IN THE COURT OF APPEALS OF NEW MEXICO

KATHERINE MORRIS, M.D., AROOP MANGALIK, M.D., and AJA RIGGS,

Plaintiffs-Appellees,

v.

KARI BRANDENBERG and GARY KING,

Defendants-Appellants.

Court of Appeals No. 33,630
D. Ct. Cause No. D-202-CV-2012-02909

APPELLEES' ANSWER BRIEF

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INTRODUCTION

In this case of first impression in New Mexico, Doctors Morris and Mangalik seek a declaration that they cannot be prosecuted under New Mexico's assisted suicide statute, NMSA 1978, Section 30-2-4 (hereinafter "Section 30-2-4"), if they provide aid in dying to a competent, terminally ill patient who requests it. (RP0023.) Aja Riggs ("Ms. Riggs"), who has endometrial cancer, wants the comfort of knowing that if her disease causes unbearable suffering in the terminal phase, her physician can lawfully prescribe medicine that she may (or may not) take to achieve a peaceful death. (RP0029.)

Dr. Morris and Dr. Mangalik originally filed Complaint against the District Attorney for Bernalillo County and the Attorney General of the State of New Mexico ("Defendants"). (RP0001.) Subsequently, having learned of the litigation on the radio and wanting to help the physicians' effort to provide this medically sound option to patients like herself who wanted it, Ms. Riggs joined the suit. (RP0023.) Plaintiffs made two general claims: first, Section 30-2-4 does not prohibit the medical practice of aid in dying; second, if it does, the statute is unconstitutional as applied because it violates their right to happiness, free speech, due process of law, and/or equal protection under the New Mexico Constitution. (RP0030-0034.)

Following a denial of Defendants' motion to dismiss (except for Plaintiffs' free speech claim) and a trial on the merits, Judge Nash found that Section 30-2-4 did prohibit aid in dying, but that the prohibition violated New Mexico's constitutional guarantees of the rights to happiness and due process. (RP0232, ¶ 5.) The relevant proceedings, the evidence introduced therein, and Judge Nash's holdings are discussed below.

I. The Facts Presented at Trial Support the Trial Court's Decision

The parties agree that at any given moment in New Mexico there are terminally ill patients who find the suffering from their illness to be unbearable, despite efforts to relieve pain and other distressing symptoms. (RP154.) Some of those patients want the option of aid in dying. (Id.) The parties further agree that "[a]id in dying refers to the practice of a physician providing a mentally competent terminally ill patient with a prescription for medication which the patient may choose to ingest to achieve a peaceful death and thereby avoid further suffering." (Id.)

At trial, Plaintiffs presented six witnesses. Dr. Nicholas Gideonse, M.D., recognized by the court as an expert in end-of-life care and the practice of aid in dying, testified about the similarities between the removal or refusal of life sustaining treatment, terminal sedation, and aid in dying; the established standard of care for aid in dying; how the practice has positively impacted end-of-life care

in Oregon; and the demographics of the patients who choose aid in dying. (V3-TR-4 through V3-TR-70.)

Dr. Eric Kress, M.D., recognized by the court as an expert in end-of-life care, generally, and aid in dying as practiced in Montana, testified about end-of-life options and the practice of aid in dying following the Montana Supreme Court's opinion making clear the practice was legal in that state. (V2-TR-145 through V2-TR-195.)

Dr. David Pollack, M.D., recognized by the court as an expert psychiatrist in the area of end-of-life concerns and decision-making, testified principally that, psychologically, aid in dying is not suicide and doctors are called upon frequently to determine competence and can readily do so. (V2-TR-68 through V2-TR-134.)

Dr. Morris testified to the suffering patients dying of cancer typically confront; her experience providing aid-in-dying to two patients in Oregon; and why calling those deaths "suicide" offended her. (V2-TR-17 through V2-TR-53.)

Ms. Riggs testified she does not want to suffer needlessly should her cancer progress and wants the comfort of knowing aid in dying is an option. (V2-TR-53 through V2-TR-67.)

Adrianne Dare described the positive impact aid in dying had on her mother and her family. (V2-TR-134 through V2-TR-145.)

This compelling testimony evidenced the personal autonomy and dignity at the heart of this case as well as the factual basis for the trial court's recognition of the fundamental right at stake.

A. Terminal Illness

Plaintiffs' witnesses described that the dying process was often extremely difficult for patients, interfering with vital functions, including eating, drinking, breathing, and circulation. (E.g., V3-TR-12:16-22.) The mainstay of pain management remains opiate treatment, which severely diminishes a patient's ability to participate in activities they enjoyed previously. (V3-TR-12:23-25; V3-TR-13:1-16.) Some patients, despite best efforts, have pain that is intractable. (V3-TR-13:17-19.)

Dr. Morris recalled a patient with unrelenting, unmanageable pain. (V2-TR-23:2-16.) He had been a six-foot-five, two-hundred and eighty pound firefighter when diagnosed with metastasis to his spine from skin cancer. (Id.) His treatment team had tried everything to control his symptoms, but when awake, he sobbed in unrelieved pain. (Id.) The only effective treatment was to sedate him to unconsciousness. (Id.)

Dr. Morris testified about a patient who had advanced cancer with a tumor that could not be entirely removed through surgery because it had invaded a life-sustaining organ. (V2-TR:2-18.) The patient's breast cancer had grown so rapidly

it had outgrown its blood supply, killing part of the tumor, which decomposed, emanating odor so foul the patient could not eat. (Id.) Dr. Morris surgically removed as much of the tumor as possible, as well as ribcage and chest wall, but was limited by the fact the patient's heart lay under the tumor. (Id.)

Dr. Morris described how fluids accumulate in cancer patients, causing rapid distention of their abdomen, bloating within a week from flat to appearing pregnant with twins. (V2-TR:3-24.) Though fluid can be manually drained, it re-accumulates quickly, causing great discomfort; in extreme cases, swelling is so severe that the patient's skin splits open and the fluid seeps from the openings. (Id.)

In addition to pain, terminally ill patients may experience inexorable and progressive loss of autonomy. (V2-TR-153:11-18) Tasks as simple as getting out of bed, using the toilet, or taking a shower become impossible. (Id.) They can become unable to enjoy the activities that gave their lives meaning. (E.g., V2-TR-30:7-14).

Some patients seek aggressive curative treatment until the end. (V3-TR-13:20-25; V3-TR-14:1-22.) Some die as side effect of that aggressive treatment. (Id.) However, there frequently comes a time when patients and physicians accept that curative options have been exhausted, will not improve the outcome, and that it is in the best interest of the patient to receive care to relieve symptoms and

facilitate autonomy. (Id.) At that point, terminally ill patients are often referred to hospice, which focuses on helping dying patients remain as comfortable as possible. (V2-TR-152:4-13.) Some patients, however, even with excellent palliative care provided by hospice, want to control the time and manner of their deaths through aid in dying. (V3-TR-14:20-22.)

B. End-of-Life Options

Plaintiffs' witnesses described the standard of care for aid in dying, the impact its availability has on patients and end-of-life care, and how a death from aid in dying is fundamentally different from suicide. The witnesses also testified about other end-of-life treatment options, including terminal sedation and the removal and refusal of life sustaining treatment. These options, the parties agree, are lawful. (RP0068.)

1. Terminal sedation

Terminally ill patients experiencing unmanageable pain may choose to have their physician induce unconsciousness, so they will have no awareness of suffering. (V-3-15:25; V-3-16:1-16.) This is accomplished by the intravenous administration of high levels of medication. (Id.) Hydration and nutrition are withheld. (Id.) Unconscious, without food and water, the patient dies. (Id.) This practice is called terminal or palliative sedation. (V-3-TR:13-19.) The physician's intent is to alleviate suffering; however, the physician knows that the high levels of

medication and withholding of hydration and nutrition will inevitably result in the patient's death. (V3-TR-19:5-15.)

"Terminal sedation is a last resort or extreme treatment mode for intractable, unrelenting pain." (V3-TR-15:18-20.) "Nobody gets to terminal sedation on hospice without living through at least a short period of being in hell." (V2-TR-155:16-19.) Often, before terminal sedation is deemed an appropriate option, a patient's illness has progressed such that they are incompetent, or the treatment has rendered them incompetent, and their "physicians are making decisions without the patient's explicit consent, or family members are making decisions, not really knowing what the patient would exactly want[.]" (V3, TR39:6-12.)

When a patient has been terminally sedated, the sedation is the proximate cause of death but not the "but for" cause, which is the underlying disease. (V3, TR-16.) On the death certificate, the physician indicates the cause of death was the underlying illness, not the medication that hastened death or a cardiac or respiratory arrest, for example, the high levels of medication administered. (V2-TR-158:13-17.) The manner of death recorded on the death certificate is "natural." (V3, TR-20:1-12.)

2. Removal or Refusal of Life Sustaining treatment

Patients also have a right to refuse or direct the withdrawal of life-sustaining treatment notwithstanding that doing so will result in death. Often patients are

unconscious when others—family members or physicians, depending on who is available—make the decision to withdraw life-sustaining treatment. (V3-TR-22:11-25.) Examples of a conscious patient refusing life sustaining treatment include a patient requesting the removal of a heart pump or ceasing dialysis. (See, e.g., V3-TR-22:20-24 and V3-TR-24:1-11.) When a patient requests removal of life-sustaining treatment, a physician not only assists in the removal of whatever implement was keeping the patient alive, but also provides palliative care to ensure the patient does not suffer in the interim before death. (V3, TR-23:2-17.)

When life support is removed or refused, the cause of death is not deemed the removal or refusal of the support, although the patient would not have died that day if life support were not removed. (V3, TR-23:18-25.) In other words, the death certificate would indicate the underlying illness -not the removal of support- as the cause of death. (Id.) Thus, when a physician removes a heart pump, the patient dies of cardiac arrest as a proximate result of the removal. (Id.) The cause indicated on the death certificate is the underlying condition, heart disease. (Id.) Further, the manner of death is recorded as natural. (V3, TR-20:1-12.)

3. Aid in dying

Aid in dying is the medical practice of providing a terminally ill, competent person with a prescription for medication that the patient may choose to take in order to achieve a peaceful death if the patient finds his dying process unbearable.

a. *Standard of care*

The physician witnesses who have provided aid in dying testified that there is a controlling standard of care for the practice derived from the Oregon experience, where aid in dying has been available since 1998. (V2-TR-39:4-9; V-3-TR:19-25.) In addition, the standard of care for aid in dying is reflected in clinical practice guidelines. (V2-TR-40:5-9; V3-TR-31:5-8.) These witnesses also testified that there need not be a statutory scheme defining the practice, as there was at the inception of open, legal, practice in Oregon, and the standard of care is now established. (V2-TR-39:3-12; V3-TR-31:9-11; V3, TR-19-25.) Generally, the standards of care for medical care, even procedures involving life and death, are not set forth statutorily. (V-3-29:21-22.)

Physicians are by nature cautious and make certain they understand the standard of care for any new treatment prior to providing it. (V-2-TR-38:19-25; V-2-TR-29:1-2.) Dr. Kress refused the first patient who approached him requesting aid in dying even though that patient was terminally ill, competent, and otherwise qualified. (V2-TR-159:19-22; V2-TR-160:11-20; V2-TR-161:9-25.) At that time, Dr. Kress did not know the legality of the practice in Montana or the standard of care. (V2-TR-162:2-22.) After that request, he took the time to both learn and feel comfortable providing the option to the next qualifying patient who asked him. (V2-TR-163:21-25; V2-TR-164:1-20.) To learn the standard of care, he read about

the practice in medical journals and consulted with experienced physicians. V-2-164:1-20.) Physicians frequently must learn the standard of care for new practices in this manner. (V-2-38:19-25.)

The standard of care includes the requirement that an eligible patient for aid in dying be a terminally ill, competent, adult who has made repeated requests over multiple visits. (V-2-164:21-25; V-2-165:1-23.) The patient must be able to self-administer the medication. (Id.)

Though the standard of care for aid in dying was informed by the Oregon Death with Dignity Act, the Oregon law has been significantly augmented by physicians who provide aid in dying to include important care that is not detailed in Oregon's act. (V3-TR-30:17-25; V3-TR-31:1-4.) For example, though unwritten, a physician should explore a patient's fears and needs related to a death from terminal illness and seek first to provide solutions and reassurance when a patient initially requests aid in dying. (Id.)

Standard of care dictates that a patient is terminally ill when they have less than six months to live. (V3-TR-26:6-14.) To establish terminality, and therefore eligibility for aid in dying, two physicians must agree to the diagnosis. (V2-TR-165:8-23.) Though a six-month diagnosis can have some variability, physicians become more and more accurate the closer to death a patient becomes and they tend to over, rather than under, estimate life expectancy. (V3-TR-25:3-21.)

Physicians also diagnose terminality for eligibility for hospice and terminal sedation. (V3-TR-25:24-25.)

There is a well-accepted and understood standard of care for gauging competence (decision-making capacity), as physicians have to do so daily, under equally consequential circumstances. (V3-TR-26:15-25; V3-TR-27:1-15.) For example, when a patient gives or refuses consent for medical treatment, a physician must assess competency. (Id.)

A competent patient is able to understand the information presented to them about diagnosis, prognosis, and options, and make a reasoned decision. (Id.) A competent patient's decision is not driven by mental illness. (Id.)

Physicians have tools for differentiating decisions born of mental illness and those that are informed and rational. (V3-TR-27:16-25; V3-TR-28:1-16.) When a patient is terminally ill, they may be situationally depressed. (V2-TR-77:9-25.) Indeed, the illness has taken their future and their bodily integrity, and it would be unusual for a terminally ill patient to not exhibit some depressive symptoms. (V3-TR-27:20-25; V3-TR-28:1.) However, that does not necessarily render the patient ineligible. (V2-TR-77 through 80.) One means physicians use to differentiate between this appropriate symptomology and someone whose depression is interfering with their ability to make a rational decision is to ask the patient whether they would want aid in dying if their disease disappeared. (V3-TR-28:21-

25; V3-TR-29:1-16.) Most patients say no, of course not. (Id.) But sometimes, a patient responds with some hesitation. (Id.) In those instances, the physician refers the patient to a psychiatrist for a consultation. (Id.)

Because a patient must be competent to elect aid in dying, patients with conditions that impair understanding and rational decision making, like Alzheimer's, are ineligible. (V3-TR-28:8-20.)

As when a physician terminally sedates a patient, when physicians provide aid in dying they do so to relieve suffering and provide comfort to their patients, not with the intent to end their lives—the disease is doing that; though, of course, they know death will result. (V2-TR-48:1-4.) Like terminal sedation or removal of life support, in states where aid in dying is expressly authorized by law, the practice is to list the underlying illness as the cause of death. (V3, TR-18:5-25; TR-19:1-3; V3, TR-20:1-12.) Correspondingly, the manner of death is designated as natural. (V3, TR-20:1-12.)

b. *Oregon statistics*

A significant number of those prescribed the medication for aid in dying never ingest it. (V3-TR-44:4-12.) Still, the availability of the medicine provides great comfort to patients, knowing that they will not be forced to needlessly endure horrific suffering if they do not wish to do so. (V3, TR-36:21-25; V3, TR-1-5.)

Even more patients who explore the option with their physician do not ultimately pursue the prescription. (V3-TR-44:1-9.) This may be because, according to standard of care, a physician's first response to a patient's request for aid in dying should be to ensure everything has been done to ease symptoms and fear. (V3-TR-45:1-25.)

In Oregon, because aid in dying is available, terminally ill patients are more comfortable addressing their fears related to a death from terminal illness with their physicians; and, as a result, end-of-life care has improved. (V3-TR-45:1-25; V3-TR-52:14-25.) Patient engagement has also increased. (V3-TR-52:14-25.) Oregon's terminally ill are enrolled in hospice earlier and at much higher rate compared to peers in other states. (V3-53:8-15.) Dying patients in Oregon receive significantly improved palliation as compared to such patients in other states. (V3-TR-53:16-24.)

The most common terminal illnesses for Oregon patients who have received a prescription for aid in dying are cancer, amyotrophic lateral sclerosis (Lou Gehrig's disease), emphysema, and AIDS. (V3-TR-46:1-19.) .

C. The psychology of aid in dying.

Once patients obtain the prescription, its availability provides great comfort even if they do not ultimately ingest the medicine. (V3, TR-36:21-25; V3, TR-1-5.)

When a patient does ingest the medication, it is not an act of suicide. (V2-TR-112:5-13.) Terminal sedation and the removal or refusal of life-sustaining treatment are not suicide either. (V3-TR-19:20-25; V3-TR-20:1-2; V3-TR-23:18-19.)

Indeed, physicians who have provided aid in dying reject the suggestion that these patients have committed suicide. (V2-TR-28:18-29:6.) If their patients could have, they would have lived. (Id.) In response to counsel's question about whether a patient he had provided aid in dying to had committed suicide, Dr. Gideonse stated:

> I can't imagine loving children and ex-wives assembling to celebrate and be with him around a violent suicide for which there was no recourse. This was a valued life, and I cannot imagine him wishing that life to end. I had asked him the question I mentioned before: If the disease were different and they had a cure, would he have accepted that treatment. Of course, he would have. He looked at me like I was crazy… He chose a different manner to avoid the loss of [autonomy].

(V3-TR-34:17-35; V3-TR-35:6-11.) Dr. Morris rejects the notion that her patients who chose aid in dying committed suicide. Of one patient, she said: "she wanted to live. She wanted more time with her children. She wanted more time with her husband and her family and her garden, and she wasn't given that option. And I think that – I think that she chose to end her suffering, not her life." (V2-TR-28:21-25.) When someone refers to Dr. Morris's patient as having committed suicide, she gets angry. (V2-TR-29:1-3.) "This was a very graceful, smart, wonderful person

that contributed a lot to this world, and to have her end, which was so peaceful and so beautiful, be characterized in a negative fashion is very upsetting." (V2-TR-29:3-6).

Plaintiffs-Appellees' expert psychiatrist, Dr. Pollack, agrees with the treating doctors. Fundamentally, he explained "suicide is a distinctly different act than requesting aid in dying." (V2-TR-73:11-12.) The person who commits suicide usually has a psychiatric condition, often depression, and acts impulsively. (V2-TR-73:13-21.) They hide their intention and act in isolation. (V2-TR-94:4-12.) A suicide represents a life cut short, an act of destruction. In stark contrast, aid in dying is a carefully considered act intended to preserve one's sense of self and coherent self-image. (V2-TR-73:20-25.) These patients are focused on their quality of life during the dying process and maximizing time with family before they die. (V3-TR-79:20-23.) The primary reason patients elect aid in dying is they find the progressive and inexorable loss of autonomy and dignity caused by their disease to be unbearable. (V3-TR-35:7-15.) When patients ingest the medication, their families are often gathered so that everyone can say farewell. (V3-TR-33:6-9.)

The effect of suicide in contrast to aid in dying on family members is also stark. Survivors of suicide are usually shocked and angry, left to wonder why their loved one could not confide in them. (V2-TR-96:11-19.) The act leaves them less connected to their loved one. (Id.) Conversely, aid in dying patients are often

surrounded by their families when they ingest the medicine. (V2-TR-28:11-12.) Family members feel glad that their loved-one's wishes were honored and to have been present with them at the end. (V2-TR-37:12-15; V2-TR-97:1-5.)

Patients who elect aid in dying do so because they value autonomy. (V3-TR-50:10-20.) For them, the option of terminal sedation, which involves a period of limbo in unconsciousness, with all bodily needs attended to by others who stand a grim vigil, may be an unacceptable alternative. (V3, TR-38:4-19.) They value mental clarity and dignity. (V3, TR-38:4-12.)

Plaintiff Ms. Riggs does not know if she would ultimately want to avail herself of aid in dying, but she knows she wants the option. (V2-TR-64:4-12.) She does not "want to suffer needlessly at the end." (V2-TR-63:13-25; V2-TR-64:4-22.) She does not want to lie in bed, dying, in pain, or struggling to not be in pain, or be unconscious with all her loved ones around her waiting for her to die. (V2-TR-60:20-25.) But in New Mexico, prior to her participation in this case and the trial court's ruling, Ms. Riggs did not feel comfortable confiding her desire to have the option of aid in dying to anyone because she did not want to implicate loved ones or her physicians in a criminal act if she ultimately did take steps to avoid the final ravages of terminal illness. (V2-TR-61:1-19.) She had determined that if she were to avoid continued pain and incapacitation, she would have to die alone, like many other patients before her. (Id.)

II. Findings of Fact and Conclusions of Law

The trial court adopted findings consistent with the above testimony. (RP0217-0222.) The court concluded that Section 30-2-4 prohibits aid in dying, but that the prohibition, as applied to aid in dying, is unconstitutional under New Mexico's constitutional guarantees of due process of law and the right to seek and obtain safety and happiness.[2] (RP0223-0229.) The court stated it, "[could not] envision a right more fundamental, more private or more integral to the liberty, safety and happiness of a New Mexican than the right of a competent, terminally ill patient to choose aid in dying." (RP0228.) Strictly scrutinizing the Section 30-2-4's infringement of the fundamental right to aid in dying, the court held that the Defendants had not fulfilled their burden to prove the assisted suicide act, as applied to aid in dying, furthered a compelling interest by the least restrictive means. (RP0229.)

STANDARD OF REVIEW

Two distinct standards apply when a New Mexico court reviews findings and conclusions.

> When a party is challenging a legal conclusion, the standard for review is whether the law correctly was applied to the facts, viewing them in a manner most favorable to the prevailing party, indulging all

[2] Defendants argue that the "case turns on whether" aid in dying "is a right guaranteed by Article II, Section 4." Brief in Chief at 9, FN4. However, the trial court's holding actually finds a constitutional right under both Article II, Section 4, and Article II, Section 18's substantive due process provisions. (RP0232, ¶ 5.)

> reasonable inferences in support of the court's decision, and disregarding all inferences or evidence to the contrary.

Golden Cone Concepts, Inc. v. Villa Linda Mall, Ltd., 1991-NMSC-097, ¶ 8, 113 N.M. 9 (citation omitted). In light of this standard the trial court's legal determinations are reviewed de novo. See Coulston Found. v. Madrid, 2004-NMCA-060, ¶ 9, 135 N.M. 667. On the other hand, where a party seeks to challenge factual findings made by a district court, "the judgment of the trial court will not be disturbed on appeal if the findings of fact entered by the trial court are supported by substantial evidence and are sufficient to support the judgment[.]" Sunwest Bank of Albuquerque, N.A. v. Colucci, 1994-NMSC-027, ¶ 8, 117 N.M. 373 (citations omitted).

Defendants did not dispute or otherwise object to the witnesses presented to the trial court and may only therefore challenge the trial court's legal conclusions. Haaland v. Baltzley, 1990-NMSC-086, ¶ 14, 110 N.M. 585 ("Facts stipulated to are not reviewable on appeal.") (citation omitted). Thus, Defendants-Appellants must meet the burden of establishing that the trial court erred as a matter of law. This they cannot do.

ARGUMENT

The trial court should be affirmed. The right of a terminally ill, competent adult to choose aid in dying if their suffering becomes unbearable is fundamental or, at the very least, important under the New Mexico Constitution. Defendants

cannot demonstrate that preventing a competent, terminally ill adult from electing aid in dying furthers any interest, important, compelling or otherwise. The availability of aid in dying should not be subject to popular will as Defendants argue.

Before the Court is one of the most private, intimate decisions made in a lifetime—how we face our own deaths. That decision should be reserved to the individual, informed by our most deeply held values, beliefs, and unique circumstances. For terminally ill patients, life will soon end. They are not "taking" their own life. Indeed such patients have typically fought long and hard to cure their illnesses, enduring surgery and/or chemotherapy and/or radiation, and/or other aggressive medical interventions. The lives of such patients are being taken by the inexorable progression of their terminal diseases. Medicine cannot change that fact. All these patients have in their control is how the inevitable will occur. Some will want the option of ingesting medication to achieve a peaceful death should their suffering become unbearable.

Prior to the Judgment in this case, terminally ill New Mexicans had "limited control of their own inevitable destiny by the medical profession and even less by the State. They [knew] they [were] going to die from their terminal illness, yet [were] prohibited from choosing the time, place and means to achieve a peaceful end." (RP0218, ¶ 4.) As the trial court questioned, "[i]f decisions made in the

shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of [New Mexico's] constitutional guarantees, then what decisions are?" (RP0228-0229, ¶¶ HH.)

Below, Plaintiffs first address the fundamental right under the New Mexico Constitution for a terminally ill patient, competent patient to seek aid in dying and then turn to the meaning of Section 30-2-4.

I. This Court should affirm the trial court's conclusion that the New Mexico Constitution protects a qualifying patient's right to choose aid in dying.

As stated in Griego v. Oliver, 2014-NMSC-003, 316 P.3d 865:

> [t]he very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty, and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections.

Id., ¶ 1 (citation omitted). The choice of a qualifying patient to seek a peaceful death through aid in dying is, as the trial court found, such a right; protected by the New Mexico Constitution's rights to happiness and due process. See N.M. Const., art. II, §§ 4; 18.

Because the right of a terminally ill, competent patient to seek aid in dying is fundamental (or, at the very least, important), the Defendants must demonstrate that their infringement of that right furthers compelling or significant interests.

Defendants have not and cannot meet this burden. Moreover, even if the rights at issue here were not fundamental or important, the prohibition is not rationally related to any interests.

A. Federal law is not controlling.

Defendants wrongly rely on Washington v. Glucksberg, 521 U.S. 702, 735 (1997), to argue reversal of the trial court's Judgment. Glucksberg is not dispositive for two reasons. First, Plaintiffs do not bring a claim under the United States Constitution. Instead, Plaintiffs bring claims pursuant to Sections 4 and 18 of Article II of the New Mexico Constitution. And those independent constitutional protections command that terminally ill, competent patients who seek a peaceful end can do so without undue state interference.

Second, while it is true that the U.S. Supreme Court declined to find a federal constitutional right to choose aid in dying in Glucksberg, thereby avoiding the imposition of a national rule, it instead left the matter for states to determine its legality for themselves. Id. at 719; id. at 735. ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."). A few years later, in Gonzales v. Oregon, 546 U.S. 243, 267 (2006), the U.S. Supreme Court rejected an attempt to nullify the decision Oregon made to permit aid in dying, and recognized that aid in

dying could be a legitimate medical practice. In short, the trial court's Judgment is not at odds with the U.S. Supreme Court's doctrine, but rather carries out the duty of the state as recognized by the Supreme Court.

Even if it were at odds, New Mexico courts do not follow federal analysis of parallel constitutional provisions in lock-step. Instead, "New Mexico courts independently analyze state constitutional guarantees when federal law begins to encroach on the sanctity of those guarantees." State v. Granville, 2006-NMCA-098, ¶ 14, 140 N.M. 345 (internal citations and quotations omitted). The court "may diverge from federal precedent for three reasons: a flawed federal analysis, structural differences between state and federal government, or distinctive state characteristics." New Mexico Right to Choose/NARAL v. Johnson, 1999-NMSC-005, ¶ 28, 126 N.M. 788 (quoting Gomez, 1997-NMSC-006, ¶ 17). "Any one of these reasons may provide sufficient justification for departing from federal precedent." Montoya v. Ulibarri, 2007-NMSC-035, ¶ 19, 142 N.M. 89; see also Griego v. Oliver, 2014-NMSC-003 (where the Court found an independent right under the New Mexico Constitution without first analyzing federal law). The Glucksberg analysis is both flawed and in discord with New Mexico's distinctive state characteristics.

When the Glucksberg Court ruled, it had to do so in a vacuum, without information about how the practice of aid in dying would impact patients and end-

of-life care because at that time there was no open practice in the U.S. The Glucksberg Court was concerned with the possibility that "vulnerable groups-including the poor, the elderly, and disabled persons" could be subject to "coercion and undue influence in end-of-life situations" including aid in dying. Glucksberg, 521 U.S. 702, 731-32. The Court feared aid in dying would become a cost saving measure for families. Id., at 732.

However, the data from Oregon over the seventeen years that aid in dying has been legal has shown that these fears were unwarranted. As the trial court judge found here, "[t]he available studies regarding who elects to utilize aid in dying do not demonstrate any overuse by especially vulnerable groups. There is no evidence that vulnerable groups are targeted by caregivers, family members or physicians who utilize aid in dying to hasten the deaths of vulnerable, terminally ill patients." (RP0222.) In fact, it is not the elderly who most avail themselves of aid in dying, but rather people between sixty and sixty-five years old. Moreover, patients who seek aid in dying are unusually highly educated, with at least 50% holding bachelor's degrees, about double the average in the general population. The patients are well insured: those with health insurance to pay for continued aggressive treatment until death was 100% in 2012, and in prior years, between 97% and 99.5%, whereas 17% of Oregon's population as a whole is uninsured. In Oregon, patients seeking aid in dying are predominantly Caucasian and are

statistically overrepresented. These statistics demonstrate that the perils speculated about in Glucksberg failed to materialize.

Additionally, the Glucksberg Court was concerned that permitting patients to choose aid in dying might start "down the path to voluntary and perhaps even involuntary euthanasia." Id. at 732. However, there is no evidence that aid in dying has been utilized in any way other than in accordance with the standard of care developed in Oregon: limited to terminally ill, mentally competent patients who are able to self-administer the medication. Unlike the Glucksberg Court, this Court has the benefit of years of data demonstrating that aid in dying has not produced any of the feared harms.

In addition, New Mexico has a long, proud, extraordinary history of respecting patient autonomy and dignity at the end of life. New Mexico was the first state to adopt the Uniform Health Care Decisions Act,[3] which provides for advance planning in health care decision-making, permits withdrawal of life prolonging treatment, and protects a patient's right to choose to receive pain medication that may hasten death. See NMSA 1978, § 24-7A-1-18 (1995). The withdrawal of life-prolonging medical care in accordance with the Act, even when death is the intended and foreseen result, does not constitute suicide. See NMSA,

[3] See Prot. & Advocacy Sys., Inc. v. Presbyterian Healthcare Servs., 1999-NMCA-122, ¶ 6, 128 N.M. 73.

1978 § 24-7A-13. It replaced the Right to Die Act,[4] through which New Mexico became one of the first three states in the country to recognize advance directives in any form, and it capped two decades of New Mexico legislation designed to give dying patients more control over their dying process. Through these statutes, the early adoption of a Pain Relief Act[5] (which protects a patient's right to obtain adequate pain relief, even if that results in the death of the patient), and other legislation, the New Mexico Legislature has shown assiduous respect for the decision-making autonomy of dying patients.

Our case law also reflects distinctive commitment to medical autonomy and respect for human dignity in the provision of medical care. In a case reviewing the scope of the Uniform Healthcare Decisions Act (ultimately decided on different grounds), this Court announced, "[e]ven if the medical facts are clear, different patients can make markedly different, but still reasonable, choices, depending on their religious beliefs, their assessments of the joys of life, their tolerance for pain, their regard for others, and a multitude of other factors." Prot. & Advocacy Sys., Inc. v. Presbyterian Healthcare Servs., 1999-NMCA-122, ¶ 16, 128 N.M. 73. Moreover, this Court pointed to patient autonomy and privacy to maintain the confidentiality of a criminal defendant's blood test. See State v. Roper, 1996-

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[4] Id.

[5] NMSA 1978, § 24-2D-1 to 6 (2012).

NMCA-073, 122 N.M. 126. In accord with the Glucksberg Court's invitation to state courts to independently address the issue, New Mexico's enduring respect for patient autonomy should guide this Court's decision.

Even if affirmance would seem a departure from U.S. Supreme Court precedent, such departure is not uncharacteristic in New Mexico when warranted. Indeed, time and time again, New Mexico courts have adopted a different view than their federal counterparts as to what constitutes a reasonable expectation of privacy and how much state interference is acceptable in a free and open society. See, e.g., State v. Granville, 2006-NMCA-098, ¶¶ 11-14, 140 N.M. 345 (listing the many instances New Mexico courts have found greater protections than federal and finding an independent right to privacy in trash); See Montoya, 2007-NMSC-035, ¶ 22 (recognizing the New Mexico constitution provides broader equal protection and due process protections than the federal). Given these increased protections, the Court should depart from Glucksberg and find a right to aid in dying under the New Mexico Constitution.

B. This Court should affirm the trial court's conclusion that there is a fundamental right to choose aid in dying pursuant to Article II, Sections 18 and 4.

In finding Section 30-2-4 unconstitutional as applied to aid in dying, the trial ultimately concluded:

> This Court cannot envision a right more fundamental, more private or more integral to the liberty, safety and happiness than the right of a competent, terminally ill patient to choose aid in dying. If decisions made in the shadow of one's imminent death regarding how they and their loved ones will face that death are not fundamental and at the core of these constitutional guarantees, then what decisions are?

(RP0228-0229, ¶ HH.) Thus, the ruling of the trial court is rooted in the liberty interest found in the due process clause of Article II, Section 18 of the New Mexico Constitution, and the protection of "natural, inherent and inalienable rights" articulated in Article II, Section 4. The record and the established law of this jurisdiction compel affirmance of that ultimate conclusion.

1. The substantive due process clause of Article II, Section 18 protects the fundamental right of competent terminal patients to aid in dying.

Barring competent, terminally ill adults from seeking aid in dying violates the distinct guarantees of Article II, Section 18's substantive due process clause by depriving them of the fundamental right to autonomous medical decision making and a dignified, peaceful death. "A fundamental right is that which the Constitution explicitly or implicitly guarantees." Howell v. Heim, 1994-NMSC-103, ¶ 14, 118 N.M. 500 (quoting Richardson v. Carnegie Library Restaurant, Inc., 1988-NMSC-084, ¶ 28, 107 N.M. 688 overruled on other grounds by Trujillo v. City of Albuquerque, 1998-NMSC-031, 125 N.M. 721).

"In examining the constitutionality of a statute for substantive due process, [a court] determine[s], as a threshold matter, the nature of the private interest at stake." State v. Druktenis, 2004-NMCA-032, ¶ 52, 135 N.M. 223. Namely, whether the right is fundamental or important and therefore afforded more exacting review. In general, fundamental rights are those "that are so 'implicit in the concept of ordered liberty' that 'neither liberty nor justice would exist if they were sacrificed.'" ACLU of NM v. City of Albuquerque, 2006-NMCA-078, ¶ 16 139 N.M. 761 (quoting Glucksberg, 521 U.S. at 721). Defendants argue that fundamental rights are limited to those rights explicit in the constitution. Defendants are wrong.

The U.S. Supreme Court has recognized a variety of fundamental liberties under the due process clause that are not explicit, including the right to marital privacy, Griswold v. Connecticut, 381 U.S. 479 (1965); to have children Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942); to direct education and upbringing of one's children, Meyer v. Nebraska, 262 U.S. 390 (1923); and to bodily integrity, Rochin v. California, 342 U.S. 165 (1952).

As the trial court noted, New Mexico courts have also recognized fundamental personal rights including "the rights of parents in the care, custody, and control of their children, In Re Pamela G., 2006-NMSC-019, ¶ 11, 139 N.M. 459; the freedom of personal choice in matters of family life, Jaramillo v.

Jaramillo, 1991-NMSC-101, ¶ 20, 113 N.M. 57, and the right to family integrity. Oldfield v. Benavidez, 1994-NMSC-006, ¶ 14, 116 N.M. 785[,]" (RP0228 ¶ GG.) all implicit in the liberty interest protected by the due process clause.

Moreover, the U.S. Supreme Court has repeatedly recognized that individual rights to privacy and bodily integrity are fundamental. See, e.g., Roe v. Wade, 410 U.S. 113 (1973) (recognizing the right of privacy protects a woman's right to choose whether to terminate a pregnancy); Cruzan by Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) (suggesting the Due Process Clause protects an interest in refusing medical care, even if that precipitates the individual's death); Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 849 (1992) ("It is settled now ... that the Constitution places limits on a State's right to interfere with a person's most basic decisions about... bodily integrity."); Washington v. Harper, 494 U.S. 210 (1990) (recognizing a constitutionally protected interest in bodily integrity); Albright v. Oliver, 510 U.S. 266 (recognizing that due process most commonly protects bodily integrity). In the Roe decision, the Supreme Court also "stressed the importance of the relationship between the patient and physician." Glucksberg, 521 U.S. 702, 778 (Souter, J., concurring) (citing Roe, 410 U.S. at 153, 156). Furthermore, the Supreme Court has "assumed, and strongly suggested, that the Due Process Clause protects the

traditional right to refuse unwanted lifesaving medical treatment." Glucksberg, 521 U.S. at 720 (citing Cruzan, 497 U.S. at 278-279).

Thus, the U.S. Supreme Court's explicit recognition of a patient's right to bodily integrity and the right to refuse life-sustaining treatment, coupled with the New Mexico's heightened protections under its due process, see Montoya, 2007-NMSC-035, ¶ 22, properly led the district court to conclude that the right to request aid in dying is another of the implicit and fundamental rights under the New Mexico Constitution. See also Washington v. Glucksberg, 521 U.S. 702, 777 (1997) (Souter, concurring) (quoting Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.").

This is particularly true in New Mexico considering the protections afforded under the inherent rights provision, see Art. II, Section 4, N.M. Const., and the expanded protections against due process violations afforded under the New Mexico Constitution. See Montoya, 2007-NMSC-035, ¶ 22.

2. The inherent rights guaranteed by Article II, Section 4 also protects the fundamental right to aid in dying.

In Griego, 2014-NMSC-003, ¶ 1, our Supreme Court opened its landmark decision declaring the unconstitutionality of this state's marriage laws with the text of Article II, Section 4. Section 4's prominence in that opinion demonstrates the

Court's commitment to recognizing the expanded, independent rights New Mexicans enjoy under their constitution. The Griego court ultimately ruled on equal protection grounds, id., ¶ 67, but not without recognizing the inherent rights guaranteed under Article II, Section 4.

Defendants point to a dearth of case law addressing Article II, Section 4. However, this Court, in discussing Article II, Section 4, recognized that it "protect[s] a variety of rights." State v. Sutton, 1991-NMCA-073, ¶ 23, 112 N.M. 449. Article II, Section 4, must provide protections beyond the rights explicitly protected elsewhere in the New Mexico constitution, as constitutions must be "construed so that no part is rendered surplusage or superfluous." Hannett v. Jones, 1986-NMSC-047, ¶ 13, 104 N.M. 392 (internal citation omitted).

Defendants rely on two cases considering Article II, Section 4 that do not inform this Court's inquiry because neither of the cases confronted the scope of rights protected by that provision. In Blea v. City of Espanola, 1994-NMCA-008, ¶ 20, 117 N.M. 217, the Court specifically stated that the issue was not what the New Mexico Constitution does or does not protect. The issue was whether immunity had been waived under the Tort Claims Act, and the court concluded it had not. Id.

In Lucero v. Salazar, 1994-NMCA-066, ¶ 6, 117 N.M. 803, another Tort Claims Act waiver case, the Court assumed that plaintiff family members of a man shot by police without justification had a cause of action under Article II, Section

4, but the plaintiffs were unforeseeable as injured parties and therefore could not recover. Id., ¶ 8.

Furthermore, similar inherent rights provisions in other state constitutions have been viewed as giving strong support to other liberty and equality provisions. For example, in interpreting the North Dakota inherent rights clause, the North Dakota Supreme Court noted: "[t]he pursuit of happiness...includes 'the right to enjoy the domestic relations and the privileges of the family and the home... without restriction or obstruction ...except...as may be necessary to secure the equal rights of others[.]'" Hoff v. Berg, 595 N.W.2d 285 (N.D. 1999). The Iowa Supreme Court has similarly linked the rights of safety and happiness directly to familial protection: "[w]hat dearer or more unalienable right has a parent than that of acquiring and protecting property for his offspring? What contributes more to his pursuit of happiness?" Stemple v. Herminghouser, 3 Greene 408, 1852 WL 39 (Iowa 1852).

The New Mexico Supreme Court in NARAL, 1999-NMSC-005, ¶ 54, 126. N.M. 788, held that the state's Equal Rights Amendment which, like Article II, Section 4 enjoys no federal analog, protected a woman's right to obtain coverage through Medicaid for a medically necessary abortion. Like Article II, Section 4's inherent rights provision, the scope of the ERA had not been defined before the

court relied on it in NARAL. Still, the court showed willingness to rely on the clause in the appropriate case, and should do the same here.

With recent New Mexico case law serving as impetus and other states serving as example, the trial court was correct in finding that Article II, Section 4 as establishes a fundamental right to choose aid in dying.

C. The State's interest in Section 30-2-4 does not outweigh the right of a terminally ill, competent patient to choose aid in dying under any level of scrutiny.

The trial court found that a terminally ill, competent patient has a fundamental right to choose aid in dying under both Article II, Section 4's inherent rights provision and under Article II, Section 18's substantive due process provision. (RP0232 ¶ 5.) Recognizing that fundamental rights are protected by substantive due process, the trial court went on to weigh the state's interest in prohibiting aid in dying under a due process analysis using strict scrutiny. (Id.) This Court should affirm the trial court's ruling that Defendants failed to prove a compelling interest and, therefore, Section 30-2-4 "violates our State Constitution when applied to aid in dying." (RP0232 ¶¶ LL-MM.)

1. The State cannot show a compelling interest sufficient to survive strict scrutiny.

Because terminally ill competent patients in New Mexico have a fundamental right to die with dignity, prohibiting exercise of that right violates due process. Accordingly, the state must show that the application of Section 30-2-4 to

aid in dying is necessary to achieve a compelling state interest. See ACLU of N.M. v. City of Albuquerque, 2006–NMCA–078, ¶ 19, 139 N.M. 761 (holding that heightened scrutiny applies when a law violates a fundamental right). As the trial court found, "Defendants failed to prove that NMSA 1978, § 30-2-4 furthers a compelling state interest by criminalizing physician aid in dying." (RP0299, ¶ LL.)

Defendants admittedly have an interest in preventing suicide. Aid in dying is not suicide, however. The trial court found that "[m]edical and mental health professionals, including Plaintiffs' experts and Amicus Curiae New Mexico Psychological Association, distinguish aid in dying from suicide." (RP0220, ¶ 14.) The record shows that the person who commits suicide usually has a psychiatric condition, often depression, and acts impulsively. A suicide represents a life cut short, an act of destruction. Whereas aid in dying is a well-considered act intended to preserve one's coherent sense of self. These patients desperately wish that they could live the long life they imagined; but they cannot.

Defendants are also unable to establish any negative consequence to others who do not want the option of aid in dying where it is openly available. After hearing the testimony of physicians where aid in dying is legal, the trial court specifically found "[w]hen aid in dying is an openly available practice, end of life care for all terminally ill patients improves through better pain treatment, earlier and increased referrals to hospice and better dialogues between physicians and

their terminally ill patients about end of life care and wishes." (RP0221, ¶ 24.) Additionally, aid in dying has not negatively impacted vulnerable populations, as discussed previously.

The Defendants general interest in life is also insufficient to overcome the interests of a terminal patient seeking a peaceful death. Prohibiting patients from choosing aid in dying would severely infringe their rights to privacy, autonomy, liberty, and bodily integrity. As the trial court recognized, terminally ill patients "are subjected to invasive medical tests and procedure, loss of autonomy and control, extreme pain and other equally insidious indignities." (RP0218, ¶ 3.) "The activities which give their lives meaning are stripped away, one after the other, as their disease progresses." Id. Moreover, "[s]ome terminally ill patients have pain that cannot be relieved despite the best efforts of the medical profession to do so." Id. at ¶ 7. The reality a competent, terminally ill patient would face if prohibited from choosing aid in dying is a reality no person should be forced to endure because of an asserted general interest in preserving life. This general interest cannot be allowed to outweigh a competent patient's considered and rational choice to seek a more peaceful death. The Court should affirm the trial court's finding that it did not.

Indeed, Defendants cannot point to any valid interest that they have in preventing a terminally ill, competent adult from achieving the death that they want. Defendants nor Section 30-2-4 can prevent the inevitable.

2. Even if aid in dying were not a fundamental right, the state has failed to show Section 30-2-4 is substantially related to an important government interest.

The U.S. Supreme Court has developed, and New Mexico courts have adopted, an intermediate level of scrutiny that lies "between the extremes of rational basis review and strict scrutiny." Clark v. Jeter, 486 U.S. 456, 461 (1988). Intermediate scrutiny has been applied to laws that implicate an important, but not fundamental, right. Id. (citations omitted). If the right to choose aid in dying were not a fundamental right, it is certainly an important right worthy of intermediate scrutiny. "This level of scrutiny is triggered by...legislation that impinges upon an important—rather than fundamental—individual interest." Marrujo v. New Mexico State Highway Transp. Dep't, 1994-NMSC-116, ¶ 11, 118 N.M. 753. Under intermediate scrutiny the government must show that the challenged legislative enactment is substantially related to an important governmental interest. Id.; see also Trujillo v. City of Albuquerque, 1998-NMSC-031, ¶ 15, 125 N.M. 721.

Courts have found a variety of rights to be important, including: the right to move about freely, see Ramos v. Town of Vernon, 353 F.3d 171 (2nd Cir. 2003); the right to vote, see Gomillion v. Lightfoot, 364 U.S. 339, 340 (1960); the right to

equal education, see Griffin v. County Sch. Bd. of Prince Edward County, 377 U.S. 218, 222 (1964); the right to equal protection from statutes relying on sex as a decision making factor, see Craig v. Boren, 429 U.S. 190, 192 (1976); and the right to access partial-birth abortion. See Stenberg v. Carhart, 530 U.S. 914 (2000). The common thread in these decisions is personal choice. This is not to say that the government can never impinge on citizens' ability to make decisions for themselves, but the constitution requires it to avoid prohibiting or unduly burdening important rights, unless the reasons for such restrictions are substantially related to an important government interest.

The manner in which we approach our final moment is deeply personal, informed by a variety of factors. That the right to determine the nature of that moment could be anything less than important is inconceivable. Further, any interest the Defendants' could articulate in regulating aid in dying gives when weighed against the important right of a patient to exercise medical decision making, especially end-of-life decision making. As the record in this case makes clear, the interests that a terminally ill patient has in seeking aid in dying are substantial, whereas the concerns articulated by the states in Glucksberg, and of concern to the Court in 1997, have failed to arise in states that have adopted the practice.

The Defendants also cannot claim that the prohibition on aid in dying is somehow *de minimus*, and therefore substantially related to their purported interests, because of the availability of other end-of-life alternatives. Although it is true that there are other legal, end-of-life options, such as terminal sedation and the removal of life-sustaining devices, the availability of methods that are less favorable to some patients does not mean that those methods are appropriate or desirable in every situation. See Stenberg v. Carhart, 530 U.S. at 937 ("[w]here...medical opinion believes a procedure may bring with it greater safety for some patients..., we cannot say that the presence of a different view proves the contrary"); Prot. & Advocacy Sys., 1999-NMCA-122, ¶ 16 ("Even if the medical facts are clear, different patients can make markedly different, but still reasonable, choices, depending on their religious beliefs, their assessments of the joys of life, their tolerance for pain, their regard for others, and a multitude of other factors.").

Therefore, because access to aid in dying is an important right that affects the well-being of the patient, it may not be prohibited simply because alternative options exist. Thus, Section 30-2-4 unduly burdens terminally ill but competent patients' right to access aid in dying through entirely disallowing the practice and must be stricken as applied to Plaintiffs on that ground.

3. The state has also failed to show any rational basis to prevent the practice of aid in dying.

As applied to aid in dying, Section 30-2-4 cannot survive even rational basis scrutiny. Defendants argue that the Glucksberg rationale applies in this case and that the state's interests in preventing suicide are sufficient to bar aid in dying under rational basis review. In applying rational basis, the court determines whether the law is rationally related to a legitimate government interest. See Trujillo, 1998-NMSC-031, ¶ 14 125 N.M. 721. "This level of scrutiny applies in economic and social legislation, classifications based on property use, and business and personal activities that do not involve fundamental rights." Marrujo, 1994-NMSC-116, ¶ 12, 118 N.M. 753.

A law will typically survive this level of scrutiny unless the plaintiff overcomes the overwhelming burden of proving that the law is wholly irrational. Glucksberg, 521 U.S. at 722. "It is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other." Casey, 505 U.S. 833, 851. "That theorem, however, assumes a state of affairs in which the choice does not intrude upon a protected liberty." Id. (internal citations omitted). Thus, if prohibiting aid in dying abridges constitutional guarantees without a rational basis it must be abandoned.

Since Glucksberg was decided, two more states have expressly legislated the practice of aid in dying, Washington and Vermont.[6] Montana has recognized the right of its citizens to choose aid in dying through a decision by its supreme court. Baxter v. State, 2009 MT 449, 354 Mont. 234, 224 P.3d 1211. In Hawaii, the practice is emerging subject to professional practice standards absent a statute or court decision.[7] What is starkly different for a court considering a constitutional claim to a protected right to choose aid in dying today from when the United States Supreme Court considered the issue in 1997 is that today a court stands in a landscape rich with data about how an open practice of aid in dying impacts patients and physicians. This concern about lack of evidence was controlling for some of the Justices in Glucksberg, especially Justice Souter who indicated the factual dispute was determinative. See Glucksberg, 521 U.S. at 786 (Souter, J., concurring).

The evidence produced at trial in this case shows that aid in dying does not harm any state interests when it is open and legal. To the contrary, the practice actually improves end-of-life care overall; the practice has not negatively impacted vulnerable populations, indeed it is largely utilized by highly educated persons

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[6] See, infra, notes 8, 9.

[7] See Kathryn L. Tucker, "Aid in Dying: an End-of-Life Option Governed by Best Practices," *Journal of Health & Biomedical Law*, vol. 8, pp 9-26 (2012).

who have exercised a good deal of autonomy through their lives and seek to continue to do so at the very end, who are not in need of protection from their own informed decision about how they will cross the threshold to death.

Also reflected by the record in this case (a record unavailable to the Glucksberg court), there is in fact little distinction between the act of a physician administering medication to terminally sedate a patient, aiding a patient in removal of life-support, and prescribing medication for the purpose of aid in dying. The trial court recognized that both patients who elect to withdraw of life sustaining intervention or terminal sedation receive medical assistance to "hasten the inevitable death of the terminally ill patient[,]" but neither of these medical practices is considered suicide under Section 30-2-4. (RP0218-0219, ¶¶ 6-8.) Yet in all instances—withdrawal of life-sustaining intervention, palliative sedation, and aid in dying—the physician primarily acts to alleviate suffering, and in all instances, the underlying disease is the cause of death. There is, therefore, not rational basis for treating these end-of-life options differently, especially where such a prohibition interferes with a protected liberty interest in the right to one's bodily integrity.[8]

[8] For this same reason, the Court could also find that if Section 30-2-4 prohibits aid in dying, it also violates the equal protection clause of Article II, Section 18 of the New Mexico Constitution. There is no justification to criminalize physicians who provide aid in dying differently from those who withdraw life-sustaining interventions or who provide terminal sedation.

II. Aid in dying is not prohibited by Section 30-2-4.

While the trial court found that terminally ill, competent patients have a constitutional right to aid in dying, this Court may opt not to reach the constitutional issues, finding that Section 30-2-4 does not prohibit the practice.[9] "[The] ultimate goal in statutory construction is to ascertain and give effect to the intent of the Legislature." State v. Smith, 2004-NMSC-032, ¶ 8, 136 N.M. 372 (internal citations and quotations omitted). To determine legislative intent, the court first looks at the language used and the plain meaning of that language. See State v. Moya, 2007-NMSC-027, ¶ 6, 141 N.M. 817. As the trial court recognized, courts should

> exercise caution in applying the plain meaning rule. Its beguiling simplicity may mask a host of reasons why a statute, apparently clear and unambiguous on its face, may for one reason or another give rise to legitimate (i.e., nonfrivolous) differences of opinion concerning the statute's meaning. The plain meaning rule must yield on occasion to an intention otherwise discerned in terms of equity, legislative history, or other sources.

(RP0223, ¶ G, internal citations and quotations omitted.)

[9] In a similar case in Montana, Baxter v. State, 2009-MT-449, 354 Mont. 234, 224 P.3d 1211, the trial court held for plaintiffs on constitutional grounds. The Montana Supreme Court declined to reach constitutional issues, ruling for plaintiffs/appellees on statutory grounds.

The Legislature's use of the term "suicide" in the title of Section 30-2-4 clearly contemplates individuals who are not already dying, and nothing suggests it reaches a competent, dying patient's decision to achieve a peaceful death. Consideration of the act of suicide in contrast to the choice of a competent dying patient to elect a peaceful death reveals that these acts are fundamentally different. Unlike an individual whose life is cut short through an irrational, suicidal act, the lives of patients who seek aid in dying are being taken by the inexorable progression of their terminal diseases.

Dr. Pollack's testimony demonstrated that "suicide is a distinctly different act than requesting aid in dying." This distinction was also explained in a well-reasoned amicus brief submitted to the trial court by the New Mexico Psychological Association. (RP0159-0173.) As Justice Stevens explained in his concurrence in Glucksberg:

> I agree that the State has a compelling interest in preventing persons from committing suicide because of depression, or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying.

Glucksburg, 521 U.S. at 747. The plain language of Section 20-2-4 does not, therefore, prohibit aid in dying.

Section 30-2-4's history and background also inform the intended scope of the statute. See State v. Smith, 2004-NMSC-032, ¶ 10, 136 N.M. 372 ("In addition

to...the statutory language, we also consider the history and background of the statute."). New Mexico's assisted suicide statute was passed in 1963, long before modern medicine resulted in the prolonged dying that has become the norm today. As articulated by a leading medical commentator: "For all but our most recent history, dying was typically a brief process... These days, swift catastrophic illness is the exception; for most people, death comes only after long medical struggle with an incurable condition..."[10] Sometimes the struggle is unbearable. The option of aid in dying empowers terminally ill patients who find themselves trapped in an unbearable dying process with the option of a more peaceful death. This option was not considered by legislators in 1963. The first published discussion of a case involving aid in dying appeared in the New England Journal of Medicine, in 1991, by Dr. Timothy Quill.[11] As a result, New Mexico legislators would not have known about the practice in 1963 and could not have intend to include aid in dying.

Furthermore, including physician aid in dying within the ambit of Section 30-2-4 would contradict New Mexico's long, proud tradition of public policy promoting autonomy in end-of-life decision making as discussed previously. See,

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[10] Atul Gawande, *Letting Go: What Should Medicine Do When It Can't Save Your Life?*, NEW YORKER, August 2, 2010, available at http://www.newyorker.com/reporting/2010/08/02/100802fa_ fact_gawande.

[11] Timothy E. Quill, M.D., *Death and Dignity – A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691 (1991).

e.g., Uniform Health Care Decisions Act, NMSA 1978, § 24-2D-1 to 6 (2012). If a statute is ambiguous, the Court may consider the clear policy implications of various constructions. See Smith, 2004-NMSC-032, ¶ 10.

Like New Mexico, Montana also has a public policy that values medical autonomy in medical decision-making. The Montana Supreme Court relied on this public policy to hold that its statutory prohibition against assisted suicide did not include the conduct of a physician providing aid in dying. See Baxter, 2009 MT 449. That court, looking at the Montana statute, which empowers individuals to execute advance directives, Mont. Code Ann. § 50-9-103, like New Mexico's Uniform Health Care Decisions Act, found the statute reflected policy vesting citizens with broad autonomy over medical decision-making and that the choice for aid in dying was the sort of decision citizens are empowered to make.

> There is thus no indication in the homicide statutes that physician aid in dying...is against public policy...Rights of the Terminally Ill Act very clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions, even if enforcement of those decisions involves direct acts by a physician. Furthermore, there is no indication in the...Act that an additional means of giving effect to a patient's decision— in which the patient, without any direct assistance, chooses the time of his own death—is against public policy.

Baxter, 2009 MT 449, ¶ ¶ 26-28.

New Mexico's esteemed public policy of honoring an individual's medical autonomy could guide this Court, as it guided the Montana court, to determine that the assisted suicide statute does not include aid in dying. [12]

III. The trial court's declaration that 30-2-4 unconstitutional does no violence to the separation of powers.

Finally, Defendants claim that our Courts' recognition of aid in dying violates separation of powers. This argument fails. "The separation of powers doctrine precludes the Legislature from stepping into the judiciary's exclusive domain of prescribing the rules of judicial practice and procedure and similarly precludes the judiciary from overturning or contradicting a constitutional legislative declaration of substantive law." Salopek v. Friedman, 2013-NMCA-087, ¶ 59 (citation and internal alterations omitted). Indeed,

> It is emphatically the province and duty of the judicial department to say what the law is. Those who apply the rule to particular cases, must of necessity expound and interpret that rule. If two laws conflict with each other, the courts must decide on the operation of each.

Marbury v. Madison, 5 U.S. 137, 177-78 (1803); Sw. Cmty. Health Services v. Smith, 1988-NMSC-035, ¶ 16, 107 N.M. 196 (citing Marbury). It is emphatically the province and duty of the Courts of New Mexico to either hold that Section 30-

[12] In the wake of the Montana Supreme Court ruling, the Montana legislature considered whether to enact a statute prohibiting aid in dying. It declined to do so. See Span, Paula, *In Montana, New Controversy over Physician-Assisted Suicide*, The New York Times, April 15, 2014, available at http://newoldage.blogs.nytimes .com/ 2013/04/15/a-montana- doctor-defends-physician-assisted-suicide/.

2-4 violates the rights of its citizens, or that it does not. See, e.g., Salopek v. Friedman, 2013-NMCA-087, ¶ 61 (affirming Wachocki v. Bernalillo County Sheriff's Dept., 2010-NMCA-021, 147 N.M. 720 (filed 2009) aff'd, 2011-NMSC-039, 150 N.M. 650, in which the Court of Appeals held that the New Mexico Tort Claims Act's cap on damages did not violate separation of powers.).

CONCLUSION

For the forgoing reasons, this Court should affirm the trial court's Judgment on this issue of first impression and great public importance.

STATEMENT AS TO ORAL ARGUMENT

Because of the importance of the constitutional issues at stake and because Plaintiffs believe oral argument will aid the Court, Plaintiffs request oral argument.

STATEMENT OF COMPLIANCE RULE 12-213 NMRA

As required by Rule 12-213(G) NMRA Appellees hereby certify that the body of this brief complies with Rule 12-213(F)(3) NMRA because:

1. The body of this brief the contains a total of 10,992 words excluding the parts of the brief exempted by Rule 12-213(F)(1) NMRA.
2. This brief has been prepared in a proportionally spaced typeface using Microsoft Word 2013 in 14 point Times New Roman.

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CERTIFICATE OF SERVICE

I hereby certify that on August 29, 2014, a copy of the Plaintiffs/Appellees' Response Brief was served upon to the Attorneys for Defendants/Appellants in conformance with Rules 12-307; 12-307.1 and 12-307.2 NMRA.

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