IN THE SUPREME COURT OF THE STATE OF NEW MEXICO

KATHRINE MORRIS, M.D.,
AGROOP MANGALIK, M.D. and
AJA RIGGS

Plaintiffs-Petitioners,

v. S. Ct. No. 35,478

KARI BRANDENBERG, in her official capacity
as District Attorney for Bernalillo County,
New Mexico, and GARY KING, in his official capacity
as Attorney General of the State of New Mexico,

Defendant-Respondent.

AMICUS BRIEF OF DISABILITY RIGHTS AMICI: NOT DEAD YET, ADAPT, AUTISTIC SELF ADVOCACY NETWORK, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, NATIONAL COUNCIL ON INDEPENDENT LIVING, AND THE UNITED SPINAL ASSOCIATION

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STATEMENT OF ISSUES PRESENTED

The Court of Appeals held that there is no fundamental right to aid in dying under the New Mexico Constitution, reversing the district court's ruling that NMSA 1978, Section 30-2-4, New Mexico's Assisted Suicide statutory prohibition against "deliberately aiding in the taking of a ['mentally competent, terminally ill person's'] own life" is unconstitutional. *See Morris v. Brandenberg*, 2015-NMCA-___, 2015 WL 4757633 (August 11, 2015). Not Dead Yet, ADAPT, Autistic Self Advocacy Network, Disability Rights Education and Defense Fund, National Council on Independent Living, and United Spinal Association (collectively the "Disability Rights Amici"), organizations with members in New Mexico, support the Court of Appeals majority's and Attorney General's position that Section 30-2-4 does not violate any New Mexico constitutional provisions.

As confirmed by the Court of Appeals majority, this case does not concern the settled issue of the individual's right to refuse treatment, even if it might result in death. *See Morris*, 2015-NMCA-___, ¶ 28. Certainly, people have a "right to die" by removing their life supports, refusing life supports, and letting nature take its course. This case concerns only whether there is a New Mexico constitutional right to receive active "Physician Aid in Dying" or physician assisted suicide.

Were this Court to reverse the Court of Appeals' decision, it would soon face a number of related issues in future cases, including the following:

- Why should a constitutional right be limited to people who have a disabling condition that is labeled "terminal"? Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?
- Why should the constitutional right be limited to providing only lethal medications? Why not lethal injections?
- If such a constitutional right exists, why should a person's right be limited to "aid" only from doctors? What about family members, friends, or advocates?

BACKGROUND

Petitioners claim, and the District Court found, that prohibiting "mentally competent, terminally ill" people from obtaining a lethal dose of drugs from a third party violates their "liberty, safety and happiness interest … to choose aid in dying…." District Court Findings (hereinafter "D.C. Findings"), ¶ II. The New Mexico Constitution actually refers to "certain, natural, inherent and inalienable rights, among which are the rights of enjoying … ***life*** and liberty … and of seeking and obtaining safety and happiness." N.M. Const., art. II, § 4 (emphasis added).[1] After trial, the District Court held that "the liberty, safety and happiness interest"

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[1] The Plaintiff Aja Riggs had only a "fear" her cancer would return and wanted "peace of mind" if it would return. District Court Findings ¶¶ 12-13.

protected by the New Mexico Constitution guaranteed competent, terminally ill patients the “fundamental right” to choose “aid in dying” but did not refer to “life.” *Id.* ¶ HH. Because the District Court determined that Section 30-2-4 affected a fundamental right, it applied strict scrutiny and found that Defendants had failed to prove that the statute furthers a compelling state interest by criminalizing physician-assisted suicide. *Id.* ¶ LL.

In a fractured opinion, the Court of Appeals reversed the District Court, with the majority finding that Section 30-2-4 does not affect a fundamental right. Petitioners have now sought expedited review by this Court.

Whether there is a constitutional right in New Mexico to physician-assisted suicide must be addressed and understood from the perspective of the only class of people who will be adversely affected and impacted were such a right to be found: people with disabilities. The Disability Rights Amici represent a very broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people whose disabilities existed from birth or were acquired during their lifetimes. Many are now, or at some point have been, erroneously labeled "terminal" by a physician. Many have had doctors threaten to remove life sustaining treatment on an involuntary basis and have had to fight to receive continued care.

In fact, although pain (or the fear of pain) is often cited as the primary reason for enacting assisted suicide laws, doctors actually report that they issue lethal prescriptions because of patients' "loss of autonomy," D.C. Findings ¶ 26, and "feelings of being burden," and that "[p]atients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors."[2]

Major issues include the inadequacy of symptom control, difficulties in the person's relationships with family, and psychological disturbances – especially grief, depression, and anxiety.

> The desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self […] Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: 'I'm inconveniencing, I'm still inconveniencing other people who look after me and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't. I wouldn't. No. I'd rather die.' [3]

These are quintessential disability issues. The Disability Rights Amici's members

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[2] William Breitbart, MD et al, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, Am. J. Psychiatry 153, 238-242 (1996). *See also* Robert Pear, *A Hard Charging Doctor on Obama's Team*, N.Y. Times, April 18, 2009, at A14 (noting that pain is "a common stereotype of patients expressing interest in euthanasia. In most cases… the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones").

[3] Block SD & Billings JA, *Patient Requests to Hasten Death. Evaluation and Management in Terminal Care*, Archives of Internal Medicine, 154(18):2039-47 (Sept. 26, 1994).

know that these feelings are not inevitable, that their causes are and have been successfully addressed and that, most importantly, these emotions do not justify a lethal response.

Assisted suicide authorizes doctors to decide who is eligible – i.e., whose condition is "terminal" and whose desire to commit suicide is "rational.” In the context of our current healthcare system, with profit motives of insurance and managed care companies, and financial and other pressures on family members and individuals, the risks of subtle and even blatant coercion are great.

No one is immune from the pervasive societal assumptions surrounding the disability label. Fear, bias, and prejudice against disability are inextricably intertwined in these assumptions and play a significant role in assisted suicide. Our society values and desires “healthy” bodies and minds. The idea that any person with a disability could be a happy, contributing member of society is outside the experience or thinking of most non-disabled persons. Severe disability is viewed as worse than death, thus justifying the deadly exception to laws for suicide prevention and laws against homicide. These views and assumptions are strongly opposed by people with disabilities.

The District Court use the term “dignified death” to justify assisted suicide, D.C. Findings, ¶30, but when asked what "indignities" concern them, nondisabled people invariably describe the need for assistance in daily activities like bathing, toileting, and other disability realities. These should never be the basis for a societal double standard for providing suicide assistance only to people with disabilities, including those labeled "terminal," but suicide prevention to the rest of society.

SUMMARY OF ARGUMENT

Given the fractured nature of the Court of Appeals' majority opinion, this amicus brief focuses on the District Court's decision and why it was wrong, and then responds to issues raised in Judge Vanzi's dissent in the Court of Appeals' opinion.

The Court of Appeals' majority is correct - there is no fundamental right, under the New Mexico or United States Constitutions, to assistance from a doctor or any other third party in committing suicide. Moreover, there are compelling State interests in prohibiting assisted suicide for all, including people with disabilities, terminal and nonterminal. State-sanctioned assisted suicide degrades the value and worth of people with disabilities and violates the antidiscrimination rights, protections and mandates of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*

ARGUMENT

I. STANDARD OF REVIEW

When there are no disputed material facts, an appellate court applies a de novo standard of review. *State v. Reyes–Arreola,* 1999–NMCA–086, ¶ 5, 127 N.M. 528. “A strong presumption of constitutionality surrounds a statute.” *Ortiz v. Taxation & Revenue Dep't,* 1998–NMCA–027, ¶ 5, 124 N.M. 677. Therefore, a party challenging the constitutionality of a statute has the burden of proving it is unconstitutional beyond a reasonable doubt. *City of Farmington v. Fawcett,* 1992–NMCA–075, ¶ 6, 114 N.M. 537. “In construing a particular statute, a reviewing court's central concern is to determine and give effect to the intent of the [L]egislature.” *N.M. Dep't of Health v. Compton,* 2001–NMSC–032, ¶ 18, 131 N.M. 204 (internal citations and quoted authority omitted).

II. ASSISTED SUICIDE DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES

A. Assisted Suicide Is Part of the Long and Tragic History of Discrimination Against People with Disabilities

Assisted suicide must be viewed against the backdrop of the United States' long and tragic history of state-sanctioned discrimination against the disabled. The Supreme Court has acknowledged that at least one of the forms of such discrimination – the practice of withholding lifesaving medical assistance by medical professionals from children with severe disabilities – demonstrates a "history of unfair and often grotesque mistreatment" arising from a legacy in this country of "prejudice and ignorance," and continuing well into the 20th century. *City of Cleburne, Texas v. Cleburne Living Center*, 105 S. Ct. 3249, 3262, 3266.

(1985) (Stevens, J., joined by Burger, C.J., concurring), (Marshal, J., joined by Brennan & Blackmun, JJ., concurring).

Such attitudes, unfortunately, are not completely in the past. Prominent Ethicists, such as Peter Singer of Princeton University,[4] have advocated the killing of infants with severe disabilities based on a belief that they will not lead a "good" life and will burden their parents and society.

B. The District Court Decision Denies People with Disabilities the Benefit of the State's Suicide Prevention Protections

Assisted suicide singles out some people with disabilities, those labeled "terminal" or very severely impaired, for different treatment than other suicidal people receive. This lethal discrimination is viewed as justified based on the mistaken belief that a severe disability – which may cause, for example, use of a wheelchair or incontinence, or may require assistance bathing, eating, toileting, or other activities of daily living – is worse than death.

The District Court's decision, immunizing physicians for assisting the suicides of persons with "terminal" disabilities or conditions, turns on its head the general assumption that suicide is irrational and is a "cry for help." For people who are disabled, suicide is presumed understandable and acceptable. The District Court's ruling permits doctors to affirmatively facilitate suicide, an

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[4] *See* Peter Singer, *Taking Life: Humans, in* PRACTICAL ETHICS, 175-217 (2d ed. 1993)

act that would be a crime but for the person's disability and a label of “terminal.” Persons with severe health impairments will be denied the benefit of New Mexico's suicide prevention laws and programs. Indeed, the District Court's holding guarantees these suicide attempts will succeed – unlike those of the majority of other persons with suicidal ideation who are not disabled. A practice that the State would otherwise expend public health resources to prevent is instead actively facilitated based on a "terminal" label, however unreliable and slippery such predictions may be.

The United States Supreme Court has recognized that suicide is a practice that States throughout the country actively discourage through laws and prevention programs. *See Washington v. Glucksberg*, 521 U.S. 702, 711 (1997). By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a disabled person to do so, the law assumes that the non-disabled person's life is intrinsically more valuable and worthwhile than a disabled person's life.

Perhaps no attitude strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, stereotypes, barriers preventing assistance with activities of daily living, and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living. As the U.S. Supreme Court has recognized:

> The State's interest here [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference ... " The State's assisted-suicide ban reflects and 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 as everyone else's.

Glucksberg, 521 U.S. at 732.

C. Denying People with Disabilities the Benefit of Both State Suicide Prevention Laws and the Enforcement of Homicide Laws Violates the ADA

Responding to the long and tragic history of discrimination against people with disabilities, in 1990 Congress enacted the Americans With Disabilities Act ("ADA"), 42 U.S.C. § 12101 *et seq*., the basic civil rights statute for people with disabilities. To address and remedy the "serious and pervasive social problem" of discrimination against individuals with disabilities, 42 U.S.C. § 12101(a)(2), Congress substantively required that "no qualified individual with a disability shall. . . be excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity ...." 42 U.S.C. § 12132; *See* 28 C.F.R. § 35.130(b) (discrimination includes denying or not affording an opportunity for people with disabilities to benefit from services either equal to or as effective as those afforded nondisabled persons).

Sanctioning assisted suicide only for people with disabilities, and denying them suicide prevention services based on a doctor's prediction of terminal status or other justification violates the ADA because the presence or absence of disability determines whether New Mexico:

- Enforces its laws requiring health professionals to protect individuals who pose a danger to themselves;
- responds to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities; and
- investigates and enforces its abuse and neglect and homicide statutes in cases reported as assisted suicides.

A doctor's determination of someone's eligibility for assisted suicide confers absolute legal immunity on the doctor, and all State suicide-related procedures are set aside. The existence of a disability should never be the basis for these distinctions.

II. Assisted Suicide Poses Serious, Unavoidable Threats to People with Disabilities That New Mexico Has a Significant State Interest in Preventing

As the U.S. Supreme Court has recognized, assisted suicide is contrary to well-established medical ethics. *See Glucksberg*, 521 U.S. at 731 (quoting

American Medical Association, Code of Ethics section 2.211 (1994)); *see also Vacco v. Quill,* 521 U.S. 793, 801 n.6 (1997) (discussing medical profession's distinction between withholding treatment and assisted suicide). This rejection is firmly grounded in the potential harm the District Court's decision poses to the lives of people with disabilities.

A. The Difficulty in Ensuring Decisions to Die Are Not Coerced or Made by Others Is a Critical State Interest

Evidence exists that some persons killed under assisted suicide laws may "choose" suicide under pressure from others, and New Mexico has a significant State interest to ensure that does not happen. There is no way to ensure that persons are not unduly pressured by family members, because of financial, emotional, or other reasons.

“Choice” is a very slippery concept, filled with significant outside pressures. For example, Kate Cheney was an 85-year old woman with cancer in Oregon, and her psychologist was concerned that Ms. Cheney was not competent to make the decision to die and that her daughter was unduly pressuring her to choose assisted suicide. The daughter simply obtained an opinion from a second psychologist, who determined Ms. Cheney was competent. Ms. Cheney was accordingly prescribed lethal medication and died on August 29, 1999.[5] Similarly, given the extraordinarily high cost of health care, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not unduly pressuring a person to request "aid in dying" for financial reasons. Doctors must not be immunized for active measures to cause death.

B. The Law's Assumption that Suicide is "Rational" When Committed by a Person with a Disability Is Not Valid

As the *Glucksberg* decision recognized, "those who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." 521 U.S. at 730. The Court continued, "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Id.* Pain is rarely the reason people consider assisted suicide. Most people do so because they fear they will be dependent and a burden on their families. A study of cancer patients showed that those with depression were four times more likely to want to die.[6]

In a survey of psychiatrists, over half were "not at all confident" they

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[5] Evelyn Hoover Barnett, *Is Mom Capable of Choosing to Die?*, The Oregonian, Oct. 16, 1999, at Gl -2.

[6] *See* William Breitbart et al., *Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA 2907, 2909 (Dec. 13, 2000).

could assess in a single consultation whether a psychiatric condition impaired a person's judgment; only six percent were "very confident."[7] This is because such assessments are inherently subjective and unreliable. As one research analysis concluded:

> There is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting [physician-assisted suicide]... There are no clinical criteria to guide such an assessment - just as there are no criteria to assess the rationality of any person's decision to commit suicide.[8]

C. The Uncertainty of Diagnosing a "Terminal Illness"

The diagnosis and prognosis of a "terminal condition" is inherently uncertain. Because terminal conditions are so often misdiagnosed, the District Court's decision opens the door to assisted suicide for many people with disabilities who are not "terminally ill" within any predictable time frame. The medical profession's predictions of the capabilities and life spans of people with disabilities have been historically unreliable. The risks to newly disabled people, such as those with significant spinal cord injuries, are particularly great. As the National Council on Disability has reported, "people

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[7] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY, 595 (Apr. 2000).

[8] Brendan D. Kelly et al., *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box*, 181 British J. Psychiatry 278, 279 (2002).

with disabilities are aware of enough instances of dramatic mistakes that many of them have a healthy skepticism of medical predictions, particularly as it relates to future life quality."[9] Evan Kemp, Director of the Equal Employment Opportunity Commission under President George H.W. Bush, wrote:

> As a disabled person, I am especially sensitive to the "quality of life" rationale that is frequently introduced in the debate [over assisted suicide]. For the past 47 years I have lived with a progressive neuromuscular disease that first began to manifest itself when I was 12. My disease, Kugelberg Weylander Syndrome, has no known cure, and I have no hope for "recovery." Upon diagnosis, my parents were informed by the physicians treating me that I would die within two years. Later, another group of physicians was certain that I would live only to the age of 18. Yet here I am at 59, continuing to have an extraordinarily high quality of life.[10]

D. The District Court's Assumption that Disability Intrinsically Deprives Life of Dignity and Value Is Not Valid

Many people identified as candidates for assisted suicide could benefit from supportive care or treatment, such as counseling, pain medication, or in-home consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, or lack of independence and choice. The National Council on Disability has found that

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[9] National Council on Disability, *Assisted Suicide: A Disability Perspective* at 27- 28, *available at* http://www.ncd.gov/publications/1997/03241997.

[10] Evan J. Kemp, *Could You Please Die Now?*, Wash. Post, Jan. 5, 1997, at C1.

"improving laws, policies, programs, and services for people with disabilities . . . would go a long way toward assuring that any self-assessment or decision about the quality of life of an individual with a disability would be made in an optimal context of independence, equality of opportunity, full participation, and empowerment."[11]

Research demonstrates the lack of this type of assistance and support, rather than any intrinsic aspect of a person's disability, is the primary motivation for suicide. Assisted suicide, however, assumes that a medical condition inherently makes life unworthy of continuation. Its availability causes medical practitioners to ignore other measures and services that might cause someone to reconsider their desire to die. As a doctor at New York's Memorial Sloan-Kettering Cancer Center has observed, assisted suicide "runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care." [12]

The question how to address the psychological and social needs that underlie the desire to die, however, is typically lost in a simplistic mental "competency" determination. One study noted that "the focus on

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[11] National Counsel on Disability, *supra* note 9, at 13.

[12] Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED 54 (Jan. 2, 1997).

competence may distract from adequate attention and resources on the person and their circumstances ....”[13] Another study concluded that competency determinations "do not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide."[14]

III. THE CREATION OF A NEW MEXICO CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE FOR A CLASS OF PEOPLE BASED ON THEIR HEALTH AND DISABILITY STATUS IS A LETHAL FORM OF DISCRIMINATION

A. People with Disabilities Are the Class of People Who Will Be Affected If a Right to Assisted Suicide Is Found

The issue before the Court goes far beyond the 1980's cases in which courts dismissed the state interest in protecting the lives of these disabled individuals and found a "right to die" through the withdrawal of routine life-sustaining treatment. See *e.g., Bouvia v. Superior Court*, 179 Ca. App. 3d 1127, 255 Cal. Rptr. 297 (1986), *review denied* (June 5, 1986); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989). With appropriate treatment and services, many of them would be alive today. However, even in those cases, the courts specifically distinguished any right involving active physician-assisted suicide. Before this Court is the

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[13] Ganzini et al., *supra* note 7, at 600.

[14] James V. Lavery, et al, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*. LANCET, 358 (9279), 366 (2001).

request to obliterate this distinction. It is against the backdrop of these and other cases that your *amici* request protection from the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

B. Adequate State Safeguards Cannot Be Adopted to Protect People with Disabilities from Assisted Suicide Threat

1. Any Purported Limitation of the Right to Assisted Suicide to Terminally Ill Persons Will Not Protect People with Disabilities

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected, 42 U.S.C. § 12101 (a)(7), assisted-suicide "safeguards" cannot prevent abuse against people with disabilities. History demonstrates that assisted suicide has not and will not be limited to terminally ill persons.[15]

At issue is nondisabled peoples' intense fear of becoming disabled. When a person with a disability states a desire to die, nondisabled people believe the request is reasonable because they project their own biases and believe that living with a severe disability is a life of dependency, indignity and helplessness; in short, worse than death. The wish to die is based on the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids. Medical professionals, jurists and the public consistently ignore

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[15] *See* H. Hendin and K. Goley, *Physician-Assisted Suide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613 (2008).

underlying treatable depression, lack of health care or other supports, and exhaustion from confronting systemic discrimination. When medical professional s and the media use phrases like "imprisoned by her body," "helpless," "suffering needlessly," and "quality versus quantity of life," purportedly in a humanistic and compassionate way, they are really expressing fear of severe disability and a very misguided condemnation, "I could never live like that." Society translates these emotions into a supposedly rational social policy of assisted suicide. Whenever permanent disability is defined as the problem, death is the solution. The wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from the same emotional disturbance or illogical despair that nondisabled persons face.

The medical profession is not immune to these erroneous assumptions. Research shows that doctors frequently project the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-prolonging treatment."[16] It is particularly important to note that research on suicidal feelings among people with terminal illnesses demonstrates that such feelings are remediable through other means, including pain management, hospice

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[16] S. Miles, *Physicians and Their Patients' Suicide*, 271 JAMA 1786 (1994).

services and counseling.[17] As long as physicians believe that a person with a severe disability has a "life unworthy of living," lethal errors and abuses will occur.

Safeguards cannot protect one from family pressures due to financial burdens which may accompany a disability, especially when the health care system may not pay for assistance in daily living activities. Nor can safeguards stop families from doctor-shopping when one doctor says the person is not "terminal" or acting "voluntarily," to find another doctor who will say otherwise. Nor can a state ensure that the medical professionals have prescribed adequate antidepressant and pain medications before providing lethal drugs.

2. Any Purported Limitation of a Right to Assisted Suicide Only in Cases of "Voluntary" Requests Will Not Protect People with Disabilities from Abuse

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary, but is a forced "choice." The Disability Amici are profoundly disturbed by the finding of a constitutional right for assisted suicide in a society which refuses to find a concomitant right to adequate health care to stay alive. Now managed health care, with its emphasis on cost containment, further abridges the choices and endangers the lives of people with disabilities. Until society is committed to providing life

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[17] Most death requests, even in terminally ill people, are propelled by despair and treatable depression. H. Hendin and Gerald Klerman, *Phvsician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. OF PSYCH. 143 (Jan.1993).

supports, including in-home personal assistance services and technology supports, there is not voluntary choice.

Without health care and consumer-directed personal care services, people with disabilities do not receive what they need to live as independently and with as much autonomy as possible. Without the professional commitment to help make living worthwhile for people with disabilities, which is the core of suicide prevention, people with disabilities, including those whose conditions are terminal, will not receive the support necessary for informed and voluntary decisions. There are no safeguards that can protect against these prejudices and realities.

Finally, no system of safeguards can control conduct which results in the death of the primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all citizens equally. If physicians are granted full legal immunity for assisted suicide, no meaningful barrier to active involuntary euthanasia will exist to protect the lives of members of this minority group.

IV. RESPONSE TO JUDGE VANZI'S DISSENTING OPINION

A. People With Disabilities, Whether Terminal or Nonterminal, Should Receive Equal Protection of Laws Pertaining to Suicide Prevention and Homicide

The dissent admits that risks of abuse impacting vulnerable people would be important considerations, and notes that there is evidence of abuse in the context of withholding and withdrawal of treatment. *See Morris*, 2015-NMCA-___, at ¶¶ 130-131, 136. At least on these two points, the Disability Amici agree. However, we are at a loss to see how legalizing assisted suicide will not make matters worse than they already are. Assisted suicide expands the population of people who are eligible to have their lives ended medically. Currently, such abuses impact people who depend on life-sustaining treatment. Unconscionably, the healthcare system and related authorities have done little or nothing to prevent such abuses. Assisted suicide laws expand the number of people eligible to have their lives ended medically to include anyone given a terminal prognosis. The Disability Amici have a great deal of experience with incorrect terminal prognoses, and the involuntary denial of care that can result from a "terminal" label.

The more vulnerable members of the disability community should not be viewed as expendable. And that is the crux of the Disability Amici's disagreement with the dissent, which states that "[t]he speculative possibility that vulnerable individuals might be induced or coerced to hasten their deaths cannot justify denying to all New Mexicans the constitutional right to aid in dying." *Id.* ¶ 135. There are at least three responses to the dissent's core claim that the dangers of assisted suicide are a mere "speculative possibility": 1) the language of the Oregon and Washington assisted suicide statutes, which leave gaping holes in patient protection but provide a blanket of immunity based on a claim of "good faith" to participants in the death; 2) the common sense factual and legal analyses by numerous courts that have considered the issue; and 3) cases of mistake and abuse which have come to light despite the law's minimal reporting requirements, the lack of investigation by authorities, and the impact of strict health care confidentiality laws.

First, nothing in the provisions of the Oregon and Washington assisted suicide statutes[18] prohibits an heir or caregiver from suggesting assisted suicide to an ill person, or taking the person to the doctor to make a request. If the person has a speech impairment, such as due to a stroke, or speaks another language, the laws provide that a patient may communicate "through a person who is familiar with the patient's manner of communicating." *See, e.g.*, Oregon DWD Act, 127.800 § 1.01(3). The statutes allow an heir to be a witness to the assisted suicide request as

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[18] Oregon Death With Dignity Act, ORS 127.865, Washington Death With Dignity Act, RCW 70.245

long as the second witness is not an heir. In addition, both witnesses can be complete strangers who merely check the patient's identification. In either case, the witnesses' certification that the patient is not being coerced is lacking in foundation and persuasive value. In addition, once the prescription for lethal drugs is issued, there are no further witness requirements, including at the time of ingestion of the lethal drugs and death. As Washington elder law attorney Margaret Dore has written:

> Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi. This scenario would seem especially significant for patients with money. A California case, People v. Stuart, states: "[F]inancial considerations [are] an all too common motivation for killing someone . . . .[19]

For a full analysis of the flaws in the Oregon and Washington statutes, please see the full article cited above.

Second, a recent California case provides a far more comprehensive and persuasive review of previous court rulings in assisted suicide cases than the dissent in the instant case. *O'Donnell v. Harris*, San Diego Superior Court Case No. 37-2015-00016404-CU-CR-CTL (July 24, 2015), provides what the Disability

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[19] Margaret Dore, Esq., "'Death with Dignity': A Recipe for Elder Abuse and Homicide (Albeit Not by Name)," 11 Marquette Elder's Advisor 387, 2010, *available at* http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html.

Rights Amici view as a common sense analysis that gives realistic weight to the many dangers that legalizing assisted suicide poses, particularly in an aging population in which, according to federal estimates, one in ten elders are abused.[20]

In granting a demurrer without leave to amend, the Superior Court of San Diego, eloquently summarized the many dangers of legalizing assisted suicide raised by previous courts:

> Since "Aid in Dying" is quicker and less expensive, there is a much greater potential for its abuse, e.g., greedy heirs-in-waiting, cost containment strategies, impulse decision-making, etc. Moreover, since it can be employed earlier in the dying process, there is a substantial risk that in many cases it may bring about a patently premature death. For example, consider that a terminally ill patient, not in pain but facing death within the next six months, may opt for "Aid in Dying" instead of working through what might have been just a transitory period of depression. Further, "Aid in Dying" creates the possible scenario of someone taking his life based upon an erroneous diagnosis of a terminal illness, which was, in fact, a misdiagnosis that could have been brought to light by the passage of time. After all, doctors are not infallible.
>
> Furthermore, "Aid in Dying" increases the number and general acceptability of suicide, which could have the unintended consequence of causing people who are not terminally ill (and not, therefore, even eligible for "Aid in Dying") to view suicide as an option in their unhappy life. For example, imagine the scenario of a bullied transgender child, or a heartsick teenaged girl whose first boyfriend just broke up with her, questioning whether life is really worth living. These children may be more apt to commit suicide in a society where the terminally ill are routinely opting for it.

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[20] *See* D. Heitz, "U.S. Official: Elder Abuse is 'Broad and Widespread'," Healthline News (Jan. 27, 2014), *available at* http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714.

Id. at 8.

Third, if this Court is not persuaded to uphold the Court of Appeals' ruling based on a purely legal analysis of the record below, the Disability Amici urge this Court to remand for further proceedings to ensure the submission of a fully-developed factual evidentiary record – something that was lacking in the trial proceedings below.

B. If This Court Does Not Uphold the Court of Appeals Opinion, the Court Should Remand to Ensure a Full Development of the Facts in the District Court

The dissent below contains numerous comments regarding the State Attorney General's approach to this case. The Disability Amici were not able to attend the District Court or Court of Appeals proceedings below, and thus the dissent is the first information we had that the State called no witnesses and presented no evidence of abuses in Oregon and Washington, where assisted suicide is legal as a result of ballot initiatives. Moreover, the State reportedly indicated that, if a right to commit suicide were found, it could not meet the burden of proving the State's interest in banning assisted suicide under either a strict scrutiny or intermediate standard of review.

The Disability Amici strongly disagree with the State's position and handling of this case, which endangers the lives of people with both terminal and nonterminal disabilities. Perhaps the State is unaware of the relevant facts and requires assistance in making its case. To ensure a factually complete and accurate record, we urge this Court to direct the District Court upon remand to allow one or more of the organizations comprising the Disability Amici to intervene in the case and present the factual evidence and legal analysis necessary to demonstrate that the State's interest in a statute banning assisted suicide clearly meets either a strict scrutiny or intermediate standard of review.

If necessary, one or more organizations represented by the Disability Amici offer to intervene to assist in this matter. Below, we outline some of the evidence that we would seek to bring before the trial court – evidence of assisted suicide abuses in Oregon and Washington, as well as the deficiencies of patient protections in the Oregon and Washington assisted suicide laws.

C. The Disability Amici Can Provide Factual Evidence Demonstrating Assisted Suicide Abuses in States Where It Is Legal, As Well As Relevant Testimony from Physicians, Patients, Attorneys and Law Enforcement

The dissent makes a number of statements about the abilities of physicians that are contradicted by well-known research. For example, the dissent asserts:

> Doctors are typically capable of differentiating between clinical depression and a sincere, informed decision to seek aid in dying, and they are required by the standard of care to take a patient-centered approach to the issue, ensuring that all options have been meaningfully discussed by first exploring a patient's needs and fears related to death from terminal illness.

Morris, 2015-NMCA-___, at ¶ 133. From the Disability Amici's perspective, this image of physicians' knowledge can best be described as unrealistic and naive.

A majority of clinical and forensic psychiatrists believe that the presence of major depressive disorder should result in an automatic finding of incompetence to make decisions about assisted suicide. Further, while only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit, the Oregon assisted suicide law provides that a patient could be diagnosed with depression but still receive a lethal prescription based on one visit, if the doctor is willing to give an opinion that the person's judgment is not impaired. No treatment for depression is required by the assisted suicide statutes.[21]

In addition, the top five reasons that prescribing physicians report for assisted suicide requests are psycho-social reactions to disability. Two of them are loss of autonomy (92%) and feelings of being a burden on others (40%).[22] Nevertheless, neither the Oregon nor Washington laws include home care options in the list of required disclosures, nor do they ensure that home care will be

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[21] *See* L. Ganzini, et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psych., 595, 598 (April 2000); L. Ganzini, et al., *Attitudes of Oregon Psychiatrists Towards Assisted Suicide*, 153 AM. J. PSYCH, 1469 – 75 (1996).

[22] *See* Oregon Public Health Division Reports, *available at* https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf.

provided if desired. The Disability Amici's experience is that most doctors know little or nothing about home and community based long-term care.

The Disability Rights Education and Defense Fund has compiled a summary of *Oregon and Washington State Abuses and Complications*.[23] The following case examples illustrate some of the issues highlighted by that report (citations omitted but available in the online document):

- Kate Cheney, 85, died by assisted suicide under Oregon's law even though she had early dementia. Her physician had declined to provide the lethal prescription. Her managed care provider then found another physician to prescribe the lethal dose. The second physician ordered a psychiatric evaluation, which found that Cheney lacked "the very high level of capacity required to weigh options about assisted suicide." Cheney's request was denied, and her daughter "became angry." Another evaluation took place, this time with a psychologist who insisted on meeting Cheney alone. Disturbingly, the psychologist deemed Cheney competent while still noting that her "choices may be influenced by her family's wishes and her daughter, Erika, may be somewhat coercive." Cheney soon took the drugs and died, but only after spending a week in a nursing home.

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[23] *Available at* https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf

- Michael Freeland, age 64, had a 43-year medical history of acute depression and suicide attempts. Yet when Freeland saw a doctor about arranging an assisted suicide, the physician said he didn’t think that a psychiatric consultation was “necessary.” But the law’s supporters frequently insist that as a key safeguard, depressed people are ineligible. When Freeland chanced to find improved medical and suicide prevention services, he was able to reconcile with his estranged daughter and lived two years post-diagnosis. Oregon’s statistics for the years 2011 – 2014 show that each year, only 3% of patients (or fewer) were referred for psychological evaluation or counseling before receiving their prescriptions for lethal drugs. N. Gregory Hamilton, M.D., Distinguished Fellow of the American Psychiatric Association, demonstrated how Oregon’s flimsy safeguards do not protect people with psychiatric and other mental health disabilities. Moreover, a majority of clinical and forensic psychiatrists believe “that the presence of major depressive disorder should result in an automatic finding of incompetence” to make decisions about assisted suicide. And only six percent of Oregon psychiatrists are confident they can diagnose depression after one visit, yet the Oregon and Washington State definitions of a psychiatric consultation permit one visit only.

- Linda Fleming, the first to use the Washington state law, was divorced, had had financial problems, had been unable to work due to a disability, and was forced to declare bankruptcy. Yet the Director of Compassion & Choices of Washington said that her situation presented "none of the red flags" that might have given his group pause in supporting her request for death. But we are told by proponents that financial pressures have never played a role.
- Thomas Middleton was diagnosed with Lou Gehrig's disease, moved into the home of Tami Sawyer in July 2008, and died by assisted suicide later that very month. Middleton had named Sawyer his estate trustee and put his home in her trust. Two days after Thomas Middleton died, Sawyer listed the property for sale and deposited $90,000 into her own account. It took a federal investigation into real estate fraud to expose this abuse. Sawyer was indicted for first-degree criminal mistreatment and first-degree aggravated theft, partly over criminal mistreatment of Thomas Middleton. But the Oregon state agency responsible for the assisted suicide law never even noticed.
- Patrick Matheny received his assisted suicide prescription by Federal Express. He couldn't take the drugs by himself so his brother-in-law helped. Commenting on the Matheny case, Dr. Hedberg of Oregon Department of Human Services said that "we do not know exactly how he helped this

person swallow, whether it was putting a feed tube down or whatever, but he was not prosecuted …." The state's official annual report on assisted suicide deaths did not take note of this violation of the Oregon law. Proponents regularly insist that the law's self-administration requirement is a key safeguard against abuse that is scrupulously followed, and that Oregon's reports have thoroughly reflected all key circumstances as the law has unfolded.

- Barbara Wagner's case underscores the danger of legalizing assisted suicide in the context of our broken U.S. health care system. Wagner, a 64-year-old great-grandmother, had recurring lung cancer. Her physician prescribed Tarceva to extend her life. Studies show the drug provides a 30 percent increased survival rate for patients with advanced lung cancer, and patients' one-year survival rate increased by more than 45 percent. However, the Oregon Health Plan sent Wagner a letter saying the Plan would not cover the beneficial chemotherapy treatment, "but … it would cover … [among other things,] physician-assisted suicide."
- Wendy Melcher died in August 2005 after two Oregon nurses, Rebecca Cain and Diana Corson, gave her overdoses of morphine and phenobarbital. They claimed Melcher had requested an assisted suicide, but they administered the drugs without her doctor's knowledge, in clear violation of Oregon's law.

> No criminal charges have been filed against the two nurses. The case prompted one newspaper to write, "If nurses—or anyone else—are willing to go outside the law, then all the protections built into [Oregon's] Death with Dignity Act are for naught."

Physician witnesses that the Disability Amici would call if the case were remanded and they were permitted to intervene include:

- Dr. Herbert Hendin – Former Medical Director of the American Suicide Prevention Foundation, and co-editor of the book, "The Case Against Assisted Suicide";
- Dr. Kathleen Foley – Physician at Memorial Sloan Kettering Cancer Center, and co-editor of the book, "The Case Against Assisted Suicide";
- Dr. Ferdinando L. Mirarchi – Author of studies on physician withholding of life-sustaining treatment without patient consent;
- Dr. Ezekiel Emanuel – Author of "Four Myths About Doctor-Assisted Suicide,"[24] in which he states: "Patients themselves say that the primary motive is not to escape physical pain but psychological distress; the main drivers are depression, hopelessness and fear of loss of autonomy and

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[24] *Available at* http://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/?_r=0.

control. . . . In this light, physician-assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."

- Dr. Ira Byock – Internationally renowned expert in palliative care;
- Dr. Gregory Hamilton - Distinguished Fellow of the American Psychiatric Association; and
- Dr. William Toffler – Director of the Oregon based Physicians for Compassionate Care.

The Disability Amici would also like to call as witnesses one or more individuals who acquired severe disabilities through trauma or illness, and wanted to die at a time when their condition could have met the definition of "terminal." Finally, the Disability Amici would like to call one or more witnesses from law enforcement who deal with crimes of elder abuse, and attorneys from the disability protection and advocacy system who bring litigation to save the lives of individuals with disabilities from unlawful third party decisions to withdraw life-sustaining treatment.

CONCLUSION

People with disabilities in New Mexico are seriously threatened by physician-assisted suicide. The Disability Rights Amici request this Court to recognize that, cloaked in the false rhetoric of "death with dignity," and "aid in dying," physician-assisted suicide threatens the civil rights, and the lives, of a profoundly oppressed and marginalized people.

The Disability Amici are aware that our members have not been declared a "suspect class" entitled to strict scrutiny analysis of statutes that discriminate against us. However, we hope that the time will come when old, ill and disabled people are recognized as a class entitled to strict scrutiny protection. That is the expansion of constitutional rights that we hope to see. As we have argued in the Court of Appeals and again here, people with disabilities, whether those disabilities are terminal or nonterminal, deserve equal protection under the laws and professional standards pertaining to suicide prevention and homicide law enforcement.

If this Court does not see fit to simply uphold the Court of Appeals' ruling in this case, we hope that we will have the chance to assist in doing what the State Attorney General did not do in the trial court below: to present the case for giving compelling and dispositive weight to protecting old, ill and disabled people from the risks of mistake, coercion and abuse inherent in assisted suicide laws.

Respectfully submitted,

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