a societal

[2] California, Colorado, Delaware, Hawaii, Illinois, Maine, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, D.C., Washington. Compassion & Choices, *States Where Medical Aid in Dying is Authorized*, https://compassionandchoices.org/states-where-medical-aid-in-dying-is-authorized/ (last visited Feb. 24, 2026).

good that governments have the solemn responsibility to defend. The recent trend in some states of legalizing assisted suicide is a threat to vulnerable individuals and erodes the commitment of government to protect them. These laws are a Pandora's Box, and the harm that they inflict on vulnerable groups is already evident in jurisdictions that have allowed the practice. *See* Sec. II.

II. Delaware's End of Life Options Act fails Substantive Due Process.

The Fourteenth Amendment forbids the states from infringing on fundamental rights, such as the right to life, Sec. I, *supra*, "*at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993). Delaware has no legitimate purpose in helping people kill themselves, and the EOLOA is not narrowly tailored, regardless.

A. The state has a compelling interest in protecting life and no legitimate interest in helping individuals kill themselves.

The Supreme Court in *Glucksberg* recognized numerous governmental interests in banning assisted suicide. First, the state has "an unqualified interest in the preservation of human life." *Glucksberg*, 521 U.S. at 728 (citation omitted). Importantly, this interest includes protecting "all persons' lives, from beginning to end, regardless of physical or mental condition . . . even those who are near death." *Id.* at 729-30.

Second, the "State has an interest in preventing suicide, and in studying, identifying, and treating its causes." *Id*. at 730. This is because it is a "serious public-health problem" and is often the result of a mental disorder and uncontrolled pain which are often difficult to diagnose. Legalization of assisted suicide makes it more difficult for states to protect and treat mentally ill persons or those suffering from untreated pain. *Id*. at 730-31.

Third, the state has "an interest in protecting the integrity and ethics of the medical profession." *Id.* at 731. Allowing assisted suicide could erode the trust between patients and their doctors. *Id*. The American Medical Association continues to condemn assisted suicide because it "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." AMA Code of Medical Ethics, *Physician-Assisted Suicide*, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide (last visited Feb. 26, 2026).

Fourth, "the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes." *Glucksberg*, 521 U.S. 731. The Court noted the "real risk of subtle coercion and undue influence in end-of-life situations" which might

cause many to resort to assisted suicide "to spare their families the substantial financial burden of end-of-life health-care costs." *Id*. at 732.

Studies suggest that doctors themselves are not immune to exercising coercive power over their patients in their medical decisions. One study found that the overwhelming majority of doctors (83.6%) had implicit bias against disabled persons, although they self-reported as being unbiased. Given the "growing body of knowledge linking disparate health outcomes to providers' clinical decision making," the implications for the coercive impact that attending physicians may exercise over their patients' end-of-life decisions is extremely concerning. Laura VanPuymbrouck et al., *Explicit and Implicit Disability Attitudes of Healthcare Providers*, 65 Rehab. Psych. 101 (2020). Of doctors who treat patients with disabilities, 82.4% tend to view them as having a worse quality of life than non-disabled persons. The study found that "[p]otentially biased views among physicians could contribute to persistent health care disparities affecting people with disability." Lisa I. Iezzoni et al., *Physicians' Perceptions of People with Disability and Their Health Care,* 40 Health Affs. (Feb. 2021).

Another retrospective study compared two sets of patients who had sustained traumatic brain injuries ("TBI"). Life-sustaining treatment had been withdrawn from one set but not the other. The study found that a

substantial proportion of individuals with TBI whose treatment had not been withdrawn survived and achieved at least partial independence. This means that those in the corresponding group from whom life-sustaining treatment had been withdrawn could have had a similar outcome had treatment not been withdrawn. The study advised a "more cautious clinical approach" to withdrawal of life-sustaining treatment in TBI patients. William Sanders et al., *Recovery Potential in Patients Who Died After Withdrawal of Life-Sustaining Treatment: A TRACK-TBI Propensity Score Analysis,* 41 J. Neurotrauma (Oct. 21, 2024). The concern that physician bias towards disabled persons could result in subtly coerced decisions to hastily withdraw life support or request assisted suicide is therefore very well-founded.

Fifth, the state has an interest in "protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference.'" *Glucksberg*, 521 U.S. at 732. An assisted-suicide ban "reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's." *Id.*

Lastly, the state has an interest in avoiding the slippery slope that could be created by legalizing assisted suicide, leading to voluntary and even

involuntary euthanasia. *Id*. at 732-33. This concern has been confirmed by the practice of euthanasia in the Netherlands, as noted in *Glucksberg*:

> The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent.

Id. at 734.

In contradiction to 1,400 years of legal history supporting the fundamental right to life, the state's compelling interest in protecting life, and the specific state interests against assisted suicide enumerated in *Glucksberg*, the State of Delaware has asserted a state interest in granting the terminally ill the ability "to pass on their own terms, without unnecessary pain, and surrounded by the people they love most." Appellant's Opening Brief ("AOB") at 38. But this stated interest ignores the actual effect of the EOLOA. The Act implicitly incentivizes disabled persons to commit suicide by placing the imprimatur of the law on the practice, thereby removing the historical stigma associated with it. The law even states, contrary to objective reality, that a request or prescription for, or the dispensing of, medication to end life does not "constitute . . . assisted-suicide." Del. Code Ann., tit. 16, § 2512C(c)(2).

Additionally, the involvement of a medical practitioner with whom the patient has a confidential and likely trusting relationship conveys medical legitimacy to a decision to kill oneself. Patients tend to assume that their doctors are acting in their best interests and according to accepted medical practice. Studies have suggested that this trust may be misplaced in the case of disabled persons. *Supra* at 13-14. Those who would otherwise be reluctant, perhaps out of shame or fear, to kill themselves are lured by the possibility of this apparently sanitized option.

Therefore, the relevant question is whether the state has any level of interest in encouraging people to forgo their constitutional right to life. Can a state put its finger on the scales to encourage individuals to waive trial by jury or the right to vote? Can they do this only for selected groups, say Black people? *See* AOB 42-43; App. A82-A88, paras. 103-23. Can a state incentivize individuals to voluntarily place themselves into slavery, contrary to the Thirteenth Amendment? Can a state honor a contract to sell body parts? Since the government is responsible for safeguarding these rights, the answer should be a resounding "No." The state's interest in enabling and facilitating suicide through the EOLOA is diametrically opposed to and irreconcilable with the historically and legally recognized state interests in protecting life and preventing suicide. *See* Sec. I; *supra* at 11-15. It therefore

cannot rise to the level of a legitimate state interest, let alone a compelling one.

The assumption that life is intrinsically good and is not a means to some other end has been called the "inviolability-of-life principle." As the Declaration states, it is "self-evident." We indeed can see evidence of the respect for life every day when we follow traffic laws, help our disabled loved ones, express shock at murder, and decry unequal treatment of vulnerable people. Neil Gorsuch, *The Future of Assisted Suicide and Euthanasia* 158-59 (Robert George ed., 2006).

The implication from this principle that human life is a basic good is that "we can and should refrain from actions intended to do it harm." *Id*. at 163. It rules out acts done with the intent to kill, such as assisted suicide, while allowing for removal of life-sustaining medical treatment or administration of pain-relieving drugs. *Id*. at 164-65. By contrast, the EOLOA places human lives on a sliding scale according to which some people's lives are more important than others, a premise that strikes at the heart of equal protection. *See* AOB 42-43; App. A82-A88, paras. 103-23.

Finally, the Act does not necessarily further the rosy picture presented by the state that dying individuals will be "surrounded by the people they love most" at the time of death. It does not require that family members be

notified at all or any witnesses be present at the moment the patient takes the lethal medication. Del. Code Ann., tit. 16, § 2508C. Instead, the law allows "the people they love most" to be kept in the dark and not be told of their loved one's death until after the fact, if then. Given that many people who resort to assisted suicide do so out of fear of being a burden to family members, App. A86, para. 119, patients may choose not to notify them, depriving them of any opportunity to try to dissuade their loved one from the irreversible act of suicide. The family's last memory of their loved one will instead be of the patient dying alone, not surrounded by their comforting presence. The EOLOA therefore can intensify the devastating effects of suicide on remaining family members. Gorsuch, *supra*, at 93.

B. The EOLOA is not narrowly tailored.

To be narrowly tailored, a law must be "specifically and narrowly framed to accomplish" its purpose, *Fisher v. Univ. of Texas*, 570 U.S. 297, 311 (2013), and "necessary" to achieve the state's compelling interest. *Students for Fair Admissions, Inc. v. President and Fellows of Harv. Coll.*, 600 U.S. 181, 207 (2023).

There are other medically acceptable and widely used methods to alleviate patients' physical suffering short of helping them kill themselves. The American Medical Association counsels physicians not to engage in

assisted suicide and instead advises them to proactively "respond to the needs of patients at the end of life." Specifically

> Physicians:
> (a) Should not abandon a patient once it is determined that cure is impossible.
> (b) Must respect patient autonomy.
> (c) Must provide good communication and emotional support.
> (d) Must provide appropriate comfort care and adequate pain control.

AMA Code of Medical Ethics, *supra* at p. 12. Palliative care, including the use of opioids, can control pain in cancer patients up to 70-90% of the time. Tony O'Brien & Christopher Kane, *Pain Services and Palliative Medicine – an Integrated Approach to Pain Management in the Cancer Patient*, Brit. J. Pain (Nov. 2014). Palliative sedation, "the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms" can be an ethical option used by hospice to treat pain in those "extreme situations" when palliative care is not sufficient and "after all available expertise to manage the target symptom has been accessed" with the intention of alleviating pain, never of shortening life. Am. Acad. Hospice & Palliative Med., *Palliative Sedation*, https://aahpm.org/advocacy/where-we-stand/palliative-sedation/ (2014). "Such decisions should be guided by a holistic approach to care giving, a commitment lovingly to accompany the person and his or her family and other loved ones throughout the illness, and a regard for their desire for an

adequate preparation for death." International Association of Catholic Bioethicists, *The Use of Sedatives in the Care of Persons Who Are Seriously Ill or Dying: Ethical Distinctions and Practical Recommendations*, Nat'l Cath. Bioethics Q. 489, 500 (Autumn 2012).

The EOLOA does not directly address patients' pain; it simply authorizes their killing. With the availability of far less drastic options, there is no practical reason to resort to killing patients. Furthermore, it is common knowledge that doctors are not always correct in their prognoses, and there is evidence that their biases against disabled persons may contribute to a failure to provide adequate health care alternatives. *Supra* at 13-14. The decision for assisted suicide is neither "necessary" nor "specifically and narrowly framed" to relieve the pain of patients with disabilities.

Therefore, the EOLOA is not "narrowly tailored" as strict scrutiny requires and denies substantive due process to the ill and disabled. *Glucksberg*, 521 U.S. at 721. *See also* AOB 37-40.

III. The EOLOA does not satisfy Procedural Due Process.

In the procedural due process context, the factors a court must consider are 1) the private interests involved, 2) the governmental interests involved, and 3) the value of procedural requirements in determining what process is due. *Washington v. Harper*, 494 U.S. 210, 229 (1990).

A. The individual's interest in receiving assistance in committing suicide is not sufficient to overcome the state's compelling interest in protecting life.

The Plaintiffs' interest in this case is their fundamental right to life which is endangered by the EOLOA. The lower court opinion in numerous places cites the "voluntary" nature of the decision to commit suicide to rebut the Plaintiffs' concern. App. A21, A28. However, because suicide is not a crime, there are currently no legal deterrents to killing oneself. Thus, individual autonomy is not the issue. The question is whether individual autonomy *and* a desire for assistance in committing suicide are sufficient to allow a state to legalize providing such assistance. Historically, legally, and medically, the answer has always been "No."

Until recently, suicide and assisted suicide were nearly universally proscribed by the English and American legal systems. *See* Sec. I and II.A. The voluntary nature of the act of suicide never influenced its felony status. The 1980 Model Penal Code condemned assisted suicide, which resulted in many states enacting or revising their bans. *Glucksberg*, 521 U.S. at 715-16. Only in the past few decades, have states decriminalized physician assisted suicide, while still viewing suicide in general as against the interests of the individual and society. All states provide access to the 988 suicide prevention hotline. *988 Suicide & Crisis Lifeline,* FCC (last updated Aug.

28, 2025), https://www.fcc.gov/988-suicide-and-crisis-lifeline. Most states express disapproval of suicide via statutes dealing with durable powers of attorney over health care, in living will statutes, and in laws allowing for the involuntary commitment of people who are a danger to themselves as a result of mental illness. *Glucksberg*, 521 U.S. at 729 n.12. Therefore, historically, the idea that individual autonomy is sufficient to overcome the state's compelling interest in protecting life and discouraging suicide is unfounded. Indeed, the existence of laws enabling assisted suicide works against the state interest in reducing suicide. *Id*. at 730-31.

Furthermore, the law has never recognized an individual's legal right to do whatever he wants with his own body. "But the liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint." *Jacobsen v. Massachusetts*, 197 U.S. 11, 26 (1905) (holding that state law mandating compulsory vaccination for the protection of public health and safety was not a violation of due process). If personal autonomy is sufficient to remove legal consequences for assisting a suicide, then logically there is no reason why the same would not also be true for any homicide perpetrated at the request of the victim. But our legal system has never allowed such a justification.

"The consent of a homicide victim is 'wholly immaterial to the guilt of the person who caused [his death].'" *Glucksberg*, 521 U.S. at 714.

The implications of an autonomy justification for assisted suicide are far-reaching. Indeed, the belief that "an autonomy-based right to assisted suicide belongs to all competent adult patients" has been asserted by some assisted suicide proponents. Gorsuch, *supra*, at 98. Should the law therefore also recognize an autonomous decision to place oneself into slavery so that the slave owner would face no legal repercussions? Or a decision to pay another to maim oneself so that the maimer would not be legally responsible? "The power of the federal courts to enforce the terms of private agreements is at all times exercised subject to the restrictions and limitations of the public policy of the United States as manifested in the Constitution, treaties, federal statutes, and applicable legal precedents." *Hurd v. Hodge*, 334 U.S. 24, 34-35 (1948). The extensive and longstanding commitment of the United States and our English forebears to the protection of life and the discouraging of suicide establishes that public policy. The state's affirmative duty to protect human life is therefore not subject to an individual's autonomous desire to die.

Furthermore, a request for suicide is widely recognized by the medical community as a sign of mental illness. Johns Hopkins Medicine, *Depression*

and Suicide, (last visited Feb. 25, 2026), https://www.hopkinsmedicine.org/health/conditions-and-diseases/depression-and-suicide. The presence of mental illness in an individual is strong evidence that the request for suicide is not truly voluntary and therefore nullifies consent. Indeed, "[M]any people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Glucksberg*, 521 U.S. at 730. Physician-assisted suicide should be properly viewed as a violation of good medical practice and of patient autonomy. The risk that mentally incompetent individuals would be lured into killing themselves is too great to justify departing from our longstanding legal tradition.

B. The procedural "safeguards" of the EOLOA cannot satisfy Due Process.

The Due Process Clause "promotes fairness" in governmental decisions which deprive any persons of life, liberty and property and "by barring certain government actions *regardless of the fairness of the procedures used to implement them* . . . serves to prevent governmental power from being 'used for purposes of oppression.'" *Daniels v. Williams*, 474 U.S. 327, 331-32 (1986) (emphasis added) (internal citation omitted) (holding that the Due Process Clause protects individuals from intentional, not negligent, actions of government). Plaintiffs have listed numerous ways

in which the Act fails to provide adequate safeguards to protect Plaintiffs. AOB 41-42; App. A89-A98.

In addition, it is doubtful that any number of procedures could ever satisfy due process in this context. In support of the governmental interest in banning assisted suicide as a means of avoiding the slippery slope towards euthanasia, the *Glucksberg* Court noted that despite "various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia." *Glucksberg*, 521 U.S. at 734. All too often, assisted suicide and voluntary euthanasia laws (as is practiced in the Netherlands) are a Trojan horse for abandoning the medically vulnerable to the coercive powers of their own worst fears or of the people around them who may not have their best interests at heart. *Supra* at 13-14. Assisted suicide laws can in fact be cloaks for government power "used for purposes of oppression," *Daniels,* 474 U.S at 331-32, even if that oppression is at the hands of private parties, including doctors whom the EOLOA has empowered to oppress vulnerable individuals.

In 2002, the Netherlands passed the Euthanasia Act which governs when a physician can euthanize a patient. The practice is allowed for both physical and psychiatric reasons. It includes provisions for children as young as twelve. Children between the ages of sixteen and eighteen need not have parental consent, although the parents should be consulted. Martin Buijsen, *Euthanasia in The Netherlands. History, Developments and Challenges*, 17 L. & Religion Mag. 77, 84-85 (Aug. 31, 2022).

In 2005, under the Groningen Protocol, which is separate from the Act, five criteria, including parental consent, were promulgated for the euthanasia of newborns with lethal drugs. A. A. Eduard Verhagen, *Neonatal Euthanasia in the Context of Palliative and EoL Care*, 28 Semin. Fetal Neonatal Med. (Jun. 2023). Cases of neonatal euthanasia are referred to a prosecutor for review under the Protocol and, if found in conformity, the doctors are not prosecuted because their actions are "found to be in accordance with good practice." A. A. Eduard Verhagen, et al., *Deliberate Termination of Life in Newborns in The Netherlands; Review of all 22 Reported Cases between 1997 and 2004*, Dutch J. Med. (Jan. 22, 2005).

The Netherlands issues an annual report from its Regional Euthanasia Review Committees. It indicates a steady increase in euthanasia, including its use for only psychiatric conditions. In 2024, euthanasia accounted for

5.8% of total deaths in the Netherlands, up from 5.4% in 2023, for a 10% increase in euthanasia deaths between the two years. Regional Euthanasia Review Committees, *Regional Euthanasia Review Committees Annual Report 2024* 4, (March 2025), https://www.euthanasiecommissie.nl/site/binaries/site-content/collections/documents/2024/03/24/index/rte-annual-report-2024.pdf ("Annual Report"). In 2024, there were 9,753 cases of termination of life on request (voluntary euthanasia), representing 97.9% of all cases and a fourfold increase over the number cited in *Glucksberg* from 1990. *Glucksberg*, 521 U.S. at 734. Assisted self-administration of lethal drugs (187) and a combination of the two (eighteen cases) comprised the rest. Annual Report at 15. There was a 250% increase in euthanasia deaths requested by those with dementia between 2020 and 2024. *Id.* at 16-17. While most cases involved physical suffering, there were 219 cases of euthanasia for psychiatric disorders alone (2.2% of total cases). *Id*. at 13-15. This represents a 250% increase over 2020. *Id*. at 17. Three of the euthanasia cases involved minors between the ages of twelve and eighteen; two of those were solely for psychiatric reasons. *Id.* at 19-20. The social science evidence documenting the role that doctors play in clinical care decisions and the

concerning increase in euthanasia cases in the Netherlands both serve as a stark warning to jurisdictions of the long-term negative impact of the law.

A case of a Dutch woman who was euthanized in 2016 clearly illustrates the difficulty of determining whether consent is truly "voluntary." The woman, who was suffering from Alzheimer's disease, had expressed a wish to be euthanized at a time of her choosing. At the time of the procedure, the doctor sedated the woman and asked the family to hold her down while she administered the drug. Prosecutors asserted that the woman showed resistance and that the doctor had not ensured consent. BBC, *Dutch Doctor Faces Trial in Landmark Euthanasia Case* (Aug. 26, 2019), https://www.bbc.com/news/world-europe-49478304. Ultimately, the court ruled in favor of the doctor, asserting that all requirements of the law had been met and that the doctor acted lawfully and in compliance with the patient's wishes. BBC, *Dutch Euthanasia Case: Doctor Acted in Interest of Patient, Court Rules* (Sep. 11, 2019), https://www.bbc.com/news/world-europe-49660525.

The experiences of other jurisdictions confirm the slippery slope as procedural safeguards have been removed after enactment. For instance, in 2021, Canada removed its requirement that patients' deaths had to be "reasonably foreseeable." This allowed non-terminal patients with incurable

diseases in an advanced state of irreversible decline such as multiple sclerosis, quadriplegia, blindness, and chronic back pain to be eligible for assisted suicide. And, following the lead of the Netherlands, in 2027, Canada will allow patients with mental illness only to obtain assisted suicide. The Canadian Parliament is even considering expanding the law to include minors. *See* App. A96-A97. Recent deaths in Canada include patients who cited poverty and lack of social support as their reasons for desiring death. *Id*. at A144.

Colorado, Vermont, Oregon and California have similarly expanded their assisted suicide laws since enactment. App. A97-A98. The decision in *Glucksberg* seems prescient: "Each step, when taken, appears a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance." *Glucksberg*, 521 U.S. at 735 (citation omitted).

* * *

The governmental interest in protecting human life is unquestionably compelling and the Plaintiffs' interest in their right to life is fundamental, while Delaware's asserted interests are insubstantial and without principled limitation. The EOLOA is not narrowly tailored to alleviate patient pain. The "safeguards" in the EOLOA are inadequate, and the experience of other

jurisdictions with physician-assisted suicide illustrates the unlikelihood that any other procedural steps would be sufficient to protect the interests of vulnerable individuals. The EOLOA fails to satisfy procedural due process.

CONCLUSION

For the foregoing reasons, this Court should reverse the District Court's opinion and remand for further proceedings on Plaintiffs' claims.

Respectfully submitted,

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CERTIFICATE OF BAR MEMBERSHIP

I hereby certify that this brief complies with 3d Cir. L.A.R. 46.1 as I am a member of the bar of this Court and am currently in good standing.

/s/ *Joseph Stanton*
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CERTIFICATION OF COMPLIANCE

1. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) It has been prepared in a proportionally spaced typeface using Microsoft 365 in 14-point Times New Roman font.

2. The brief complies with the length requirements of Fed. R. App. P. 29(a)(5) and 32(a)(7)(B) because it contains 6,440 words, excluding the parts of the brief exempt by Fed. R. App. P. 32(f), as determined by the word-count function of Microsoft 365.

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I hereby certify that on February 27, 2026, I electronically filed the foregoing Brief of *Amici Curiae* with the Clerk of the Court for the United States Court of Appeals for the Third Circuit using the CM-ECF system. The State of Delaware is a Filing User and will be served electronically by the Notice of Docket Activity.

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