

COPY

IN THE NEW MEXICO COURT OF APPEALS

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

Plaintiffs-Appellees,

v.

COURT OF APPEALS OF NEW MEXICO  
ALBUQUERQUE

FILED

SEP 08 2014

*Wendy F Jones*

No. 33,630

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

Defendants-Appellants.

COURT OF APPEALS OF NEW MEXICO  
ALBUQUERQUE

FILED

SEP 12 2014

*Wendy F Jones*

On Appeal from the New Mexico District Court  
Second Judicial District, County of Bernalillo  
District Court Judge Nan Nash

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**BRIEF OF AMICUS NEW MEXICO PSYCHOLOGICAL ASSOCIATION  
IN SUPPORT OF THE PLAINTIFFS-APPELLEES**

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STATEMENT OF COMPLIANCE

Pursuant to Rule 12-210.G NMRA 2013, this is to certify that this Amicus Brief complies with the requirements of Rule 12-201.F(3) NMRA 2014. The number of words contained in the body of the Reply Brief as defined in Rule 12-201.F(1) is 5,678 words. This word count was obtained using the Microsoft Office Word program.

A handwritten signature in black ink, appearing to read "Robert Schwartz". The signature is stylized and cursive.

Robert Schwartz

## INTEREST OF AMICUS<sup>1</sup>

The New Mexico Psychological Association (NMPA) is the largest organization of professional doctorate-level psychologists in New Mexico and the leading source of professional standards and policy for psychologists who practice within the state. It has been established to promote quality research and the highest level of qualified professional practice in psychology, to improve the qualifications and usefulness of psychologists by upholding and maintaining the highest standards of professional ethics, conduct, education, and achievement, and to increase and diffuse psychological knowledge throughout New Mexico. N.M. Psychological Ass'n., *Constitution and Bylaws, Section 2* (2005). It is the primary authority to speak on behalf of psychologists and their patients, and those who provide related mental health services and their patients, in New Mexico, and it is concerned with assuring that the law in New Mexico permits and encourages the highest level of psychological practice.

The NMPA is committed to providing high quality mental health care to all New Mexicans. In doing so, members often provide services to those who are contemplating suicide, and to family members and friends of those who have committed suicide. Its members have also provided services to competent adults

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<sup>1</sup> No counsel for any party authored any part of this brief, and no person or organization outside of the amicus itself made any monetary contribution to fund the preparation or the submission of this brief. This disclosure is made pursuant to NMRA, Rule 12-215(f).



who are terminally ill and facing imminent death, and to their friends and family members. Some of these terminally ill patients are also considering asking their physicians for Aid in Dying (AID)<sup>2</sup> if their suffering during the dying process becomes too difficult to bear, and some of these patients have been referred to psychologists for counseling by the physicians from whom they sought AID.

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<sup>2</sup> In adopting the term “Aid in Dying,” the New Mexico Psychological Association joins its sister organization, the Washington State Psychological Association, which has stated: “A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disrespectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals.” Judith R. Gordon, *New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices*, Wash. State Psychological Ass’n. (Jan. 8, 2007), [http://www.wapsych.org/resource/resmgr/Docs/New\\_WSPA\\_Policy\\_on\\_Value-Ne.docx](http://www.wapsych.org/resource/resmgr/Docs/New_WSPA_Policy_on_Value-Ne.docx). The term has been adopted by several other organizations and most academic writers. Even those who do not choose that terminology do not use “suicide” or “assisted suicide” to describe the AID process. See, for example, the new edition of the leading Health Law casebook, Furrow et al., *Health Law* (7th ed. 2013), which refers to “medically assisted dying.”

While several years ago terms like “assisted suicide” had been used to describe a competent, terminally ill patient’s decision to seek a physician’s help in prescribing medication that could hasten the dying process, over the last several years responsible health care providers, lawyers, academics and others have stopped referring to this process as any form of “suicide.” The general consensus is that “aid in dying” is more accurate, sensitive, and consistent with the professional literature in the field. “Aid in dying” is the better descriptive term, and it avoids presuming any sets of values. Consistent with the propriety of “aid in dying,” the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine (the organization of JD-MDs), the American Student Medical Association, and the American Medical Women’s Association have all recently rejected using the term “assisted suicide,” mostly in favor of “aid in dying.” For the most part, the only individuals and organizations continuing to refer to the practice using the word “suicide” are those who, for political, religious or philosophical reasons, advocate against it. The movement to use the neutral term “aid in dying” has only accelerated in the last few months. See D. Orentlicher, T. Pope and B. Rich, *The Changing Legal Climate for Physician Aid in Dying*, JAMA online (published April 14, 2014)(citing this New Mexico litigation).

Just as advocates for aid in dying now refer to it as “death with dignity,” opponents of aid in dying call it “assisted suicide.” Of course, no one on either side opposes dignity, and no one on either side wants someone considering suicide to go untreated or unprotected. In short, “assisted suicide” now is a pejorative term used for political purposes by those who believe it to be morally wrong.

The NMPA recognizes that if a psychologist is required to treat a patient considering AID like a patient considering suicide, that psychologist cannot possibly provide adequate care that is consistent with the psychologist's professional standard of care.

The NMPA and its members recognize that AID and suicide are fundamentally different psychological phenomena, and that these different categories of patients must be treated differently by the law for their patients to be able to get adequate psychological support at the end of life. Psychologists think of suicide as their greatest challenge, and they work tirelessly to prevent their patients from committing suicide. They also recognize that AID involves almost no substantive theoretical overlap with suicide. Being required to treat competent terminally ill patients seeking AID as potential suicide "victims" will undermine the quality of care they can provide just when dying patients need their help the most. This view of psychologists on this issue is especially important because psychologists are experts on mental health care related to suicide in this country. They are uniquely well positioned to understand the actual consequences of the determination of the issues before this Court on those who are at risk for suicide and those who seek access to aid in dying from their physicians.

The Board of the New Mexico Psychological Association, after protracted and serious discussion over several months, decided unanimously to support the Plaintiffs in this case, and to seek permission from the Court to file an amicus brief on behalf of the Plaintiffs, because of the importance of the resolution of this case to the quality practice of psychology in New Mexico.

### ARGUMENT

**I. SUICIDE IS FUNDAMENTALLY DIFFERENT FROM AID IN DYING. THOSE WHO CHOOSE SUICIDE REJECT LIFE; THOSE WHO CHOOSE AID IN DYING EMBRACE LIFE.**

**A. SUICIDAL IDEOLOGY ARISES FROM IMPAIRED COGNITION OF TEMPORARY PROBLEMS THAT ARE ACTUALLY TREATABLE; AID IN DYING, ON THE OTHER HAND, ARISES FROM ACCURATE COGNITION OF PHYSICAL CONDITIONS THAT ARE TRULY INCURABLE.**

Psychologists are trained to assess suicide risk and, as a matter of course, to consider that risk in every patient. The State of New Mexico has long authorized licensed psychologists and physicians (and lately other mental health care professionals) to certify that a patient should be detained and evaluated in the event that the patient presents a risk of serious harm to him or herself. NMSA 1978 § 43-1-10(A)(4). Psychologists figure prominently in suicidology and research into the causes and prevention of suicide. *See, e.g.,* Edwin S. Shneidman, *The Suicidal Mind* (1998). Determining whether a patient poses a risk of suicide and

how to address that risk are central to the practice of psychology in New Mexico, as elsewhere.

One substantial difference between suicidal patients and those who seek AID is that suicidal patients do not realize that their condition is amenable to treatment, and that they can overcome their urge to commit suicide. Their mental health pathology can be treated. See Thomas Reisch et al., *Efficacy of Crisis Intervention*, 20(2) *Crisis: J. of Crisis Intervention and Suicide Prevention*, 78-85 (1999). Those who seek access to AID, on the other hand, are actually suffering life-ending illnesses that cannot be cured. They have no misunderstanding of their condition, and the reason they seek access to AID is because no medical treatment can make the continuation of life possible; that is exactly what makes them terminally ill. Suicidal patients react to their misunderstood condition by applying distorted logic; those seeking AID react to their fully and correctly understood terminal condition by applying well reasoned logic that is consistent with the values that they have embraced for years or decades.<sup>3</sup>

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<sup>3</sup> David A. Pollack, M.D., psychiatrist and witness qualified by the court as an expert in end-of-life care and decision-making, provided clear, well supported and completely unrebutted testimony that “[suicide] is a despairing, lonely experience, whereas the person who requests aid in dying is doing this . . . to alleviate symptoms but, more positively, to maintain the relationships, the connections, and the sense of self being more integrated to the point where they end their life. And so it’s more maintaining peace, joy, relief . . . or what you might define as happiness.” 2 Tr. 94:22-25, 95:1-4. “[People who seek AID] focus[ ] on maintaining the quality of life that is something that they cherish[ ] and they want to capitalize on as much as possible in the time they have left whereas the person who is depressed and suicidal turns inward, becomes isolated.” 2 Tr. 79:20-25, 80:1-2.

Suicide motivation arises from an emotional crisis which interferes with logic and planning. Thomas Joiner, *Myths About Suicide*, 39 (2010). Suicidal patients tend to be severely depressed such that they are unable to contemplate a future without the intense emotional anguish from which they currently suffer. 2 Tr. 73:9-21. Such crises may derive from loss of a loved one, a business reversal, a personal humiliation, or any number of factors. The unifying response is a misplaced cognition that the situation will never improve; that there is no hope to right the ship. In suicidal patients, negative emotion narrows cognitive focus. Joiner, *Myths About Suicide* at 34. The suicide motive is deeply irrational. The psychologist treating a suicidal patient seeks to restore reason and thus restore hope, as is reasonable for persons with a long life ahead of them.

By contrast, the problem confronting the terminally ill patient arises from an irreversible physical calamity. She or he is dying of an incurable disease. See 2 Tr. 73:11-13 (Dr. Pollack testifying that “suicide is a distinctly different act than requesting aid in dying. . . because the person is already in the process of dying who is requesting this.”). See also 2 Tr. 119:12-15 (“suicide” should not be used to describe the acts of people “who are not psychiatrically ill and who are already in the process of dying.”) For these patients, the recognition that there is no hope for future physical improvement is accurate, not irrational. To treat a mentally competent terminally ill patient who seeks access to AID to avoid unbearable

suffering as equivalent to a lovesick teenager or a homeowner losing the family home to foreclosure would be to completely misunderstand the psychological condition and the therapeutic role in each of those cases. It is for this reason that it is so offensive for those who have finally come to grips with their terminal condition, sometimes after a great deal of psychotherapy, and who thus seek access to AID, condescendingly to be told that they are demonstrating mental health pathology and that they are suicidal.

**B. IN CASES OF SUICIDE, RATIONAL CONTROL IS INTERRUPTED BY DEFICIENCIES IN IMPULSE CONTROL. IN CASES OF AID IN DYING, THE PATIENT'S RATIONAL CONTROL PREVAILS.**

The suicidal patient's functioning is characterized not only by impaired cognition, as described above, but by disrupted impulse control. *See* 2 Tr. 73:17-21 (Dr. Pollack testifying that “[t]he act of suicide is usually impulsive. It’s solitary. It’s done without consulting or even allowing friends or family to know about the act, whereas with aid in dying, a person goes through a deliberative process.”); *see also, e.g.,* Roy Baumeister, *Suicide as Escape from Self* 90-133 (1990). In evaluating the risk of suicide in any new patient, the psychology practitioner is taught to look for the “three P’s”: pain, pressure, and perturbation. “Pain” stands for emotional anguish, “pressure” stands for a feeling of being overwhelmed, and “perturbation” stands for agitation. Edwin S. Shneidman, *Autopsy of a Suicidal Mind* (2004). This “pain, pressure and perturbation”

precipitate sudden, unannounced, lethal and often violent acts, like suicide. They are the quintessence of irrationality and loss of personal control. The three P's analysis describes virtually every real suicide, and it suggests why we are so concerned when there is a risk of suicide.

Fifteen years of data from Oregon regarding an open practice of AID show that patients who choose AID act as a result of a careful, fully vetted deliberation, always after a period long enough to establish the enduring nature of the desire, usually in consultation with their families and other personal and religious advisors, and always after discussion with their physicians. See 2 Tr. 94:1-22, 95:1-9. This is the opposite of deficient impulse control; this is truly deliberative action. 2 Tr. 73:1-22, 74:1-16. The physician plaintiffs in this case point out that they would require a carefully reasoned, voluntary, informed and enduring request for a prescription for AID before they would consider writing one. Further, as you might expect from the self-selected group of patients who ask their doctors about aid in dying, they are carefully deliberative and well educated. Last year in Oregon and in Washington over half of those employing the Death with Dignity Acts had graduated from college, and almost all had education beyond high school. Or. Pub. Health Div., *Oregon's Death with Dignity Act 2013* (2014) available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>; Wash. State Dept. of Health, *2013*

*Death With Dignity Act Rep., Exec. Summary* (2013) available at [http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-](http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf)

[DeathWithDignityAct2013.pdf](http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf) (posted February 14, 2014)(76% of those employing the Death with Dignity Act last year had at least some college). This subset of the population seeking to act in a self-determined and autonomous manner at their death is well able to understand their options and choose among them.

The question of how much suffering to bear before death arrives is intensely personal and will turn on values and beliefs an individual has developed over the course of a lifetime. Empowering the individual with control over this question preserves an essential sense of autonomy. *See* 2 Tr. 94:22-25, 95:1-4 (expert witness testifying that those who choose AID “feel less anguish, less focus about what’s going to happen, so that they can then focus on what they want to do with those precious hours, days, months that they have left to use the fullest . . . in a peaceful way”). 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 and Alina Perez, *Therapeutic Death, A Look at Oregon’s Law*, 6(2) *Psychol. Pub. Pol’y & L.* 511-518 (2000).



The collaboration between physician and patient over time reflects a deliberative, rational process, the antithesis of impulse-driven behavior. 2 Tr. 99:1-18 – 101:1-7. The nature of the deliberative process in every case of AID is made even more impressive by the fact that all of those choosing AID have made the decision to do so while in the course of regularly seeing health care providers, other than psychologists, who are treating other physical disease conditions, most often cancer, which afflicts the vast majority of those who choose AID under the Oregon statute. *See* Or. Pub. Health Div., *Oregon's Death with Dignity Act 2013* (2014). Poor impulse control is a defining characteristic of suicide; it is not present in those choosing aid in dying. AID and suicide are at the opposite extremes of the continuum of rational thought and conduct, and ought not be conflated. 2 Tr. 110:1-20 – 112:1-13.

**C. SUICIDE LEAVES FAMILY MEMBERS DISTRAUGHT, OFTEN DESTROYED, AND VIRTUALLY ALWAYS EMOTIONALLY TRAUMATIZED. AID IN DYING BRINGS FAMILIES TOGETHER AND ALLOWS FAMILIES TO DEAL SUCCESSFULLY WITH GRIEF.**

The act of suicide is usually lonely and alienated, leaving in its wake a distraught family. *See* Thomas Joiner, *Myths About Suicide* 123 (2010). Psychologists see countless family members who struggle to make sense of an irrational, final act planned and committed without their knowledge, support or consultation. At the least, family members feel abandoned and disempowered after

a suicide. They feel utterly without control, and they also feel they failed their suicidal family member. They are also likely to feel resentment resulting in complex grief. See Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide*, 25(1) J. of Crisis and Suicide Prevention 12-18 (2004).

The experience of family members following AID is very different. See 2 Tr. 96:25, 97:1-6 (Dr. Pollack testifying that most family members of those who choose AID “have described feeling more prepared for the person’s death and more at peace in relationship to it whereas those who have a sudden loss of a close person feel a lot of unfinished business, disconnected, no closure . . . and feel maybe in some ways cheated”). At the Seattle Cancer Care Alliance, families of patients who opted for AID frequently expressed gratitude after the patient obtained the prescription, regardless of whether the patient ever ingested the medication. They felt they could support their family member by supporting the decision to access AID. They referenced an important sense of patient control and family support in an uncertain situation. See Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 New Eng. J. Med. 1417 (2013). In these cases the patient’s acquisition of some sense of control over his time and manner of death, whether the medication is ingested or not, may well have a positive emotional effect on the family, sharing in the pain and loss, as well as on the patient himself. 2 Tr. 97:1-10, 98:1-14.

There is little doubt that recognizing the patient's right to control the timing of his or her death has given Washington families greater ability to join together for support of their loved ones at that crucial moment. Similar findings in Oregon show that the family survivors of patients who choose AID do not suffer the adverse mental health impacts suffered by family members of suicide victims. *See* Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. of Pain and Symptom Management 807 (2009).

**D. SUICIDAL PATIENTS WHO ARE SAVED FROM SUICIDE OFTEN GO ON TO LEAD LONG AND PRODUCTIVE LIVES, THANKFUL THAT THEIR SUICIDES WERE AVERTED. THOSE WHO ARE DENIED AID IN DYING GENERALLY LIVE ONLY A BIT LONGER, OFTEN WITH HORRIFIC SUFFERING, FRUSRATED BY THE DENIAL OF CONTROL AND AUTONOMY AT THE END OF LIFE.**

As an impulse-driven event, the act of suicide irrationally aims to permanently end its victim's intense anguish by ending his biological life. Thomas Joiner, *Myths About Suicide* 7 (2010). Psychologists sometimes ruefully refer to suicide as "a permanent solution to a temporary problem," since the patient sees no hope in a circumstance where a rational person would be able to find hope. That is often the very purpose of therapy. Research into suicide shows that persons restrained from suicide by jumping off a bridge, for example, often go on to lead productive lives. In one leading study, virtually all bridge jumpers who survived

recalled experiencing profound regret during the four seconds it took to reach the water. Richard Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 *Suicide and Life-Threatening Behavior* 1-13 (1978).

Psychologists sometimes use Reasons For Living (RFLs) as a therapy technique with suicidal patients. See David Jobes, *Managing Suicidal Risk* 22-23 (2006). These include plans and goals for the patient's future, family, friends, responsibilities to others, enjoyable trips, and anything else which gives the patient affirmative reasons to fight through a lethal depression. The evocation of hope can be one of the most important and central elements of healing. See C. E. Yahne, and W. R. Miller, *Evoking Hope*, in American Psychological Association, *Integrating Spirituality into Treatment: Resources for Practitioners* 217-233 (1999). As Dr. Chuck Elliott, a prominent Albuquerque psychologist, teaches, "It is our job to give our patients hope." If that hope can be restored and the patient saved from a suicide that would later be the source of terrible regret, the psychologist or other person who managed to do so can count that as an important success – effectively, the saving of a life.

The result of denying AID is far different. No life is saved. No suffering is averted; indeed, the patient's physical suffering will most likely last longer and perhaps grow even more horrific before the final ravages of the cancer or other

disease culminate inevitably in death. The psychological suffering at being denied the autonomy to determine how much agony to endure before death arrives will often be profound. The meaning of a terminal diagnosis is that death will come soon, regardless of medical treatment. From a physiological point of view, and from the perspective of the progression of the underlying disease, it will make little difference whether a patient has access to AID; the patient is going to die soon in any case. From a psychological perspective, though, the utter and final lack of control that comes from being denied the opportunity to avoid unbearable suffering at the end of life is extremely important. It can lead to resentment, frustration, a sense of being powerless and captive of a miserable final stage of dying. The patient's frustration is also likely to extend to the patient's family members, who feel that they failed the patient when she needed their help the most and when she was helpless to act without medical assistance to end her suffering. See Barbara Coombs Lee and James L. Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 279-280 (2000)

When a psychologist intervenes to prevent suicide, that intervention helps his patient, both physically and mentally, in the short run and in the long run. An intervention to prevent AID will not have such a salutary effect. It will exacerbate physical pain and mental suffering in the short term, and will have no effect on the long term because the patient will die of the underlying disease whether a

psychologist intervenes or not. It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

**II. PSYCHOLOGISTS HAVE THE TRAINING AND ABILITY TO DETERMINE THE MENTAL CAPACITY OF TERMINALLY ILL PATIENTS TO CHOOSE AID IN DYING. THERE ARE ESTABLISHED GUIDELINES FOR ASSESSMENT OF DECISIONAL CAPACITY OF THE TERMINALLY ILL.**

Virtually everybody recognizes that refusing to allow AID will force some decisionally capable and terminally ill people to endure suffering they find intolerable at the end of life. Some, however, are willing to accept this to avoid the risk that some terminally ill patients might be incorrectly determined to have decisional capacity to choose AID when, in fact, they do not have that capacity. That concern is unfounded.

The practice of psychology has developed clear standards of care for capacity determinations. Psychologists are often called upon to determine a patient's capacity under the Uniform Health Care Decisions Act, NMSA 1978 § 24-7A-11. *See also* NMSA 1978 § 24-7A-1(C) (New Mexico statutory definition of capacity). Mental health professionals in New Mexico and across the nation recognize best practices to make such determinations, and those professionals are routinely trained in making exactly this kind of determination. See James L. Werth, G. Benjamin and T. Farrenkopf, *Requests for Physician*

*Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 Psych., Pub. Pol. & L. 348 (2000), and Charles H. Baron, *Competency and Common Law: Why and How Decision-Making Capacity Criteria Should be Drawn from the Capacity-Determination Process*, 6 Psych., Pub. Pol. & L. 373 (2000). In fact, over the last several years special attention has been given to the determination of decisional capacity in those who face terminal illness and, more generally, in the elderly (from whom the terminally ill are disproportionately drawn). By way of immediate example, the Amicus has offered programs to its members and other health care professionals over the last two months in Albuquerque on working with patients with dementia (September 27, 2013) and in suicide risk assessment (November 8, 2013), and in Santa Fe on dealing with depression and despair, including end of life despair (September 27, 2013). See New Mexico Psychological Association, *Upcoming NMPA Workshops* (listing a current schedule of the active NMPA education program touching on these issues) available at [ww.nmppsychology.org/displaycommon.cfm?an=1&subarticlenbr=25](http://ww.nmppsychology.org/displaycommon.cfm?an=1&subarticlenbr=25). Where they have been called upon to do so, professional mental health associations have developed nationally respected standards specifically for assessing a person's capacity to choose AID. See, e.g., Washington State Psychological Association, *The Washington Death with Dignity Act: WSPA Guidelines For Mental Health*

*Professionals* (2010) available at [http://www.wapsych.org/resource/resmgr/Docs/DWD\\_Guidelines\\_6-3-09.pdf](http://www.wapsych.org/resource/resmgr/Docs/DWD_Guidelines_6-3-09.pdf). See also Tony Farrenkopf and James Bryan, *Psychological Consultation Under Oregon's 1994 Death With Dignity Act: Ethics and Procedures*, 30(3) *Prof. Psychol.: Research and Practice*, 245-249 (1999). Dr Pollack spent considerable time on the witness stand describing the process that is routinely used by psychiatrists and psychologists in making these determinations of capacity, and explaining the source of standards of care for doing so. See 2 Tr. 74:16 et seq.

A mental health professional will not always be required to evaluate the capacity of a terminally patient who chooses AID, of course. Under the Uniform Health Care Decisions Act, a patient is presumed to have decisional capacity to make a health care decision (like choosing AID, if her physician believes that is among her appropriate choices). NMSA 1978 § 24-7A-11(B). If there is any question, though, physicians can consult with a mental health professional to avoid any uncertainty about the patient's capacity. See NMSA 1978 § 24-7A-11(C). As the experience in Oregon and Washington suggests, physicians occasionally do so. There may have been a time when mental health professionals were not trained to make such determinations in the terminally ill, and there was a time when those professionals had no professional standards to apply in making those decisions, but that time is long past. Making capacity determinations at the end of life is now a



regular function of psychologists and other mental health professionals. *See* 2. Tr. 74:1-20 – 76:1-10, 103:15-19, 104:2 (expert testifying that “it is the same circumstance” when a person is terminally ill and mentally competent to make a decision to end a life-sustaining treatment and when a person is terminally ill and mentally competent to make a decision to choose aid in dying). There are adequate tools for professionals to make these determinations, and these professionals are well trained to do so.

**III. PSYCHOLOGISTS HAVE SPECIAL LEGAL AND ETHICAL OBLIGATIONS WITH REGARD TO SUICIDE. IT WOULD UNDERMINE THE WORK OF PSYCHOLOGISTS TO REQUIRE THEM TO TREAT AID IN DYING AS SUICIDE, AND IT WOULD DESTROY PSYCHOLOGISTS’ ABILITY TO COUNSEL TERMINALLY ILL PATIENTS WHEN THEIR ASSISTANCE IS MOST DESPERATELY NEEDED.**

It is extremely important that psychologists be able to treat suicidal patients and prevent suicides. It is equally important for psychologists to be able to counsel family members and friends of those who have committed suicide, or are threatening to do so. As a matter of law, psychologists and other mental health workers are permitted to issue certificates authorizing a law enforcement officer to detain by force and hospitalize a patient who is threatening suicide, and the standard of care requires that psychologists issue such certificates when the threat is one of imminent harm. A psychologist would be at risk of civil liability to both

the patient and to others, including the patient's family members, if the psychologist were to breach this legal obligation.

At the same time, psychologists also have a duty to provide counseling to those who are approaching death due to terminal illness and to their family members. Many physicians – oncologists, geriatricians and others – refer their patients to mental health providers for counseling when they are diagnosed as terminally ill. In order to provide adequate care and support to these patients, a psychologist needs to be able to respond appropriately to a patient's mental state and address their issues with flexibility and with respect for the values, beliefs and physical situation of the patient.

It would be inappropriately condescending and it would undermine the psychologist-patient relationship for a mental health professional to treat a rational and entirely non-pathological decision of a patient to inquire into AID as an expression of suicidal ideation. Treating the decision to inquire about AID the same as one to ruminate about suicide would require application of an entirely inappropriate form of analysis and counseling. *See 2 Tr 91:11-23* Dr. Pollack testifying that “it would be really hard . . . on a psychiatric basis” to say that a person who is seeking to end life-sustaining treatment, just as a person seeking AID, is endangering him or herself such that the person needs to be committed). The standard of care for treating a suicidal patient would require issuance of a

certificate which would authorize a law enforcement officer to detain the dying patient who was considering AID. This would utterly and completely destroy the trust necessary to make the psychologist-patient relationship useful, and, as a practical matter, it would end the psychologist-patient relationship, thus depriving the patient of an opportunity to benefit from the professional knowledge of the psychologist. Further, requiring psychologists to treat AID as suicide would discourage oncologists and others from referring their patients for mental health services, and it would discourage patients from seeking out mental health services on their own as well.

The practice of good professional psychology in New Mexico requires that the law recognize the fundamental distinction between AID and suicide, and that the law recognize that AID is not a form of suicide.

**IV. IN BALANCING STATE INTERESTS AGAINST A PATIENT'S LIBERTY INTEREST IN DECISIONMAKING AT THE END OF LIFE, NO WEIGHT SHOULD BE ACCORDED ANY ALLEGED STATE INTEREST IN PROLONGING DEATH OR PREVENTING AID IN DYING.**

Applying strict scrutiny analysis in this case, the trial court determined that “the right of a competent, terminally ill patient to choose aid in dying” was a fundamental liberty interest that must be weighed against countervailing state interests to determine whether there was a sufficiently “compelling state interest” to limit that right under the New Mexico Constitution. RP 0217-0229. If this court

were to apply the lower intermediate level of scrutiny in this case, it would be required to weigh the important interest of competent, terminally ill patients in seeking amelioration of their final suffering against any asserted state interests to determine if the state action was substantially related to an important governmental interest. Even if the court were to apply the lowest level of constitutional scrutiny, it must find that the state has acted in furtherance of a legitimate state interest for that state action to comport with the New Mexico Constitution. See *Trujillo v. City of Albuquerque*, 1998-NMSC-031, par. 15, 125 N.M. 721, *Marrujo v. N.M. State Hwy. Transp. Dep't*, 1994-NMSC-116, par. 11, 118 N.M. 753 and *ACLU of NM v. City of Albuquerque*, 2006-NMCA-078, par. 19, 139 N.M. 761.

The New Mexico Psychological Association has concluded that the interest of individual patients in choosing how much suffering they can tolerate at the end of life should be treated as a fundamental liberty interest. For the reasons articulated above, it is an extraordinarily personal and individual matter, and the psychological and emotional consequences of being forced by the state to undergo unbearable suffering that could be avoided by appropriate and available medical intervention is cruel to both the patient and to those family members and others who care about the patient.

As a consequence of its deep concern about the problems caused by suicide in this society, the New Mexico Psychological Association also believes that the

result of the constitutional balancing would be the same without regard to which level of scrutiny were applied. The primary countervailing state interests raised by the State in this case are the interest in preventing suicide, the interest in preserving life, and the interest in protecting innocent third parties, like family members of those who might choose AID. As the evidence introduced at the trial court indicates, however, even if AID were found to constitute “suicide,” none of the reasons for the state to intervene to protect its citizens from suicide are implicated when this form of medical care is at issue. Similarly, while the amicus agrees that New Mexico has an interest in preserving life, the evidence shows that prohibiting AID does not ultimately protect any human life. In fact, it is the inability to control final suffering the patient can foresee – not AID -- that is likely to undermine a patient’s will to continue to live. Finally, there is no evidence whatsoever that AID has any adverse effect on any family members or other innocent third parties. Indeed, quite the opposite appears to be true: it is the inability to help one who is suffering, and who could be relieved through AID, that leads to devastating psychological trauma for those who truly care for the dying patient.

## CONCLUSION

For the reasons stated above, the Amicus New Mexico Psychological Association requests that the Court grant the Plaintiffs the relief sought in their Complaint in this case.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Robert Schwartz".

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**CERTIFICATE OF SERVICE**

I certify that I served the Brief of Amicus New Mexico Psychological Association in Support of the Plaintiffs-Appellees on all counsel of record listed below by Regular U.S. Mail on the 8<sup>th</sup> day of September, 2014.

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