Testimony in support of HF 2262 on behalf of Compassion & Choices
HF 2262 Subcommittee, Committee on Health & Human Services
February 17th, 2026, 12:00pm

Chair Harris and members of the Subcommittee,

My name is Callie Riley, Regional Advocacy Director at Compassion & Choices. We are the nation's oldest and largest nonprofit organization working to improve the quality of end-of-life care. We advocate for legislation to improve the quality of care for terminally ill patients and affirm their right to determine their own medical treatment options as they near the end of life. I am offering these comments in support of HF 2262, the Iowa Our Care, Our Options Act, to authorize medical aid in dying for terminally ill Iowans.

Across the country, lawmakers like yourselves are examining the experience of the fourteen other jurisdictions that have authorized this compassionate medical practice and developing legislative approaches to meet the needs of their constituents who want the ***option*** to die peacefully, if their suffering becomes intolerable at life's inevitable end.

We no longer have to hypothesize about what will happen if this medical practice is authorized in Iowa. Thirteen states, Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, Montana, New Mexico, Delaware, Illinois, New York, as well as the District of Columbia, have authorized the compassionate option of medical aid in dying. Today, more than one in four people in the United States have access to this end-of-life care option.

We now have almost 30 years of experience since the law was first enacted in Oregon and over a decade of combined evidence from the laws passed in those 13 other authorized jurisdictions. That includes annual statistical reports from nine authorized jurisdictions and countless evidence-based studies and case reviews published in reputable, peer-reviewed journals. More information about how medical aid in dying operates in authorized jurisdictions is available in Compassion & Choices' most recent guide, "Medical Aid in Dying: A Policy to Improve Care & Expand Options at Life's End."[1]

The legislation before you includes the same strict eligibility criteria and core safeguards as other authorized jurisdictions

[1] Available online at https://compassionandchoices.org/wp-content/uploads/2024/02/final_medical-aid-in-dying-policy-book02.13.2026.pdf

- To be eligible for medical aid in dying, the individual must have a terminally ill diagnosis with a prognosis of 6 months or less to live and be mentally capable.

- The patient must be fully informed of all their end-of-life options, including hospice, palliative care and pain management.
- No patient qualifies for medical aid in dying solely because of their advanced age or disability.

- The patient must be making an informed decision free from pressure or coercion, and

- The patient must self-administer the medication. Medical aid in dying legislation explicitly prohibits injection or infusion via a vein or any other parenteral route as a safeguard against abuse.

In addition,

- Doctors, hospice professionals and pharmacists who personally oppose medical aid in dying are not required to participate.

- Those who do participate are provided immunities against prosecution as long as they meet the requirements clearly established in the law.

The evidence is clear: Medical aid in dying laws which contain the same core safeguards found in the Oregon Death with Dignity Act and other laws - as this legislation does - protect patients, afford the dying autonomy and compassion during the most difficult time and improves end-of-life care across the continuum.

The cost of inaction however, is immense.

Terminally ill residents don't have the luxury of endless deliberations; they need the relief that this law affords them right now. Not a single additional person will die if you authorize medical aid in dying, but far fewer will suffer.

I come to you not just as a professional advocate for end-of-life options, but also as a daughter of Iowa. I grew up in the West End of Council Bluffs, and spent my childhood in this beautiful state. I am also someone with firsthand experience of the power of medical aid in dying to bring relief to a dying person. My sister was recently diagnosed with metastatic pancreatic cancer. She is fighting to live, but knows that her time may be short. She lives in Oregon, where she has the option of medical aid in dying if she so chooses. She has told me clearly that, while she does not know if she will access Oregon's Death with Dignity Act, merely having this care option available to her has given her peace of mind as she considers what the end of her life will look like.

I urge you to let the evidence, experience, data, and strong public support for this end-of-life care option guide your policymaking. Thank you again, Chair Harris and Members of the Subcommittee, for your leadership on this important issue.

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