IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE
AT NASHVILLE

JOHN JAY HOOKER, DR. W. BARTON CAMPBELL, M.D., DR. JEFFREY A. SOSMAN, M.D., and DR. ROBERT BALLARD, M.D.,	)	
Plaintiffs,	)	
v.	)	**Docket No. 15-0615-II** **Chancellor Carol L. McCoy**
HERBERT SLATERY III, in his official capacity as Tennessee Attorney General; WILLIAM E. HASLAM, in his official capacity as Governor of Tennessee; and GLENN FUNK, in his official capacity as District Attorney for Davidson County, Tennessee,	)	
Defendants.	)	

BRIEF OF *AMICI CURIAE* IN SUPPORT OF THE DEFENDANTS: BIOETHICS DEFENSE FUND; CATHOLIC MEDICAL ASSOCIATION, NASHVILLE GUILD; CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS; CONCERNED WOMEN FOR AMERICA; FAMILY ACTION COUNCIL OF TENNESSEE; TENNESSEE RIGHT TO LIFE

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Admission pro hac vice pending

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The Bioethics Defense Fund; Catholic Medical Association, Nashville Guild; Christian Medical & Dental Associations; Concerned Women for America; Family Action Council of Tennessee; and Tennessee Right to Life submit this Brief of Amici Curiae in support of Defendants' Motion for Judgment on the Pleadings and Defendants' Response to Plaintiffs' Oral Motion for Judgment on the Pleadings.

INTRODUCTION

The founding documents of the United States place great value on human life. The Declaration of Independence, for example, provides that "all men . . . [have] certain unalienable Rights," including "Life, Liberty, and the pursuit of Happiness." THE DECLARATION OF INDEPENDENCE para. 2. The Tennessee Constitution likewise recognizes that we have "invaluable rights," TENN. CONST. art. I, § 19; and confirms that one of the core purposes of governments is to secure the people's "safety," TENN. CONST. art. I, § 1. These rights may "never be violated on any pretense whatsoever." TENN. CONST. art. XI, § 16. The Tennessee legislature and citizens, including *Amici*, cherish this fundamental, inherent right. They passed TENN. CODE ANN. § 39-13-216 (1993) to protect it by criminalizing deliberate assistance in someone else's suicide, apparently for the specific purpose of outlawing physician-assisted suicide.[1]

[1] *See, e.g.*, Emily R. Mason, *Ignoring It Will Not Make It Go Away: Guidelines for Statutory Regulation of Physician-Assisted Death*, 45 NEW ENG. L. REV. 139, 145 (2010); Charles F. Fenton, III, *Crimes Against the Person: Provide for the Criminal Offense of Offering to Assist in the Commission of Suicide and Committing an Act in Furtherance Thereof*, 11 GA. ST. U. L. REV. 103, 103-04 (1994) (noting that 1993, when Tennessee passed its law banning assistance in suicide, was the year many state legislatures passed laws for the purpose of banning physicians

Yet in this case, what Plaintiffs propose threatens to deprive Tennessee 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 Tennessee Constitution and TENN. CODE ANN. § 39-13-216, Plaintiffs would have this Court invent an entirely new "right": while ordinary citizens still could not assist someone's suicide, physicians – the trusted medical professionals who pledge to "do no harm" – could. And to accomplish this, Plaintiffs ask this Court to intrude on the legislature's powers: powers that the legislature is already in the process of utilizing as it considers whether to legalize and legitimize assisted suicide.

In order to uphold the fundamental values of the State of Tennessee, the history and tradition of this State and Nation, and universal, enduring notions of human dignity, this Court should reaffirm Tennessee citizens' interest in life, safety, sound public policy, and medical integrity by affirming State authority to enforce TENN. CODE ANN. § 39-13-216.

INTEREST OF *AMICI*

Amici are the Bioethics Defense Fund; Catholic Medical Association, Nashville Guild; Christian Medical & Dental Associations; Concerned Women for America; Family Action Council of Tennessee; and Tennessee Right to Life. The Catholic Medical Association, Nashville Guild and Christian Medical & Dental Associations wish to preserve medical integrity and public health and safety in Tennessee on behalf of their

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from assisting in suicide due to backlash from the deaths and scandals involving Dr. Jack Kevorkian).

member physicians and Tennessee residents. Bioethics Defense Fund, Concerned Women for America, Family Action Council of Tennessee, and Tennessee Right to Life, on behalf of their Tennessee constituents and members, wish to maintain a healthy respect for all human life, and advocate for the preservation of life through natural death.

Amici contest any characterization of physician-assisted suicide as "peaceful," "dignified," or a means of avoiding further suffering, as well as 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. They further reject that assisted suicide is a "treatment option," as alleged in Plaintiffs' Complaint, ¶ 26.

SUMMARY OF THE ARGUMENT

Plaintiffs would have this Court ignore clear constitutional precedent, its own role in Tennessee government, the needs of Tennessee residents, and the integrity of the medical profession, to strike down Tennessee's ban on assisted suicide (including physician-assisted suicide, i.e., the *active* taking of a life through prescription of lethal drugs).

The context of the happiness clause of Article I, § 1 of the Tennessee 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 § 1 is determined to broaden substantive rights, this Court is still required to apply a due process analysis. Since the right to die is neither a fundamental

part of U.S. or Tennessee history and tradition, nor implicit in ordered liberty, TENN. CODE ANN. § 39-13-216 is subject only to rational basis review. To do otherwise would be to turn these very rights on their head.

No right enumerated in the Tennessee Constitution suggests the right to enlist a third party in taking one's life. To the contrary, throughout history, Americans and Tennesseans have enjoyed these enumerated 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. Tennessee, 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.

Assisted suicide puts patients at risk. 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 risk a bitter death in trying to make a so-called problem go away.

Assisted suicide is harmful and destructive not only for the individuals who consider it, but for society at large, including elder adults and individuals with disabilities. People with disabilities are in equal possession of the fundamental right to

life, and moreover, 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 utilitarian vision of population control.

Tennessee, 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).

Rather than give these vital interests their due deference, Plaintiffs would have this Court venture far afield of its constitutionally appointed authority. High-risk controversial policy considerations warrant deference to democratic institutions, and courts are to respect the legislature's ability to use its assets and resources to determine what is best for Tennessee. 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 this Court were to legitimize assisted suicide, 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. There Is No Constitutional Right to Physician-Assisted Suicide, and TENN. CODE ANN. § 39-13-216 Survives Strict Scrutiny.

TENN. CODE ANN. § 39-13-216 is entitled to and survives rational basis scrutiny, *see* section III *infra*, but survives even strict scrutiny. It provides that assisting in a suicide consists of intentionally providing another person with the means by which he

intentionally and directly takes his own life, intentionally participating in a physical act by which another person directly and intentionally brings about that person's own death, or providing the means or participates in the physical act with actual knowledge and clear intent. § 39-13-216(a). It is a Class D felony, § 39-13-216(g), and perpetrators are subject to civil damages, § 39-13-216(e). There is no exception made for doctor-prescribed suicide perpetrated by physicians, but there are exceptions for withholding or withdrawing medical care, prescribing pain relief. § 39-13-216(b).

As *Amici* for the Plaintiffs confirm, *Amici Curiae* Brief of Anonymous Clients in Support of the Plaintiffs at 8, § 39-13-216 is entitled to a presumption of constitutionality. *In re Petition of Burson*, 909 S.W.2d 768 (Tenn. 1995). Courts are to give great deference to the Legislature, and every doubt is to be resolved in favor of constitutionality. *State v. Lyons*, 802 S.W.2d 590 (Tenn. 1990). Thus, Courts must adopt statutory constructions that avoid constitutional conflict. *Marion County Bd. v. Marion Co. Election Comm'n*, 594 S.W.2d 681 (Tenn. 1980).

Importantly, assisted suicide is distinct from the right to refuse medical treatment. As cited by the U.S. Supreme Court, the American Medical Association has repeatedly emphasized the "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." And the U.S. Supreme Court has held that the right to refuse treatment is not the "right to hasten death," but instead flows from the right to retain bodily integrity, prevent "unwanted touching," and preserve individual autonomy. The Tennessee Constitution also protects against these harms via its privacy rights. TENN. CONST. art. I, § 1, 2, 3, 7, 8, 19, 27.

There is no federal law on the subject of assistance in suicide, and both of the two seminal court cases on assisted suicide, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (also enumerating the prohibitions or condemnations of assisted suicide in 50 jurisdictions, including 47 States, the District of Columbia, and 2 Territories, 521 U.S. at 710 n.8), and *Vacco v. Quill*, 521 U.S. 793 (1997), flatly deny any constitutional right to it.

In *Glucksberg* the U.S. Supreme Court denied any due process right to assisted suicide. The Court held that an assisted suicide ban furthered such compelling state interests as the preservation of human life and the protection of the mentally ill and disabled from medical malpractice and coercion, and prevented those moved to end their lives because of financial or psychological complications. The Court further expressed concern that if it declared assisted suicide a constitutionally protected right, they would start down the path to voluntary and perhaps involuntary euthanasia.

In *Vacco v. Quill*, the Court found no equal protection right to assisted suicide, holding that there was a legitimate state interest in preventing doctors from assisting in suicide, even for terminally ill patients in great pain. The Court held that the judiciary must look to the Constitution, rather than to the stated "importance" of a right, when determining whether that right is fundamental.

Together, these two cases decided that the government's interest in preserving life and preventing intentional killing outweighs the patient's interest in choosing to die. Thus states may exercise their compelling state interest in protecting vulnerable human life through their civil and criminal laws. For hundreds of years, this was expected, and

universal. As the Supreme Court said in 1997, "even as the States move to protect and promote patients' dignity at the end of life, they remain opposed to assisted suicide."[2]

This opposition continues today. Yet Plaintiffs here grossly misstate both the holding and Chief Justice Roberts' dissent in *Obergefell v. Hodges*, 135 S.Ct. 2584 (2015) (slip opinion) in a feeble attempt to build up their case. But you cannot make bricks without straw, and Plaintiffs' effort likewise fails. While *Obergefell* may cast doubt on the standing of *Glucksberg* as the linchpin of substantive due process jurisprudence,[3] this limitation critically only applies to *Glucksberg*'s breadth, not in the least to its application and clear constitutional precedent in the area of assisted suicide. Plaintiffs lay a trail of breadcrumbs to persuade this Court to abandon all precedent and legal standards, citing a case far older than the twenty-year-old *Glucksberg* to do so. But leading constitutional scholars have rejected just such an argument as Plaintiffs', and affirmed that *Glucksberg* remains solid precedent rejecting a constitutional right to assisted suicide.[4]

Thus, the level of judicial scrutiny continues to depend on the nature of the interest at stake. *State v. Robinson*, 29 S.W.3d 476, 481 (Tenn. 2000) (discussing the tripartite framework for constitutional review: strict scrutiny for fundamental rights, intermediate

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[2] *Vacco v. Quill*, 521 U.S. 793, 805-06 (1997).

[3] *Glucksberg* is described by Chief Justice Roberts as "the leading modern case setting the bounds of substantive due process" in his expression of concern about any backslide from its holding of substantive due process to those rights supported by the Constitution or by precedent. *Obergefell*, 135 S.Ct. 2584, 2621 (slip opinion) (Roberts, J., dissenting).

[4] *See, e.g.*, Jack M. Balkin, *Bye, Bye,* Glucksberg, BALKINIZATION (June 27, 2015), available at http://www.balkin.blogspot.com/2015/06/bye-bye-glucksberg.html ("After *Obergefell*, *Glucksberg* is clearly no longer the leading case on substantive due process, if it ever was. It is the leading case on assisted suicide.").

scrutiny for important rights, and rational basis and presumption of constitutionality for all others). And in Tennessee, scrutiny analysis is the same for due process and equal protection under both state and federal constitutions. *State v. Burns*, 205 S.W.3d 412, 416 (Tenn. 2006); *Calaway ex rel. Calaway v. Schucker*, 193 S.W.3d 509, 518 (Tenn. 2005).

The origin of the purported right to die is paramount to the court's analysis. The Supremacy Clause of the U.S. Constitution provides that the federal constitution is the ultimate "Law of the Land." *See* U.S. CONST. art. VI, § 2. No Tennessee law may deprive a Tennessean any right afforded by the federal constitution. *See Miller v. State*, 584 S.W.2d 758, 760 (Tenn. 1979). "Tennessee courts are rightfully reluctant to find greater protection from the text of the state constitution where the protections of the federal constitution suffice." *Planned Parenthood of Middle Tennessee v. Sundquist*, 38 S.W. 3d 1, 12 (Tenn. 2000). Under this interstitial approach, Tennessee 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. Because physician-assisted suicide is not protected by the federal constitution, *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997), Tennessee state courts look to the language of the text to determine whether the Tennessee constitution provides any additional protection. *Sundquist,* 38 S.W. 3d at 13-15.

Departure from *Glucksberg* is unnecessary under Article I, § 1 of the Tennessee Constitution, which states that the government is to "advance" the people's "peace, safety, and happiness." TENN. CONST. art. I, § 1. While there are structural differences between the language of the state and federal constitutions, an aspirational goal of "advance[ing]" "happiness" guarantees no more right to assisted suicide than does the

federal constitution. And there is nothing unique about Tennessee and no fundamentally different traditions, history, or morals that could make physician-assisted suicide more acceptable in this State than in any other state in the Union. And under the Due Process 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 may not be lightly cast aside.

If Plaintiffs were consistent in their analysis and properly acknowledged the dangerous path to a "right to happiness," they 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 TENN. CONST. art. I, § 1 Permitted Departure from Federal Precedent, Tennessee's History and the Purpose of the Natural Rights Clauses Demonstrate That There Is No Fundamental Right to Assisted Suicide in the Tennessee 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.

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.

Plaintiffs are far afield in trying to twist the Tennessee Constitution's happiness clause to guarantee substantive rights. Such 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, Plaintiffs wish an impractical application of the natural rights clause. Together, these facts 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 Tennessee Constitution acknowledges the liberty tradition of the American republic and preserves that notion in Tennessee's incorporating document. This provision was merely the declaration of an end goal; it was the remaining sections (e.g., 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 unalienable 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; it would be a wholly impractical legal guarantee. The *pursuit* of happiness is an aspirational goal, not a substantive right.

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." Marshal J. Ray, *What Does the Natural Rights Clause Mean to New Mexico?*, 39 N.M. L. REV. 375, 390 (2009) (quoting *State v. Phelps*, 128 N.W. 1041 (Wis. 1910)). Thus the character, but not the substance, of the rights is 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. There must be an 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.

Due process analysis must be properly applied to strike the necessary balance between individual liberty and society's interests, and not stretched to encompass aspirational goals.

III. History, Tradition, and Tennessee'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, Tennessee history and tradition. It is not implicit in the concept of ordered liberty. And even if it were fundamental, the state interests of Tennessee 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

The United States Supreme Court handily disproved assisted suicide as 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.

At colonial common law, both suicide and assistance in suicide were unlawful. Tennessee adopted the common law as it existed at that time, with no exception made for assisting in suicide or creating any such right. *See Dunn v. Palermo*, 522 S.W.2d 679 (Tenn. 1975). Tennessee courts continue to note the strong public policy against suicide and the state interest in its citizens' lives: To "attempt [suicide] would constitute a grave public wrong and we hold that the State has a compelling interest in protecting the life and promoting the health of its citizens." *State ex rel. Swann v. Pack*, 527 S.W.2d 99, 113 (Tenn. 1975). The State of Tennessee has also consistently specifically prohibited assisted suicide in its laws at least since 1993, apparently for the specific purpose of

banning physician-assisted suicide,[5] the very act for which Plaintiffs request an exception. 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. In 1993, at a time when assisted suicide was well-known to be a practice in some parts of the world, the Tennessee legislature specifically rejected it. 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 long been a form of criminal homicide in Tennessee. This history is critical in understanding the Tennessee Constitution. The fact that assisted suicide is a crime and the fact that the legislature has never made a carve-out for the known practice of doctor-assisted suicide, mean that the legislature could not possibly have intended to create or protect a supposed "right" to assisted suicide.

And Tennessee 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). Only three U.S. states and one county have decriminalized physician-assisted suicide: Oregon in 1994, Washington in 2008, Vermont in 2013, and New Mexico (by court ruling, now up on appeal) in 2014. In Montana, *Baxter v. Montana*, 354 Mont. 234 (2009), merely allowed a possible consent defense to murder charges, and Vermont has

[5] *See supra* n. 1.

considered repeal of its dangerous law.[6] Only five countries have legalized assisted suicide, and bills and lawsuits have failed worldwide, including in Australia, France, New Zealand, Scotland, and at the European Court of Human Rights.

And of course, not all bills have passed, nor have all voter referendums. States from California to Massachusetts have recognized the strong public policy against doctor-prescribed suicide and voted it down. Prescribed suicide failed in California five times. Even in Washington, prescribed-suicide proponents made repeated attempts, starting in 1991, before it passed. New Hampshire overwhelmingly rejected a prescribed-suicide bill last year with a vote of 219-66. Prescribed suicide is not an idea whose time has come; it is a threat that has failed more than 140 times in more than half the states already this year, even as its advocates try to present "softer, gentler" bills focused on "death with dignity" rather than the grim truth. In fact, of the 30 states and District of Columbia that have considered prescribed suicide this session, few bills received a hearing. None have passed assisted suicide. And assisted suicide bills in Connecticut have failed to get a single committee vote in three consecutive years despite advocates spending over $500,000. Each year, support has dropped, and advocate Tim Appleton has publicly admitted that if the bill had been voted on, it would have set the movement back by years. In the legislatures, assisted suicide seems to be at a dead end.

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

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[6] *See, e.g.*, http://www.truedignityvt.org/time-take-second-look-vermonts-assisted-suicide-law-indeed/.

purported right to assistance in suicide is not fundamental – and without fundamentality, TENN. CODE ANN. § 39-13-216 requires only rational-basis review.

B. Tennessee's Interests

Even were this Court to classify physician-assisted suicide as a fundamental right, Tennessee's interests are sufficiently compelling to prohibit physician-assisted suicide. They include (1) preserving Tennessee's interest in the sanctity and affirmation of the value of human life; (2) protecting individuals who are physically, mentally, and/or psychologically vulnerable from making or having thrust upon them a decision with permanent consequences; (3) preventing the expansion of assisted suicide, suicide, and abuse to other members of society; and (4) upholding the integrity of the medical profession. 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).

Voters, too, have expressed concern about the bitter reality of so-called "death with dignity." Over 2/3 of U.S. voters oppose assisted suicide, according to a New England Journal of Medicine poll.[7] Gallup polling predicates its questions on severe

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

physical pain, skewing the results, but even they have seen support for assisted suicide drop.[8] Voters are concerned about serious deficiencies, consequences, and dangers, such as the risk of inaccurate diagnoses, a reduction in end-of-life options, 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" – just as Ezekiel Emanuel in the *New York Times* reported are most likely to be abused.[9] Tennessee 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,

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[8] *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=.

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

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, in affirming that there is no equal protection right to assisted suicide, 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"). Likewise in Tennessee, there is no equal protection right to assisted suicide. Thus, TENN. CODE ANN. § 39-13-216 prohibiting assisted suicide, whether the perpetrator is a physician or an "Average Joe," in no way conflicts with TENN. CODE ANN. § 32-11-110(a), which provides that the "withholding or withdrawal of medical care from a declarant in accordance with this

chapter shall not, for any purpose, constitute a suicide, euthanasia or homicide."[10] To suggest otherwise without clear constitutional support is to craft a legal argument out of whole cloth.

To follow Plaintiffs' wishes would be to promote 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). 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 coverage of those who have committed assisted suicide and the 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.[11]

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[10] This is known as the "Tennessee Right to Natural Death Act," furthering the point that the right asserted is not to assistance in an unnatural death.

[11] *See* Xavier Symons, *Media Ethics 101: How Not to Report Suicide*, BIOEDGE, Aug. 16, 2014, available at http://www.bioedge.org/index.php/bioethics/bioethics_article/11102.

2. *Protecting Physically, Mentally, and/or Psychologically Vulnerable Patients*

Depression

Based on numerous studies, noted bioethicist Ezekiel J. Emanuel, in an opinion piece in the *New York Times*, found that the reason for requesting assistance in 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, physician-assisted suicide looks less like a good death in the face of unremitting pain and more like plain old suicide."[12] And both depression and pain can be treated effectively. Yet non-psychiatric physicians do not even believe themselves capable of adequately evaluating the need for counseling. In one study, 94% indicated that they could not determine whether a psychiatric disorder was impairing the judgment of a patient who requested prescribed suicide in a single session.[13]

In Oregon, one study specifically states that depression as a factor for requesting prescribed suicide is overlooked.[14] Those suffering from depression need care and treatment. The National Alliance on Mental Illness states that depression affects "one's thoughts, feelings, behavior, mood and physical health."[15] Those suffering from

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

[13] *See* L. Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469 (1996); *see also* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1852925/; http://www.cmaj.ca/content/184/4/413.short (discussing screening issues).

[14] *See* Linda Ganzini et al., *Prevalence of Depression and Anxiety in Patients Requesting Aid in Dying: Cross Sectional Survey*, 337 BRITISH MED. J. 1682 (2008). *Available at* http://www.bmj.com/content/337/bmj.a1682.full.

[15] *What is Depression*, NAT'L ALLIANCE ON MENTAL ILLNESS (last accessed July 24, 2014). http://www.nami.org/Template.cfm?Section=depression.

depression are going unnoticed and untreated. Amidst this vulnerability they are entrusted with a decision of whether or not they wish to die.

Oregon and Washington do require that doctors refer patients who may have psychological impairments to a consulting physician,[16] but overall, fewer than 10% of those requesting suicide drugs have been referred. In 2014 in Oregon, only three patients of the 155 who requested doctor-prescribed suicide were referred for a psychological evaluation.[17] In 2013 in Oregon, only two of the 71 patients who actually committed assisted suicide were referred for counseling.[18] 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.[19]

Complaints have been filed against a doctor in Belgium who pressured a depressed woman into assisted suicide; she died without her son even being able to say farewell.[20] In another case, a physician thought his patient was depressed and unfit for assisted suicide, but against his judgment, the patient doctor-shopped, got the prescription, and killed himself – the doctor couldn't protect him.[21] There is an inherent conflict of interest

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[16] OR. REV. STAT. § 127.825; WASH. REV. CODE. ANN. § 70.245.060.

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

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

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

[20] *See, e.g.*, Michael Cook, *Official Complaint Lodged Against Leading Belgian Euthanasia Doctor*, BIOEDGE, Feb. 23, 2014. http://www.bioedge.org/index.php/bioethics/bioethics_article/10861.

[21] *See* Dr. Charles J. Bentz, Letter to the Editor, *Oregon Doctor Could Not Save Patient from Assisted Suicide*, MONTANA STANDARD, Jan. 27, 2013

between depression and doctor-prescribed suicide. When a patient is suffering from depression, removal of lethal means is central to treating the patient. But the very object of assisted suicide is to hand over the gun.[22]

As psychiatrist and author David D. Burns has said, "Depression has been called the world's number one public health problem. In fact, depression is so widespread it is considered the common cold of psychiatric disturbances. But there is a grim difference between depression and a cold. Depression can kill you."

Misdiagnosis and Misprognosis

Decisions to commit assisted suicide are equally influenced by misdiagnosis. More than 40% of patients with disorders of consciousness are misdiagnosed.[23] This rate has not changed despite medical advances over the last 15 years.[24] Overall, it is estimated that up to 15% of diagnoses are incorrect in most areas of medicine.[25]

Too, prognoses are often wrong. Currently, where assisted suicide is legal in the United States, it requires a six-month terminal prognosis, but many people outlive that.

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

[22] *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). *Available at* http://www.pccef.org/articles/art28.htm.

[23] *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).

[24] *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).

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

Harvard professor of sociology and medicine Nicholas Christakis agrees that doctors often get terminality wrong in determining eligibility for hospice care.[26] 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. *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.* 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 U.S. 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. Then over seventy-five years old, he gave himself a couple of months at most. His doctor gave him six months and sent him to hospice. But he lived almost two and a half years after all of this,[27] 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 assisted suicide.[28]
- Jeanette Hall, once in favor of assisted suicide, testifies to this. After she was diagnosed with cancer, her physician talked her out of taking prescribed-suicide pills; now she says, "I am so happy to be alive!"[29] So far, Jeanette has lived fourteen more years – a life of dignity.

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[26] *See* Nina Shapiro, *Terminal Uncertainty*, SEATTLE WEEKLY, Jan. 13, 2009, http://www.seattleweekly.com/2009-01-14/news/terminal-uncertainty/.

[27] *See id.*; Bonnie Bartel Latino, *The Late Dr. William E. Mayer Worthy of Being Remembered*, MILITARY WRITERS SOCIETY OF AMERICA, Jan. 1, 2012.

[28] *See* Shapiro, *supra.*

[29] 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.

Fewer people would want to hasten their death if they knew just how uncertain doctors really are about prognoses, and on what a fatally false premise they're relying.

Economic and Social Duress

Individuals facing economic duress may well feel pressured into taking the "easy," "cheap" way out. 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 their insurance companies, but readily offered coverage for suicide pills, like Barbara Wagner and Randy Stroup under Oregon Medicaid. In Wagner's case, the chemotherapy cost $4000, and the pills only $50.[30] While insurance companies rarely testify on assisted suicide legislation, they do take advantage of these laws after the fact. The legalization of doctor-prescribed suicide provides a cheap alternative to palliative care: killing the person. Some patients may be left with suicide as the only financially feasible option.

There are also social 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.

The Medicine of Assisted Suicide

Then, when a person does commit suicide with the help of a doctor, he has to choke down one of two kinds of barbiturates, bitter drugs that take usually 3-48 hours to

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

[30] *See* Ken Stevens, MD, Aff *Available at* http://maasdocuments.files.wordpress.com/2012/09/signed-stevens-aff-9-18-12.pdf

kill. Vomiting is common; some patients have regained consciousness after taking the drugs, and 1 in 5 patients don't die from the drugs at all.[31] Comparisons to lethal injection are not out of place. Put simply, death by doctor-prescribed suicide can be excruciating and humiliating.

3. Guarding Society from the Expansion of Assisted Suicide, Suicide, and Abuses

Elder Abuse

Jurisdictions with legalized doctor-prescribed suicide and euthanasia show higher rates of elder abuse, physical and financial.[32] A study conducted by Metlife Insurance identifies elders as prime targets of financial abuse.[33] More than 50% of the culprits are family members. So far, the victims of assisted suicide have been primarily over 65, educated, well-off, and covered by private insurance, indicating potential material gain for heirs upon their demise. Prescribed suicide only creates broader opportunities for elder exploitation and the abuse of individuals with disabilities. And if public acceptance grows, the fears expressed by Ezekiel Emanuel in the *New York Times* article will be realized as insurance companies reap the savings and assisted suicide trickles down to those less educated and less well-off. As disability rights advocate Ana Acton recently wrote, "Physician assisted suicide disproportionately affects the poor and people living

[31] *See, e.g., Euthanasia Deaths "Not Easy,"* BBC NEWS, Feb. 24, 2000; Kenneth Chambaere et al., *Physician-assisted Deaths Under the Euthanasia Law in Belgium*, 182 CAN. MED. ASS'N J. 6 (2010).

[32] Margaret Dore, *"Death with Dignity": A Recipe for Elder Abuse & Homicide (Albeit Not by Name)*, 11 MARQ. ELDER ADVISOR 387, 396 (2010).

[33] *See Broken Trust: Elders, Family, and Finances*, METLIFE MATURE MKT. INST. (2009). https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf.

with disabilities. That explains, at least in part, why there is widespread opposition from virtually every disability rights group in the nation. . . . Assisted suicide doesn't exist in a vacuum . . . ."[34]

Suicide Contagion

When it comes to assisted suicide, the concerns are real. Those states and foreign countries that have legalized prescribed suicide have seen an enormous increase in deaths by suicide. Prescribed suicide rates go up, for whatever reason, and regular suicide rates go up, too, in a phenomenon known as "suicide contagion."[35]

Studies have shown that media coverage of suicides inspires more suicides,[36] and journalism students are taught the harm of suicide reporting.[37] Celebrity suicides inspire

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[34] Ana Acton, *The Progressive Case Against Assisted Suicide*, HUFFINGTON POST, Aug. 4, 2014. Available at http://www.huffingtonpost.com/ana-acton/the-progressive-case-agai_1_b_5648126.html.

[35] *A Deadly Conflict of Interest*, EUTHANASIA PREVENTION COALITION, Nov. 25, 2013 (stating that there has been a 500% increase in euthanasia cases in Belgium in ten years); http://www.epce.eu/en/a-deadly-conflict-of-interest/; *Euthanasia Requests Rose in 2012*, DUTCH NEWS, Sep. 24, 2013 (finding that euthanasia rose by 13% in the Netherlands) http://www.dutchnews.nl/news/archives/2013/09/euthanasia_requests_rose_in_20.php; *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) http://public.health.oregon.gov/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx.

[36] *See, e.g.*, S. Stack, *Media Coverage as a Risk Factor in Suicide*, 57 J. Epidemiol. Community Health 238 (2003); E. Etzersdorfer et al., *A Dose-Response Relationship Between Imitational Suicides and Newspaper Distribution*, 8 Arch. Suicide Res. 137 (2004); http://www.thedailybeast.com/articles/2014/05/01/teen-copycat-suicides-are-a-real-phenomenon.html.

[37] *See, e.g.*, http://www.who.int/mental_health/prevention/suicide/resource_media.pdf; http://www.nimh.nih.gov/health/topics/suicide-prevention/recommendations-for-reporting-on-suicide.shtml.

more suicides – some people have even killed themselves at celebrity funerals.[38] After Saddam Hussein was publicly hanged, the rate of suicide rose; young men were hanging themselves.[39] And there's a link between assisted suicide and regular suicide. Places that have legalized assisted suicide have seen an enormous increase in deaths by non-doctor suicide. In Oregon, the suicide rate has skyrocketed.[40]

The Expansion of Assisted Suicide

Further, in every jurisdiction where it has been legalized, the practice of assisted suicide has crept beyond the limits originally imposed. One year in Washington, 12% of doctors received a request for prescribed suicide, and 4% for euthanasia. Again, the patient concerns most often perceived by physicians were worries about loss of control, being a burden, being dependent on others for personal care, and loss of dignity. And only rarely did doctors consult with each other on these cases.[41] This year, a bill was introduced in Oregon to expand the six-month terminal diagnosis to a full year.[42] And in

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[38] *See, e.g.*, Ruan Lingyu (3 suicides during the funeral procession), Yukiko Okada, Marilyn Monroe, Hideto Matsumoto, Mohamed Bouazizi.

[39] *See, e.g.*, http://www.nbcnews.com/id/16624940/ns/world_news-mideast_n_africa/t/copycat-hangings-follow-saddam-execution/#.VVClvU1OXIV.

[40] In 1998 physician-assisted suicide was legalized in Oregon. In 2000 Oregon's suicide rate was "increasing significantly." http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf. In 2007 Oregon's suicide rate was 35% above the national average. http://maasdocuments.files.wordpress.com/2013/02/oregon-suicide-info_001.pdf. In 2010 Oregon's suicide rate was 41% above the national average. http://choiceisanillusion.files.wordpress.com/2014/02/oregon-suicide-report-2012-through-2010-pdf.pdf. And the rate continues to increase. *See, e.g.*, http://www.alexschadenberg.blogspot.ca/2013/05/suicide-rate-in-oregon-continues-to.html.

[41] http://jama.jamanetwork.com/article.aspx?articleid=399087.

[42] Oregon H.B. 3337 *See,* http://www.nationalrighttolifenews.org/news/2014/04/netherlands-and-belgium-what-lies-at-the-bottom-of-the-slippery-slope/

Washington, the legislature had to introduce a bill just to encourage doctors to offer treatment options to patients, and not just death.[43]

Many cases are going unreported, leading to an utter lack of accountability.[44] Assisted suicide causes a desensitization and insensitivity for the plight of the infirm.[45] And of those countries that have legalized it, prescribed suicide for purely physical suffering has been extended to psychological and emotional suffering.[46]

Even more disturbing is that in Belgium half of people being euthanized are killed without an explicit request.[47] 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; ... euthanasia [for] children and people with dementia." "[I]t is clear that in practice the

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[43] Washington S.B. 5919, *See,* http://lawfilesext.leg.wa.gov/biennium/2015-16/Pdf/Bills/Senate%20Bills/ 5919.pdf

[44] *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)

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

[46] *See, e.g.*, *supra*; Bruno Waterfield, *Belgian Killed by Euthanasia After a Botched Sex Change Operation*, THE TELEGRAPH, Oct. 1, 2013 http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html.

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

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."[48] All this has led one Belgian former proponent of prescribed suicide to recant his former position, lamenting at the fact that the sick and disabled are being marginalized by assisted suicide.[49]

There are also reported cases of individuals who have been killed without having any underlying symptoms, where the doctor simply made a mistake.[50] One Swiss autopsy found that the diagnosis that led the patient to choose suicide was wrong. For three Oregon assisted suicide victims, the annual report doesn't seem to know what was wrong with them.

Inadequate Protections

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[48] Dave Andrusko, *Netherlands and Belgium: What Lies at the Bottom of the Slippery Slope*, NATIONAL RIGHT TO LIFE NEWS TODAY, Apr. 23, 2014 Available at http://www.nationalrighttolifenews.org/news/2014/04/netherlands-and-belgium-what-lies-at-the-bottom-of-the-slippery-slope/; *Euthanasia Requests Rose in* 2012, DUTCH NEWS, Sep. 24, 2013 (stating that two cases involving dementia were being investigated to determine if there was actually informed consent); http://www.dutchnews.nl/news/archives/2013/09/euthanasia_requests_rose_in_20.php; *Children's Euthanasia Bill Signed by Belgian King*, RUSSIA TODAY, published Mar. 03, 2014, 3:14pm, edited Mar. 5, 2014, 11:54am. http://rt.com/news/belgium-king-sign-euthanasia-bill-566/.

[49] *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. 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.

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

The protections in place in each state where doctor-prescribed suicide has been legalized are wholly inadequate. Current laws generally require that there be witnesses at the time the patient requests the pills, but when the patient actually takes them, there may be no witnesses[51] or consent, and there's no way to be sure it's actually the patient choosing to take them or administering the poison. The doctor is only there about 7% of the time.[52] Prescribed suicide expert Margaret Dore talks about the possibility that someone who receives a dose in accordance with the statutory requirements then becomes incompetent or falls asleep—a situation ripe for abuse.

One study found that in the Flemish part of Belgium, one-third of euthanasia cases occurred without consent. In Belgium, nearly half of all cases of euthanasia are not reported, and a written request for euthanasia was absent in 88%.

4. Upholding the Integrity of the Medical Profession

Physicians are concerned about doctor-prescribed suicide as a threat to their profession and to their conscience. Doctor-prescribed suicide laws and bills contain at best only the most limited conscience protection for doctors to avoid coercive or mandatory participation in death[53] – the same healing professionals who have sworn to

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[51] *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)

[52] *See* PATIENTS RIGHTS COUNCIL, REPORTED ASSISTED-SUICIDE DEATHS IN OREGON & WASHINGTON STATE, www.patientsrightscouncil.org, April, 2010. http://www.patientsrights council.org/site/wpcontent/uploads/2011/02/OR_WA_Reported_Deaths_04_10.pdf. Reported_Deaths_04_10.pdf.

[53] Our nation's Constitution and statutes protect against coercing physicians to prescribe lethal drugs and fulfill the "assisting" part of "assisted suicide." The First Amendment's Free Exercise Clause provides that "Congress shall make no law … prohibiting the free exercise of religion,"

"first do no harm." 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."[54] 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, prescribed suicide is fraught with uncertainty (like about terminal diagnoses) and risk. Some prescribed-suicide bills would even press physicians to equivocate on death certificates by citing an underlying terminal disease as a prescribed suicide victim's cause of death.

The U.S. Supreme Court has stated that the government undoubtedly "has an interest in protecting the integrity and ethics of the medical profession."[55] And so, as expressed by Justice Scalia in his *Gonzalez v. Oregon* dissent:

> "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. . . . [T]he 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

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and court cases such as *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308 (9th Cir. 1974), and *Taylor v. St. Vincent's Hospital*, 523 F.2d 75 (9th Cir. 1975), have recognized that the freedom of religion includes that of those who respect life. The Church Amendments provide that recipients of federal healthcare funding can't require employees to take a life, or discriminate based on an employee's refusal; the Church Amendment passed 372/1 in the House and 92/1 in the Senate, and supporter Sen. Ted Kennedy proclaimed: "I believe that the Court will sustain the judgment to protect individual rights and liberties." As the U.S. Congress stated, in passing the Religious Freedom Restoration Act and restoring the compelling interest test to laws that substantially burden religion, "the framers of the Constitution, recognizing free exercise of religion as an unalienable right, secured its protection in the First Amendment to the Constitution." 42 U.S.C. § 2000bb(a). Numerous state laws provide similar protections.

[54] Peter Tyson, *The Hippocratic Oath Today*, NOVA, Mar. 27, 2001.

[55] *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

> 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.'"[56]

The physician cannot both heal someone and take their life at the same time. As far as the American Medical Association is concerned, doctor-prescribed suicide is "fundamentally inconsistent with the physician's professional role" as a healer.[57]

This is even true in Switzerland. A recent study from the Swiss Academy of Sciences found that although most of the doctors polled approved of doctor-prescribed suicide, most were unwilling to actually do it – only 111/1318 had, even though as is typical, the Swiss doctor is not expected to be present at the actual time of death (that grim task is done by prescribed-suicide groups).

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

Plaintiffs would have this Court strip the Tennessee legislature of its proper position as the promulgator of State policy. The legislative branch is tasked with passing law and directing its implementation. "The legislative authority of th[e State of Tennessee] shall be vested in a General Assembly," TENN. CONST. art. II, § 3, including passing laws such as the ban on assisted suicide, which "advance" the people's "peace, safety, and happiness." TENN. CONST. art. I, § 1. "No person or persons belonging to one of these departments shall exercise any of the powers properly belonging to either of the

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[56] *Gonzales v. Oregon*, 546 U.S. 243, 285-86 (2006) (Scalia, J., dissenting) (internal citations omitted).

[57] HEALTH AND ETHICS POLICIES OF THE AM. MED. ASS'N HOUSE OF DELEGATES § H-140.952 (2009). *Available at* http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf.

others . . . ." TENN. CONST. art. II, § 2. Therefore, any decriminalization of physicians assisting in someone's suicide must be handled by the legislature, not the judiciary.

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, 33; *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 to bear responsibility for promoting health, safety, and welfare. And the legislature here has considered the dangers inherent in assisted suicide and listened to the will of the people in continuing to ban assisted suicide. *See supra* § III(B) on polling trends.

This issue is one of first impression for Tennessee, 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. June 2, 2010) (non-precedential opinion). The court listed numerous compelling

policies that motivated its decision. Many are shared by the State of Tennessee 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 Tennessee legislature has consistently banned assisted suicide, and on June 9, 2015, in advance of the next legislative session, the state Senate's Health and Welfare Committee conducted a multi-hour hearing on this issue, receiving testimony from, *inter alia*, Plaintiff Hooker. This Court should defer to the Legislature's judgment.

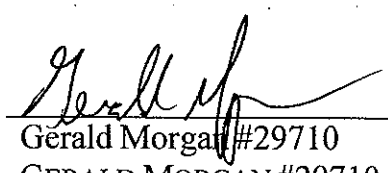
The Florida Supreme Court also declined to overextend its power by refusing to make sensitive judgments on the policy implicated by physician-assisted suicide. The court denied a challenge to Florida's ban on assisted suicide. It remarked that judicial action defeating the legislature's prohibition of 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 Tennessee'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 Tennessee 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 imposing a high cost to human flourishing.

CONCLUSION

The Tennessee 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. Tennessee'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 Tennesseans. 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. And the State must not let Plaintiffs pull the wool over its eyes by distinguishing the sub-practice of doctor-prescribed suicide from assisted suicide more broadly. 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, no one is safe. The principles and policies are delicate and for consideration by the legislature, not the courts. On the other hand, the death of assisted suicide is something we can all live with. By preserving Tennessee's ban on doctor-prescribed death, 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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I hereby certify that on July 22, 2015, true and correct copies of BRIEF *AMICI CURIAE* IN SUPPORT OF THE DEFENDANTS were served upon all counsel of record via U.S. First-Class Mail:

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