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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

Lonny Shavelson, M.D., *et al.*, Plaintiffs, v. California Department of Health Care Services, *et al.*, Defendants.	Civil Action No. 3:21-cv-06654-VC **BRIEF OF *AMICI CURIAE* CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS AND COPTIC MEDICAL ASSOCIATION OF NORTH AMERICA IN SUPPORT OF DEFENDANTS' MOTIONS TO DISMISS**

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INTERESTS OF *AMICI CURIAE*[1]

Amici curiae are two associations of Christian healthcare professionals. The Christian Medical & Dental Associations is an organization of 16,000 members that provides resources, networking opportunities, education, and a public voice for Christian healthcare professionals and students in order to preserve a space for Christians in the medical field. CMDA educates, encourages, and equips Christian healthcare professionals to glorify God. The Coptic Medical Association of North America aims to unite Egyptian Christian medical professionals from North America and to provide compassionate healing worldwide by serving the sick, mentoring future generations, and equipping local ministries. *Amici* seek to ensure that California's decision to outlaw euthanasia[2] is upheld in order to guard against the grave harms that euthanasia would threaten to the medical profession and to the many thousands of religious believers who practice in it.

ARGUMENT

Whether and to what extent doctors should be allowed to participate in intentionally ending the lives of their patients is one of the most important questions in public bioethics. The vast majority of states allow no physician participation at all. California is one of nine states that have passed laws allowing physicians to "assist" a patient's suicide by making lethal drugs available. But each stops there. *No state* allows what the plaintiffs in this case now demand: that doctors be allowed to actively euthanize patients by administering the lethal dose to them.

Many, including *amici*, steadfastly oppose allowing physicians even to assist suicide. Under this view, any participation in the decision to intentionally end a patient's life threatens dire consequences for the medical profession and especially for the most vulnerable among us. But the

[1] No party's counsel authored this brief in whole or in part; no party's counsel contributed money that was intended to fund preparing or submitting the brief; and no person contributed money that was intended to fund preparing or submitting the brief.

[2] The term "euthanasia" in this brief refers to "the administration of a lethal agent by another person to a patient." Am. Med. Ass'n, Code of Med. Ethics, Op. 5.8, https://bit.ly/3fJ4oAJ (last visited Jan. 28, 2022) [hereinafter AMA Ethics Op. 5.8].

fact that a state has chosen to allow physician-assisted suicide does not compel it to take the next, even more dangerous, step of endorsing active euthanasia. As this Court recognized, "the line between assisted suicide and euthanasia is a significant one." ECF No. 28, at 4.

For one, that line is significant because euthanasia exacerbates assisted suicide's already grave risk that patients could be killed against their will. *See id.* But a state's interest in regulating this matter of life and death does not begin and end with a patient's consent. More fundamentally, the prohibition against euthanasia also reflects the state's significant interest in avoiding the severe harms that it would inflict on the healing profession of medicine. For thousands of years, the medical profession has recognized a doctor's central duty to heal and to care for human life, however frail, until its natural end. Euthanasia, even if fully "consensual," is antithetical to this tradition. To permit doctors to actively kill their patients merely because the patient desires it would erode this ancient foundation for the practice of medicine, reduce medical professionals to mere service providers, and weaken the trust between patients and doctors that is vital to our healthcare system. And to permit medical professionals to engage in euthanasia would risk alienating—and perhaps forcing out of practice—the many thousands of individuals and organizations like *amici* whose beliefs demand that they refuse to take part in it.

For all of these reasons, even a state that allows assisted suicide still maintains a strong interest in recognizing the "time-honored line between healing and harming" and in safeguarding the medical profession from the full magnitude of harms that would result if it invited its doctors to actively kill their patients. *See Washington v. Glucksberg*, 521 U.S. 702, 731 (1997). Forcing California to become the first state to embrace euthanasia solely because it permits assisted suicide would fundamentally alter the line the state has drawn to delimit its position on this grave question of public policy.

Amici urge the Court to grant the defendants' motions to dismiss.

I. Euthanasia is Antithetical to the Long-Established Understanding of Medicine.

For thousands of years, medicine has been understood through the doctor's call to heal—never to harm—her patients. That tradition recognizes human life as inviolable and forbids the

intentional killing of a patient. Euthanasia, by permitting doctors to do exactly that, contravenes this tradition and undermines the well-founded understanding of the ends of medicine upon which American law has been built for centuries.

Modern medicine is rooted in an ancient Greek tradition that dates as early as the fifth century B.C. *See* Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* 20-28 (1999). There, physicians swore the Hippocratic Oath, an oath of medical ethics that still informs the practice of medicine today. *See Greek Medicine: The Hippocratic Oath*, Nat'l Inst. Health, https://bit.ly/33wTHPs (last visited Jan. 28, 2022). That oath bound doctors to a number of duties, including to use healing practices that "will benefit . . . patients according to [the doctor's] greatest ability and judgment" and never to do "harm or injustice to them." *Id.* And it included the command that a doctor would "never give a lethal drug to anyone if . . . asked" or "advise such a plan." *Id.* Ancient Hindu and Chinese medicine placed similar demands on their doctors. *See* Am. Coll. Physicians, *Ethics Manual* 130 (1984) [hereinafter ACP, *1984 Ethics*].

Modern medicine continues this tradition—a tradition that *amici* inherit as it was developed through Christian medical practice. Christians adopted the Hippocratic Oath with some modifications during the Middle Ages and widely circulated its prohibition against euthanasia. *See* Albert R. Jonsen, *A Short History of Medical Ethics* 17 (2000). The Christian view was and is, of course, informed by the life and teachings of Jesus Christ, whose earthly ministry involved healing miracles, and by God's commandment "thou shalt not kill." *See, e.g.*, Matthew 8:14-15; John 9:1-12; Exodus 20:13; *see also* John W. Love, *The Concept of Medicine in the Early Church*, 75 Linacre Q. 225, 229 (2008). The Christian conception of medicine "is not ordered towards the *desire* of the patient" but rather toward the dignity and "*good* of the patient, which is authentic healing in light of the nature of the human person." Michael Vacca, *Reflecting Upon the Subjective Dignity of Health Care Workers & An Appropriate Understanding of Medical Professionals*, Christ Medicus (Apr. 3, 2020), https://bit.ly/3GQEeYJ. Thus, Christian attitudes toward medicine emphasize succor for the sick and disabled—not abandonment. *See* Darrel W. Amundsen, *Medicine and Faith in Early Christianity*, 56 Bull. Hist. Med. 326, 335, 349 (1982); Gary

Ferngren, *Medicine and Health Care in Early Christianity* 109-11 (2009). This extends to a prohibition against euthanasia, whether voluntary or not. *See, e.g.*, Edward J. Larson & Darrel W. Amundsen, *A Different Death: Euthanasia and the Christian Tradition* 101 (1989). In the Christian view, a plea for suicide is "almost always . . . an anguished plea for help and love." Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), https://bit.ly/3fHsLP8 [hereinafter CDF]. As such, euthanasia is "an offense against the dignity of the human person, a crime against life, and an attack on humanity"—the antithesis of medical care. *Id.*; *see also* Father Nikolaos Hatzinikolaou, *Prolonging Life or Hindering Death? An Orthodox Perspective on Death, Dying, and Euthanasia*, 9 Christian Bioethics 187, 193 (2003) ("[The Eastern Orthodox] Church condemns as unethical and insulting for the medical profession every medical act which . . . provokes the hastening of the moment of death.").

These views are also reflected in prevailing secular conceptions of medical ethics. In the words of the American Medical Association, the practice of medicine "is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering." Am. Med. Ass'n, Code of Med. Ethics, Op. 1.1.1, https://bit.ly/34eZJnG (last visited Jan. 28, 2022) [hereinafter AMA Ethics Op. 1.1.1]. According to the American College of Physicians, the "primary goals of the physician are to relieve suffering, prevent untimely death, and improve the health of the patient while maintaining the dignity of the person." ACP, *1984 Ethics*, *supra*, at 131. Doctors assume the ethical duties of "beneficence (the duty to promote good and act in the best interest of the patient)" and "nonmaleficence (the duty to do no harm to the patient)." Am. Coll. Physicians, *Ethics Manual* (7th ed. 2019) [hereinafter ACP, *2019 Ethics*]. The President's Council on Bioethics explained the consequence of these duties when caring for patients nearing death: "Medicine, which is ethically committed to cure when possible, is also committed *always to comfort* and *always to care*. Our duty is never to abandon those who are aging and dying . . . ." President's Council on Bioethics, *Taking Care: Ethical Caregiving in our Aging Society* 116 (2005). That obligation "is the most fundamental commitment of physicians." *Id.*

These duties entail a prohibition against euthanasia, which the American Medical Association has asserted "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." AMA Ethics Op. 5.8, *supra* n.2. Other leading medical organizations agree. *See, e.g.*, ACP, *2019 Ethics*, *supra*; Am. Nurse's Ass'n, *The Nurse's Role When a Patient Requests Medical Aid in Dying* 1 (2019), https://bit.ly/3GN6dZb; World Med. Ass'n, *Declaration on Euthanasia and Physician-Assisted Suicide* (Oct. 2019), https://bit.ly/3AfOYNX. The prohibition is based in the moral precept that "human life is fundamentally and inherently valuable, and that the intentional taking of human life by private persons is always wrong." Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* 157 (2006). This principle is "the strongest explanation for why society has drawn the lines it has in the law and medical ethics at the end of life, as well as the clearest, most consistent secular expression and defense for our current regime that proscribes intentional killings but does not seek to enforce any broader rule interfering with patient autonomy and choice." *Id.* at 165.

American law has long enforced these views. Indeed "for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide." *Glucksberg*, 521 U.S. at 710. In the United States, Founding Father Benjamin Rush reasoned that "every man possesses an absolute power over his own liberty and property, but . . . has no right to dispose of his life." Benjamin Rush, *The Selected Writings of Benjamin Rush* (Dagobert D. Runes ed. Philosophical Library 1947), https://bit.ly/3IoYfWC. And American attitudes against euthanasia strengthened after seeing the horrors of Nazi Germany, where mass executions started from a "subtle shift" in which physicians accepted "that there is such a thing as life not worthy to be lived," first targeting "the nonrehabilitable sick." Leo Alexander, *Medical Science Under Dictatorship*, 241 N. Eng. J. Med. 39, 44 (July 14, 1949); *see also* Gorsuch, *supra*, at 31-38. Still today, no state allows euthanasia. *See* Bob Roehr, *Assisted Dying Around the World*, BMJ (Sept. 10, 2021), https://bit.ly/3GiMgbZ. California's prohibition against euthanasia simply continues this unbroken American legal tradition.

II. A State Has Unquestionable Interests in Protecting the Practice of Medicine from the Many Harms Threatened by Euthanasia.

Even as several states have legalized physician-assisted suicide, still none has condoned euthanasia. For good reason. Though assisted suicide itself threatens dire consequences for the medical profession and for vulnerable patients, euthanasia has long been seen as even "more morally objectionable and socially more dangerous." N.Y. State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 145 (1994). For one, euthanasia amplifies assisted suicide's already grave risk of patient coercion. *See* ECF No. 28, at 4. More deeply, even if a patient's consent to euthanasia could somehow be assured, a state would still have every interest in outlawing euthanasia to guard against the heightened threats it poses to the integrity of the medical profession and to the ability of the many doctors who object to euthanasia on religious or moral grounds to continue to practice medicine.

A. Euthanasia Would Undermine the Integrity of the Medical Profession and Threaten the Doctor-Patient Relationship.

Because euthanasia is squarely at odds with the foundations of medicine, California has an overwhelming interest in outlawing it in order to "protect[] the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731. Indeed, permitting doctors to participate in euthanasia would demean the practice of medicine into one that merely offers services on demand and would inhibit patients' ability to trust that doctors will pursue their best interests.

First, euthanasia degrades the medical profession by treating doctors as mere service providers. "The heart of the medical profession is not providing services." Y. Tony Yang & Farr A. Curlin, *Why Physicians Should Oppose Assisted Suicide*, 315 J. Am. Med. Ass'n 247, 248 (2016). Rather, the longstanding view of medicine recognizes the doctor's professional care and judgment as separate from the patient's desires. "Being a professional is . . . more than being a technician." Leon R. Kass, *Neither Love Nor Money: Why Doctors Must Not Kill*, 94 Pub. Interest 25, 29 (1989). Doctors bear "special obligations . . . to serve the patient's interest because of the specialized knowledge that physicians possess," and they must exhibit "compassion, courage, and patience" as they counsel patients according to their best judgment. ACP, *2019 Ethics*, *supra*. A

doctor's "aim is not simply to execute instructions . . . but to develop a true ethic of caregiving." President's Council on Bioethics, *supra*, at 88. This includes the duty to care for the most vulnerable among us, including the disabled or the dying, and "to do everything we reasonably can to *benefit* their lives." *Id.* at 211-12. The historical primacy of this duty over submission to a patient's desires is exemplified by Benjamin Rush's advice to medical students in 1789: "Yield to [your patients] in matters of little consequence, but maintain an inflexible authority over them in matters that are essential to life." Benjamin Rush, *Observations on the Duties of a Physician, and the Methods of Improving Medicine* 6 (1789).

Euthanasia, conversely, is based on a "provider of services model" in which a doctor merely fulfills a patient's requests. Farr A. Curlin & Christopher O. Tollefsen, *Conscience and the Way of Medicine*, 62 Persps. in Biology & Med. 560, 560 (2019). A physician's duty to treat life as inviolable "rejects the view that a patient's choice for death can make killing him right." Kass, *supra*, at 38. But a regime that allows euthanasia on demand relies on the opposite premise: that it is acceptable to kill so long as the patient desires it. Daniel P. Sulmasy et al., *Non-Faith-Based Arguments Against Physician-Assisted Suicide and Euthanasia*, 83 Linacre Q. 246, 248 (2016). Under such a regime, doctors would be degraded from their role as "guides and healers" to "customer-service representatives." Talya Miron-Shatz, *Can Patients Decide Their Own Care?*, Wall St. J. (Oct. 7, 2021), https://on.wsj.com/3H03ewA; *see also* Pauline S.C. Kowenhoven et al., *Developments in Euthanasia Practice in the Netherlands: Balancing Professional Responsibility and the Patient's Autonomy*, 25 Eur. J. Gen. Prac. 44, 47 (2019) (euthanasia harms the "preferred model" of "shared decision-making" where patients "generally trust[] the physician's judgement").

This transactional model of medicine harms everyone involved. For patients, it risks abandonment, leaving them without the guidance they need in critical moments of illness. *See* Miron-Shatz, *supra*; O. Carter Snead, *What It Means to Be Human: The Case for the Body in Public Bioethics* 245 (2020) ("Vulnerable people facing the possibility of life's end do not seek to assert their unencumbered wills. They want help from . . . experts committed to caring for them."). For doctors, it contributes to the present crisis where nearly half report feeling professional fatigue,

in part from "the gradual loss of meaning and betrayal of the personal nature of the healing vocation in the corporatizing of medical care." Stephen Muse, *Quality Care and the Soul of the Physician*, J. Fam. Med. & Disease Prevention, May 24, 2019, at 1. And for society, it threatens to distort medical practice into "a species of contract, ungoverned by any deep ethical norms" that are needed to ensure its proper function. President's Council on Bioethics, *Beyond Therapy: Biotechnology and the Pursuit of Happiness* 306 (2003).

Second, and closely related, a medical profession that practices euthanasia will alienate its patients and lose their trust. "[T]rust . . . is essential to the doctor-patient relationship." *Glucksberg*, 521 U.S. at 731; *accord* AMA Ethics Op. 1.1.1, *supra*. That trust is rooted in doctors' solidarity with the sick and disabled. Yang & Curlin, *supra*, at 248. Patients place themselves in positions of great vulnerability when they turn to doctors for help with life's most intimate needs—a delicate relationship that can endure only if the patient trusts that the doctor will not abuse it. *See* Lois Snyder Sulmasy et al., *Ethics and the Legalization of Physician-Assisted Suicide*, 167 Annals of Internal Med. 576 (2017). Once doctors abandon their most basic commitment not to kill, such trust can hardly be assured. Especially in moments of extreme vulnerability, a patient may fear that her doctor will advise against complex treatment in favor of more expedient death. *See* Kass, *supra*, at 35. Indeed, by opening the door to euthanasia, "patients and families may become suspicious about the doctor's intentions at a time when they have the greatest need for help." Charles L. Sprung et al., *Physician-Assisted Suicide and Euthanasia: Emerging Issues from a Global Perspective*, 33 J. Palliative Care 197, 200 (2018).

These concerns are particularly severe for individuals with disabilities or others who may fear that society does not value them fully. Even without euthanasia, persons with disabilities often face discrimination from doctors who believe their lives are not worth living. The National Council on Disability has warned that many medical professionals "still hold a deficit-oriented medical framework of disability" that views a person with a disability as "better off dead than alive." Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* 15 (2019), https://bit.ly/33PMmds. If doctors were to begin *actively killing* their patients, disabled persons would have even greater

reason to fear that doctors will avoid what is best for their health in the goal of eliminating their perceived "burden" on society. *See, e.g.*, Meghan Parker, *Our Problem with Assisted Suicide: Why Disability Advocates Worry About Making It Easier for Physicians to Help New Yorkers Die*, N.Y. Daily News (Oct. 22, 2019), https://bit.ly/3GMJhcL. And guided by examples elsewhere, disabled persons may worry that these decisions could eventually be made entirely against their will. *See, e.g.*, Mason L. Allen, *Crossing the Rubicon: The Netherlands' Steady March Towards Involuntary Euthanasia*, 31 Brook. J. Int'l L. 535, 535 (2006).[3]

These objections to euthanasia are not theoretical; they are warnings of which state policymakers are well aware. In California and elsewhere, disability-rights groups have been among the most resolute opponents to assisted-suicide and euthanasia laws, based in part on their concern for the harm they would do to the already-sensitive relationship between doctors and disabled individuals. *See, e.g.*, Anna Gorman, *Advocates for Disabled Are Troubled by California's Assisted Suicide Bill*, Kaiser Health News (June 29, 2015), https://bit.ly/3FOIrL4; *National Disability Organizations that Oppose the Legalization of Assisted Suicide*, Disability Rts. Edu. & Def. Fund, https://bit.ly/3KFXLNR (last visited Jan. 28, 2022). Similar objections have been raised against the laws' broader effects on patient trust. *See, e.g.*, N.Y. State Task Force, *supra*, at 105 (describing opponents' concern that euthanasia would "undermine the integrity of medicine and the patient-physician relationship . . . [e]ven in the absence of widespread abuse" by harming trust and "chang[ing] the way that both the public and physicians view medicine"). Indeed, California's assisted-suicide law initially stalled amid a flurry of opposition, including the California Medical Association's concern that it "would undermine trust in the physician-patient relationship" and the Association of Northern California Oncologists' assertion that it was "contrary to a physician's oath and primary responsibility to do no harm." Cal. Senate Comm. on Health, Report on SB 128, at 14-15 (Mar. 23, 2015), https://bit.ly/3fKTLgJ.

[3] It is ironic that the plaintiffs seek to compel a result that may especially threaten disabled individuals through a claim under the Americans with Disabilities Act, which was passed to remedy the "serious and pervasive social problem" of disability discrimination. Americans with Disabilities Act of 1990, Pub. L. 101-336, 104 Stat. 327, 328 (July 26, 1990).

In short, euthanasia "[c]ontradicts the physician's professional role and undermines the distinctive solidarity" of doctors and their patients. Yang & Curlin, *supra*, at 248. For obvious reasons, every state in the country has sought to avoid those consequences.

B. Euthanasia Imposes Critical Barriers to the Practice of Religious Physicians.

For many medical professionals, like *amici*, the dictate to treat human life as inviolable is not merely ethical practice but is religious duty. A regime of state-sanctioned euthanasia would impose significant obstacles to the participation of these religious believers in the medical field, threatening in turn to dramatically limit available healthcare resources in the state.

Amici participate in the centuries-old tradition of Christian medical practice. As outlined above, that tradition affirms the absolute inviolability of human life and, consequently, it absolutely prohibits participation in euthanasia. *See, e.g.*, CDF, *supra*; Hatzinikolaou, *supra*. Such beliefs are hardly unique to the Christian faith. *See, e.g.*, *Religious Groups' Views on End-of-Life Issues*, Pew Research Ctr. (Nov. 21, 2013), https://pewrsr.ch/3ItT2Nz (detailing that in Judaism, Islam, and Buddhism the majority teaching prohibits euthanasia). *Amici*'s religious beliefs also include a duty to care for the sick and disabled, as Christ did, and never to abandon them or denigrate the inherent dignity of their lives. But if the practice of sound medicine were suddenly understood to include the active killing of one's patients—and particularly the killing of those who are most vulnerable due to disease or disability—religious health care professionals like *amici* may soon find the consequent pressures to violate these commands an unreasonable barrier to practice.

While doctors currently have the ability to conscientiously object to assisted suicide in California, the assurances offered by such exemptions may wither as they are tested by competing claims for an entitlement to the service. Indeed, opponents to SB 128 "warn[ed] of a slippery slope, citing countries such as the Netherlands or Belgium" where assisted-suicide laws have greatly expanded, fearing that "what is voluntary today may be mandated tomorrow." Cal. Senate Judiciary Comm., Report on SB 128, at 21 (Apr. 7, 2015), https://bit.ly/3fKTLgJ. Consider the experience of Canada, where religious medical professionals face harm from their refusal to provide euthanasia. For example, a Canadian court recently ruled that conscientious objectors must

provide an "effective referral" to patients seeking euthanasia so that they do not feel "rejection, shame and stigma." Barry Bussey, *Stigma and Shame*, Convivium (May 22, 2019), https://bit.ly/3FOoQuL. Many doctors have expressed that such referrals make them complicit in the killing of another and may require them to leave the profession. *Canadian Court Tells Doctors They Must Refer for Euthanasia*, Coal. for HealthCARE and Conscience (Jan. 20, 2021), https://bit.ly/3Kod11T. Euthanasia advocates in Canada have also argued against conscientious objections in areas where there may not be another willing provider because they inhibit a "right" to that "care." Julia Panchuk & Lorraine M. Thirsk, *Conscientious Objection to Medical Assistance in Dying in Rural/Remote Nursing*, 28 Nursing Ethics 766, 766 (2021), https://bit.ly/3AgGS7y. Some even argue that religious medical professionals should remove themselves from the practice altogether. *Id.* And one Canadian local government recently withdrew funding from a hospice that refused to provide euthanasia. Karin Larsen, *B.C. Pulls $1.5M in Funding from Metro Vancouver Hospice for Refusing to Allow Assisted Dying*, CBC News (Feb. 25, 2020), https://bit.ly/3nJLxtO.

Moreover, even where doctors have not been sanctioned for their refusal to participate in euthanasia, a study of doctors in the Netherlands found that euthanasia requests "have a substantial impact on physicians." Kirsten Evenblij et al., *Physicians' Experiences with Euthanasia: A Cross-Sectional Survey Amongst a Random Sample of Dutch Physicians to Explore Their Concerns, Feelings and Pressure*, 20 BMC Family Practice, no. 177, 2019, at 9. Indeed, nearly half of the doctors surveyed "felt pressure by society in general to grant [euthanasia] requests"—with doctors who refused requests reporting the greatest pressure of all. *Id.* at 3. Doctors who refused a euthanasia request were also "more likely to dread" assessing future requests and "dealing with the relatives of a patient," who were often the very source of that pressure. *Id.* at 6. "As a result," the study warns, "physicians may experience less room for a careful decision making process [in considering euthanasia requests] and . . . may even feel forced to cross their own moral boundaries." *Id.* at 9. In short, even if doctors in California were never *forced* to participate in euthanasia, the mere availability of it elsewhere could drive those with moral or religious convictions against euthanasia out of the practice as a result of the immense pressures placed upon them.

Altogether, whether through social pressure or government command, a regime of state-endorsed euthanasia may effectively result in "an ultimatum" to the many thousands of religious medical providers like *amici* to "[e]ither engage in conduct . . . contrary to the traditional Christian understanding" of medical care "or abandon a mission that dates back to the earliest days of the Church." *Fulton v. City of Philadelphia*, 141 S. Ct. 1868, 1884 (2021) (Alito, J., concurring). That result could be devastating both for doctors of faith and for the healthcare system. Nearly one in five hospitals in America is religiously affiliated. Maryam Guiahi et al., *Patient Views on Religious Institutional Health Care*, JAMA Network Open, Dec. 27, 2019, at 1, 2. Catholic hospitals alone account for sixteen percent of California hospitals. *Representing California's Catholic System and Hospitals*, Alliance of Catholic Health Care, https://bit.ly/3rAQDd5 (last visited Jan. 28, 2022). And a substantial number of medical professionals in secular institutions have religious commitments. *See, e.g.*, Kristin A. Robinson et al., *Religious and Spiritual Beliefs of Physicians*, 56 J. of Relig. & Health 205, 210, 212 (2017) (finding that 29% of Mayo Clinic doctors reported that religious or spiritual beliefs influenced their decision to become a doctor and 64% considered religion important in their lives). California's refusal to endorse euthanasia helps ensure that the many thousands of religious medical professionals who object to its practice may continue to pursue their vocations and to provide the critical healthcare the state needs.

CONCLUSION

Although California allows doctors to assist a patient's suicide, the state has refused to invite doctors to kill the patient themselves. To be sure, assisted suicide and euthanasia present many similar harms. But euthanasia magnifies each of those harms, and the difference between the two, as this Court observed, is significant. And, as the State as argued, ECF No. 46, at 10-13, forcing California to become the only state in the country to cross that line would fundamentally alter the limits of its assisted-suicide law. For these reasons, *amici* urge the Court to grant defendants' motions to dismiss.[4]

[4] The Notre Dame Law School Religious Liberty Clinic thanks students Joshua Lacoste, Daniel Loesing, and Olivia Rogers for their work on this brief.

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Respectfully submitted,

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