No. 33,630

IN THE COURT OF APPEALS OF THE STATE OF NEW MEXICO

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

Plaintiff-Appellees,

v.

GARY KING, Attorney General of the State of New Mexico,

Defendant-Appellant.

ON APPEAL FROM THE SECOND JUDICIAL DISTRICT COURT,
COUNTY OF BERNALILLO, NEW MEXICO, JUDGE NAN G. NASH

BRIEF OF *AMICI CURIAE*: STATE OF NEW MEXICO SENATORS WILLIAM F. BURT, MARK MOORES, STEVEN P. NEVILLE, WILLIAM E. SHARER, AND PAT WOODS; STATE OF NEW MEXICO REPRESENTATIVES PAUL C. BANDY, SHARON CLAHCHISCHILLIAGE, DAVID M. GALLEGOS, JASON C. HARPER, YVETTE HERRELL, AND JAMES R.J. STRICKLER; AND CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS

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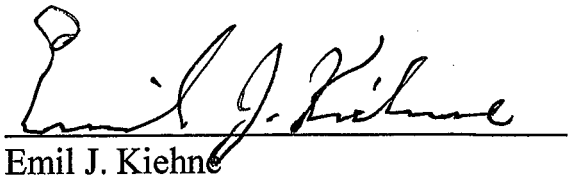
TABLE OF CONTENTS

CERTIFICATE OF COMPLIANCE

As required by Rule 12-213(G), we certify that the brief complies with the type-volume limitation of Rule 12-213(F)(3). According to Microsoft Office Word 2010, the body of this brief, as defined by Rule 12-213(F)(1), contains 9,866 words using Times New Roman.



Emil J. Kiehne

TABLE OF AUTHORITIES

Cases:

Constitutional Provisions:

Statutes:

Rules and Regulations:

Other Authorities:

INTRODUCTION

The New Mexico Constitution places great value on human life. It provides that "[a]ll persons . . . have certain natural, inherent and inalienable rights," including "the rights of enjoying and defending life" and "of seeking and obtaining safety . . . . " N.M. CONST. art. II, § 4. The New Mexico legislature and citizens, including *Amici*,[1] cherish these fundamental, inherent rights, and passed NMSA 1978 § 30-2-4 (1963) to protect them by criminalizing deliberate assistance in someone else's suicide.

Yet in this case, the District Court's decision threatens to deprive New Mexico residents of their fundamental rights to life and safety, and their protection against discrimination, coercion, and an early grave. Rather than adhere to the plain language of the New Mexico Constitution and NMSA 1978, § 30-2-4, the District Court has invented an entirely new "right": ordinary citizens may not assist someone's suicide, but physicians – the trusted medical professionals who pledge to "do no harm" – may. The District Court reached this conclusion based on the dubious notion that: "This Court cannot envision a right more fundamental, more

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[1] No party's counsel authored this brief either in whole or in part, and no counsel, party, or other individual or entity made any monetary contribution intended to fund the preparation or submission of this brief.

Pursuant to N.M.R.A. 12-215(B), all parties received notice of *Amici*'s intent to file this brief on August 1, 2014, more than fourteen days prior to the due date of August 22, 2014.

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." (RP 229-31.) Setting aside the District Court's intrusion on the legislature's powers, its failure to define key terms it employs such as "mentally competent" and "terminally ill," and its utter lack of proposed oversight of these "assisted suicides," it is wholly illogical that the court should overrule the will of the citizens who enacted NMSA 1978 § 30-2-4 to prevent these situations.

But this Court has the power to undo the grave injustice wrought below. In order to uphold the fundamental values of the State of New Mexico, the history and tradition of this State and Nation, and modern notions of human dignity, this Court should reaffirm New Mexico and its citizens' interest in life, safety, sound public policy, and medical integrity by reversing the lower court and restoring the State's authority to enforce NMSA 1978 § 30-2-4.

SUMMARY OF PROCEEDINGS AND INTEREST OF *AMICI*

Amici adopt the Summary of Proceedings as contained in the Defendant-Appellant's Brief in Chief.

Amici are New Mexico legislators and the Christian Medical & Dental Associations. The New Mexico legislators are interested in defending their well-researched and well–reasoned law, as well as of the important New Mexico public policies that it embodies. The Christian Medical & Dental Associations wish to

preserve medical integrity and public health and safety in New Mexico on behalf of their member physicians and New Mexico residents.

Amici contest the district court's characterization of physician-assisted suicide as "peaceful," "dignified," and a means of "avoid[ing] further suffering," as well as its broad characterizations of end of life care under a physician-assisted suicide regime and survivors' (i.e., family members and loved ones') approval of suicide when it is sanctioned by a physician. (RP 220, 222-23.)

SUMMARY OF THE ARGUMENT

The District Court ignored clear constitutional precedent, the needs of New Mexico residents, the integrity of the medical profession, and its own role in New Mexico government when it struck down New Mexico's ban on assisted suicide (including physician-assisted suicide, i.e., the *active* taking of a life through prescription of lethal drugs).

The history, context, and purpose of Article II, § 4 of the New Mexico Constitution demonstrate that it was designed to memorialize the government's purpose as understood by the constitutional framers, not substantively guarantee the right to happiness. Yet even to the extent that § 4 is determined to broaden substantive rights, the District Court was still required to apply a due process analysis. Since the right to die is neither a fundamental part of U.S. or New Mexico history and tradition, nor implicit to ordered liberty, NMSA 1978, § 30-2-4 is

subject only to rational basis review. The district court here, however, elected to skirt its requirement to adhere to federal constitutional analysis, and instead took it upon itself to define the "right to enjoy life and liberty and to seek and obtain safety and happiness." In so doing, it has turned these very rights on their head.

No right enumerated in the New Mexico Constitution suggests the right to enlist a third party in taking one's life. To the contrary, throughout history, Americans and New Mexicans have enjoyed these rights without an opposite right to death. For well over 200 years, no state condoned assisted suicide. The overwhelming majority of States—and the U.S. Supreme Court—reject a fundamental right to die or to physician-assisted suicide. New Mexico, too, has banned physician-assisted suicide to assert its compelling interests in preserving life, protecting the vulnerable, and upholding the integrity of the medical profession.

Not only are individuals with disabilities in equal possession of the fundamental right to life, in the past several decades, they have experienced dramatically improved lives due to groundbreaking new research, modern assistive devices, and the continuing eradication of societal misconceptions and reduction of disability discrimination. Physician-assisted suicide flies in the face of all the progress that has been made; it discriminates against the infirm and promotes calculated, if theoretically self-elected, termination of human beings because of a

perceived imperfection. Modern civilization has long rejected this ulilitarian vision of population control.

New Mexico likewise has an interest in affirming the medical profession as a healing profession with the duty to "do no harm." Prescribing fatal medication with the express intent to kill flies in the face of that duty. The integrity of the profession depends on its ability to utilize the best practices, with the best information, to promote patient well-being. In contrast, physician-assisted suicide is fraught with uncertainty and risk. Terminal diagnoses can be inaccurate. More than 40% of patients with disorders of consciousness are misdiagnosed, *see, e.g.*, Martin M. Monti et al., *Willful Modulation of Brain Activity in Disorders of Consciousness*, 362 NEW ENGLAND J. OF MED. 579 (2010) (noting that the rate of misdiagnosis of disorders of consciousness is approximately 40%); K. Andrews et al., *Misdiagnosis of the Vegetative State: Retrospective Study in a Rehabilitation Unit*, 313 BRITISH MED. J. 13 (1996) (finding a 43% misdiagnosis rate, even among long-term patients). This rate has not changed despite medical advances over the last 15 years. *See* Caroline Schnakers et al., *Diagnostic Accuracy of the Vegetative and Minimally Conscious State: Clinical Consensus Versus Standardized Neurobehavioral Assessment*, 9 BMC NEUROLOGY 35 (2009). Overall, it is estimated that up to 15% of diagnoses are incorrect in most areas of

medicine. *See* Eta S. Berner & Mark L. Graber, *Overconfidence as a Cause of Diagnostic Error in Medicine*, 121 AM. J. MED. S2 (2008).

And depression reduces the capacity to make life and death decisions. Moreover, the false promise of death "with dignity" ignores the realities of actual deaths via physician-assisted suicide. With the growth of and trailblazing improvements in palliative care, there is no excuse to destroy life simply because it grows imperfect, old, or frail. By prohibiting assisted suicide, more attention and focus can be directed toward palliative care and research improving the latter days of a person's life, rather than making a so-called problem go away.

Rather than give these vital interests their due deference, the district court ventured far afield of its constitutionally appointed authority. High-risk controversial policy considerations warrant deference to democratic institutions, and the court was to respect the legislature's ability to use its assets and resources to determine what is best for New Mexico. Otherwise, an institution designed primarily for responding to problems is at risk of creating them. And the legislative scramble that would ensue in an effort to regulate the industry of death if the lower court's decision is allowed to stand, would only cause confusion and uncertainty as funding and programs going towards the future of palliative care are diverted to the impossible task of regulating death. Rather than resuscitating medieval notions about the value of human life, it is better to secure a future of compassion for the

hurting. The focus should be on improving lives, not maximizing discriminatory notions of utility.

ARGUMENT

I. The District Court Misapplied Constitutional Precedent and Improperly Dismissed New Mexico's Rational Basis for Prohibiting Physician-Assisted Suicide.

NMSA 1978, § 30-2-4 (hereinafter "Assisted Suicide Ban") is entitled to rational basis scrutiny and a presumption of constitutionality, but the district court ignored this.

The level of judicial scrutiny depends on the nature of the interest at stake. *See Marrujo v. N.M. State Highway Transp. Dep't*, 1994-NMSC-116, ¶¶ 9-12, 118 N.M. 753 (discussing the tripartite framework for constitutional review: strict scrutiny for fundamental rights, intermediate scrutiny for important rights, and rational basis and presumption of constitutionality for all others). And in New Mexico, scrutiny analysis is the same for due process and equal protection under both state and federal constitutions. *Id.* at 9.

The origin of the purported right to die is paramount to the court's analysis. Under the interstitial approach, New Mexico courts first determine if a right is protected by the federal constitution. If it is, then only federal precedent is relevant to a determination of fundamentality. *See State v. Gomez*, 1997-NMSC-006, ¶¶ 19-22, 122 N.M. 777, 932 P.2d 1; *see also generally* N.M. CONST. art II, § 1 ("the

Constitution of the United States is the supreme law of the land"). Because physician-assisted suicide is not protected by the federal constitution, *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997), New Mexico state courts should only depart from federal analysis for one of three reasons: (1) a flawed federal precedent, (2) structural differences between the state and federal governments, or (3) distinctive state characteristics. *Gomez*, 1997-NMSC-006, ¶ 19.

It is unclear why the trial court determined that departure from *Glucksberg* was necessary under Article II, § 4 of the New Mexico Constitution [hereinafter, "natural rights clause"], which states that "[a]ll persons . . . have certain natural, inherent and inalienable rights, among which are the rights of enjoying and defending life and liberty, of acquiring, possessing, and protecting property, and *of seeking and obtaining safety and happiness*." N.M. CONST. art. II, § 4 (emphasis added). The court relied heavily on this clause to depart from federal precedent, but failed to explain why. Plaintiffs failed to demonstrate that each element of the test was met. First, there was no argument or suggestion that federal precedent (i.e., *Washington v. Glucksberg*) is flawed. Second, there are structural differences between state and federal government, but no evidence that these are implicated by assisted suicide. Third, there is nothing unique about New Mexico and no fundamentally different traditions, history, or morals that could make physician-assisted suicide more acceptable here than in any other state in the Union. Yet the

District Court skipped ahead to the due process clause for its bifurcated legal analysis.

Once at the due process clause, there is no longer any excuse whatsoever to avoid federal precedent. The state and federal provisions are identical. And under this analysis, the U.S. Supreme Court has conclusively determined that physician-assisted suicide is not a fundamental right. *Glucksberg,* 521 U.S. at 725 ("The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection."). This should not have been so lightly cast aside.

Similarly inconsistent, the District Court here took two stances on the specificity of NMSA 1978, § 30-2-4, declaring that "[s]ome state legislatures, including Arkansas and Idaho, have enacted laws with specificity to make clear their state's prohibition against aid in dying. These states did so despite their preexisting prohibition against assisted suicide. Statutes which specifically include aid in dying as assisting suicide are more specific than NMSA 1978, § 30-2-4." (RP 222.) Yet it also claimed that "NMSA 1978, § 30-2-4 currently prevents terminally ill New Mexicans, at their most vulnerable time, from seeking relief which is medically recognized and medically available." (RP 221.)

If the district court was consistent in its analysis and properly acknowledged the dangerous path to a "right to happiness," it would have explained why prohibiting assisted suicide was a deprivation of happiness, not of due process, or else adhered to the federal constitutional due process precedent.

II. Even if N.M. CONST. art. II, § 4 Permitted Departure from Federal Precedent, New Mexico's History and the Purpose of the Natural Rights Clauses Demonstrate That There Is No Fundamental Right to Assisted Suicide in the New Mexico Constitution.

Only traditionally and historically rooted rights enjoy protection as fundamental rights; they must be implicit in the concept of ordered liberty such that, without them, liberty would cease to exist. In contrast, allowing a fundamental "right to happiness" would produce an absurd guarantee foreign to rational government.

Given the tradition of prohibiting assisted suicide for many hundreds of years, it is wholly implausible that such a right has either existed all along despite being so reviled over the centuries, or that it suddenly sprang into existence.

The district court was far afield in attempting to twist the New Mexico Constitution's happiness clause to guarantee substantive rights. These clauses have been used in multiple state constitutions, and are understood not as substantive guarantees, but as simple statements that the government aspires to a certain ideal. Moreover, the result of the trial court's decision produces an impractical

application of the natural rights clause. Together, these facts—wholly ignored by the court below—demonstrate an entirely different purpose for the inclusion of the natural rights clause in a state constitution.

A. *The History of Natural Rights Clauses from the Early Twentieth Century Demonstrates Their Non-Substantive Purpose.*

The inclusion of a natural rights clause in the New Mexico Constitution acknowledges the liberty tradition of the American republic and preserves that notion in New Mexico's incorporating document. During the New Mexico constitutional convention, among the "rough and tumble" political fights and battles, discussion and controversy over article II, § 4 were nonexistent. Marshall J. Ray, *What Does the Natural Rights Clause Mean to New Mexico?*, 39 N.M. L. REV. 375, 388 (2009). It is highly unlikely that an uncontroverted clause would have the broad-reaching guarantees assigned to it by the district court. This provision was merely the declaration of an end goal; it was the remaining sections (i.e., due process) that served to further the stated end.

Natural rights provisions acknowledge the purpose of government: establishing social order through the protection of fundamental human rights. This concept is familiar to all Americans. As the Declaration of Independence famously states, "all men are endowed by their Creator with certain inalienable Rights, among these are Life, Liberty, and the pursuit of Happiness." THE DECLARATION

OF INDEPENDENCE para. 2 (U.S. 1776). But no one would argue that the American Founders intended to guarantee happiness.

Other state clauses similarly demonstrate these principles. The Wisconsin Supreme Court distinguishes between inalienable rights and natural rights, WISC. CONST. art. I, § 1, on the understanding that natural rights denote "the functional character of rights of members of a community in an unorganized state." Ray, *supra* at 390 (quoting *State v. Phelps*, 128 N.W. 1041 (Wis. 1910)). Thus the character, but not the substance, of the rights are expressed by the natural rights clause. Natural rights exist as a fundamental part of being human. But these rights must also give way, at times, to greater communal interests. The trial court presented no intelligible limit on a right to happiness. But unqualified inalienability of rights would mean that no government interest would be compelling enough to protect the needs of society.

After declaring that "the liberty, safety, and happiness interest of a competent, terminally ill patient to choose aid in dying is a fundamental right" (RP 230), the court below shifted gears to its due process analysis, which – when properly applied and not stretched to encompass aspirational goals – strikes the necessary balance between individual liberty and society's interests.

B. A Substantive Right to Happiness Is a Wholly Impractical Legal Guarantee.

New Mexico courts have had little opportunity to interpret the natural rights provision of the New Mexico. *See, e.g., Richardson v. Carnegie Library Restaurant, Inc.*, 1988-NMSC-084, ¶ 29, 107 N.M. 688, 763 P.2d 1153 (1988), *overruled on other grounds by Trujillo v. City of Albuquerque*, 1998-NMSC-031, 125 N.M. 721, 965 P.2d 305. The trial court made note of this in its findings of facts and conclusions of law, but failed to take this into account when interpreting the clause. The fact that the Supreme Court has shied away from § 4 is good evidence it is more ornament than substance. This is understandable, given the inherent subjectivity of happiness. Without credence to the overall context of constitutional interpretation, people could wish up any right as long as it "makes them happy." Courts would become the supreme arbiters, or "superlegislatures," and the happiness provision could be used to tear down democratically enacted statutes that do not conform to their own ideology. This is hardly a "blessing of liberty," as is "guaranteed" in the preamble to the New Mexico Constitution. N.M. CONST. pmbl. Rather, the history and context of the provision must be examined and strictly adhered to.

The New Mexico Supreme Court has wisely avoided a head-on collision with § 4 by refusing to give any substance to the natural rights clause. *See, e.g., Lucero v. Salazar*, 1994-NMCA-066, ¶¶ 6-8, 117 N.M. 803, 877 P.2d 1106

(avoiding a cause of action for deprivation of happiness by ruling on the issue of causation in a suit against a police officer who killed the plaintiff's father); *Blea v. City of Espanola*, 1994-NMCA-008, ¶¶ 20-21, 117 N.M. 217, 870 P.2d 755 (finding that the natural rights clause guarantees were not sufficient "constitutional guarantees" to trigger waiver of sovereign immunity as permitted by statute). The district court should have done likewise.

III. History, Tradition, and New Mexico's Interests Support the Preservation of the Value of Human Life and the Protection of the Medical Profession's Integrity, Not Physician-Assisted Suicide.

Physician-assisted suicide simply does not meet the strictures required for a right to be fundamental. It is absent from, and contrary to, New Mexico history and tradition. It is not implicit in the concept of ordered liberty. And even if it were fundamental, the state interests of New Mexico are compelling and narrowly tailored so as to justify an alleged violation of the purported right to assisted suicide.

A. History & Tradition Weigh Against Assisted Suicide

To merit strict scrutiny, a statute must "adversely affect a fundamental personal right[. . .]." *Vandolsen v. Constructors, Inc.*, 1984-NMCA-023, ¶ 4, 101 N.M. 109, 678 P.2d 1184, 1187. Fundamental rights are those such as "[F]irst Amendment rights, freedom of association, voting, interstate travel, privacy, and

fairness in deprivation of life, liberty, or property . . . ." *Marrujo*, 1994-NMSC-116, ¶ 10, 118 N.M. 753, 887 P.2d at 757. These are rights that, if violated, "shock the conscience" as they are "implicit in the concept of ordered liberty." *Bounds v. State ex rel. D'Antonio*, 2013-NMSC-037, ¶ 50, 306 P.3d 457 (quoting *Wagner v. AGW Consultants*, 2005-NMSC-016, ¶ 30, 137 N.M. 734, 114 P.3d 1050 (internal citation and quotation marks omitted). Physician-assisted suicide meets none the requirements for fundamentality.

The United States Supreme Court handily disproved that assisted suicide is a fundamental right. The Court stated that "the decision to commit suicide with the assistance of another . . . has never enjoyed similar legal protection [as the right to refuse unwanted medical treatment]." *Glucksberg*, 521 U.S. at 725. This stems from the dramatic contrast between the passive right to refuse treatment, and the active right to life-ending prescription drugs. This distinction is deeply rooted in America's "history and constitutional traditions." *Id.* Forced medical intervention was a battery and violation of autonomy, which made refusal of treatment an exercise of a patient's autonomy. *Id.* But there is no analog for the right to deadly prescriptions. This requires the affirmative intervention of a third party. *Id.* Nor is there a fundamental right to have a member of a well-respected profession intentionally induce the death of someone to whom she is to be a healer.

The State of New Mexico has also consistently prohibited assisted suicide since at least 1865. *See Revised statutes and laws of the Territory of New Mexico: in force at the close of the session of the Legislative Assembly ending February 2, 1865,* at Chapter II, Sec. 9, page 320 (St. Louis, R.P. Studley and Co., printers, 1865) ("Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of murder in the third degree"); *see also* N.M. Complied Laws 1885, § 696 (same); N.M. Compiled Laws 1897, §1072 (same). In 1907, the Legislature amended the statute to read "Every person deliberately assisting another in the commission of self-murder shall be deemed guilty of manslaughter." *See* N.M. Laws 1907, Ch. 36, § 4, p. 42. The 1907 version of the statute existed at the time the New Mexico Constitution was adopted at Statehood, and continued in effect until 1963. *See* NMSA 1915, § 1462; NMSA 1929, § 35-307; NMSA 1941, § 41-2408; and NMSA 1953, § 40-24-8. In 1963, the Legislature repealed this statute, and simultaneously enacted a replacement. *See* N.M. Laws 1963, at Ch. 303, p. 825 (repealing previous statute); and Ch. 303, § 2-5, p. 836. The 1963 version of the statute, which has remained unchanged ever since, provides "Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth degree felony." It was originally compiled at NMSA 1953, § 40A-2-5, and is now compiled at NMSA 1978, § 30-2-4. Moreover, in the Uniform Health-Care

Decisions Act ("UHCDA"), the legislature circumscribed assisted suicide out of personal autonomy in medical and end-of-life decision-making. The UHCDA explicitly states that it does not authorize "mercy killing, assisted suicide, [or] euthanasia . . . ." NMSA 1978, § 24-7A-13(C) (1995). Such action on the part of the legislature, representative of the collective will, is strong evidence of a history and tradition *against* physician-assisted suicide, not in favor. There is no example whatsoever of this state endorsing the intentional taking of life.

Thus, far from being a deeply-rooted tradition, assisted suicide has been a form of criminal homicide in New Mexico for at least the past 149 years. This unbroken history is critical in understanding what the New Mexico Constitution means. Our Supreme Court has said that in interpreting the state constitution, "[t]he most important consideration" is to "interpret the constitution in a a way that reflects the drafters' intent." *State v. Lynch*, 2003-NMSC-020, ¶ 24, 134 N.M. 139. The fact that assisted suicide was a crime at the time the New Mexico Constitution was enacted, and the fact that it said nothing about assisted suicide, mean that the framers could not possibly have intended to create or protect a supposed "right" to assisted suicide.

And New Mexico is not alone. The concept of physician-assisted suicide is relatively foreign to this nation, as the Supreme Court has extensively observed. For "over 700 years, the Anglo-American common-law tradition has punished or

otherwise disapproved of both suicide and assisted suicide." *Washington v. Glucksberg*, 521 U.S. 702, 710 (1997); *see also id.* at n.9 (noting that this tradition goes back as far as the pre-Norman era (i.e., more than 1,000 years)). Only three U.S. states have decriminalized physician-assisted suicide: Oregon in 1994, Washington in 2008, and Vermont in 2013. In Montana, *Baxter v. Montana*, 354 Mont. 234 (2009) merely allowed a possible consent defense to murder charges, and Vermont is considering repeal of its dangerous law.[2] New Hampshire overwhelmingly rejected an assisted-suicide bill earlier this year, with a vote of 219-66. There is simply no deeply rooted tradition or history of physician-assisted suicide (to the contrary, the history points even more vehemently to the right to life), so the purported right to assistance in suicide is not fundamental – and without fundamentality, the Assisted Suicide Statute requires only rational-basis review.

B. New Mexico's Interests

Even were this Court to classify physician-assisted suicide as a fundamental right, New Mexico's interests—ignored by the trial court—are sufficiently compelling to prohibit physician-assisted suicide. They include (1) preserving New Mexico's interest in the sanctity and affirmation of the value of human life; (2)

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[2] *See, e.g.*, http://www.patientsrightsaction.org/18-vt-senate-president-says-he-d-support-repeal-of-assisted-suicide-law.htm.

protecting individuals who are physically, mentally, and/or psychologically vulnerable from making or having thrust upon them a decision with permanent consequences; (3) upholding the integrity of the medical profession; and (4) avoiding the slippery slope to non-voluntary euthanasia of adults and children. And there are other areas of concern such as the effectiveness of assisted-suicide drugs. *See* Kenneth Chambaere et al., *Physician-assisted Deaths Under the Euthanasia Law in Belgium: A Population-based Survey*, 182 CAN. MED. ASS'N J. 6 (2010) (explaining how some patients have vomited and have even regained consciousness after taking the drugs, enduring both severe pain and humiliation). New Mexico should invest instead in a future of palliative care, pain management and psychological alleviation, and disease management.

The decision to take one's life is, of course, very private. But a state's interest in social order permits interference when the line from private to public is breached, such as when a third party is enlisted to bring about an intentional death. This is an important difference between refusal of treatment and assisted suicide. It is at the heart of all of the concerns that follow.

1. Affirmation of the Value of Human Life

"[E]ven as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide." *Vacco v. Quill*, 521 U.S. 793, 805-06 (1997). There is a stark difference between exercising one's right

not to undergo unwanted extraordinary measures and pressing a physician to prescribe what is essentially a poison for the purpose of suicide.

As cited by the U.S. Supreme Court in *Vacco*, 521 U.S. at 801 n.6, the American Medical Association has emphasized the "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." American Medical Association, Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide*, 10 ISSUES IN LAW & MEDICINE 91, 93 (1994); *see also* American Medical Association, Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2230-2231, 2233 (1992) ("The withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence," but assisted suicide "is contrary to the prohibition against using the tools of medicine to cause a patient's death"); New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 108 (1994) ("[Professional organizations] consistently distinguish assisted suicide and euthanasia from the withdrawing or withholding of treatment, and from the provision of palliative treatments or other medical care that risk fatal side effects").

The ruling of the lower court rested upon a draconian notion of human worth. The state has an unqualified interest in the protection of all life, and need not make discriminatory judgments about the value of life for different classes of

individuals—certainly none based on mental or physical illness. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 262 (1990). The court and Plaintiffs would make value judgments about the quality of human life *based on terminality, age, or disability.* This discrimination is a violation of the laws of this country and the morals of its people. The ADA prevents discrimination or disparate treatment of those who have disabilities. *See* 42 U.S.C. § 12132 (West 1990). Because people with terminal illnesses are physically affected in all areas of bodily function and are often subjected to both physical and mental impairment, many of those who are "terminally ill" will also be disabled for purposes of the ADA. *See* 42 U.S.C. § 12102. And recent media coverage of Robin Williams's suicide, when contrasted with open promotion of assisted suicide to elder adults by a suspended Australian physician, sheds further light on the classes of suicide-vulnerable individuals and society's differing reactions based on the person's age and health. *See* Xavier Symons, *Media Ethics 101: How Not to Report Suicide*, BIOEDGE, Aug. 16, 2014.[3]

There is concern too about the accuracy of terminal diagnoses and prognoses. Many people who are terminally diagnosed outlive the six-month diagnosis generally required for physician-assisted suicide in the three states where it is legal. This may create a false premise upon which a decision to die is made—a

[3] Available at http://www.bioedge.org/index.php/bioethics/bioethics_article/11102.

recklessly fatal fallacy. Many regulations lack effective criteria to determine just what it means to be terminal and how long that person will live. Fewer people would want to hasten their death if they knew just how uncertain doctors really are about prognoses.

Harvard professor of sociology and medicine Nicholas Christakis agrees that doctors often get terminality wrong in determining eligibility for hospice care. *See* Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/. At least 17% of patients outlived their prognosis in a recent study. *See id.* In recognition of this disturbing fact, Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, has declared that six months is an arbitrary figure. *See id.* And real-world stories support the claims made by experts in the field:

- Maryanne Clayton, diagnosed with Stage IV lung cancer at age 62, was told by her doctor that she had two to four months to live. She lived four to five more years and had enough time to try groundbreaking treatment methods, which improved her life. She did almost die once, but not by prescription—by a hot air balloon accident. None of this would have happened if she had followed Plaintiffs' plan for patients like her. *See id.*
- Dr. J. Randall Curtis recalls a patient suffering from septic shock and multiple organ failure. He thought she would live "days to weeks." *Id.*

(internal quotations marks omitted). This same woman recovered and visited him six to eight months later. Dr. Curtis described this as "humbling" and "the kind of thing in medicine that happens frequently." *Id.*

- Dr. Bud Mayer, former Assistant United States Secretary of Defense, was diagnosed with pneumonia and congestive heart failure. He had a stroke five years later. He then had a kidney fail a year after that, and was at last diagnosed with angina. Now over seventy-five years old, he gave himself a couple of months at most. But his doctor gave him six months and sent him to hospice. He lived almost two and a half years after all of this, *see id.*; Bonnie Bartel Latino, *The Late Dr. William E. Mayer Worthy of Being Remembered*, MILITARY WRITERS SOCIETY OF AMERICA, Jan. 1, 2012, and recalled that even those years of his life were a "wonderful, peaceful" period for him—and he believes it would have been cut short by physician-assisted suicide. *See* Shapiro, *supra.*

The uncertainty surrounding the terminality determination indicates that the State of New Mexico has a compelling and rational interest in declaring that the risk is not worth it. Increasing the quality of life through improvements in palliative care, counseling, and innovative solutions to end-of-life care should be the focus.

2. Protecting the Vulnerable

The choice to end a life is final. Yet due to the circumstances inherent in terminal care, there are legitimate concerns about the capacity and vulnerability of those making the decision, including elder adults and individuals with disabilities, individuals suffering from depression, and those facing economic and social duress. The State of New Mexico has a compelling interest in protecting all of them.

a. Elder Adults and Individuals with Disabilities

New Mexico has a compelling interest in preventing and reducing elder abuse, which is a serious problem in New Mexico, but jurisdictions with legalized assisted suicide and euthanasia produce statistics consistent with elder abuse. Margaret Dore, *"Death with Dignity": A Recipe for Elder Abuse & Homicide (Albeit Not by Name)*, 11 MARQ. ELDER ADVISOR 387, 396 (2010). The New Mexico Adult Protective Service has recently seen a 27% increase in referrals to their agency, along with 11,027 reports of neglect and abuse in 2013. *See Adult Abuse Awareness*, N.M. AGING & LONG-TERM SERVS. DEP'T .[4] In contradiction to state policy, assisted suicide will increase the frequency of elder abuse in New Mexico even further.

[4] http://www.nmaging.state.nm.us/Adult_Abuse_Awareness.aspx (last visited July 23, 2014).

Comparing the Washington and Oregon assisted suicide laws, assisted suicide expert Margaret Dore, Esq., notes the juxtaposition of physician-assisted suicide and elder abuse. These are deficiencies in a legislative and regulatory scheme. Without deference to the legislature, an unregulated, court-created scheme of physician-assisted suicide could cause even greater exploitation of the vulnerable. *See* Part IV, *infra*, for further discussion.

To date, the victims of physician-assisted suicide have primarily well-educated and covered by private insurance, indicating potential material gain for heirs upon their demise. *See* Dore, *supra*, at 397, n.60. The majority are also over sixty-five, and hence more likely to have heirs. *See id.* at 397. Dore notes a study conducted by Metlife Insurance identifying elders as prime targets of financial abuse. *See Broken Trust: Elders, Family, and Finances*, METLIFE MATURE MKT. INST. (2009).[5] More than 50% of the culprits are family members who seek financial gain from their elder relatives at a time when they are most vulnerable. *See id.* And physician-assisted suicide only creates broader opportunities for elder exploitation and the abuse of individuals with disabilities.

As disability rights advocate Ana Acton recently wrote, the expansion of physician-assisted suicide "disproportionately affects the poor and people living with disabilities. That explains, at least in part, why there is widespread opposition

[5] https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf.

from virtually every disability rights group in the nation. . . . Assisted suicide doesn't exist in a vacuum . . . ." Ana Acton, *The Progressive Case Against Assisted Suicide*, HUFFINGTON POST, Aug. 4, 2014.[6]

Current laws generally require that there be witnesses at the time the patient requests the poison, but no such requirement exists relevant to the time of actual administration. *See* WASH. REV. CODE. ANN. §§ 70.245.010-904 (West 2009); OR. REV. STAT. §§ 127.800-897 (containing only a "suggestion" that the doctor "remind" the patient of the importance of having another person present when she takes the medication). As Dore points out, there is no requirement or enforcement to ensure that it is actually the patient administering the medicine. The laws do not require consent at the time the pill is taken, either. Dore, *supra* at 377-88. On average, the physician is present at administration about 7% of the time. *See* PATIENTS RIGHTS COUNCIL, REPORTED ASSISTED-SUICIDE DEATHS IN OREGON & WASHINGTON STATE, www.patientsrightscouncil.org, April, 2010.[7]

Dore cites the case of an individual who receives a dose in accordance with the statutory requirements, but then becomes incompetent or falls asleep—a situation that is ripe for abuse. *See* Dore, *supra* note 24, at 394. Physician-assisted suicide flings open the door to abuse and exploitation of elder adults and

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[6] Available at http://www.huffingtonpost.com/ana-acton/the-progressive-case-agai_1_b_5648126.html.

[7] http://www.patientsrightscouncil.org/site/wp-content/uploads/2011/02/OR_WA_Reported_Deaths_04_10.pdf.

individuals with disabilities. New Mexico has a compelling interest in preventing elder abuse and mistreatment of individuals with disabilities through prohibiting assisted suicide.

b. Individuals Suffering from Depression

There is strong evidence of a direct link between requests for suicide pills and depression. The National Alliance on Mental Illness states that depression affects "one's thoughts, feelings, behavior, mood and physical health." *What is Depression*, NAT'L ALLIANCE ON MENTAL ILLNESS (last accessed July 24, 2014).[8] Doctors often have difficulty even diagnosing, much less treating, those who are suffering from depression and depressive symptoms. *See* William Breitbart & Barry D. Rosenfeld, *Physician-Assisted Suicide: The Influence of Psychosocial Issues*, INT'L ASS'N FOR HOSPICE & PALLIATIVE CARE (accessed July 24, 2014).[9] Patients who suffer from depression are going unnoticed and untreated. Yet amidst vulnerability they are entrusted with a decision of whether or not they wish to die. The State of New Mexico has a compelling interest in seeing to it that people suffering from the illness of depression are treated, not killed.

In Oregon, the Death with Dignity Act requires that a physician refer patients who may have psychological impairments to a consulting physician. OR.

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[8] http://www.nami.org/Template.cfm?Section=depression.

[9] http://hospicecare.com/resources/ethical-issues/essays-and-articles-on-ethics-in-palliative-care/physician-assisted-suicide-the-influence-of-psychosocial-issues/#.

REV. STAT. § 127.825. Washington has a similar provision. WASH. REV. CODE. ANN. § 70.245.060. These provisions supposedly ensure the appropriate state of mind for requesting suicide pills. But fewer than 10% of those requesting suicide drugs have been referred to a psychologist. Depression is being overlooked among those requesting assisted suicide.

Studies are suggesting that depression and hopelessness are key motivating factors behind a patient request for physician-assisted suicide. *See* Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JOURNAL OF AM. MED. 19 (2000).[10] Based on numerous studies, a writer in the *New York Times* noted that the reason for assisted suicide is rarely pain, or even fear of pain. Instead, the reason is typically "depression, hopelessness and fear of loss of autonomy and control. . . . In this light, assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."[11] And both depression and pain can be treated effectively, but patients need more funding and CME for doctors, not for them to throw in the towel.

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[10] *Available at* http://jama.jamanetwork.com/article.aspx?articleid=193281#REF-JOC01512-4.

[11] http://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/.

In 2013 in Oregon, only two of the 71 patients who actually committed physician-assisted suicide were referred for counseling.[12] In one particularly clear-cut case, a man with a 43-year history of suicide attempts, paranoia, and depression was deemed not to require counseling prior to assisted suicide.[13] Complaints have been filed against a doctor in Belgium due to the death by assisted suicide of a woman who was depressed. *See, e.g.*, Michael Cook, *Official Complaint Lodged Against Leading Belgian Euthanasia Doctor*, BIOEDGE, Feb. 23, 2014.[14] Her physician pressured her into taking the medication. She died without her son even being able to say farewell. *See id.* In another case, a physician could not protect his patient whom he thought was depressed and unfit for assisted suicide. Against his wishes and judgment, the patient obtained a prescription from another doctor and killed himself. *See* Dr. Charles J. Bentz, Letter to the Editor, *Oregon Doctor Could Not Save Patient from Assisted Suicide*, MONTANA STANDARD, Jan. 27, 2013.[15]

In Oregon, one study explains that depression as a factor for requesting assisted suicide is overlooked. About 16% of patients requesting assistance in suicide are depressed or suffering from anxiety. *See* Linda Ganzini et al.,

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[12] *See* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf.

[13] *See, e.g.*, http://dredf.org/public-policy/assisted-suicide/some-oregon-assisted-suicide-abuses-and-complications/.

[14] http://www.bioedge.org/index.php/bioethics/bioethics_article/10861.

[15] http://mtstandard.com/news/opinion/mailbag/oregon-doctor-could-not-save-patient-from-assisted-suicide/article_a4b605ba-6767-11e2-bf94-0019bb2963f4.html.

Prevalence of Depression and Anxiety in Patients Requesting Aid in Dying: Cross Sectional Survey, 337 BRITISH MED. J. 1682 (2008).[16] These statistics indicate that depression could be at the root of some people's desire to end their own life. This should be treated, not dismissed.

Depression and physician-assisted suicide presents an inherent conflict of interests. When a patient is suffering from depression, removal of lethal means is central to treating the patient. But the very object of physician-assisted suicide is to provide a lethal means to end life. *See, e.g.*, N. Gregory Hamilton & Catherine Hamilton, *Competing Paradigms to Responding to Assisted-Suicide Requests in Oregon: Case Report*, AMERICAN PSYCHIATRIC ASSOCIATION ANNUAL MEETING SYMPOSIUM ON ETHICS AND END-OF-LIFE CARE: NEW INSIGHTS AND CHALLENGES, (May 6, 2004).[17] It is certainly rational for the State of New Mexico to conclude that it should encourage improvement of palliative and elder care, instead of courting the dangers of assisted suicide. Risking assisted suicide with depressed and anxious patients is like lighting a candle in a gunpowder magazine.

c. Individuals Facing Economic and Social Duress

Insurance, physician pressure, and even family members contribute to end-of-life struggles. There are tragic cases of people who have been denied care by

[16] *Available at* http://www.bmj.com/content/337/bmj.a1682.full.
[17] *Available at* http://www.pccef.org/articles/art28.htm.

their insurance companies, but readily offered coverage for suicide pills. The legalization of assisted suicide provides a cheap alternative to palliative care: killing the person. Some patients may be left with suicide as the only feasible option financially. The very threshold generally required by law for assisted suicide eligibility (a terminal, six-month diagnosis) increases the likelihood that a person will not have the care they truly need covered by insurance. *See* Ken Stevens, MD, Aff.[18] From a purely economic point of view, the vulnerable are out of luck; the treatment they really need may cost thousands of dollars, but the "problem" – the patient – can be made to go away with $50 in pills. *See, e.g.*, Susan Harding, *Letter Noting Assisted Suicide Raises Questions*, KATU, July 30, 2008, *available at* http://www.katu.com/news/specialreports/26119539.html (relating the story of Barbara Wagner, who wasn't ready to die. Instead of covering a new drug that could help her cancer, the Oregon Health Plan offered to pay for her assisted suicide); Susan Donaldson James, *Death Drugs Cause Uproar in Oregon*, ABC NEWS, Aug. 6, 2008 (explaining that Wagner's prescriptions were about $4,000 a month, whereas the assisted suicide pills were only about $50, a one-time cost).[19] The State of New Mexico has a compelling interest in ensuring that its citizens and residents are never subjected to such unconscionable pressures.

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[18] *Available at* http://maasdocuments.files.wordpress.com/2012/09/signed-stevens-aff-9-18-12.pdf

[19] http://abcnews.go.com/Health/story?id=5517492&page=1&singlePage=true.

There are also sociological pressures that can contribute to a person's desire to end their life. A majority of people facing terminal illness feel lonely. They feel like they are a burden on their family and caretakers. When their doctor is offering a way out, the pressure mounts.

Some doctors can provide pressure that can be difficult to resist, especially when the doctor's suggestions fail to emphasize the patient's right to live. *See, e.g.*, David Shaywitz, *"But Doctor, I Want to Live": The Other Side of the "Dignified Death" Debate*, FORBES, Dec. 18, 2013.[20] When a patient says he or she wants to die, it is usually the result of an underlying insecurity. *See* William Toffler, MD, *What People Mean When They Say They Want to Die*, CHOICE IS AN ILLUSION (discussing what people really mean when they say they want to die).[21] Being a burden to others, and fear of a decline in personal dignity, rank among the primary motivations for seeking assisted suicide. *See* Anthony L. Black et al., *Physician-assisted Suicide and Euthanasia in Washington State*, 275 J. AM. MED. ASS'N 12, (1996); William Yardley, *Report Finds 36 Died Under Assisted Suicide Law*, NY TIMES, at A17, March 5, 2010; Kenneth R. Stevens, Jr., *Pain and Physician-assisted Suicide — What is Going On?* PHYSICIANS FOR COMPASSIONATE CARE EDUC. FOUND., Aug. 25, 2008 (finding that pain is an illusory motivation for

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[20] http://www.forbes.com/sites/davidshaywitz/2013/12/18/but-doctor-i-want-to-live-the-other-side-of-the-dignified-death-debate/.

[21] http://www.choiceillusion.org/p/what-people-mean_25.html (last visited July 24, 2014).

assisted suicide and that "[t]here is not one case in Oregon of assisted suicide being used for actual untreatable uncontrollable pain.").[22] New Mexico should has a compelling interest in encouraging real solutions to patient suffering, both mental and physical, rather than allowing people to be pressured into assisted suicide, which may seem to them like the path of least resistance. Instead, New Mexico should provide better care. Doctors who provide real treatment and stand up against the assisted-suicide culture improve lives. Patient Jeanette Hall, once in favor of physician-assisted suicide, testifies to this. After she was diagnosed with cancer, her doctor talked her out of taking assisted-suicide pills; now she says, "I am so happy to be alive!" Jeanette Hall, Letter to the Editor (online), *Assisted Suicide Prompts Some Terminally Ill Patients to Give Up on Life Prematurely*, RAVALLI REPUBLIC, Nov. 28, 2012, 6:15am.[23] Jeanette lived at least twelve more years—a life of dignity.

3. The Slippery Slope of Euthanasia

Those states and foreign countries that have legalized assisted suicide have seen an enormous increase in deaths by suicide. *A Deadly Conflict of Interest*, EUTHANASIA PREVENTION COALITION, Nov. 25, 2013 (stating that there has been a

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[22] http://www.pccef.org/articles/art70.htm.

[23] http://ravallirepublic.com/news/opinion/mailbag/article_e05fa28b-dd72-5688-a321-654cc86fc213.html.

500% increase in euthanasia cases in Belgium in ten years);[24] *Euthanasia Requests Rose in 2012*, DUTCH NEWS, Sep. 24, 2013 (finding that euthanasia rose by 13% in the Netherlands);[25] *Death with Dignity Act-2013*, OR. PUB. HEALTH DEP'T (last visited July 23, 2014) (indicating that over the last 16 years, assisted suicide has risen, with a record high in 2012; as of 2013, rates had slightly declined, but not all reports were available at the time of publishing).[26]

Many cases are going unreported, which is a major concern for accountability. *See* Bregje D. Onwuteaka-Philipsen et al., *Trends in End-of-Life Practices Before and After the Enactment of the Euthanasia Law in the Netherlands from 1990 to 2010: A Repeated Cross-sectional Survey*, THE LANCET, Tbl. 4 (published online July 11, 2012).[27] The prevalence of the practice causes a desensitization and insensitivity for the plight of the infirm. *See, e.g.*, Ezekiel J. Emanuel, *Whose Right to Die?,* THE ATLANTIC, Mar. 1, 1997, 12:00pm (dispelling many of the myths about assisted suicide, long before the practice was internationally prevalent).[28] Of those countries that have legalized it, assisted suicide for purely physical suffering has been extended to psychological and

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[24] http://www.epce.eu/en/a-deadly-conflict-of-interest/.

[25] http://www.dutchnews.nl/news/archives/2013/09/euthanasia_requests_rose_in_20.php.

[26] http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx.

[27] http://press.thelancet.com/netherlands_euthanasia.pdf.

[28] http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/304641/?single_page=true.

emotional suffering. *See, e.g.*, *supra*; Bruno Waterfield, *Belgian Killed by Euthanasia After a Botched Sex Change Operation*, THE TELEGRAPH, Oct. 1, 2013.[29] Even more disturbing is that in Belgium numerous people are being euthanized without an explicit request. *See, e.g.*, Tinne Smets et al., *Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases*, 341 BRITISH MED. J. 5174 (2010) (finding that only fifty percent of cases of euthanasia are actually reported in Flanders).[30] The State has a legitimate and compelling interest in not being forced down this potentially dangerous road.

Dr. Peter Saunders has observed that "[i]t is widely acknowledged that euthanasia is out of control in Belgium." There's been "a 500% increase in cases in ten years; one third involuntary; half not reported; euthanasia for blindness, anorexia and botched sex change operations; organ transplant euthanasia; plans to extend euthanasia to children and people with dementia." Writing before the Belgian Senate vote last February, Saunders observed, "[I]t is clear that in practice the boundaries are continually migrating and the nation's moral conscience is shifting year on year. Call it incremental extension, mission creep or slippery slope – whatever – it is strongly in evidence in Belgium." Dave Andrusko, *Netherlands*

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[29] http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html.

[30] *Available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950259/pdf/bmj.c5174.pdf.

and Belgium: What Lies at the Bottom of the Slippery Slope, NATIONAL RIGHT TO LIFE NEWS TODAY, Apr. 23, 2014.[31]

There are also reported cases of individuals who have been killed without having any underlying symptoms, where the doctor simply made an "error." Malcolm Curtis, *Doctor Acquitted for Aiding Senior's Suicide*, THE LOCAL, published Apr. 24, 2014, 10:19 GMT +2:00 (reporting that the doctor was ultimately not held accountable for his negligence).[32] One Belgian former proponent of assisted suicide has recanted his former position upon seeing the results, lamenting at the fact that the sick and disabled are marginalized by assisted suicide. *See* Steve Doughty, *Don't Make Our Mistake: As Assisted Suicide Bill Goes to Lords, Dutch Watchdog Who Once Backed Euthanasia Warns UK of 'Slippery Slope' to Mass Deaths*, DAILY MAIL, July 9, 2014, 5:40pm EST, updated July 10, 2014, 3:44am EST.[33] Those with dementia and other psychological disorders are being exploited and eliminated, and even children are being euthanized in Belgium. *See, e.g.*, *Euthanasia Requests Rose in* 2012, DUTCH NEWS, Sep. 24, 2013 (stating that two cases involving dementia were being investigated to

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[31] Available at http://www.nationalrighttolifenews.org/news/2014/04/netherlands-and-belgium-what-lies-at-the-bottom-of-the-slippery-slope/.

[32] http://www.thelocal.ch/20140424/swiss-doctor-acquitted-for-aiding-seniors-suicide.

[33] http://www.dailymail.co.uk/news/article-2686711/Dont-make-mistake-As-assisted-suicide-bill-goes-Lords-Dutch-regulator-backed-euthanasia-warns-Britain-leads-mass-killing.html?ITO=1490&ns_mchannel=rss&ns_campaign=1490.

determine if there was actually informed consent);[34] *Children's Euthanasia Bill Signed by Belgian King*, RUSSIA TODAY, published Mar. 03, 2014, 3:14pm, edited Mar. 5, 2014, 11:54am.[35]

The threat of a slippery slope is demonstrated by the steady, downward progression of other countries that have legalized assisted suicide. New Mexico has a rational and compelling interest in preventing even the possibility that the vulnerable and weak will be exploited in these ways.

4. Integrity of the Medical Profession

Assisted suicide is no guarantee of peace or a humane and dignified death. When a person commits suicide with the help of a doctor, he has to choke down a bitter drug that takes usually between three and forty-eight hours to kill. Vomiting is common, and 1 in 5 patients don't die from the drugs at all. *See, e.g., Euthanasia Deaths "Not Easy,"* BBC NEWS, Feb. 24, 2000.[36] Physicians believe that it would be cruel and contrary to their professional standards to subject New Mexico's weakest citizens to even more pain by ending their lives in such an excruciating way.

And physicians are worried about the cheapening of their profession:

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[34] http://www.dutchnews.nl/news/archives/2013/09/euthanasia_requests_rose_in_20.php.

[35] http://rt.com/news/belgium-king-sign-euthanasia-bill-566/.

[36] Available at http://news.bbc.co.uk/2/hi/health/655143.stm.

> Virtually every relevant source of authoritative meaning confirms that the phrase "legitimate medical purpose" does not include intentionally assisting suicide. "Medicine" refers to "[t]he science and art dealing with the prevention, cure, or alleviation of disease." WEBSTER'S SECOND 1527. . . . Indeed, the AMA has determined that "'[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer.'" "[T]he overwhelming weight of authority in judicial decisions, the past and present policies of nearly all of the States and of the Federal Government, and the clear, firm and unequivocal views of the leading associations within the American medical and nursing professions, establish that assisting in suicide . . . is not a legitimate medical purpose."

Gonzales v. Oregon, 546 U.S. 243, 285-86 (2006) (Scalia, J., dissenting) (internal citations omitted). The District Court here might even press physicians to equivocate on death certificates by citing an underlying terminal disease as the cause of death.

The medical profession is a profession of healing. Physicians who are committed to "doing no harm" should not be subjected to the degraded practice of medicine created by assisted suicide. This language ostensibly emanates from the Hippocratic Oath, which provides that a physician was not to provide deadly medicine to his patients. A form of this oath is still administered to medical students today. For a brief introduction to the evolution and impact of the Hippocratic Oath over the years, *see* Peter Tyson, *The Hippocratic Oath Today*, NOVA, Mar. 27, 2001. In fact, most versions of the Hippocratic Oath have physicians swear, "I will give no deadly medicine to any one if asked, nor suggest

any such counsel." And the U.S. Supreme Court has stated that the government undoubtedly "has an interest in protecting the integrity and ethics of the medical profession." *Glucksberg*, 521 U.S. at 731. The physician cannot both heal and take life. As far as the American Medical Association is concerned, physician-assisted suicide is "fundamentally inconsistent with the physician's professional role" as a healer. HEALTH AND ETHICS POLICIES OF THE AM. MED. ASS'N HOUSE OF DELEGATES § H-140.952 (2009).[37] Doctors are the tip of the spear when it comes to combating illness. The State of New Mexico has a compelling interest in ensuring that physicians, and indeed all medical providers, act in accord with medical standards that improve life—not destroy it.

IV. The Judiciary Should Not Overreach Into Delicate Policy Determinations Where the Consequence Is Truly "Life or Death."

The trial court ultimately failed to give proper respect to the New Mexico legislature as the promulgator of policy in New Mexico. The legislative branch is tasked with passing law and directing its implementation. "[T]he legislature shall have all powers necessary to the legislature of a free state," N.M. CONST. art. IV, § 2, including passing laws. such as the ban on assisted suicide, which "provid[e] for the preservation of the public peace, health or safety." N.M. CONST. art. IV, § 1. "[N]o person or collection of persons charged with the exercise of powers properly

[37] *Available at* http://tinyurl.com/AMAH140-952.

belonging to one of these departments, shall exercise any powers properly belonging to either of the others." N.M. CONST. art. III, § 1.

Sensitive policy judgments are better suited to "legislative therapy and not judicial surgery." *Varos v. Union Oil of Cal.*, 1984-NMCA-91, ¶ 7, 101 N.M. 713, 688 P.2d 31; *see also Maestas v. Hall*, 2012-NMSC-006, ¶ 21, 274, P.3d 66 (holding that "adhering to state policies is a way in which courts can give effect to the will of the majority of the people."). Legislative deference and adherence to the constitutionally required separation of powers prevents judicial overreach into areas of sensitive policymaking. It allows the branch of government that is better suited to effecting the will of the people bear responsibility for promoting health, safety, and welfare.

The legislature has listened to the will of the people in continuing to ban assisted suicide. Over two-thirds of U.S. voters oppose physician-assisted suicide, according to a New England Journal of Medicine poll.[38] Gallup polling, in contrast, predicates its questions on severe physical pain, skewing the results. Yet even the Gallup polls have seen support for physician-assisted suicide drop.[39] People are concerned about serious deficiencies, consequences, and dangers, such as the risk

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[38] *See* http://www.nejm.org/doi/full/10.1056/NEJMclde1310667.

[39] *See* http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx; *see also* ALEC M. GALLUP & FRANK NEWPORT, EDS., THE GALLUP POLL: PUBLIC OPINION 2004 at 280-81, available at http://books.google.com/books?id=uqqp-sDCjo4C&pg=PA281&lpg=PA281&dq=.

of inaccurate diagnoses, a reduction in end-of-life options (for example, Oregon Medicaid denied chemotherapy to patients Barbara Wagner and Randy Stroup, but offered to cover assisted suicide instead), the documented broadening of assisted suicide's application to non-terminal illnesses and conditions, sloppy procedures on the part of doctors, and increased pressure from facilities and families on elder or infirm adults and disabled individuals, particularly those in health care facilities. People are worried that the focus will be on saving money – not saving lives – and worry about the fate of "poor, poorly educated, dying patients who pose a burden to their relatives" – those the *New York Times* has reported are most likely to be abused.[40]

This issue is one of first impression for New Mexico, but the Connecticut Supreme Court has already determined that physician-assisted suicide implicates too many areas of policymaking to warrant court interference. In a similar case to this one, patients and their physicians sought declaratory and injunctive relief to prevent prosecution under CONN. GEN. STAT. ANN. § 53a-56 (West 1969) (Connecticut's ban on assisted suicide), but were denied. The court found that "[l]egislative determination is particularly important given the significant medical, legal, and ethical concerns about legalized physician-assisted suicide." *Blick v. Office of Div. of Crim. Justice*, CV095033392, 2010 WL 2817256, at *9 (Conn.

[40] *See* http://opinionator.blogs.nytimes.com/2012/10/27/four-myths-about-doctor-assisted-suicide/.

June 2, 2010) (non-precedential opinion). The court listed numerous compelling policies that motivated its decision. Many are shared by the State of New Mexico and warrant deference to the legislature on this issue. The Court noted the following policies: threat to the elderly; utilitarian focus and calculation of the value of human life; integrity of the medical profession and the doctor-patient relationship; and the potential slippery slope once the door to physician assisted suicide is open. *Blick v. Office of Div. of Crim. Justice*, CV095033392, 2010 WL 2817256, at *10 (Conn. June 2, 2010).

That court's recognition is particularly relevant in light of the legislative history of Connecticut's assisted-suicide ban. The court found that the legislature had held hearings on numerous amendments that would have permitted assisted suicide. These hearings included both professional and public commentary on the concept of legalized physician-assisted suicide. Ultimately, this was a dispositive factor. The court reiterated a vital principle of its jurisprudence, stating, "[i]t is the legislature which must determine the requirements of public policy for the state and, if the legislature is of the opinion that the broad provisions of the[ ] statute [ ] should stand unchanged, for [the Court] to read an exception into [it] is to pre-empt the legislative function." *Id.* at *11 (alterations in original) (internal quotation marks and citation omitted). Thus, it recognized that the Connecticut legislature had not acted to permit assisted suicide, and decided that it would not presume to

do anything different. Similarly, the New Mexico legislature has consistently banned assisted suicide, and refused to extend the right to die to assisted suicide when it enacted the UHCDA. This Court should defer to the legislature's judgment.

The Florida Supreme Court also declined to overextend its power by refusing to make sensitive judgments on the policy implicated by physician-assisted suicide. The court denied a challenge to Florida's ban on assisted suicide. It remarked that judicial action defeating the legislature's prohibition of assisted suicide would "run the risk of arrogating to ourselves those powers to make social policy that as a constitutional matter belong only to the legislature." *Krischer v. McIver*, 697 So. 2d 97, 103 (Fla. 1997); *see also id.* at n.5 (quoting *Shands Teaching Hosp. & Clinics, Inc., v. Smith*, 497 So. 2d 644, 646 (Fla. 1986)) ("[O]f the three branches of government, the judiciary is the least capable of receiving public input and resolving broad public policy questions based on a societal consensus.") (alterations in original). In its essential respects, the Florida statute prohibits the same conduct as New Mexico's ban on assisted suicide. *See* FLA. STAT. ANN. § 782.08 (West 1971). It is sound jurisprudence to refer physician-assisted suicide to the legislature for determination.

If the State of New Mexico is to entertain any right to assisted suicide, that right must be granted by the legislature. Plaintiffs remain free to attempt to

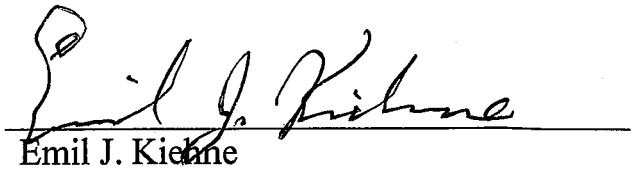
convince the legislature to change the ban on assisted suicide. If the legislature were to agree with Plaintiffs, it could create the necessary rules and regulatory agencies and other bodies that have the ability, albeit limited and thus far unsuccessful, to make assisted suicide "safer." Only a legislature has the adequate resources and tools necessary to make delicate policy decisions of this nature. This is especially true for decisions implicating life and a high cost to human flourishing.

CONCLUSION

The New Mexico Constitution must be understood in its proper historical and textual context. An appropriate analysis, consistent with the traditions, history, and precedent of this State, demonstrates that the so-called right to have another assist in the deliberate ending of life cannot be fundamental. New Mexico's longstanding prohibition of physician-assisted suicide is supported by the State's rational and compelling interest in preserving the value of life, protecting the vulnerable, and upholding the integrity of the medical profession—for the good of all New Mexicans. It is the State's prerogative to prevent the tragic and unpredictable consequences to life, the vulnerable, and the medical profession that result from assisted suicide. In a State that is willing to devalue the lives of its poor, poorly educated, dying patients, and especially those who depend on others in some way and are most in need of our care and protection, no one is safe. The

principles and policies are delicate and for consideration by the legislature, not the courts. By reversing, this Court will prevent the reckless endangerment of life, discrimination against the infirm and disabled, and an egregious overreach of judicial authority.

Respectfully submitted,



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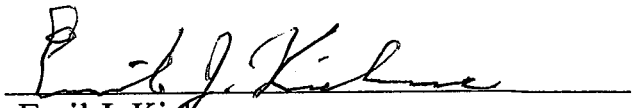

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