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ALBUQUERQUE  
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Wendy F Jones

IN THE COURT OF APPEALS OF THE STATE OF NEW MEXICO

NO. 33,630

COURT OF APPEALS OF NEW MEXICO  
ALBUQUERQUE

~~FILED~~  
~~SEP 09 2014~~  
~~Wendy F Jones~~

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

**Plaintiffs-Appellees,**

v.

**GARY K. KING, Attorney General of the State of New Mexico,**

**Defendant-Appellant.**

*On Appeal from the 2nd Judicial District, Bernalillo County, New Mexico,  
District Court Judge Nan G. Nash*

**AMICUS CURIAE BRIEF OF AMERICAN MEDICAL WOMEN'S  
ASSOCIATION, AMERICAN MEDICAL STUDENT ASSOCIATION AND  
NEW MEXICO PUBLIC HEALTH ASSOCIATION**

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## **SUMMARY OF PROCEEDINGS**

The American Medical Women's Association ("AMWA"), the American Medical Student Association ("AMSA"), and the New Mexico Public Health Association ("NMPHA") (collectively, "*amici curiae*") adopt the Summary of Proceedings in Plaintiffs-Appellees Answer Brief. All parties received timely notice of *amici curiae*'s intent to file this brief.

### **STATEMENT OF INTEREST OF *AMICI CURIAE***

*Amici curiae* are membership associations comprised of medical professionals, medical students, and public health professionals and advocates dedicated to improving medical care and promoting public health. AMWA is a national organization focused on the advancement of women within the medical profession and the improvement of women's health. Its membership is comprised of physicians, medical students and other health care professionals across all specialties. AMSA is a national organization representing the concerns of physicians-in-training, dedicated to improving both medical training and medical care to the entire American population. NMPHA, the state affiliate of the American Public Health Association ("APHA"), aims to promote public health practice, policies, and systems that support health equity in the state of New Mexico. NMPHA's membership consists of physicians and academics, government and private employees, community-based and non-

profit organizations, and a wide range of public health professionals and other health care workers.

As national organizations of medical professionals and public health professionals and advocates, *amici curiae* will assist the Court in understanding the current evidence supporting the availability of aid in dying and the evolution in physician understanding of aid in dying. *Amici curiae* believe that their perspective and arguments will not be adequately presented by the parties or other *amici curiae*.

As part of their missions to improve medical care and the public health, *amici curiae* support end-of-life care policies that improve patient quality of life, preserve patient autonomy, and protect the integrity of the practice of medicine. Under this framework and after a careful review of the evidence, *amici curiae* support the availability of aid in dying—the practice of a physician prescribing medication to a mentally competent, terminally ill patient that the patient may self-administer to bring about a peaceful death—under the current standard of care.

## ARGUMENT

The question before the Court is whether a mentally competent, terminally ill patient should have the right, in his or her dying days, to make his or her own end-of-life treatment choices including the choice to end the patient's intractable suffering or protracted dying process through a peaceful, dignified death on the

patient's terms via aid in dying. *Amici curiae* believe that imposing criminal liability on physicians who provide aid in dying to mentally competent, terminally ill patients is inconsistent with the State's public health interests.

Evolving modern medical science has made great strides in curing illness and extending life but, in doing so, can extend the dying process so long that a terminally ill patient may feel trapped in a torturous, inexorable, lingering decline. And although palliative care has made great strides in reducing terminal suffering, it may not always provide relief of distressing symptoms or intractable pain. Increasingly, patients dying from terminal illnesses want control over the timing and manner of their deaths. And a fraction of terminally ill patients confront a dying process so prolonged and marked by such extreme suffering and deterioration that they decide that a swifter, gentler, more dignified end through aid in dying is preferable to the alternatives.

The data from sixteen years of clinical experience with aid in dying in Oregon, Washington, Vermont, Montana, and Hawaii demonstrate that aid in dying improves patients' experiences in their dying days and end-of-life care overall, does not have a disproportionate effect on vulnerable populations, and is appropriately used as a last resort in a very small subset of eligible patients. The current standard of care for aid in dying includes important safeguards to prevent abuse and to ensure that patients do not use aid in dying because end-of-life care is

inadequate, because of coercion or treatable mental health conditions, or because the patient desires not to burden others. Properly reflecting the empirical evidence here and the right of competent New Mexico patients who are in the terminal stages of dying to have control over their deaths, the District Court rightfully found that these patients have a right to aid in dying under the New Mexico Constitution and that the State's asserted interests are not a basis for criminalizing the exercise of this right. *Amici curiae* respectfully request that this Court affirm the District Court's ruling and prohibit the state from criminalizing aid in dying.

**I. The District Court's Decision Reflects the Empirical Evidence and the Medical Community's Policies Supporting Aid in Dying as Part of Evolving End-of-Life Care.**

Sixteen years of clinical experience with aid in dying, practiced openly now in five states, has alleviated the concerns initially raised about aid in dying. The availability of aid in dying has been shown to have a positive effect on patients, their families and the medical profession, and concerns about a disproportionate impact on vulnerable populations have not been realized. As a result, a growing trend of medical professional and public health organizations, clinicians, and the public support aid in dying.

**A. Clinical Experience Demonstrates the Availability of Aid in Dying is Consistent with the State's Public Health Goals.**

Three states, Oregon, Washington and Vermont, have statutes affirmatively making aid in dying available. Oregon's Death with Dignity Act ("ODWDA")

was passed in 1994 and fully implemented in 1998. OR. REV. STAT. §§ 127.800–127.897 (1994). Washington passed its Death With Dignity Act (“WDWDA”) in 2008, WASH. REV. CODE § 70.245 (2008), and in 2013, the Vermont legislature passed the Patient Choice at the End of Life Act (“PCEOL”), legalizing aid in dying. VT. STAT. ANN. tit. 18, §§ 5281-5292 (2013).

Aid in dying is also practiced in Montana and Hawaii without death with dignity statutes. In December 2009, the Montana Supreme Court held that the state’s homicide statute did not encompass the provision of aid in dying, thereby legalizing aid in dying in the state. *Baxter v. Montana*, 224 P.3d 1211, 1215–16 (2009). The court stated: “We find no indication in Montana law that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy.” *Id.* at 1215. In 2011, physicians in Hawaii began an open practice of aid in dying based on an understanding that it was not prohibited by the state’s laws. *See generally* Kathryn L. Tucker, *Aid in Dying: An End of Life Option Governed by Best Practices*, 8 J. HEALTH & BIOMED. L. 9, 11–12 (2012).

The ODWDA and WDWDA both require physician reporting to the state, OR. REV. STAT. § 127.865 (1994), WASH. REV. CODE § 70.245.150 (2008), so experiences with aid in dying in Oregon and Washington have been extensively documented and studied. The resulting body of evidence shows that the availability of aid in dying (1) is positive for patients and their families;

(2) improves end-of-life medical care overall; (3) does not have a negative impact on vulnerable populations; and (4) is used to achieve a dignified, peaceful death in only a very small set of patients.

**1. The Availability of Aid in Dying is Positive for Patients and Their Families.**

The availability of aid in dying has psychological benefits, even for the many terminally ill patients who do not ultimately ingest the medication they obtain through aid in dying. Consistently, the three most frequently cited concerns motivating aid in dying requests are loss of autonomy, decreasing ability to participate in activities making life enjoyable, and loss of dignity. *See, e.g.* Oregon Dep't. of Health, *Death With Dignity Ann. Rep. (2013)*, available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx> [hereinafter “2013 Oregon Death With Dignity Annual Report”]; Washington State Department of Health, *2013 Death with Dignity Act Report*, available at <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf> [hereinafter “2013 Washington Death with Dignity Act Report”]; Barbara Coombs Lee, *Oregon’s Experience with Aid in Dying: Findings From the Death with Dignity Laboratory*, ANNALS. N.Y. ACAD. SCI.

(2014) [epub ahead of print]<sup>1</sup>. Simply providing the option to consider aid in dying bolsters the terminally ill's sense of autonomy, control, and choice.

A study in which a 33-item Quality of Death and Dying Questionnaire was administered to patients who had received aid in dying prescriptions, patients who had requested but not received prescriptions, and patients who had not pursued aid in dying found that those patients receiving aid in dying prescriptions had higher quality ratings on items measuring symptom control and on items related to preparedness for death than those who did not pursue aid in dying or those who began the process but did not complete a request. Kathryn A. Smith et al., *Quality of Death and Dying in Patients who Request Physician-Assisted Death*, 14 J. PALLIATIVE MED. 445 (2011). The authors concluded that aid in dying may meet

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<sup>1</sup> See also Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 ARCH. INTERNAL MED. 489, 490 (2009) (finding that the chief reasons for pursuing aid in dying were loss of independence, wanting to control the time and manner of death and die at home, and the prospect of worsening pain or quality of life and the inability to care for themselves); Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALLIATIVE MED. 381 (2003) (finding physicians receiving requests for aid in dying perceive patients as wanting to control their deaths); Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 NEW ENG. J. MED. 582, 584 (2002); Amy D. Sullivan et al., *Legalized Physician-Assisted Suicide in Oregon-The Second Year*, 342 NEW ENG. J. MED. 598, 601 (2000).



the goal of relieving worries about future discomfort, pain, and loss of control, and a request was not a reflection of poor care.<sup>2</sup> *Id.*

In addition, the data show that the availability of aid in dying is positive for patients' families. A study comparing family members of patients who requested aid in dying with family members of decedents who did not found "little impact on mental health outcomes." Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who request Physician Aid in Dying*, 38 J. PAIN AND SYMPTOM MGMT. 807, 813 (2009). But families of patients who requested aid in dying felt more prepared for the death, felt more accepting of their loved one's death, and were less likely to agree that they wanted more opportunities to care for the loved one. *Id.*<sup>3</sup>

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<sup>2</sup> Compare Susan W. Tolle et al., *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, 15 J. CLINICAL ETHICS 111, 118 (2004) (finding that overall symptom distress predicted whether a patient initially considered the option of aid in dying), with Ganzini, *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, *supra* at 584 (finding that the most important reasons for receiving an aid-in-dying prescription were "desire to control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless, and being ready to die" rather than symptom distress).

<sup>3</sup> See also Smith, *supra*; Ganzini, *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, *supra* at 586 (surveying hospice workers and reporting that family caregivers of aid-in-dying patients were more likely to feel positive meaning in caring for the patient and were more prepared for and accepting of the death than family caregivers of patients who had not requested aid in dying); Elizabeth Trice Loggers et al., *Implementing a Death With Dignity Program at a Comprehensive Cancer Center*, (continued...)

## 2. The Availability of Aid in Dying Improves End-of-Life Care.

The data show that the availability of aid in dying improves end-of-life medical care overall by improving physician self-education and awareness of palliative care options, increasing referrals to hospice care and improving pain management, and improving communications about end-of-life care between physicians and patients.

The availability of aid in dying increases physician knowledge of, and comfort with, end-of-life treatment options. A study of 2,641 physicians eligible to prescribe aid in dying in Oregon found that 76% of physicians reported efforts to improve their knowledge of the use of pain medication in the terminally ill and 79% of physicians reported that their confidence in prescribing of pain medications had improved. Linda Ganzini, et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 J. AM. MED. ASS'N 2363, 2366 (2001). The study also found that 69% of physicians reported efforts to improve their recognition of psychiatric disorders, such as depression. *Id.* at 2365; *see also* Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted*

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368 NEW ENG. J. MED. 1417, 1420 (2013) (finding that patients, caregivers and family members “frequently express gratitude after the patient receives the prescription, regardless of whether it was ever filled or ingested, typically referencing an important sense of control in an uncertain situation”).

*Suicide: A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208 (2003); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267 (1996).

In another study, hospice nurses and social workers in Oregon reported observing an increase in physicians' knowledge of palliative care and an increase in physician's willingness to refer patients to hospice and to care for hospice patients between 1998 and 2003. Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past 5 Years*, 1 PALLIATIVE & SUPPORTIVE CARE 215 (2004). Ganzini et al. found that a third of physicians increased referrals to hospice following the availability of aid in dying and perceived that the availability of hospice for their patients had increased since the passage of the ODWDA. Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *supra*.

Since the availability of aid in dying in Oregon, that state's pain management practices have improved. The annual Progress Report Card on state pain policies published by the University of Wisconsin School of Medicine and Public Health's Pain & Policy Studies Group<sup>4</sup> rated Oregon's pain policy as a C+

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<sup>4</sup> The report is supported by the American Cancer Society, The American Cancer Society Cancer Action Network, Inc., and the LIVESTRONG Foundation.

2000 and 2003, improving to a B+ in 2006-2007, and then to an A since 2008.

University of Wisconsin School of Medicine and Public Health, *Achieving Balance in State Pain Policy: A Progress Report Card (Second Edition)* (2006), available at [http://www.ucan.cc/Utah%20Pain%20Initiative/PRC\\_final.pdf](http://www.ucan.cc/Utah%20Pain%20Initiative/PRC_final.pdf); University of Wisconsin School of Medicine and Public Health, *Achieving Balance in State Pain Policy: A Progress Report Card (CY 2013)* (2013), available at <http://www.acscan.org/content/wp-content/uploads/2014/07/PRC-2013.pdf>.

The availability of aid in dying also improves communication between physicians and patients regarding end-of-life care options. The United States Government Accountability Office examined the key components of end-of-life care programs in Arizona, Florida, Oregon, and Wisconsin and reported that physicians working with hospice-based palliative care providers in Oregon “are more comfortable discussing end-of-life issues with their patients since the 1997 enactment in Oregon of the Death with Dignity Act, which focused attention in the state on end-of-life care and the options available to individuals.” U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-08-66, END-OF-LIFE CARE: KEY COMPONENTS PROVIDED BY PROGRAMS IN FOUR STATES(2007) at 14. The report also states that the passage of the ODWDA “helped create an environment in Oregon where end-of-life issues are discussed more openly.” *Id.* Similarly, Ganzini et al. found that physicians perceived that more patients found conversations regarding the

ODWDA to be helpful than upsetting, regardless of whether the physician supported or opposed aid in dying. Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care since Passage of the Oregon Death with Dignity Act*, *supra*, at 2368.

### **3. Vulnerable Populations are Not Negatively Impacted By the Availability of Aid in Dying.**

There is no evidence of coercion or disproportionate impact on vulnerable populations. Far from demonstrating any disproportionate effect on the vulnerable, the data demonstrate that those who received aid in dying are equally divided between genders and mostly white, well-educated, insured, receiving hospice services, and dying of cancer or ALS. *See, e.g.*, 2013 Oregon Death With Dignity Annual Report, *supra*; 2013 Washington Death with Dignity Act Report, *supra*; Coombs Lee, *supra*.

Based on data from Oregon and the Netherlands (where aid in dying has been practiced since the 1980's), researchers found "no evidence of a heightened risk" to the elderly, minors, women, uninsured patients, poor patients, racial and ethnic minorities, patients with non-terminal physical disabilities or chronic non-terminal illnesses, or patients with psychiatric illness (including depression and Alzheimer disease). Margaret Battin, et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591, 591 (2007). They also found that

“no one received physician-assistance in dying who was not determined by two physicians to be terminally ill – that is, no one received such assistance for disability alone.” *Id.* at 594. The researchers concluded: “We found no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.” *Id.* at 597.

Likewise, the executive director of the disability advocacy group Disability Rights Oregon testified before the American Public Health Association in 2007 that he had no knowledge of any cases in Oregon to contradict the findings of that report and that his organization had never received a complaint that a person with disabilities was coerced to make use of aid in dying. Coombs Lee, *supra* (citing Declaration of Robert Joondeph, Executive Director Oregon Advocacy Center. Submitted to APHA Nov. 2007).

In addition, an analysis of the cost of care at the end of life and potential savings attributable to aid in dying indicates that aid in dying is not likely to save material amounts of money in absolute or relative terms, either for particular institutes or for the nation as a whole. Ezekiel J. Emanuel & Margaret P. Battin, *What are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?*, 339 NEW ENG. J. MED. 167, 171 (1998). This finding indicates that institutional self-interest is unlikely to encourage premature deaths if aid in dying is available.

Indeed, the data demonstrate that aid in dying is being used only in those circumstances where an informed, eligible patient and his or her physician deem it appropriate over all other available medical options. For instance, a survey of 1,902 physicians across the United States practicing in specialties most likely to receive aid in dying requests found that patients receiving aid in dying are making specific requests, have a substantial burden of physical pain and distress, and are expected to die of their illness within a month. Diane E. Meier, *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 ARCH. INTERNAL MED. 1537, 1537 (2003).

**4. Aid in Dying is Used to Achieve a Dignified, Peaceful Death in a Very Small Subset of Eligible Patients.**

In tandem with the improvement in overall end-of-life care, aid in dying is implemented infrequently and only a small fraction of patients who consider it go on to ingest the medication.

In Oregon, deaths resulting from aid in dying represent only 0.2% of deaths in the state each year. Coombs Lee, *supra*, at 2.

Moreover, one study found that terminally ill patients were about nine times more likely to consider aid in dying than to make a formal request and start the process, and nearly 200 times more likely to consider aid in dying than to follow through with obtaining a prescription. Susan W. Tolle et al., *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted*

*Suicide*, 15 J. CLINICAL ETHICS 111, 115 (2004). And a 2000 survey of Oregon physicians found that they granted one of every six requests for aid in dying, and that only one in ten requests resulted in a patient ingesting the medication. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 NEW ENG. J. MED. 557, 557 (2000). Roughly half of the prescriptions written for aid in dying result in the patient ingesting the medication. 2013 Oregon Death With Dignity Annual Report, *supra*.

The small rate of follow-through on aid in dying considerations likely reflects finding alternatives to aid in dying during the process. Physicians reported that a third of the patients who requested aid in dying changed their minds following a substantive intervention by a physician, such as symptom management, treatment of depression or referral to hospice. Ganzini, *Physicians' Experiences with the Oregon Death with Dignity Act*, *supra*, at 557. Qualitative interviews with physicians support that referral to hospice is especially successful among patients who are transitioning from curative to comfort treatments, who do not fully understand their options, or who have not yet experienced the benefits of hospice. See Linda Ganzini & Steven K. Dobscha, *Clarifying Distinctions between Contemplating and Completing Physician-Assisted Suicide*, 15 J. CLIN. ETHICS 119, 120 (2004) (citing Steven K. Dobscha et al., *Oregon Physicians' Responses to*



*Requests for Assisted Suicide: A Qualitative Study*, 7 J. PALLIATIVE MED. 450 (2004)).

For the small group of patients who ingest the prescribed medication, aid in dying permits a peaceful death on the patient's own terms. Nearly all patients who use aid in dying pass away at home. 2013 Oregon Death With Dignity Annual Report, *supra*; 2013 Washington Death with Dignity Act Report, *supra*. Patients are unconscious after a few minutes and succumb in under a half hour. 2013 Oregon Death With Dignity Annual Report, *supra*; 2013 Washington Death with Dignity Act Report, *supra*. Complications are rare, occurring in less than 3% of aid-in-dying deaths. 2013 Oregon Death With Dignity Annual Report, *supra*; 2013 Washington Death with Dignity Act Report, *supra*.

**B. Views of the Medical and Public Health Community have Evolved with the Accumulation of Clinical Experience and Empirical Evidence.**

Mounting empirical evidence and growing clinical experience have led to affirmative support for aid in dying from many medical associations, including *amici curiae* AMSA and AMWA, as well as support from a majority of physicians.

In 2007, AMWA adopted a policy position supporting the availability of aid in dying alongside the provision of palliative care, the withdrawal or withholding of life-sustaining measures, and providing only supportive care to patients who voluntarily stop eating or drinking. American Medical Women's Association

Position Paper on Aid in Dying (Sept. 2007), *available at* [http://www.amwa-doc.org/wp-content/uploads/2013/12/Aid\\_in\\_Dying1.pdf](http://www.amwa-doc.org/wp-content/uploads/2013/12/Aid_in_Dying1.pdf). In October 2013, AMWA endorsed clinical practice guidelines intended to assist physicians who practice in states which have the opportunity to aid patients in dying. American Medical Women's Association, *Advocacy History & Timeline*, <https://www.amwa-doc.org/our-work/advocacy/timeline/>; Kathryn L. Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 *Chest* 218 (2012).

AMSA's Principles include a "Principle Regarding Physician Aid in Dying" supporting the availability of aid in dying. The Principle states that AMSA supports "the passage of aid in dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death." American Medical Student Association, 2014 AMSA Preamble, Purposes and Principles at 76, *available at* [http://www.amsa.org/AMSA/Libraries/Misc\\_Docs/2014PPP.sflb.ashx](http://www.amsa.org/AMSA/Libraries/Misc_Docs/2014PPP.sflb.ashx).

APHA, NMPHA's national affiliate, adopted a policy statement in 2008 that the association supports allowing aid in dying where safeguards equivalent to those in the ODWDA are in place. American Public Health Association, *Patients' Rights to Self-Determination at the End of Life*, Policy No. 20086 (Oct. 2008), *available at* <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372>.

In addition to *amici curiae*, the American Academy of Hospice and Palliative Medicine (AAHPM) adopted a statement in 2007 that aid in dying should be available, following efforts to provide a patient the best possible palliative care to address the patient's sources of fear and suffering leading to the request. American Academy of Hospice and Palliative Medicine, Statement on Physician-Assisted Death (Feb. 14, 2007), *available at* <http://aahpm.org/positions/pad>.

The American College of Legal Medicine also adopted a policy recognizing “patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death” provided that it is done in accordance with a law regulating such a right. American College of Legal Medicine, ACLM Policy on Aid in Dying (2008), *available at*: [http://c.ymcdn.com/sites/www.aclm.org/resource/collection/11da4cff-c8bc-4334-90b0-2abbe5748d08/Policy\\_On\\_Aid\\_In\\_Dying.pdf?hhSearchTerms=%22aid+and+dying%22](http://c.ymcdn.com/sites/www.aclm.org/resource/collection/11da4cff-c8bc-4334-90b0-2abbe5748d08/Policy_On_Aid_In_Dying.pdf?hhSearchTerms=%22aid+and+dying%22).

Moreover, after a careful review of the data on the availability of aid in dying, outside observers have concluded that a law permitting aid in dying poses no risk to patients. For example, a report prepared for the Vermont legislature concluded that “it is quiet [sic] apparent from credible sources in and out of Oregon that the Death with Dignity Act has not had an adverse impact on end-of-

life care and in all probability has enhanced the other options.” Vt. Legislative Council, Oregon’s Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes § 3E (2004), *available at* [http://www.leg.state.vt.us/reports/05Death/Death\\_With\\_Dignity\\_Report.htm](http://www.leg.state.vt.us/reports/05Death/Death_With_Dignity_Report.htm). Leading scholars that originally opposed aid in dying have reversed their standpoint based on the growing clinical evidence. Arthur Caplan, Director of the Center for Bioethics and the University of Pennsylvania School of Medicine has stated: “I worried about people being pressured to do this . . . . But this data confirms . . . that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy.” William McCall, *Assisted-Suicide Cases Down in ‘04*, *Columbian* (Vancouver, Wash.), Mar. 11, 2005, at C2.

Support for aid in dying has also grown among physicians. A national survey conducted in February 2005 found that 57% of the 1,088 physicians polled believed it is ethical for a physician to assist a competent, dying patient to hasten death. Jewish Theological Seminary, *Physician-Assisted Suicide Survey*, <http://www.jtsa.edu/x5533.xml> (last visited Jan. 19, 2008). Similarly, an October 2005 national survey of 677 physicians and 1,057 members of the public revealed that a majority of both groups believe that physicians should be permitted to practice aid in dying. *News and Innovations*, 20 *J. PAIN AND PALLIATIVE CARE PHARMACOTHERAPY* 83, 92 (2006). A 2001 survey found that 51% of responding

physicians in Oregon supported the ODWDA and legalization of physician-assisted dying. Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *supra*, at 2366.

Along with growing physician support, the public increasingly favors the availability of aid in dying. A 2014 poll of Connecticut voters conducted by Quinnipiac University showed that voters supported aid in dying by a margin of almost two to one. Press Release, Quinnipiac University Poll, Connecticut Voters Back Suicide Bill Almost 2-1, Quinnipiac University Poll Finds (Mar. 6, 2014). Likewise, a May 2013 Gallup Poll found that 70% of Americans agree that when a person has a disease that cannot be cured, “doctors should be allowed by law to end the patient's life by some painless means.”<sup>5</sup> Lydia Saad, *U.S. Support for Euthanasia Hinges on How It's Described* (May 29, 2013), available at <http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx>. Similarly, a poll released by the Pew Research Center in January 2006 found that 60% of Americans believe a person has a moral right to end their own life if they are faced with great pain and no hope of improvement (an increase of nearly

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<sup>5</sup> In addition, people's views are strongly affected by language. A smaller majority (51%) agreed that, when a person has a disease that cannot be cured and is living in severe pain, doctors should be allowed by law “to assist the patient commit suicide if the patient requests it.” *Id.*

twenty percentage points since 1975) and 53% believe a person has a moral right to end their life if suffering from an incurable disease. News Release, The Pew Research Center, More Americans Discussing – and Planning – End-of-Life Treatment; Strong Public Support for Right to Die at 2, 8, 12 (Jan 5, 2006). According to the same study, by more than eight to one (84% to 10%), the public approves of laws that let terminally ill patients make decisions about whether to be kept alive through medical treatment. *Id* at 4.

**II. To the Extent New Mexico’s Criminal Prohibition on Assisted Suicide Prohibits Aid in Dying, it Violates the New Mexico Constitution.**

The District Court properly found that mentally competent, terminally ill patients in New Mexico have a fundamental right to choose aid in dying as part of their right to dictate their own medical treatment and make their own end-of-life care decisions. (RP0229.) Aid in dying allows patients to maintain their autonomy and control over their medical treatment and to make the incredibly personal and difficult decision as to whether the dying process has become unbearable and should no longer be extended. As discussed above, the empirical evidence from sixteen years of clinical experience with aid in dying demonstrates that providing such a medical option benefits patients, families and the medical profession, and has an appropriate place in the continuum of end-of-life care practices. As such, no State interest, including the interests in preserving life and maintaining the integrity of the practice of medicine, is an appropriate basis on which to

criminalize aid in dying. Thus, to the extent that New Mexico's prohibition on assisted suicide, NMSA 1978, § 30-2-4, makes it a criminal act to provide aid in dying, the statute violates the New Mexico Constitution.

Although the District Court properly held that if aid in dying is deemed to fall within the confines of New Mexico's prohibition on "assisting suicide," NMSA 1978, § 30-2-4, then the statute's prohibition on aid in dying violates New Mexico's constitution, the District Court erred in finding that providing aid in dying is subject to NMSA 1978, § 30-2-4. As discussed below, aid in dying is recognized as an important end-of-life care practice that is governed by well-established medical standards and is a fundamentally different mental and physical process from suicide.

**A. The District Court Properly Held that the New Mexico Constitution Includes a Fundamental Right by a Mentally Competent Terminally Ill Patient to Choose Aid in Dying.**

The District Court properly held that the choice of a mentally competent, terminally ill patient to seek a peaceful death through aid in dying is a fundamental right protected by the New Mexico Constitution's rights to happiness and due process. The decision to choose aid in dying implicates one of the most private, intimate decisions a patient will face—how to confront dying when terminally ill and curative treatments have failed. These are not patients who are "suicidal," irrationally cutting short a potentially long, healthy life based on hopelessness or

desperation. Rather these are patients trying to maintain autonomy and control over their medical treatment in their dying days and to preserve some measure of the quality and dignity of their life through a peaceful death. Recognizing this, the District Court stated:

This Court cannot 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. 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, than what decisions are? As recognized by the United States Supreme Court in *Cruzan* "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality."

(RP0228-0229) (citing *Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261, 281 (1990) (finding that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment)).

The District Court also properly held that it was not bound by the United States Supreme Court in *Washington v. Glucksberg*, 521 U.S. 702 (1997), based on the distinct guarantees in the New Mexico Constitution. (RP0228.) The Supreme Court in *Glucksberg* explicitly left open that individual states may provide a right to aid in dying, concluding: "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.” *Glucksberg*, 521 U.S. at 735. Indeed, in *Gonzales v. Oregon*, the U.S. Supreme Court declined to nullify the ODWDA, recognizing that aid in dying could be a legitimate medical practice. 546 U.S. 243 (2006). The *Gonzales* decision and the District Court’s holding are consistent with the evolving “earnest and profound debate” that has taken place in the sixteen years of clinical experience with aid in dying that post-date *Glucksberg*. As discussed above, the evidence accumulated through clinical experience and careful analysis demonstrate that aid in dying is an appropriate element of end-of-life care.

The District Court’s holding is also consistent with New Mexico’s history of respecting a terminally ill patient’s end-of-life choices since the passage of NMSA 1978 § 30-2-4 (1963). New Mexico was one of the first states to recognize advance directives in any form when it enacted the Right to Die Act in 1977. NMSA 1978 §§ 24-7-1 to -11 (repealed 1997). New Mexico was the first state to adopt the Uniform Health Care Decisions Act, 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 to -18 (1995) (replacing the Right to Die Act). New Mexico was also an early adopter of a Pain Relief Act. NMSA 1978, §§ 24-2D-1 to -6 (1999).

Appellants agree that “end-of-life decisions undoubtedly implicate an important and fundamental right” and that a person has a “fundamental right in making his or her own end-of-life decisions.” Appellant’s Br. at 3–4. Appellants argue that the patient’s fundamental right to choose aid in dying does not confer a right by physicians to provide aid in dying. *Id.* at 4. But as a practical matter, the two are one and the same. A patient’s only means to choose aid in dying is by obtaining from a physician a legal prescription for the appropriate medication that the patient can then self-administer. If New Mexico criminalizes the writing of that prescription, the State is directly prohibiting patients from exercising their fundamental right to choose aid in dying. Thus a patient’s right to choose aid in dying must encompass a physician’s ability to legally provide aid in dying.

**B. The District Court Properly Held that No Compelling State Interest Justifies Prohibiting a Mentally Competent Terminally Ill Patient from Making His or Her Own End-of-Life Decisions.**

The State has an undeniable interest in preserving life and preventing suicide and in preserving the integrity of the medical profession and *amici curiae* strongly support public policies that promote those interests. But criminalizing aid in dying furthers neither. *First*, allowing aid in dying preserves the dignity and integrity of a terminally ill’s patient life by ensuring that such patients can maintain autonomy over their medical care and difficult end-of-life decision-making. *Second*, a standard of care for aid in dying has been established through the sixteen years of

clinical experience with the medical practice, such that the practice of aid in dying is regulated under the framework of oversight for all other medical practices.

**1. The State's Interest in Preserving Life and Preventing Suicide is not a Basis for Criminalizing the Provision of Aid in Dying.**

The State's interest in protecting life and preventing suicide is not served by imposing criminal liability on physicians who provide aid in dying. Preventing suicide carries the potential to enable individuals to go on to lead healthy productive lives. In contrast, when aid in dying is criminalized, all that is extended is a patient's suffering. Suicide and aid in dying are fundamentally different mental and physical processes and implicate different State and public health interests. Suicide refers to the desperate, senseless and tragic act of a distraught individual, cutting short what would likely be a long life. Aid in dying is the choice by a mentally competent terminally ill patient facing pain, fear, and suffering, which are not relieved by other available medical therapies, and enables a patient in his or her last days of life to avoid needless suffering and indignity by controlling the manner of his or her impending death.

Suicide arises from an irrational awareness of treatable temporary problems. Suicidal patients typically do not realize that their condition is treatable, and that they can overcome the urge to commit suicide. *See*, Brief of Amicus New Mexico Psychological Association at 4-5, *Morris v. Brandenburg*, No. CV 2012-02909 (2d

Dist., Dec. 10, 2013). On the other hand, aid in dying arises from accurate understanding of incurable physical conditions. Those who seek aid in dying are actually suffering from incurable life-ending illnesses. They have no misunderstanding as to whether or not their illness can be treated and allow them to live long and healthy lives; it cannot. The data show that patients who choose aid in dying do so as a result of a careful, fully vetted deliberation, always in consultation with their physician and usually in consultation with their families and other personal advisors, by applying well-reasoned logic that is consistent with the values that they have embraced for years or decades. *See, e.g.,* Arthur Chin et al., *Legalized Physician-Assisted Suicide in Oregon—the First Year’s Experience*, 340 *NEW ENG. J. MED.* 577, 582 (1999) (stating that many physicians reported “the decision to request a lethal prescription was consistent with a long-standing belief about the importance of controlling the manner in which they died”).

When preventing suicide, the State helps the patient, both mentally and physically, in the short term and the long run, and preserves what can be a person’s long and productive life. Patients who are saved from suicide are thankful that their death was averted. *See, e.g.,* Richard H. Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 *SUICIDE AND LIFE-THREATENING BEHAVIOR* 1 (1978). Preventing a suicide also avoids the devastation and traumatization of the suicidal patient’s family.

But when criminalizing aid in dying, the State merely extends the suffering, and the frustration of the loss of control and autonomy of a patient's dying process without meaningfully extending the patient's life. Not only is no life saved by criminalizing aid in dying, but denying the patient the autonomy to determine how much agony to endure before death arrives could result in profound psychological suffering, including resentment, frustration, and a sense of being powerless and captive of a miserable final stage of dying. *See* Brief of Amicus New Mexico Psychological Association at 10-11, *Morris v. Brandenburg*, No. CV 2012-02909 (2d Dist., Dec. 10, 2013). Even though progressive illness has robbed the patient of much, being empowered to deliberate and determine how this final bit of the life journey will unfold enhances the patient's mental state. *See* Kathy Cerminara & Alina Perez, *Therapeutic Death, A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 511-16 (2000).

The patient's frustration at being denied aid in dying is also likely to extend to the patient's family members, who feel that they failed the patient when the patient needed their help the most and when he or she was helpless to act without medical assistance to end her suffering. Families of patients who choose aid in dying, rather than being devastated and feeling like they could have saved the patient, are commonly brought together and are more prepared for the patient's death. *See* Barbara Coombs Lee & James L. Werth, *Observations on the First*

*Year of Oregon's Death with Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 268, 284–285 (2000).

Instead of a form of suicide, aid in dying is more properly viewed as one choice in the end-of-life care continuum, which already incorporates state-recognized treatment options that are intended to relieve suffering but may also likely hasten a patient's death. Such options include "palliative sedation" (also termed "terminal sedation"), withholding or withdrawing life sustaining measures, and supporting patients who voluntarily stop eating and drinking. Palliative sedation is the monitored use of medications to relieve refractory and unendurable distress by patients with a terminal illness by inducing varied degrees of unconsciousness and withholding other life-sustaining measures. The right to this option has been recognized the United States Supreme Court, the American Medical Association, and other authoritative medical literature. *See Vacco v. Quill*, 521 U.S. 793, 801-02 (1997) (O'Connor, J., concurring) ("[A] patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."); American Medical Association, Opinion 2.201 - Sedation to Unconsciousness in End of Life Care (June 2008), available at [29](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-</a></p></div><div data-bbox=)

ethics/opinion2201.page? (stating that physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care, which includes providing effective palliative treatment even though it may foreseeably hasten death); Paul Rousseau, *Palliative Sedation in the Management of Refractory Symptoms*, 2 J. SUPPORTIVE ONCOLOGY 181 (2004); Susan D. Bruce et al., *Palliative Sedation in End-of-Life Care: The Process of Palliative Sedation*, 8 J. HOSPICE & PALLIATIVE NURSING 320 (2006); Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. PALLIATIVE CARE 31 (1994).

While the increasing recognition of palliative sedation is a positive development, it does not negate the importance of the right to additional options, including aid in dying. For some patients, palliative sedation may be an acceptable option, but others may not choose an induced coma and lingering demise over the week or ten days it takes for dehydration and starvation to result in the patient's death. Kathryn L. Tucker, *The Chicken and the Egg: The Pursuit of Choice for a Human[e] Hastened-Death as a Catalyst for Improved End-of-Life Care; Improved End-of-Life Care as a Precondition for Legalization of Assisted Dying*, 60 N.Y.U. ANN. SURV. AM. L. 355, 356 (2004). Aid in dying is an important option for those suffering intolerably who do not want to submit to palliative sedation.

Aid in dying is an appropriate option in the continuum of end-of-life care that strives to maintain the quality of life of terminally ill patients. Just as palliative sedation or other end-of-life care options are not a replacement for aid in dying, aid in dying of course should not be, and in practice has not been, a replacement for the best available care to relieve the patient's suffering and fears. As noted above, the effect of allowing aid in dying is not to cut short other treatment options, but rather to improve referrals to hospice, increase physician knowledge of pain management treatment, and improve communication about end-of-life care options. The clinical evidence shows that when aid in dying is an available option, clinicians strive to ensure that it is selected only when pain care and all other treatment options prove inadequate.

Like other end-of-life care options, permitting aid in dying as a medical option for mentally competent terminally ill New Mexico patients is consistent with the State's interest in preserving the sanctity of life, not preventing suicide.

**2. The State's Interest in Protecting the Integrity and Ethics of the Medical Profession is Not a Basis for Criminalizing the Provision of Aid in Dying.**

Criminalizing aid in dying is not consistent with the State's interests in maintaining the integrity of the medical profession in New Mexico and ensuring that patients in the state receive the best possible level of care. The practice of aid in dying by medical professionals in New Mexico would be appropriately



governed just as it has in other states—under the current standard of care framework that governs the practice of medicine and the provision of all other medical services, including other end-of-life care options such as the withdrawal of life-sustaining measures or palliative sedation. A clear standard of care for providing aid in dying has been established through the sixteen years of clinical experience with aid and dying, the three state statutes on aid and dying, and guidelines from the medical profession. Should aid in dying be available in New Mexico, physicians would be held to this standard of care when making aid in dying available to patients in the state.

In New Mexico, as in other states, the medical profession and medical care is governed by professional practice standards, referred to as the standard of care, rather than specific statutes or regulations that prohibit or give affirmative permission to provide specific types of care or otherwise describe the standards or procedures for providing care. 61 AM. JUR. 2d, *Physicians, Surgeons, and Other Healers* § 189 (updated August 2014). Generally, a physician is held to the standard of care and skill of the average practitioner of the medical specialty in question, taking into account advances in the profession, or the state of the medical profession at the time. *See, e.g. Pharmaseal Labs., Inc. v. Goffe*, 90 N.M. 753, 568 P.2d 589 (1977). The development of a standard of care in medicine is left to physicians and regulated by the state Medical Boards. *See Gonzales*, 546 U.S. at

271 (quoting *Hillsborough Cnty. v. Automated Med.Labs., Inc.*, 471 U.S. 707, 719 (1985)).

Under this framework, a standard of care has been established for end-of-life care that respects the patient's autonomy and accepts other potentially life-ending practices. These practices include providing palliative support to patients who choose to stop eating and drinking, discontinuing life-sustaining treatment (*e.g.*, pacemakers, dialysis), medication for patients who wish to end life-prolonging interventions, and providing terminal sedation.

Likewise, a standard of care for providing aid in dying has emerged through clinical experience in the states where aid in dying is available and careful review by the medical profession. This standard of care is well-documented among the Oregon, Vermont and Washington statutes, clinical practice guidelines, and the policy statements of physician and public health organizations supporting aid in dying. OR. REV. STAT. §§ 127.800–127.897; WASH. REV. CODE § 70.245; VT. STAT. ANN. tit. 18, §§ 5281-5292; Kathryn Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 CHEST 218 (2012) American Medical Student Association, 2014 AMSA Preamble, Purposes and Principles at 76, available at [http://www.amsa.org/AMSA/Libraries/Misc\\_Docs/2014PPP.sflb.ashx](http://www.amsa.org/AMSA/Libraries/Misc_Docs/2014PPP.sflb.ashx).

The components of the standard of care for providing aid in dying include:

- The patient must be an adult.

- The patient must be terminally ill and two treating physicians must concur on the terminal nature of the diagnosis.
- The patient must be mentally competent and two treating physicians must concur on the competence of the patient and the ability of the patient to give informed consent.
- The patient's request for aid in dying must be free of coercion of any kind.
- If either treating physician questions the patient's ability to consent or suspects coercion, a psychiatric evaluation is required.
- The patient must make repeated requests for aid in dying with waiting periods in between requests.
- The patient must be informed of his or her ability to rescind his or her request at any time.
- The providing physician must inform the patient of all other treatment options, including hospice, comfort care, and pain management.
- Prior to providing aid in dying, all efforts should be made to address the patient's pain and suffering through palliative care and to understand the source of, and resolve, the patient's fear and concerns.
- The patient must be able to self-administer the medication.
- No physician is required to provide aid in dying upon a patient request.

Each element of the standard of care for providing aid in dying is within the current core competencies of physicians treating terminally ill patients, including assessing life expectancy and mental competency. In fact, the physicians with whom mentally competent, terminally ill patients are most likely to discuss aid in dying are those who are most trained to do so. For example, one study found that the strongest predictor for whether a physician would receive a request for aid in dying was treating a large number of terminally ill patients per year. Linda Ganzini, et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *supra*.

Current state oversight of the practice of medicine (e.g., licensure, Medical Review Boards) can regulate the provision of aid in dying as it does all other medical practices. For example, when aid in dying was decriminalized in Montana, the Montana Board of Medical Examiners stated that a complaint about a physician's practice of aid in dying would be subject to the same review applicable to any other medical practice. *See Montanans Against Assisted Suicide (MAAS) v. Bd. of Med. Exam'rs*, No. ADV-2012-1057, slip op. at 3 (Mont. Dist. Ct. Dec. 13, 2013), available at <http://maasdocuments.files.wordpress.com/2013/12/order-on-defendants-motion-to-dismiss.pdf>. The Vermont Legislature also understood that aid in dying would be governed adequately by existing professional standards. When enacting the Patient Choice at the End of Life Act, the legislature included a

three-year “sunset” on the specific statutory requirements for aid in dying, after which aid in dying in the state would be regulated as any other medical service. 2013 Vt. Acts & Resolves 292.

*Amici curiae* appreciate the need for safeguards on the availability of aid in dying to ensure that vulnerable populations are not unduly affected and that patient choices are not based in lack of competence, are not a result of coercion, and do not reflect the patient’s desire not to burden others. But the current standard of care for aid in dying accounts for such safeguards and the necessary oversight of the practice through existing systems for regulating the medical profession.

### CONCLUSION

For all these reasons, *amici curiae* AMSA, AMWA and NMPHA respectfully request that this Court affirm the District Court’s ruling that to the extent that NMSA 1978, §30-2-4 prohibits aid in dying, it violates the New Mexico Constitution. *Amici curiae* further respectfully request that this Court affirm the District Court’s permanent injunction prohibiting the State from prosecuting physicians who provide aid in dying to mentally competent, terminally ill patients.

### STATEMENT OF COMPLIANCE WITH RULE 12-213 NMRA

As required by Rule 12-213(G) NMRA, *amici curiae* hereby certify that the body of this brief complies with Rule 12-213(F)(3) NMRA because: (1) the body

of this brief contains a total of 8,379 words excluding the parts of the brief exempted by Rule 12-213(F)(1) NMRA, and (2) this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2013 in 14 point Times New Roman.

Respectfully Submitted,



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September 8, 2014

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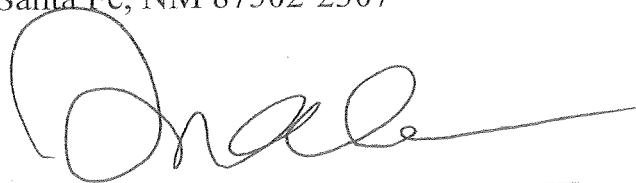
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