IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY

CIV-2015-485-235

UNDER	**The Declaratory Judgments Act 1908 and the New Zealand Bill of Rights Act 1990**
BETWEEN	**LECRETIA SEALES**
	Plaintiff
AND	**ATTORNEY-GENERAL**
	Defendant

AFFIDAVIT OF FRANK LEWIS SPRING
AFFIRMED 28 APRIL 2015

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fls

RUSSELL McVEAGH

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I, **Frank Lewis Spring**, clinical psychologist of Albuquerque, New Mexico, United States of America solemnly and sincerely affirm:

Introduction

1. I am a psychologist licensed to practise in the State of New Mexico.

2. I received my doctorate in clinical psychology from Washington University in St Louis in 1974. My clinical internship was American Psychological Association-approved, from the University of Washington in Seattle. I have been licensed to practise as a psychologist in New Mexico since 1976. In 1979 I received a juris doctor degree from the University of New Mexico School of Law and have a license to practice law, now inactive, in the State of New Mexico. A copy of my CV is annexed as "**FLS-1**".

3. I currently practice as a clinical psychologist in Albuquerque, New Mexico. I have been a member of the New Mexico Psychological Association since 1976 and served as its president in 1986-87. Over the years I have frequently lectured in New Mexico on the topics of ethics and law in mental health, and I have consulted with psychologists and mental health practitioners on these topics on a weekly basis.

4. I have provided legal consultation to the New Mexico Psychological Association ("**NMPA**") for several decades. Along with my colleague Robert Schwartz, JD, I submitted the NMPA amicus brief to the trial court in *Morris v Brandenberg*, the New Mexico physician aid in dying case.

5. The position of the NMPA is that suicide and aid in dying are very different, and require different clinical approaches. That position was recorded in the amicus brief filed on behalf of the NMPA in *Morris v Brandenberg.*

6. I have been asked to make this affidavit in relation to Ms Lecretia Seales' proceeding in order to explain how the concept of suicide, as understood by psychologists, differs from aid in dying. My expert opinion, which is reflected in the view of my professional association and that of other professional bodies, is that the two are fundamentally different and therefore lie at the opposite ends of a spectrum.

7. I have annexed to this affidavit the following documents:

   (a) the amicus brief filed in the District Court (annexed as "**FLS-2**");

   (b) the amicus brief filed in the Court of Appeal (annexed as "**FLS-3**");

   (c) the transcript of the trial insofar as it relates to the questions I have been asked to address (being pages 64 to 135 of the second volume of the transcript) (annexed as "**FLS-4**"); and

   (d) the amicus brief filed on behalf of a coalition of mental health professionals filed in the Supreme Court in the case of *Gonzales v Oregon* (annexed as "**FLS-5**").

8. I have read the Code of Conduct for Expert Witnesses and my evidence complies with that Code.

Background to the amicus brief

9. The NMPA is the major professional body for psychologists in the state of New Mexico. It does not license psychologists, but is the leading source of professional standards and policy for psychologists in New Mexico and is dedicated to upholding professional ethics and increasing and diffusing knowledge through the profession. It is the primary authority to speak on behalf of psychologists and their patients.

10. The NMPA was approached on behalf of the plaintiffs in *Morris v Brandenberg*, in order to provide its view on the differences between aid in dying and suicide. The NMPA only decided to become involved after a substantial consultation with the membership.

11. The reason the NMPA agreed to present submissions in support of the plaintiff in *Morris* was that it believed it was important that the Court understand that if a psychologist is required to treat a patient seeking aid in dying in the same way as a psychologist would treat a patient considering suicide, then the psychologist cannot possibly provide care consistent with the professional standard of care.

12. The amicus brief accurately reflects the position of the NMPA. It was reviewed by every member of the NMPA board and adopted by an overwhelming majority vote.

The NMPA's position summarised

13. Aid in dying (or "AID") refers to the situation where patients who are mentally competent, are not depressed, and are facing a terminal illness seek physician assistance to manage their dying and, in particular and where appropriate, to make available medication which if ingested would enable the patient to bring about their (inevitable) death at a time of their choosing.

14. The NMPA uses the term aid in dying, as do many professional organizations in the United States, as a neutral description of the process under discussion. Describing such deaths as a form of suicide can be distressing and problematic for loved ones of dying individuals. As I explain below, it is also inaccurate.

15. The NMPA's view is correctly stated at page 3 of the amicus brief where it is said that:

> The NMPA and its members recognize that AID and suicide are fundamentally different psychological phenomena, and that these different categories of patients must be treated differently by the law for their patients to be able to get adequate psychological support at the end of life. Psychologists think of a suicide as their greatest challenge, and they work tirelessly to prevent their patients from committing suicide. They also recognize that AID involves almost no substantive theoretical overlap with suicide.

16. The NMPA's position is that suicide is fundamentally different from aid in dying for the following reasons:

(a) The causes are different (pages 4 to 6). Suicidal ideation arises from impeded cognition of temporary problems that are treatable. Aid in dying arises from accurate cognition of physical conditions that are truly incurable. In treating a suicidal patient, the psychologist seeks to restore reason and thus allow for hope about the future. That approach has no application to the terminally ill patient requesting aid in dying, in that the desire for death is not driven by irrationality or depression. The patient has only a short time to live and is aware of imminent death. Rather than preventing a premature, meaningless death, physician aid in dying provides autonomy to a person who has practically none left, in the context of compassionate medical care. For the terminally ill patient, the task of the psychologist is to establish that the patient's desire for aid in dying is not driven by clinical depression or a psychotic process. Thereafter, the therapeutic goal of the psychologist would include assisting the patient to make the dying experience meaningful, often with the active involvement of family and friends. Interaction with such a patient is not driven off restoration of reason; rather, what may be most helpful is to provide a patient with attachment to another caring person, or to assist the client to maintain attachment to others, such as family and friends, which is where most people find meaning and comfort in their lives. The outcome of that could well be that the patient decides not to proceed with aid in dying having exercised their free will.

(b) The mental processes are different (pages 6 to 8). In cases of suicide, in addition to impaired cognition, rational control is interrupted by deficiencies in impulse control (almost always preceded by emotional anguish ("pain"), a feeling of being overwhelmed ("pressure") and agitation ("perturbation")). In cases of aid in dying, the patient's rational control prevails. The amicus brief concludes that "aid in dying and suicide are at the opposite extremes of the continuum of rational thought and conduct".

(c) The consequences of the two processes are very different (pages 8 to 11):

(i) Suicide leaves family members distraught, often destroyed, and virtually always emotionally traumatized. Aid in dying brings families together and allows them to deal successfully with grief. Studies in Oregon and Washington demonstrate that aid in dying assists families to deal with death, and family members do not suffer the adverse mental health impacts suffered by families of suicide victims.

(ii) Suicidal patients saved from suicide often go on to live long and productive lives, thankful that their suicides were averted. However, those who are denied aid in dying generally live only a little longer, often with horrific suffering, frustrated by the denial of control and autonomy at the end of life. Interventions to prevent suicide help a patient, in the short run and the long run. Interventions to prevent aid in dying have no such salutary effect: no life is saved; no suffering averted. Psychological distress is increased. The loss of autonomy will often be profound.

17. In summary, the position of the NMPA (page 11) is that:

> It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

18. I have reviewed the evidence of David Pollack, MD, who testified in the New Mexico proceeding. Dr Pollack's evidence has also been adopted by the NMPA's amicus brief for the New Mexico Court of Appeals in support of a number of propositions relating to:

- (a) The fundamental difference between suicide and aid in dying, including:
    - (i) That suicide arises from impaired cognition of temporary problems that are treatable, whereas aid in dying arises from accurate cognition of physical conditions that are incurable.[1]
    - (ii) That rational control is interrupted by deficiencies in impulse control in cases of suicide, whereas rational control prevails in cases of aid in dying.[2]
    - (iii) That suicide has traumatic emotional consequences for family members, whereas aid in dying allows families to successfully deal with grief.[3]
- (b) The ability and training of psychologists to determine the mental capacity of patients to choose aid in dying.[4]

19. I agree with what he says in respect of those matters.

20. I also do not consider that concerns about the ability of professionals to assess competency and capacity issues are justified. Capacity determinations are regularly made in respect of patients at the end of their life (and more generally) and there are adequate tools available to professionals to make those assessments. I agree with the statement of the NMPA below (page 11):

> Virtually everybody accepts that the denial of aid in dying will force some decisionally capable and terminally ill people to endure suffering they find intolerable, but some consider that some might be incorrectly determined to have capacity. The NMPA considers that concerns about decisional capacity are unfounded.

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[1] 2 Tr 73: 9-21, 79:20-25, 80:1-2, 94:22-25, 95:1-4 and 119:12-15,

[2] 2 Tr 73:1-22, 74:1-16, 94:1-22, 95:1-9, 99:1-18 - 101:1-7 and 110:1-20 - 112:1-13.

[3] 2 Tr 96:25, 97:1-10 and 98:1-14.

[4] 2 Tr 74:1-20 - 76:1-10, 103:15-19 and 104:2.

21. Finally, the difference between aid in dying and suicide has implications for treatment. For example, at least in New Mexico, psychologists have a duty of care to issue certificates authorising the intervention of law enforcement in order to detain and hospitalise a patient who is threatening suicide. They also have an ethical duty to intervene in such cases. The request by a patient for aid in dying is not an expression of suicidal ideation.

The position of other professional bodies

22. The position of other professional bodies in the United States where the aid in dying issue has arisen is consistent with that described above.

23. The "fundamentally different" psychological processes at work with a terminally ill patient have been accepted by the American Psychological Association and the American Public Health Association.

24. In *Morris* itself, the NMPA's position was explicitly supported by the American Women's Medical Association, the American Medical Student Association and the New Mexico Public Health Association. Likewise, an amicus brief was filed in the Supreme Court in *Gonzalez v Oregon* on behalf of a coalition of mental health professionals consisting of the Washington State Psychological Association, the Oregon Psychological Association, the National Association of Social Workers and the Clinical Social Work Federation. That brief stated (at page 17):

> End-of-life decisions by terminally ill patients are not akin to what is commonly termed "suicide", which is considered to be a self-destructive act often related to feelings of depression. These decisions to hasten death are more accurately paralleled to a patient's thoughtful decision to decline life-sustaining measures: a product of judgment and reason, based on the desire to maintain one's dignity in a period where death is pending.

Conclusion

25. In my expert opinion, the following conclusions can be drawn on issues of psychological practice that may be relevant to the issues before the Court in Ms Seales' case. It is my expert opinion that:

    (a) There is broad professional opinion that a request for aid in dying by a mentally competent adult who is not depressed but is enduring a terminal illness is not the expression of suicidal ideation as that term is understood, and practised, by clinical psychologists.

    (b) There is broad professional opinion that aid in dying and suicide are at opposite ends of a spectrum of decision-making. The genesis of the decision to die is entirely different, as is the appropriate response by the professional.

    (c) The consequences are also very different, both for the patient and for the family. As described above, the suicidal patient loses what is in all likelihood a long and productive life, whereas - if the request for aid in dying is actioned; the treating physician considers that the relevant criteria are met; and the patient ultimately decides to ingest the lethal drug - the terminally ill patient avoids a typically short period of intense suffering. The consequences for the family are typically devastating in the case of suicide, but consoling and healthy in the case of aid in dying.

AFFIRMED at Albuquerque, New Mexico
this 28th day of April 2015 before me:

Gloria J. Montoya

A person duly authorised to administer oaths in New Mexico, United States of America

Expires: March 8, 2017

Frank Lewis Spring

GLORIA J. MONTOYA

"FLS-1"

Curriculum Vita Frank L. Spring, PhD, JD

Professional Address:
620 Roma Blvd. NW.
Albuquerque, NM 87102
tel: (505)273-4667
email: frank.l.spring@gmail.com

Education:

BA: University of Texas at Austin, 1965

APA-Approved Internship in Clinical Psychology, University of Washington School of Medicine, 1970-71

PhD: Clinical Psychology, Washington University in St Louis, 1974

JD: University of New Mexico School of Law, 1979

Professional Licenses:

Psychologist, State of New Mexico, 1976-present

Attorney at Law, State of New Mexico, 1980-present (inactive: 2014-present)

Professional Employment:

Psychologist, Psychological and Counseling Center, University of Illinois at Champaign-Urbana, 1973-76

Attorney, Branch, Coleman, and Perkal, Albuquerque, NM, 1980-1982

Attorney, Duhigg and Cronin, PA, (subsequently Duhigg, Cronin, Spring, and Berlin, PA), Albuquerque, NM, 1982-2009

Part-time practice in clinical psychology, self-employed, Albuquerque, NM, 1976-1988

Psychologist, Samaritan Counseling Center, Albuquerque, NM, 2009-present

Professional Organizations

New Mexico Psychological Association, 1976-present

This is the annexure marked **"FLS-1"** referred to in the affidavit of **Frank Lewis Spring** affirmed at Albuquerque, New Mexico this 28 day of April 2015 before me

Signature Gloria D. Montoya
A person duly authorised to administer oaths in New Mexico, United States of America
Expires: March 8, 2017

New Mexico State Bar Association, 1980-present

New Mexico Trial Lawyers Association, 1980-2006

Professional Organization Offices

President, New Mexico Psychological Association, 1986-87

Various New Mexico Psychological Association Board Committees, 1980's to present

New Mexico Trial Lawyers Association Board of Directors, 1980's-90's

Professional Writing and Lecturing

Various articles in New Mexico Trial Lawyers Newsletter, 1980's-90's

Various articles, book reviews in New Mexico Psychological Association Newsletter, 1980's-present

Presentations before attorneys for NMTLA and NM State Bar, 1980's-2000

Presentations before mental health groups and NMPA, primarily on professional ethics and the law, 1980's-present

Statement of Principles Governing Relationship Between Attorneys and Psychologists in New Mexico (with William E. Foote, PhD), Adopted by State Bar and NMPA, 1987

"FLS-2"

IN THE SECOND JUDICIAL DISTRICT COURT
COUNTY OF BERNALILLO
STATE OF NEW MEXICO

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

Plaintiffs,

vs. No. CV 2012-02909

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

Defendants.

BRIEF OF AMICUS NEW MEXICO PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF THE PLAINTIFFS

INTEREST OF AMICUS

The New Mexico Psychological Association (NMPA) is the largest organization of professional doctorate-level psychologists in New Mexico and the leading source of professional standards and policy for psychologists who practice within the state. It has been established to promote quality research and the highest level of qualified professional practice in psychology, to improve the qualifications and usefulness of psychologists by upholding and maintaining the highest standards of professional ethics, conduct, education, and achievement, and to increase and diffuse psychological knowledge throughout New

GLORIA D. MONTOYA
NOTARY PUBLIC
STATE OF NEW MEXICO

This is the annexure marked "FLS-2" referred to in the affidavit of Frank Lewis Spring affirmed at Albuquerque, New Mexico this 28 day of April 2015 before me

Signature Gloria D. Montoya
A person duly authorised to administer oaths in New Mexico, United States of America

Expires = March 8, 2017

Mexico. N.M. Psychological Ass'n., *Constitution and Bylaws, Section 2* (2005). It is the primary authority to speak on behalf of psychologists and their patients, and those who provide related mental health services and their patients, in New Mexico, and it is concerned with assuring that the law in New Mexico permits and encourages the highest level of psychological practice.

The NMPA is committed to providing high quality mental health care to all New Mexicans. In doing so, members often provide services to those who are contemplating suicide, and to family members and friends of those who have committed suicide. Its members have also provided services to competent adults who are terminally ill and facing imminent death, and to their friends and family members. Some of these terminally ill patients are also considering asking their physicians for Aid in Dying (AID)[1] if their

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

While several years ago terms like "assisted suicide" had been used to describe a competent, terminally ill patient's decision to seek a physician's help in prescribing medication that could hasten the dying process, over the last several years responsible health care providers, lawyers, academics and others have stopped referring to this process as any form of "suicide." The general consensus is that "aid in dying" is more accurate, sensitive, and consistent with the professional literature in the field. "Aid in dying" is the better descriptive term, and it avoids presuming any sets of values. Consistent with the propriety of "aid in dying," the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine (the organization of JD-MDs), the American Student Medical Association, and the American Medical Women's Association have all recently rejected using the term "assisted suicide," mostly in suffering during the dying process becomes too difficult to bear, and some of these patients have been referred to psychologists for counseling by the physicians from whom they sought AID. The NMPA recognizes that if a psychologist is required to treat a patient considering AID like a patient considering suicide, that psychologist cannot possibly provide adequate care that is consistent with the psychologist's professional standard of care.

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

The Board of the New Mexico Psychological Association, after protracted and serious discussion over several months, decided by consensus to support the Plaintiffs in this case,

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favor of "aid in dying." For the most part, the only individuals and organizations continuing to refer to the practice using the word "suicide" are those who, for political, religious or philosophical reasons, advocate against it. In short, "assisted suicide" now is a pejorative term used primarily by those who believe it to be morally wrong.

and to seek permission from the Court to file an amicus brief on behalf of the Plaintiffs, because of the importance of the resolution of this case to the quality practice of psychology in New Mexico.

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

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

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

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

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

By contrast, the problem confronting the terminally ill patient arises from an irreversible physical calamity. She or he is dying of an incurable disease. The recognition that there is no hope for future physical improvement is accurate, not irrational. To treat a mentally competent terminally ill patient who seeks access to AID to avoid unbearable suffering as equivalent to a lovesick teenager or a homeowner losing the family home to foreclosure would be to completely misunderstand the psychological condition and the therapeutic role in each of those cases. It is for this reason that it is so offensive for those who have finally come to grips with their terminal condition, sometimes after a great deal of psychotherapy, and who thus seek access to AID, condescendingly to be told that they are demonstrating mental health pathology and that they are suicidal.

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

The suicidal patient's functioning is characterized not only by impaired cognition, as described above, but by disrupted impulse control. See, *e.g.*, Roy Baumeister, *Suicide as Escape from Self* 90-133 (1990). In evaluating the risk of suicide in any new patient, the psychology practitioner is taught to look for the "three P's": pain, pressure, and perturbation. "Pain" stands for emotional anguish, "pressure" stands for a feeling of being overwhelmed, and "perturbation" stands for agitation. Edwin S. Shneidman, *Autopsy of a Suicidal Mind* (2004). This "pain, pressure and perturbation" precipitate sudden, unannounced, lethal and often violent acts, like suicide. They are the quintessence of irrationality and loss of personal control. The three P's analysis describes virtually every real suicide, and it suggests why we are so concerned when there is a risk of suicide.

Fifteen years of data from Oregon regarding an open practice of AID show that patients who choose AID act as a result of a careful, fully vetted deliberation, always after a period long enough to establish the enduring nature of the desire, usually in consultation with their families and other personal and religious advisors, and always after discussion with their physicians. This is the opposite of deficient impulse control; this is truly deliberative action. The physician plaintiffs in this case point out that they would require a carefully reasoned, voluntary, informed and enduring request for a prescription for AID before they would consider writing one. Further, as you might expect from the self-selected group of patients who ask their doctors about aid in dying, they are carefully deliberative and well educated. In Oregon and Washington, almost half of those employing the Death with Dignity Act have graduated from college, and almost all have education beyond high school. Or. Pub. Health Div., *Oregon's Death with Dignity Act 2012* (2013), http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. For information on Washington state, see http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2012.pdf. This subset of the population seeking to act in a self-determined and autonomous manner at their death is well able to understand their options and choose among them. The question of how much suffering to bear before death arrives is intensely personal and will turn on values and beliefs an individual has developed over the course of a lifetime. Empowering the individual with control over this question preserves an essential sense of autonomy. Even though progressive illness has robbed the patient of much, being empowered to deliberate and determine how this final bit of the life journey will unfold enhances the patient's mental state. *See* Kathy Cerminara and Alina Perez, *Therapeutic Death, A Look at Oregon's Law*, 6(2) Psychol. Pub. Pol'y & L. 511-518 (2000).

The collaboration between physician and patient over time reflects a deliberative, rational process, the antithesis of impulse-driven behavior. The nature of the deliberative process in every case of AID is made even more impressive by the fact that all of those choosing AID have made the decision to do so while in the course of regularly seeing health care providers, other than psychologists, who are treating other physical disease conditions, most often cancer, which afflicts more than 80% of those who choose AID under the Oregon statute. *See* Or. Pub. Health Div., *Oregon's Death with Dignity Act 2012* (2013). Poor impulse control is a defining characteristic of suicide; it is not present in those choosing aid in dying. AID and suicide are at the opposite extremes of the continuum of rational thought and conduct, and ought not be conflated.

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

The act of suicide is usually lonely and alienated, leaving in its wake a distraught family. *See* Thomas Joiner, *Myths About Suicide* 123 (2010). Psychologists see countless family members who struggle to make sense of an irrational, final act planned and committed without their knowledge, support or consultation. At the least, family members feel abandoned and disempowered after a suicide. They feel utterly without control, and they also feel they failed their suicidal family member. They are also likely to feel resentment resulting in complex grief. *See* Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide,* 25(1) J. of Crisis and Suicide Prevention 12-18 (2004).

The experience of family members following AID is very different. At the Seattle Cancer Care Alliance, families of patients who opted for AID frequently expressed gratitude after the patient obtained the prescription, regardless of whether the patient ever ingested the medication. They felt they could support their family member by supporting the decision to access AID. They referenced an important sense of patient control and family support in an uncertain situation. *See* Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 New Eng. J. Med. 1417 (2013). In these cases the patient's acquisition of some sense of control over his time and manner of death, whether the medication is ingested or not, may well have a positive emotional effect on the family, sharing in the pain and loss, as well as on the patient himself. There is little doubt that recognizing the patient's right to control the timing of his or her death has given Washington families greater ability to join together for support of their loved ones at that crucial moment. Similar findings in Oregon show that the family survivors of patients who choose AID do not suffer the adverse mental health impacts suffered by family members of suicide victims. *See* Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. of Pain and Symptom Management 807 (2009).

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

As an impulse-driven event, the act of suicide irrationally aims to permanently end its victim's intense anguish by ending his biological life. Thomas Joiner, *Myths About Suicide* 7 (2010). Psychologists sometimes ruefully refer to suicide as "a permanent solution to a temporary problem," since the patient sees no hope in a circumstance where a rational person would be able to find hope. That is often the very purpose of therapy. Research into suicide shows that persons restrained from suicide by jumping off a bridge, for example, often go on to lead productive lives. In one leading study, virtually all bridge jumpers who survived recalled experiencing profound regret during the four seconds it took to reach the water. Richard Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 Suicide and Life-Threatening Behavior 1-13 (1978).

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

The result of denying AID is far different. No life is saved. No suffering is averted; indeed, the patient's physical suffering will most likely last longer and perhaps grow even more horrific before the final ravages of the cancer or other disease culminate inevitably in death. The psychological suffering at being denied the autonomy to determine how much agony to endure before death arrives will often be profound. The meaning of a terminal diagnosis is that death will come soon, regardless of medical treatment. From a physiological point of view, and from the perspective of the progression of the underlying disease, it will make little difference whether a patient has access to AID; the patient is going to die soon in any case. From a psychological perspective, though, the utter and final lack of control that comes from being denied the opportunity to avoid unbearable suffering at the end of life is extremely important. It can lead to resentment, frustration, a sense of being powerless and captive of a miserable final stage of dying. The patient's frustration is also likely to extend to the patient's family members, who feel that they failed the patient when she needed their help the most and when she was helpless to act without medical assistance to end her suffering. *See* Barbara Coombs Lee and James L. Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 279-280 (2000)

When a psychologist intervenes to prevent suicide, that intervention helps his patient, both physically and mentally, in the short run and in the long run. An intervention to prevent AID will not have such a salutary effect. It will exacerbate physical pain and mental suffering in the short term, and will have no effect on the long term because the patient will die of the underlying disease whether a psychologist intervenes or not. It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

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

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

The practice of psychology has developed clear standards of care for capacity determinations. Psychologists are often called upon to determine a patient's capacity under the Uniform Health Care Decisions Act, N.M.Stat.Ann., § 24-7A-11. For the New Mexico statutory definition of capacity, see N.M.Stat.Ann., § 24-7A-1(C). Mental health professionals in New Mexico and across the nation recognize best practices to make such determinations, and those professionals are routinely trained in making exactly this kind of determination. See James L. Werth, G. Benjamin and T. Farrenkopf, *Requests for Physician Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 Psych., Pub. Pol. & L. 348 (2000), and Charles H. Baron, *Competency and Common Law: Why and How Decision-Making Capacity Criteria Should be Drawn from the Capacity-Determination Process*, 6 Psych., Pub. Pol. & L. 373 (2000). In fact, over the last several years special attention has been given to the determination of decisional capacity in those who face terminal illness and, more generally, in the elderly (from whom the terminally ill are disproportionately drawn). By way of immediate example, the Amicus has offered programs to its members and other health care professionals over the last two months in Albuquerque on working with patients with dementia (September 27, 2013) and in suicide risk assessment (November 8, 2013), and in Santa Fe on dealing with depression and despair, including end of life despair (September 27, 2013). For a current schedule of the active NMPA education program touching on these issues *see* New Mexico Psychological Association, *Upcoming NMPA Workshops*, http://www.nmpsychology.org/displaycommon.cfm?an=1&subarticlenbr=25. Where they have been called upon to do so, professional mental health associations have developed nationally respected standards specifically for assessing a person's capacity to choose AID. *See, e.g.,* Washington State Psychological Association, *The Washington Death with Dignity Act: WSPA Guidelines For Mental Health Professionals* (2010), *available at* http://www.wapsych.org/resource/resmgr/Docs/DWD_Guidelines_6-3-09.pdf. *See also* Tony Farrenkopf and James Bryan, *Psychological Consultation Under Oregon's 1994 Death With*

Dignity Act: Ethics and Procedures, 30(3) Prof. Psychol.: Research and Practice, 245-249 (1999).

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

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

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

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

It would be inappropriately condescending and it would undermine the psychologist-patient relationship for a mental health professional to treat a rational and entirely non-pathological decision of a patient to inquire into AID as an expression of suicidal ideation. Treating the decision to inquire about AID the same as one to ruminate about suicide would require application of an entirely inappropriate form of analysis and counseling. The standard of care for treating a suicidal patient would require issuance of a certificate which would authorize a law enforcement officer to detain the dying patient who was considering AID. This would utterly and completely destroy the trust necessary to make the psychologist-patient relationship useful, and, as a practical matter, it would end the psychologist-patient relationship, thus depriving the patient of an opportunity to benefit from the professional knowledge of the psychologist. Further, requiring psychologists to treat AID as suicide would discourage oncologists and others from referring their patients for mental health services, and it would discourage patients from seeking out mental health services on their own as well.

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

CONCLUSION

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

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of December, 2013, I electronically filed the foregoing pleading through the *Odyssey File & Serve System,* which caused all parties or counsel registered to receive electronic service to be served by electronic means.

/s/ Frank Spring

"FLS-3"

COURT OF APPEALS OF NEW MEXICO
ALBUQUERQUE
FILED

SEP 0 8 2014

IN THE NEW MEXICO COURT OF APPEALS

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

Plaintiffs-Appellees,

v. **No. 33,630**

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

Defendants-Appellants.

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

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

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GLORIA D. MONTOYA

This is the annexure marked "**FLS-3**" referred to in the affidavit of **Frank Lewis Spring** affirmed at Albuquerque, New Mexico this 28 day of April 2015 before me

Signature ......Gloria D. Montoya......
A person duly authorised to administer oaths in New Mexico, United States of America

Expires = March 8, 2017

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STATEMENT OF COMPLIANCE

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

Robert Schwartz

INTEREST OF AMICUS[1]

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

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

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

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

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

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

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

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

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

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

ARGUMENT

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

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

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

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

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

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

By contrast, the problem confronting the terminally ill patient arises from an irreversible physical calamity. She or he is dying of an incurable disease. *See* 2 Tr. 73:11-13 (Dr. Pollack testifying that "suicide is a distinctly different act than requesting aid in dying. . . because the person is already in the process of dying who is requesting this."). See also 2 Tr. 119:12-15 ("suicide" should not be used to describe the acts of people "who are not psychiatrically ill and who are already in the process of dying.") For these patients, the recognition that there is no hope for future physical improvement is accurate, not irrational. To treat a mentally competent terminally ill patient who seeks access to AID to avoid unbearable suffering as equivalent to a lovesick teenager or a homeowner losing the family home to foreclosure would be to completely misunderstand the psychological condition and the therapeutic role in each of those cases. It is for this reason that it is so offensive for those who have finally come to grips with their terminal condition, sometimes after a great deal of psychotherapy, and who thus seek access to AID, condescendingly to be told that they are demonstrating mental health pathology and that they are suicidal.

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

The suicidal patient's functioning is characterized not only by impaired cognition, as described above, but by disrupted impulse control. *See* 2 Tr. 73:17-21 (Dr. Pollack testifying that "[t]he act of suicide is usually impulsive. It's solitary. It's done without consulting or even allowing friends or family to know about the act, whereas with aid in dying, a person goes though a deliberative process."); *see also, e.g.,* Roy Baumeister, *Suicide as Escape from Self* 90-133 (1990). In evaluating the risk of suicide in any new patient, the psychology practitioner is taught to look for the "three P's": pain, pressure, and perturbation. "Pain" stands for emotional anguish, "pressure" stands for a feeling of being overwhelmed, and "perturbation" stands for agitation. Edwin S. Shneidman, *Autopsy of a Suicidal Mind* (2004). This "pain, pressure and perturbation" precipitate sudden, unannounced, lethal and often violent acts, like suicide. They are the quintessence of irrationality and loss of personal control. The three P's analysis describes virtually every real suicide, and it suggests why we are so concerned when there is a risk of suicide.

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

Death With Dignity Act Rep., Exec. Summary (2013) *available at* http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2013.pdf (posted February 14, 2014)(76% of those employing the Death with Dignity Act last year had at least some college). This subset of the population seeking to act in a self-determined and autonomous manner at their death is well able to understand their options and choose among them.

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

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

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

The act of suicide is usually lonely and alienated, leaving in its wake a distraught family. *See* Thomas Joiner, *Myths About Suicide* 123 (2010). Psychologists see countless family members who struggle to make sense of an irrational, final act planned and committed without their knowledge, support or consultation. At the least, family members feel abandoned and disempowered after a suicide. They feel utterly without control, and they also feel they failed their suicidal family member. They are also likely to feel resentment resulting in complex grief. *See* Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide,* 25(1) J. of Crisis and Suicide Prevention 12-18 (2004).

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

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

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

As an impulse-driven event, the act of suicide irrationally aims to permanently end its victim's intense anguish by ending his biological life. Thomas Joiner, *Myths About Suicide* 7 (2010). Psychologists sometimes ruefully refer to suicide as "a permanent solution to a temporary problem," since the patient sees no hope in a circumstance where a rational person would be able to find hope. That is often the very purpose of therapy. Research into suicide shows that persons restrained from suicide by jumping off a bridge, for example, often go on to lead productive lives. In one leading study, virtually all bridge jumpers who survived recalled experiencing profound regret during the four seconds it took to reach the water. Richard Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 Suicide and Life-Threatening Behavior 1-13 (1978).

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

The result of denying AID is far different. No life is saved. No suffering is averted; indeed, the patient's physical suffering will most likely last longer and perhaps grow even more horrific before the final ravages of the cancer or other disease culminate inevitably in death. The psychological suffering at being denied the autonomy to determine how much agony to endure before death arrives will often be profound. The meaning of a terminal diagnosis is that death will come soon, regardless of medical treatment. From a physiological point of view, and from the perspective of the progression of the underlying disease, it will make little difference whether a patient has access to AID; the patient is going to die soon in any case. From a psychological perspective, though, the utter and final lack of control that comes from being denied the opportunity to avoid unbearable suffering at the end of life is extremely important. It can lead to resentment, frustration, a sense of being powerless and captive of a miserable final stage of dying. The patient's frustration is also likely to extend to the patient's family members, who feel that they failed the patient when she needed their help the most and when she was helpless to act without medical assistance to end her suffering. *See* Barbara Coombs Lee and James L. Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 279-280 (2000)

When a psychologist intervenes to prevent suicide, that intervention helps his patient, both physically and mentally, in the short run and in the long run. An intervention to prevent AID will not have such a salutary effect. It will exacerbate physical pain and mental suffering in the short term, and will have no effect on the long term because the patient will die of the underlying disease whether a psychologist intervenes or not. It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

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

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

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

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

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

A mental health professional will not always be required to evaluate the capacity of a terminally patient who chooses AID, of course. Under the Uniform Health Care Decisions Act, a patient is presumed to have decisional capacity to make a health care decision (like choosing AID, if her physician believes that is among her appropriate choices). NMSA 1978 § 24-7A-11(B). If there is any question, though, physicians can consult with a mental health professional to avoid any uncertainty about the patient's capacity. See NMSA 1978 § 24-7A-11(C). As the experience in Oregon and Washington suggests, physicians occasionally do so. There may have been a time when mental health professionals were not trained to make such determinations in the terminally ill, and there was a time when those professionals had no professional standards to apply in making those decisions, but that time is long past. Making capacity determinations at the end of life is now a regular function of psychologists and other mental health professionals. *See* 2. Tr. 74:1-20 – 76:1-10, 103:15-19, 104:2 (expert testifying that "it is the same circumstance" when a person is terminally ill and mentally competent to make a decision to end a life-sustaining treatment and when a person is terminally ill and mentally competent to make a decision to choose aid in dying). There are adequate tools for professionals to make these determinations, and these professionals are well trained to do so.

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

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

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

It would be inappropriately condescending and it would undermine the psychologist-patient relationship for a mental health professional to treat a rational and entirely non-pathological decision of a patient to inquire into AID as an expression of suicidal ideation. Treating the decision to inquire about AID the same as one to ruminate about suicide would require application of an entirely inappropriate form of analysis and counseling. *See* 2 Tr 91:11-23 Dr. Pollack testifying that "it would be really hard . . . on a psychiatric basis" to say that a person who is seeking to end life-sustaining treatment, just as a person seeking AID, is endangering him or herself such that the person needs to be committed). The standard of care for treating a suicidal patient would require issuance of a certificate which would authorize a law enforcement officer to detain the dying patient who was considering AID. This would utterly and completely destroy the trust necessary to make the psychologist-patient relationship useful, and, as a practical matter, it would end the psychologist-patient relationship, thus depriving the patient of an opportunity to benefit from the professional knowledge of the psychologist. Further, requiring psychologists to treat AID as suicide would discourage oncologists and others from referring their patients for mental health services, and it would discourage patients from seeking out mental health services on their own as well.

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

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

Applying strict scrutiny analysis in this case, the trial court determined that "the right of a competent, terminally ill patient to choose aid in dying" was a fundamental liberty interest that must be weighed against countervailing state interests to determine whether there was a sufficiently "compelling state interest" to limit that right under the New Mexico Constitution. RP 0217-0229. If this court were to apply the lower intermediate level of scrutiny in this case, it would be required to weigh the important interest of competent, terminally ill patients in seeking amelioration of their final suffering against any asserted state interests to determine if the state action was substantially related to an important governmental interest. Even if the court were to apply the lowest level of constitutional scrutiny, it must find that the state has acted in furtherance of a legitimate state interest for that state action to comport with the New Mexico Constitution. See *Trujillo v. City of Albuquerque*, 1998-NMSC-031, par. 15, 125 N.M. 721, *Marrujo v. N.M. State Hwy. Transp. Dep't*, 1994-NMSC-116, par. 11, 118 N.M. 753 and *ACLU of NM v. City of Albuquerque*, 2006-NMCA-078, par. 19, 139 N.M. 761.

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

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

CONCLUSION

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

Respectfully submitted,

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CERTIFICATE OF SERVICE

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

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"FLS-4"

GLORIA MONTOYA

This is the annexure marked "FLS-4" referred to in the affidavit of Frank Lewis Spring affirmed at Albuquerque, New Mexico this 28 day of April 2015 before me

Signature ....
A person duly authorised to administer oaths in New Mexico, United States of America

Expires Mar/8, 2017

Pollack.

THE COURT: Would you raise your right hand.

(NOTE: Witness is duly sworn.)

THE COURT: Go ahead and be seated.

DAVID A. POLLACK, M.D.

(being duly sworn, testified as follows:)

DIRECT EXAMINATION BY MS. SMITH

Q. Please state your name.

A. My name is David Pollack.

Q. And what is your profession?

A. I'm a physician and my specialty is in psychiatry.

Q. How long have you been practicing as a psychiatrist?

A. I shudder to say, 40 years.

Q. I would like to discuss a little bit of your education. Where did you receive your Bachelor's Degree?

A. Northwestern University in Evansville, Illinois.

Q. And what year did you receive that degree?

A. 1969.

Q. Where did you attend medical school?

A. University of Oklahoma. Oklahoma Health Sciences Center, I think is what it was called, in Oklahoma City.

Q. And what year did you graduate?

A. 1973.

Q. And where did you do your residency?

A. Oregon Health and Science University in Portland.

Q. And what sort of residency training did you receive?

A. It was a general adult psychiatry residency program.

Q. When did you become licensed as a physician?

A. Somewhere in that time, between '73 and '76. I had a provisional license during my residency. Before I finished the residency, I got my official medical license.

Q. And in what state?

A. For the state of Oregon.

Q. Are you Board-certified?

A. Yes, I am, in psychiatry and neurology. It's a package deal.

Q. Do you have any other distinctions in your certification that might be considered important?

A. Well, my title -- my academic title is Professor for Public Policy, and so I spend a lot of time on policy-related issues, as well as clinical practice and teaching based at the university. And among other things, I have done policy work that relates to this particular topic of aid in dying. I have done policy work at different levels -- local, state, national. I did a health policy fellowship and worked in the U.S. Senate for a year in 1999 in the office of Senator Kennedy, during which time I also participated in some activities that had to do with looking at the experience with Oregon law. I have an appointment at the University as the senior scholar in the Center for Ethics and Healthcare at

Oregon Health and Science University. I teach healthcare organizational ethics, as well as addressing ethical issues in training with medical students and psychiatry residents and other mental health professionals.

Q. In your classes that you teach, do you teach about end-of-life care?

A. I do. Certainly the subject comes up in a number of contexts, as I mentioned, in teaching medical students, in doing clinical work, in doing training with residents in psychiatry. And we have a health management MBA program at OHSU. And in the context of that program, it's actually both an MBA and a Master's of Science tracks that people have. We have a healthcare organizational ethics course in which we address end-of-life issues and some other conflicts that might occur in healthcare settings and how one goes about making responsible, ethical decisions around controversial and difficult topics.

Q. In your work do you also treat patients?

A. Yes, I do.

Q. And were there times in your career where you treated patients more frequently?

A. Yes. Certainly the first decade or two or three of my career I did mostly clinical work. And then that I had to blend, as many people as they advance in their careers in healthcare, a variety of administrative, policy, teaching, as

well as clinical work, as well as doing some consultation. I'm not a direct researcher, but I consult with people who do certain kinds of health services research.

Q. Have you written any published works on the subject of aid in dying?

A. Yes, I have. At least two things that I have co-authored. One was a report that was done for the Oregon Psychiatric Association that I and several of my colleagues put together as a position paper on what are some of the issues that relate to the psychiatric aspects of aid in dying. The other paper was published in a journal called *The Community Mental Health Journal*, and it was addressing -- this actually was published in 1998, and it was not long after -- we wrote it not long after the initiative had passed in the state, and our Department of Psychiatry at the University, being the only academic health center, we started to raise the question: Well, if this is now law, how do we as psychiatrists address this part of the law? It includes if the attending physician requests an evaluation of the person's mental status to determine if their judgment is affected by psychiatric conditions, such as evaluations to be conducted, and the psychiatrists and psychologists are the eligible professionals to do that kind of evaluation.

So one of the things we wanted to do was outline what made sense as the right kind of evaluation to do in these circumstances and then to address some ancillary issues related to that including, what are the other roles that psychiatrists and other mental health professionals may have vis-a-vis the patient, the family, the treating team in consulting with them and evaluating a number of things, helping to provide consultation to help them go through whatever the process is that they're going through. And included in that paper, in retrospect, I realize that we may have been the first ones to recommend that the terminology be shifted from "assisted suicide" to "aid in dying" or "physician aid in dying."

Q. And why is it that you thought that that shift from the terminology was important?

A. Well, this requires saying a few things about what the context is. If, as the law says, someone who is eligible in Oregon for requesting aid in dying, they have to be -- the probability of their death within six months has to be established by, I believe, a physician and a second physician to give a confirming opinion of that. So the question is not whether or not the person is going to die, but that they are going to die.

And then one needs to think about, Well, what are the different types of death that humans go through? And there can be sudden death or more chronic death, deaths that may involve some deterioration and some that may involve a much

more prolonged, lingering deterioration. And the level of functioning of the individual that is maintained during that process of dying may vary. Some people may maintain an ability to function in, what we say, an integrated way, in an integrated self throughout that whole course. Others deteriorate and lose either bodily functions or cognitive or other emotional or psychological functions, as well as coming in and out of consciousness.

And, therefore, when one is thinking about the concept of suicide versus aid in dying, I think it's important to distinguish that suicide is a distinctly different act than requesting aid in dying; A, because the person is already in the process of dying who is requesting this. The person who is committing suicide, who has a psychiatric condition, usually it's a form of depression, but sometimes it's other psychiatric conditions that may involve psychotic symptoms unrelated to being depressed. In those cases, the act of suicide is usually impulsive. It's solitary. It's done without consulting or even allowing friends or family to know about the act, whereas with aid in dying, a person goes through a deliberative process.

In fact, it requires at least two visits with a physician to have that innocence confirmed and to make sure that the person wants to do that. And it almost always involves the person discussing this with their family and friends and the support network that they have, and to do so in a way that they can establish that this is a choice that they are making out of their own free will, and to alleviate symptoms or suffering, and to maintain a quality of life and a level of integrity of themselves, their ego identity, if you will, and their functioning as long as possible. And their purpose usually in choosing to end their life at one level, in kind of an overt or manifest level, is to alleviate symptoms, to spare others from the burden of watching them dwindle away or be a shell of their former self or to feel like they are in control, have some autonomy and some control over the way that they die.

The basic existential issue generally beneath that is the desire to maintain the integrity of themselves; that they are connected to others, as Ms. Riggs said, and that they have the ability to feel together and as a whole person.

Q. One of the requirements of Oregon's Death With Dignity Act is that somebody be considered mentally competent. Do you have experience evaluating competency?

A. Yes, I do. It's important to clarify that in the process of doing an evaluation -- and part of what we try to explain in that paper I mentioned, it was both to say, Here's the kind of evaluation that one should do, but also that we need to make sure that we're training our future psychiatrists and psychologists that this is the way to do

it, so we have an organized way of making sure we have competent people doing the examinations and evaluations.

There are several things that one would want to clarify. One is simply what the person's condition is, whether they actually have a terminal illness, you know. So this involves consulting with the attending physician and finding out what the status of things is and then finding out more about what their reasons are, generally, in a process that a skilled clinician interviewer would do that doesn't suggest ideas or reasons but tries to elicit from the patient why he or she is wishing to request aid in dying. And then it's important to establish whether the person has some kind of psychiatric condition that might be interfering with their judgment or contributing to their making this choice in a way that would be perceived as not allowing them to have really free choice; that they are being driven more by their psychological stress and that that psychological stress is more than just the conditions that I'm talking about in terms of the symptoms that they are experiencing, but some profound psychological condition, like a major mood disorder -- major depression, bipolar disorder, or even a psychotic illness -- that would need to be identified as to whether they have it or if they have a history of these kinds of psychiatric conditions that usually emerge early in one's adult life. Adolescence to early adult life, those kinds of conditions would and generally seem to be present, even if they are recurrent.

And then even if someone has a psychiatric illness or condition, to make sure that if they have that condition, that it's not active at the present time and contributing to the judgment that they're trying to make. So part of my point is one can have a co-morbid psychiatric condition and that doesn't operate to rule out the possibility that their decision-making in regard to aid in dying is not legitimate and consistent with what the law expects.

Q. Doctor, let me touch just a little bit --

A. Sure.

Q. -- on some of what you said.

A. Sure.

Q. So is it common for people who are terminally ill to be depressed?

A. It is common for people who have been given bad news of one kind or another, even if you've been told that you have a chronic illness that you didn't think you were going to have, to be disappointed, to go through various stages of emotional reactions to that -- either disbelief or anger or depression -- but at some point going through a process that was originally described by Elizabeth Kübler-Ross that associates with the stages of how one deals with bad news. And she initially focused mainly on the process of dying, of

reaching a stage of acceptance and recognizing, This is the reality of where I am in my life and I go on from here. Some people get stuck in some of those stages, in either denial or in depression or in anger, and they may need help to work through that. But it's not common that people stay stuck in those stages, and so it's not surprising that someone would feel sadness, but may not meet the criteria for a clinical depression in the process of getting that news.

Q. So how do you sort out, when you're doing -- when you're evaluating somebody, how do you sort out between somebody who is working through a situation where they are either depressed by their diagnosis versus somebody whose desire for aid in dying is coming from a place that is influenced by a mental disorder?

A. There are a couple things about that. One, just looking at the symptoms and the criteria for the diagnosis of major depressive disorder and seeing whether the person meets those criteria, the two main symptoms or conditional issues are: Does the person have a prolonged experience of feeling sad, down, blue, thoughts of death or thoughts of wanting to kill themselves that lasts for at least two weeks or longer, or a diminishing of their interests in life or inability to take pleasure in life, something we call "anhedonia," coupled with certain other symptoms. There's psycho-biological symptoms that may involve difficulty with sleep or appetite that are separate from the symptoms that may be associated, say, with a cancer or with the physical illness that a person may also have, and often morbid preoccupation with suicide or a wish to die can sometimes take on delusional proportions.

Like the person may have a lot of self-incrimination: I'm a bad person or I have something bad inside of me or this is my fate for having done bad things at some point in my life. A psychiatrist or a psychologist can usually distinguish those from more rational reasons for the person to feel sad. So it's out of proportion, some of the things they are experiencing, to the reality of what their life is.

Q. And so when you're looking at some of those criteria, how would you distinguish that person seeking -- person seeking aid in dying, who might have some of those physiological symptoms that you mentioned because, you know, they might have fatigue or inability to eat?

A. That's right.

Q. So do you sort through that?

A. I think part of it in this case -- well, one of the things I should have said earlier is, in distinguishing suicide from aid in dying, there's two universes, I guess, of people, two cohorts of people you want to think about: people who have a terminal illness and people who don't have a terminal illness. Of those who don't have a terminal illness and have depression and are feeling suicidal, it's

kind of not an issue. Of those who have a terminal illness and wish to commit suicide versus those who wish to pursue aid in dying, there are distinctly different ways they present.

Part of it has to do with their motives, what they are saying they want to do. And it's often along the lines of what we heard from Ms. Riggs, or what I was describing to you earlier, about wanting to avoid the pain and suffering that they inevitably anticipate experiencing or that they have already experienced and don't want to experience again; or the hassle, burden associated with the ongoing medical interventions that are required to maintain the quality of life that they've been experiencing up until then; that they're just tired of the chemotherapy or the radiation or being plugged into things or having to have so many doctor visits or having to go to the hospital and having procedures when they would rather be spending the precious time they have left with their loved ones and the people they care about or doing things that they care about.

In other words, they're focused on maintaining the quality of life that is something that they cherish and they want to capitalize on as much as possible in the time they have left whereas the person who is depressed and suicidal turns inward, becomes isolated, even if they have people caring about them. They are less approachable and they are more morbid and less reconcilable in terms of these stages I was talking about.

Q. One of the -- now, you talked about the criteria for diagnosing depression as one of the tools that can be used to make these distinctions. Are these sorts of guidelines available to any qualified psychiatrist?

A. They are available to everyone. The DSM, which is the *Diagnostic and Statistical Manual* of the American Psychiatric Association, is widely available electronically, as well as in hard copy. Physicians often turn to it, not just psychiatrists and other mental health professionals. When I teach my family medicine residents that I work with in the clinical work I do, we look at the DSM to look at the diagnoses of people that we're evaluating together. So it's a resource that is available, and now we have the new version, the DSM V that just came out in May. So it's widely available.

Q. And so this is something that a qualified -- and any qualified psychologist could evaluate, not just someone operating under the statute in Oregon?

A. Absolutely. I would imagine any psychiatrist, most psychiatrists, most psychologists would be able to -- with the skills they have in their regular practice, would be able to evaluate. They may have to learn something more about the process that's associated with end-of-life issues, but that's

not that big a stretch for most of them.

Q. Now, you also mentioned some other kinds of mental health disorders, not just depression, and that -- and explain to me how that kind of mental health disorder could operate on a person who is seeking aid in dying.

A. Well, there are a number psychiatric -- classes of psychiatric illnesses, one of which is called "mood disorders." Mood disorders include depressive disorders, where the person mainly experiences depression as the change in their mood from being okay; and there are other folks who have what we call "bipolar disorder," where they can experience either depressive and/or manic or hypomanic mood swing, meaning elevated mood. And sometimes that manic or hypomanic mood elevation can have psychotic proportions to it, where they can get out of touch with reality and lose control in terms of some of their behavior, become very impulsive, spend a lot of money, stay up late at night because they are ambitious and eager, even though it may not make sense to people.

Similarly, people who have major mood disorders, either major depression or bipolar disorder, where they have a depressive mood swing, those can, as I alluded to earlier, have psychotic dimensions to them for some folks, where they can have delusions of a terrible illness that they're having, or that they're being punished by God for some crime or sin or some terrible thing they did, or that they may project outward onto someone or something outside of them these negative thoughts or feelings. So they may believe that, say, the FBI or the CIA is after them, or that they have done something terrible, or that they have somehow contracted a terrible disease like HIV/AIDS, even though they haven't exposed themselves to risks like that. So there are a number of ways that can manifest. So that's one thing, mood disorders.

Another is other psychotic illnesses, the most common of which is other schizophrenic disorders. And sometimes people who have schizophrenic disorders can become discouraged, despondent in relation to the course of their life not working out as they or their parents or family have thought it would, and they may either impulsively or in some kind of deliberate way end their lives as well.

Q. And so if somebody has a history of any of those sorts of mental disorders, how would you -- how would you make sure that they were not operating under those, other than the depression which we discussed?

A. In doing a standard psychological or psychiatric evaluation, one would make inquiries about the kind of symptoms the person has had, would inquire more explicitly about, "Have you had these kinds of experiences?" and be observing for nonverbal behavior and other things that might

be evidence of that kind of condition.

In addition, in doing this kind of evaluation, it's important to get collateral information, if at all possible, from family or other people that the person says, "Yes, it's okay to talk," obviously respecting their rights and getting their permission, but to talk to other people who may be involved in their support system to find out what they think about what's going on, what their past history has been and so forth.

Q. Are there some people who have their history with mental illness and their -- would make them never an appropriate candidate for aid in dying?

A. Oh, sure. There are people who may, because of the nature of the psychiatric illness they have -- there are a few that may never -- there are a number that intermittently may not be able to, because of having a psychotic process going on, in effect, may render them unable to provide informed consent.

Q. And are there some people who have a history of an illness who, despite this history, may be able to make a rational decision for aid in dying?

A. Absolutely. I alluded to that earlier. Simply the fact that someone has a history of, or even a current psychiatric condition, should not be sufficient as the only evidence that one would use to determine whether or not they are eligible to use aid in dying. If after a thorough evaluation it is shown that this person's condition is under control, they're on medications, or they're in psychotherapy and the types of symptoms they are having have to do with their psychiatric condition, have no bearing on and are minor in relation to the other reasons they are articulating for their wish to request aid in dying, in my view, it's not only appropriate to do that, it would be unjust to deny them the opportunity, if they've met the criteria the same as anyone else.

Q. Now, have you ever done an evaluation of somebody who was seeking aid in dying?

A. Yes, I have.

Q. And can you explain a little bit about what happened.

A. This was a patient who was referred to me by -- let me explain the context. I work -- the clinical work I do now and I've been doing for the last four? -- yeah, four years at the university has been providing consultation in two family medicine clinics that the university operates. And I do evaluations of patients that are referred who have more complex presentations, and so the primary care providers request me to evaluate them, do a report, give them recommendations.

And I got a request from an attending physician of a patient who was at this particular clinic about this

particular request. This man had a terminal illness and he had a psychiatric history and wanted me to make sure that the psychiatric condition that this man had had was not interfering, and in the context of that, doing the same kind of evaluation I just described to you, to do a more thorough evaluation of why was he wanting to request aid in dying and so forth.

Q. And so in that situation, what did you determine?

A. I determined, after meeting with him and his two adult siblings and one of the siblings' spouse was present in his apartment -- I went to his apartment instead of having him come to the clinic -- I talked to him by himself and then with his family members, and I determined, as I had already determined, that he met the criteria in terms of the malignancy in the course of his cancer being something that was going to cause him to die within a few months; that he had had a certain kind of psychiatric symptoms in the past; that those were under control at the time; that he had worked through his decision -- and one thing I didn't mention to you that's an important part of this evaluation is to try to determine that this is, indeed, a free and voluntary choice that the person is making and to determine that he or she is not under the undue influence, subtle or not so subtle, from other people; or that he or she is not interpreting that other people want him to do this, and it's not something he wants to do but it's something that he or she would want to do basically because they think that's what someone else wants of them, so to make sure they are not being exploited or coerced or that they have sufficient ambivalence about this but they're tending to go along with it because they think someone else wants them to.

Q. So in that situation, to safeguard from that, this coercion piece, whether real or perceived, how do you ensure -- what can you do? What tools are available to you to make that determination?

A. There are several things. One has to do with the skill of interviewing the person and trying to determine the genuineness of their statements and their request. And, secondarily, to look at and to talk to their family members about what they think and what they feel and how they have perceived this process to have gone, and then to more subtly observe the nonverbal behaviors of the participants in the interview to see if there are furtive glances or the person is, like, checking to make sure he's saying the right thing as opposed to a "This is really what I feel" kind of statement, and ruling out that kind of coercion and being, in particular, sensitive to people who, because of certain either demographic or other factors, might make them more vulnerable to being informed --

Q. Explain some of those factors.

A. Well, the kind of categories of people who are less advantaged in some way, either less education or some ethnic or cultural minority or people of a lower socioeconomic status. Some people think women or people who are older or younger, you know, certain age groups, might put them in a more vulnerable position to be discriminated against or to be influenced or exploited. And so one has to be, in particular, alert to those factors playing in a case like this, and to make sure, doubly sure, that that's not going on.

THE COURT: I need a clarification. So if I'm understanding your testimony correctly, you or a similarly-situated colleague only get called in to do this sort of evaluation if there is some question about the person with a prior -- or a history or current psychiatric condition; correct? You don't do it -- this is not done for every --

THE WITNESS: That's correct.

THE COURT: Okay. And so what I'm assuming you're describing is sort of the standard of practice for making this determination if their choice is voluntary.

THE WITNESS: That is correct.

THE COURT: Do you have an understanding as to whether those tools for determining whether the process is voluntary are applied when the doctor, the oncologist or

other treating physician, is discussing the choice with the patient?

THE WITNESS: Yes. If I may expound on this?

THE COURT: And does that take you totally off track?

MS. SMITH: Go right ahead.

THE WITNESS: I think this is consistent with what you were asking. In the law in Oregon it doesn't require that every person requesting aid in dying have a psychiatric evaluation.

THE COURT: Okay.

THE WITNESS: It requires the attending physician to determine whether that's necessary, and it's up to the attending physician to decide whether they think there is some question. And it's not necessarily, does this person have a past history, but whether they have any question that there is some mental or psychological factor that may be operating that would interfere with that person's judgment in making this request.

Now, the reason it isn't everyone is partly what I saying earlier and partly related to what Dr. Morris has probably described and probably what Ms. Riggs' physicians have described. The process of taking care of someone who has a terminal illness involves a longitudinal experience and the relationship the physician has with that person and the training that all physicians hopefully get in being able to evaluate their patients in terms of whether there is something going on emotionally or psychologically that would raise concerns. It may not be such that they have the expertise to accurately and definitively diagnose what psychiatric condition they have, but they certainly have the ability to determine whether there is something going on emotionally or psychologically that may need further clarification.

Q. (BY MS. SMITH) And this is based on the fact that this is an ongoing, long relationship where they get to know this patient?

A. Based on that, the fact that there's a longstanding or at least a continuous relationship with that patient, and that the physician has received sufficient training in his or her medical school and residency and clinical experience beyond that to be capable to make those kinds of determinations.

Q. And so when -- are there other situations that arise outside of aid in dying where physicians must determine whether this person -- whether a person is competent to make these kinds of decisions?

A. All the time.

Q. Can you --

A. This happens in clinical situations where people have,

for example, renal dialysis. Somebody's got kidney disease, chronic kidney failure and they have to go through dialysis every week or two weeks. At some point the patient says, "I don't want this anymore." They are not requesting aid in dying. They are saying, "I refuse to take this treatment." Or I just saw in the newest episode of *Treme* last night, one of the characters in *Treme* has cancer and he has said at this point, "I don't want the chemotherapy anymore." And his family is kind of mixed.

So it happens in those kinds of contexts where someone is either refusing treatment and the physician has to decide: Is this something that is a result of the person having a psychiatric illness that may require them having an evaluation to determine if the psychiatric illness is causing them to put themselves at risk and possibly leaning to what we call a "civil commitment," where you would involuntarily treat someone? So in the hospital at the university or other hospitals, a lot of times psychiatric consultations are requests from, say, the transplant service or the renal dialysis unit or certain other medical units when there is some question of someone refusing treatment.

THE COURT: In those situations, is it statutorily required, as it is in this situation? Do you know the answer to that question?

THE WITNESS: It's not statutorily required that they request a psychiatric evaluation. It is statutorily required that the physician at least make a determination if they think the person has a mental illness. It varies from state to state, but in most states there has to be some evidence that they believe the person has mental illness and because of that illness they are either unable to care for their own basic needs or they're endangering themselves or someone else. And sometimes people interpret in the medical context, this person, by refusing dialysis, is endangering themself. So we may get a request from someone and when you talk to that patient and they're saying, "Look, I know what I'm doing, and I'm just -- I'm tired of this. I'm not depressed. I just want to stop the dialysis." And it's really hard, I think, on a psychiatric basis to say, "This person needs to be committed."

Q. (BY MS. SMITH) And knowing the consequences of that action --

A. Yes.

Q. -- refusing life-sustaining treatment, consequences of that can be the end of somebody's life; correct?

A. That's correct.

Q. Just as in aid in dying?

A. Yes. Just as it is for -- as you were talking earlier about removing a feeding tube or someone simply saying, "I'm not going to take any more liquids."

Q. Now, let me try to come back to a patient that you had who had a, I think as you put it, a "co-morbid mental disorder." So what did you -- after meeting with this patient, with his family, alone and with family members, what did you determine?

A. I determined that in spite of the fact that he had a coexisting psychiatric condition that had been a problem at times in the past, he was under sufficient control at the present time; that it wasn't factoring into his request or the decision-making process that he was using to make the request for aid in dying; and that there was no reason to, on a psychiatric basis, prevent him from having that option.

Q. Now, another possible motivation for physician-aid in dying might be somebody has uncontrolled pain or symptoms; is this correct?

A. That's correct.

Q. And if you were evaluating somebody who said this is the reason they were seeking aid in dying, would you want to know more?

A. Well, one thing I would want to know is, in talking with their attending physician or their treatment team, what is it they have done? What are the other options? Are there, indeed, other options for this person to relieve the pain or other debilitating symptoms they are experiencing? The person simply saying, "I'm having too much suffering," may not be sufficient to convince me that they are at the point where they shouldn't have to take anything else. So finding out from their physician what else has been offered, and then if those proposed options, treatment options are not excessively intrusive or something that the person would, if it was explained to them, perceive to be, "Okay, I can tolerate that," then we would say, "Well, let's wait and see what happens as you go through that."

But if you determine that, in spite of whatever treatment they have done, they are really at a point where they can only provide treatment that would compromise the person's ability to maintain the integrity of themselves -- so, for example, the palliative sedation you were talking to Dr. Morris about earlier. If there's an ambivalence one might feel about that in terms of, "I'm going to be compromised in terms of my ability to remain connected, alert," some people, before getting to that point, might elect to use the aid-in-dying option.

Q. One of the things that you've mentioned, there was a difference between suicide and aid in dying, was the nature of the act being impulsive or isolated. Can you elaborate a little on that.

A. Most people who commit suicide do it without informing other people. They do it, generally, impulsively. It's important to qualify. There are people who make suicide

attempts where their intention is really to get attention and to get help. And it's a different -- we talk about the level of lethality in suicide attempts and suicidal intention. Not all suicide attempts are alike. But those who make suicide attempts where they're really intending to kill themselves are usually doing it in an isolated way. They feel some psychological isolation. They feel shame or guilt or anger or misunderstood, something like that, that separates them from others, and they feel either a fear of their family members or close connections to them knowing about what their intention is because they think they'll just put them in the hospital or they won't understand.

And they also are not thinking a whole lot about what the consequences would be. Even though sometimes they say, I'm not, it's going to hurt -- "I wouldn't kill myself because it would hurt other people," sometimes people get to a point where it's, "I don't care anymore," and it's a disconnected experience. And it is usually, as I said, impulsive, sudden, rather than something that in rarer cases is thought out and planned in a more detailed way.

Q. And how is this different from aid in dying?

A. It's a despairing, lonely experience whereas the person who requests aid in dying is doing this generally for the reasons I said earlier, to alleviate symptoms but, more positively, to maintain the relationships, the connections, and the sense of self being more integrated to the point where they end their life. And so it's more maintaining peace, joy, relief, something like that, or what you might define as happiness. I think one of the people in that *To Die in Oregon* mentions, "I'm happy now." So happiness is an important thing. And, you know, Freud described the way -- the purpose of living and being happy is to work and to love. So at some point people feel that is so compromised that they can't continue.

Q. What is the psychological effect on people who are prescribed -- who receive prescription medication for physician aid in dying?

A. It's generally a sense of relief that, I have this option, Plan B, if you will; that if the course of my dying goes okay, I mean, if I'm able to maintain that sense of feeling okay, just as Ms. Riggs said, I don't want to die. But if at some point things really deteriorate and I feel like I'm losing my, either bodily functions or my ability to be connected to others, then I will take it. So there's a sense of "in case of emergency, break glass." I've got this metaphorical fire extinguisher here I can use. That's more or less what it's like. And people then feel less anguish, less focus about what's going to happen, so that they can then focus on what they want to do with those precious hours, days, months that they have left to use to the fullest in

terms of relating to other people, thinking about what they have enjoyed in their lives, visiting places that they've enjoyed, doing activities, whether it's artistic or reading or their own professional work, whatever it is, in a peaceful way.

Q. One of the other differences you mentioned between suicide and physician aid in dying is the consequences of physician aid in dying on survivors.

A. Yes.

Q. Can you explain that.

A. Well, in the context of suicide, because it's isolated and often a surprise, the family members and others who know this person go through a surprise, usually shock and disbelief or anger, a whole set of emotional reactions, a lot of which involve, "Why didn't you tell me?" Or, "We could have done something." I wish we" -- reflecting a lack of connection between the person who committed suicide and the others who cared about, or maybe didn't care about, you in a different context.

With the person requesting aid in dying, those who are close to him or her go through this process. Even though they may have different opinions, if they can come to a position of, "My respect of your choice actually trumps whatever I would have done or what I would have preferred and, therefore, I'm going to go through this with you," most people who've gone through that process have described feeling more prepared for the person's death and more at peace in relationship to it whereas those who have a sudden loss of a close person feel a lot of unfinished business, disconnected, no closure, psychological closure, if you will, on their relationship and feel maybe in some ways cheated.

THE COURT: I'm assuming when you say "most persons," you're testifying from the basis of a study that has been done?

THE WITNESS: Yes, both in terms of clinical observations in my own experience, but also there's one study, in particular, that was done looking at the reactions of family members of persons who have gone through aid in dying, those who had received the medication or -- either those who had requested aid in dying and either had the medication and took it, or had the medication and didn't take it, as well as I think those who had requested it but never actually chose to take the prescription yet, but they had gone through that process and knew they had that option, versus a control group of people who had similar terminal illnesses -- I think it was ALS and certain kinds of cancer -- who didn't go through the --

THE COURT: Okay.

THE WITNESS: -- aid in dying request, and then they studied those family members to find out what

similarities and differences there were in them. So in appropriate clinical research approaches they had matched groups that were roughly the same in terms of demographics and age and other characteristics, and then they looked at what kinds of mental health problems either group had and other questions that they asked them about how they dealt with the person's death and so forth, and they found no differences. They found that the people who went through the aid in dying process had no greater probability of having any kind of psychological problems as a result of that. The main differences they did find were that the people who went through that process said they were more prepared for the person's death and, in a sense, were more at peace and able to accept it.

THE COURT: So the family members of the persons who chose to utilize aid in dying were basically similarly situated to family members of the people who had terminal illness and the terminal illness went to its terminal conclusion?

THE WITNESS: That's correct.

THE COURT: I know here we've been talking about suicide, but I was interested in those other two groups, so you answered my question.

Q. (BY MS. SMITH) Now, competency is one of the requirements for physician aid in dying. And how does one determine competence, not just from the standpoint of mental illnesses that may be involved, but other types of competence?

THE COURT: Counsel, I'm sorry to interrupt, even though I keep doing it, but it sounds like we're sort of starting into a new area. It's seven minutes till noon --

MS. SMITH: This is almost the end.

THE COURT: Oh, it's almost the end?

MS. SMITH: Yes.

THE COURT: Then never mind.

MS. SMITH: But we can --

THE COURT: No, please continue.

MS. SMITH: Ten minutes?

THE COURT: Yes, Absolutely.

Are you okay, Janice?

COURT REPORTER: I'm fine.

THE COURT: Okay.

Q. (BY MS. SMITH) So in determining competency, how does one go about determining competence?

A. Okay. I'll try to do this part quick.

Q. Well, take your time.

A. Well, first of all, making sure the person doesn't have some kind of gross cognitive impairment or psychological impairment is part of what I was talking about earlier in terms of the psychological or psychiatric conditions they

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might have. But then in terms of the competence to agree to or to refuse a medical procedure or treatment usually involves establishing whether the person has certain understandings: Whether they understand the nature of the illness that they have so that they understand the nature of the treatment that is being proposed or the treatments that are being proposed and the alternative treatments that might be available, and whether they understand the consequences of either accepting the treatment or rejecting the treatment. So do they understand what would happen if they did or didn't take this surgery or this medication kind of treatment. And so once one establishes that, then they can pretty well feel that that person is capable of giving that kind of informed consent to that procedure. We call it "PAR," or "PARQ" is the acronym that most medical providers use.

Q. And what does that stand for?

A. Procedures, alternatives, and risks. I forget what the Q stands for.

Q. And is it common for physicians, not just psychiatrists, but for physicians to make these sorts of determinations in their practice?

A. Very common. In fact, most physicians are obligated to have that kind of conversation with their patient and to document that they had that kind of conversation when they are proposing certain kinds of treatment, and I failed to mention, that are part of the risks. They need to have a discussion with the patient about, "Do you understand what the potential harms are of this procedure?" so that they can be clear that the person who is doing this understands the potential side effects or risks that, say, they might have a risk of dying from being under anesthesia. It's a very common procedure.

Q. If a physician has any doubts about competence, what can they do?

A. They can request a consultation from someone else to help determine that, and in some cases they might say, "Well, I don't think" -- if they establish a person isn't competent, then they can decide whether to request some kind of substituted judgment, you know, conservator or guardian, depending on the circumstances.

Q. And when it comes to determining whether coercion of some sort might be in effect, are physicians able -- in their relationship with patients able to make determinations as well?

A. I think, generally, they should be able to. Sometimes it may be more subtle and they may want to get another person to look at the situation and confirm their intuition or their beliefs or their observations.

Q. Are there situations, other situations besides aid in dying, where this might be a factor that they need to

establish?

A. Yeah. In relation to lots of medical interventions, it's an important issue to address throughout healthcare treatments.

Q. Are there situations that come up where another person's actions -- where a physician might determine that another person is acting to harm their patient?

A. I'm not sure I understand.

Q. Any kind of abuse?

A. Oh, sure. Sure. There's both the kind of subtle influencing them to make a decision, but there's also -- if there's overt evidence that someone is being abused, whether it's a child or an older person, in most states there are statutes that require a physician to report to the public authorities their suspicions of someone being a victim of some kind.

Q. And so physicians need to be on the lookout for more than just their individual patient, is that correct, in their analysis?

A. Yes; correct.

Q. And this is something that they're able to assess?

A. Yes. And we teach our medical students about this in a variety of contexts, including the ones that I think I mentioned but also including domestic violence.

Q. Now, do you believe that terminally ill -- well, let's talk a little bit about other types of medical interventions --

A. Okay.

Q. -- versus physician aid in dying. So in situations where a person -- are there certain situations where patients might seek to end a life-sustaining treatment?

A. Yes.

Q. And can you give me some examples of those situations?

A. I just mentioned a couple. The person who has cancer and is on chemotherapy and says, "I don't want anymore." The person who is on renal dialysis says, "I'm not going to do this any longer." The person who says, "No more feeding tube or extraordinary interventions for me in the event that I collapse."

Q. And do those people -- do you feel that a person who is mentally competent and terminally ill making that decision, is there any difference between that person and a person who chooses aid in dying?

A. Not really. It's the same circumstance. The main difference is they are electing to -- the person in the former situation is electing to stop something that is keeping him together, and the person in the position of requesting aid in dying is saying, "I want to stop at the point that I begin to deteriorate so I don't get to that point that I will have to be dependent on life support or

that I will lose touch with my relationships and so forth." It's really the same kind of experience.

Q. What about somebody who is seeking palliative sedation due to their suffering and wants to alleviate that suffering, do you see a difference between a person seeking palliative sedation who will receive a dose of medication?

A. No. No, I don't think there's a great deal of difference in those. It kind of depends on how lucid the person is at the point. I mean, there may be some prior advanced directive or post-physician's orders or life-sustaining treatment document that they've completed that has established that, even though that person is now at a stage where they're not able to provide that kind of consent, they have established earlier that they would like this procedure to be done, the terminal sedation, for example, and it might be done under those circumstances.

Q. Whereas with physician aid in dying that determination would be made by who?

A. The determination of --

Q. To ingest medication.

A. It has to be determined by the patients themselves, so if something happens at a point where the person is still able to voluntarily and independently consume the medication that would end their life.

Q. And the last point I'd like to make is do you believe that there are any principles of medical ethics that support the practice of physician aid in dying?

A. Yes, I do. There are -- as I said, I'm a senior scholar in the Center for Ethics and Healthcare at OHSU, and I teach a lot related to ethics, so I've done a lot of deep thinking about this. There are four principles that people generally --

Q. Before you go on, have you read any studies about the principles of ethics as related to these type of end-of-life care decisions?

A. Yes, I have. There are four principles that people generally include in terms of medical ethics and thinking about what ways to decide what to do about someone. They involve beneficence, which is doing as much good as one can; nonmaleficence, which is don't do any further harm to the person; justice, which is involving is this a fair -- is what we're doing fair; and, finally, autonomy, or respect for the person.

And beneficence, in my view, includes -- especially in terms of how our health system and our health profession has shifted to more explicitly focus on patient-centered care, persons under care, there is much more of an emphasis on patient preference. And if all other things are equal, if beneficence, nonmaleficence, and justice issues are not so dominant, then most people agree that the autonomy or respect

for the person trumps the other issues.

Beneficence needs to be looked at in terms of the overall quality of the person's life, not just, are we curing this particular organ from being as sick as it was for another four months? It's what the person believes is what he or she would determine is the quality of life which, more often than not, boils down to maintaining that sense of integrity of self.

There's another decision-making process that has been used that does take into account these principles, but it's a decision-making process that looks at what are the contexts that we're thinking about. One has to do with what are the medical considerations and situations that the person is going through; what are the facts? Another has to do with what are the person's preferences? What are the quality-of-life issues explicitly associated with their case? And, finally, what are the other context issues that have to do with the family, law, hospital policies, culture, other things that may come into play?

And so in a discussion, say, with an ethicist leading a team to decide what would be the best course of action, they would frame these things that way so they could have a rational and meaningful and comprehensive discussion of this. And I believe in many of the cases that we're talking about, when one goes through that process, they would see that cases like the ones who have been described today -- Ms. Riggs or like the one in the documentary or Dr. Morris described -- one would very likely go through that process and say, "This is actually the best choice," if this person is requesting it, that there are not ethical reasons to weigh against that.

Q. Thank you. So just -- very end -- I just want to give some more of your qualifications to make it clear to the Court, you stated that you had clinical practice experience for about twenty years or so; right?

A. Forty.

Q. Forty years. Okay. Sorry. Yes, forty. All right. So in that experience or in that time, how many evaluations -- how many times have you had to determine if somebody is mentally competent?

A. Oh, a number of times. Only once in relation to the aid in dying.

Q. But how many times generally?

A. Dozens. I have worked in court situations where there was a civil commitment process and done consultation when I have been on call at the hospital that included determining whether someone had the ability to make certain decisions for themselves. I was the medical director for Oregon Mental Health Division and so I had to deal with developing policies and processes for making those kinds of decisions, you know, dealing with things in our State Hospital system, as well as

in the acute psychiatric hospitals.

I guess in preparing for this hearing I hadn't thought -- because I don't deal with this issue on a day-to-day basis, but I had dealt with it a lot when the law first passed in '94, and the second initiative position was in '96, and in the paper that we did, and then the various other policy processes that I have been involved with, the breadth of my experience in terms of being involved both at the policy level and by just circumstance being in Oregon when this law has been enacted and seeing what the impact of the law has been. Impact not just on people who have gone through this process, but also in increasing the dialogue in our medical community about improving end-of-life care, improving hospice care, improving pain management, leaving our Board of Medical Examiners to have more clear policies about undertreatment as well as overtreatment with pain medication. I think I'm probably one of the more knowledgeable persons in the country about this particular issue in terms of policy-related things, not in terms of just the clinical side.

Q. Have you reviewed a body of literature on this subject as well?

A. Yes, I have.

MS. SMITH: I have no further questions.

THE COURT: All right.

MS. SMITH: Oh, my esteemed co-counsel has said she thinks we should break for lunch and then ask more questions.

THE COURT: All right. So you're not resting at this point in time --

MS. SMITH: I'm not resting. I take it back.

THE COURT: -- but we are going to break for lunch.

All right. We will break for lunch. The Court will be in recess until 1:30. It's important that you-all know that we're expecting about 250 jurors at 1:45, so my suggestion, certainly for counsel, is that you are in line downstairs in time, obviously, to get back to the courtroom on time.

And for members of the public, I mean, you are not prohibited in any way from coming in and out while court is in session, as long as people are doing that quietly, of course, but I just wanted everybody to know about that.

So at this point we can go off the record.

(NOTE: Recess was taken from 12:10 p.m. until 1:35 p.m.)

THE COURT: All right. Continue please.

MS. SMITH: So, Your Honor, I wanted to make one thing clear. We discussed with co-counsel or opposing counsel -- we've got a lot of co-counsels, is part of the problem -- so we discussed with opposing counsel, that

opposing counsel is stipulating to our experts as being experts for that purpose. I just wanted to let you know that.

THE COURT: Okay. So if I'm understanding you correctly, clearly, you are asking the Court to recognize Dr. Pollack as an expert?

MS. SMITH: Yes.

THE COURT: And he shall be so recognized. Are you asking to recognize Dr. Morris as an expert? She is a named party.

MS. SMITH: We're asking her as a plaintiff.

THE COURT: All right. So Dr. Pollack, Dr. Kress, and Dr. --

MS. SMITH: Gideonse.

THE COURT: -- Dr. Gideonse. All right.

MS. SMITH: And you said you accept Dr. Pollack as an expert?

THE COURT: Yes.

Q. (BY MS. SMITH) I have just a couple follow-up questions for you, Dr. Pollack. Just to clarify, is the impact on the loved ones of people who commit suicide different from the impact on loved ones of people who choose aid in dying?

A. Yes, it is. There's a significant difference. It relates in part to what I had described earlier about the difference between suicide and aid in dying, partly due to the fact that suicide is often an impulsive and solitary act. The loved ones are, more often than not, either unaware or not informed, or even if they have been concerned about their loved one being depressed or intermittently suicidal, when it happens, they're shocked and can go through a range of psychological reactions, most of them negative, that involve blame or shame or guilt or anger, surprise, but in a negative way. And those reactions, either turned inward towards the family member by themselves, or toward someone else, whether it's the person who committed suicide or some external factor; whether it's an individual or a group or something else that they can choose to put the responsibility on for this horrible thing having happened.

Whereas with aid in dying, the people who seemed to go through that, in the study that I was citing, showed that they really don't have much in the way of psychological consequences that are negative. The study that was done compared them with people who had relatives who died of similar conditions, just to see whether there was any difference based on the hypothetical premise that aid in dying would cause more psychological anguish and reactions in people, and they showed, indeed, it didn't. And, in fact, people who went through that practice with their loved one who had the terminal illness were, as I said before, more

prepared for the death of their loved one and, in a sense, more at peace.

Q. In your expert opinion, is aid in dying suicide?

A. No, it is not.

Q. And in your opinion, is the physician's act of prescribing the medication assisting suicide?

A. No, it is not. And I'll cite the paper we wrote in 1998 where we spent all of two paragraphs saying: Here is why it's preferable to use something different than the concept of suicide or assisted suicide for this process because it's really aiding the death process. The person is already in the process of dying and it is simply facilitating or hastening that process.

MS. SMITH: Thank you.

MR. FUQUA: Your Honor, before we get started, just one thing I did want to make sure that we're all clear on. In light of the question counsel asked about this witness' expert opinion, what field?

MS. SMITH: We would like him to be recognized as a qualified expert as a psychiatrist as it pertains to end-of-life care and decision-making.

MR. FUQUA: That's about what I expected. I just wanted to make sure we were all on the same page.

THE COURT: All right.

///

CROSS-EXAMINATION BY MR. FUQUA

Q. Doctor, I want to talk with you, hopefully, in a targeted way about the opinions that you have just expressed about aid in dying not being suicide and about the act of writing a prescription for aid in dying not being assisting a suicide. Your opinion that aid in dying is not suicide, would it be fair to characterize that as a psychological opinion? And when I say that, I don't mean an opinion that evidences some principle of psychology, but an opinion in your capacity as an expert in the field of psychology.

A. First of all, I'm an expert in the field of psychiatry.

Q. I'm sorry.

A. And, secondly, I would say more it's a medical opinion. I see this in relation to the medical process of caring for patients irrespective of what kind of healthcare condition they have and what the process of chronic illnesses and terminal illnesses are.

Q. Okay. So it would be fair for me to characterize that opinion as a medical opinion?

A. That's correct.

Q. It's certainly not intended to be a legal opinion, is it?

A. I don't have the credentials to make a legal opinion, I don't think.

Q. I appreciate your candor. I would agree with you on

that. The difference you elucidated this morning, I picked up anyway, is based on a number of factors -- and you will know these better than I do -- but one thing you mentioned is the patient's state of mind; correct?

A. Yes.

Q. The physical condition of the patient?

A. Yes.

Q. The consequences of the two different acts on those who survive the person who has died?

A. Those are factors to be considered.

Q. Is another one of those factors the collaboration -- I guess this is pretty closely related to the last one that we just talked about -- but collaboration between the person taking the act and that person's support of family members and friends?

A. Yes. Although I must say I don't think it is required by the law that a person has to have other people involved in their care other than their treating physician. They may not have family members involved.

Q. I don't mean to suggest that it does, Dr. Pollack.

A. Okay.

Q. I just wanted to make sure I understood the bases on which you were offering your medical opinion that aid in dying is not suicide.

A. Yes.

Q. Do you have any understanding of the pharmacological effect of taking the dosage of Seconal that is typically taken when prescribed in Oregon pursuant to the Death With Dignity Act?

A. I have a general understanding of it. Not being a pharmacologist or psychopharmacologist, even, I do understand the processes.

Q. What is your understanding?

A. Well, the barbiturates sedate central nervous system depressing qualities so that they will slow down the bodily functions of respiration, heart rate, and so forth. And in a high enough dose, they will lead to a person going into a comatose state.

Q. When you say that they will slow down those processes in a high-end dosage, is it fair to say that they will actually cause those processes to cease?

A. It will contribute to it. They may, because of coexistence of other pathological processes that the person is experiencing, whether it's not functioning as effectively in terms of respiration or their heart rate or something else, depending on the kind of illness that they have and the presence or absence of excess fluids and other complications of the illnesses or the other treatments that they're getting, the administration of those medications may collaborate or combine or in some synergistic way contribute

to the death of that person or to the cessation of certain functions.

Q. Under the circumstances you have just described, where the underlying condition would -- I think -- I don't know if you said accelerate. I may just be making that word up.

A. I didn't say accelerate.

Q. Okay. Then I am just making that word up. But in the circumstances you just described, the underlying condition works in conjunction with the barbiturate to cease something like respiration, there isn't really any way to tell which of those two things resulted in the death of the patient, is there?

A. It would be very difficult, as far as I understand it, to discern which had how much proportionate impact.

Q. Now, when you say very difficult --

A. Impossible.

Q. -- it implies to me -- okay. So not just very difficult; it would be impossible?

A. Probably. And not worth the effort if it were possible, in my view, to -- whatever the method would be, it might be very expensive to figure out what that was.

Q. When you say "it's not worth the effort," that's because of what you consider the expense to be involved in making that determination?

A. It's also because it's kind of a moot point.

Q. But what if legally it wasn't a moot point, Doctor?

A. I don't know whether it's a legal moot point or not. I'm just saying in terms of the medical system, it would be less relevant than the person has now expired.

Q. I appreciate that but, respectfully, Doctor, that wasn't the question I asked.

A. Okay.

Q. If it did make a difference legally, is it still your opinion that it wouldn't be worth it to find out?

A. I don't know how to answer that. I don't know how you would value the level of worth in relation to a legal opinion.

Q. Sure. You described this morning earlier how people who seek aid in dying present differently than people who are suicidal or at least have expressed suicidal thoughts.

A. Yes.

Q. Do you remember that testimony?

A. Yes.

Q. When you say "they present differently," you don't mean that they show different psychiatric or psychological symptoms? At least I think that would be the wrong word because that sort of implies there would be a condition that the symptoms were symptomatic of. But do you mean that they exhibit different psychological or psychiatric profiles? Is that a fair way of putting it?

A. No, I don't think that's what I meant. I think -- if you're asking me to distinguish those who are suicidal from those who are requesting aid in dying --

Q. Yes.

A. -- and how they present, there's a qualifying issue here in terms of when this presentation is that you're talking about. I'm talking about once someone has started to consider requesting aid in dying and they've considered that that's something that they want to do, the way they present is in relation to, "This seems like a choice I either want to do or I want to consider doing," and that's very different than someone who is suicidal which, more often than not -- in fact, I can't imagine when it's not a product of a psychiatric illness; that the person who is suicidal has probably a major depressive disorder or some other psychiatric disorder or a complication of a psychological adaptation to some other illness and it is leading them to be overwhelmed by both their emotional feelings and their sense of hopelessness.

Q. So based on that, it sounds like it might actually be fair to characterize the way that a person with suicidal thoughts presents as "symptoms"?

A. Yes. A person who is suicidal -- suicidal thinking is one of the symptoms that they have.

Q. Right. I would like to talk to you a little bit about the nomenclature --

A. Sure.

Q. -- about the use of the label "assisted suicide," the use of the label "aid in dying," even something like "withdrawal treatment." Would it be possible for purposes of the medical community to differentiate between different kinds of suicides? Those that involve the kinds of things that you're talking about with people who present with suicidal ideation and suicides of the people who do not present with those symptoms but are, instead, the kind of people who are seeking aid in dying?

A. I wouldn't use the same terms that you're using. I don't think my use of the term "suicide" includes people who are not psychiatrically ill and who are already in the process of dying.

Q. I'm sorry. I think you just said your use of the term "suicide" includes those people?

A. I said it does not include.

Q. Does not. Okay. Thank you. That's what I would have expected you to say. I just wanted to make sure I heard you correctly. But the question I'm asking is maybe a little bit more abstract than that. I mean, you use particular nomenclature to express a psychiatric idea; correct?

A. Yes.

Q. I guess what I'm asking is, does it matter what the

particular nomenclature you use is so long as the understanding in the medical and psychiatric community is what you have just expressed? Do you understand what I'm asking?

A. Well, I'm not entirely sure if we invented a new word that represented a concept and everyone said, "Yes, we can use that word for it and we will," okay. If you're saying can we apply -- you were saying a little while ago, can there be different types of suicide? There may be different types of suicide, but of the various types of suicide that I can conceive of, the person who's requesting aid in dying doesn't fit within that range of types of suicide.

Q. I think what I was really getting at is what you mentioned first, where you were just talking about having sort of created a phrase that the medical community has adopted.

A. Uh-huh.

Q. And do you think that's a fair way of characterizing what's happened with the phrase "aid in dying"?

A. I think it has become a more apt description of what has been a relatively more recent phenomenon in terms of the healthcare interventions or responses to these end-of-life conditions.

Q. I'd like to talk with you just a little bit about how recent those changes are. I think you testified earlier, from what I can glean from your CV, you were in Oregon in 1994 and 1996 --

A. That's correct.

Q. -- when these laws were passed; correct?

A. Yes.

Q. Now, in 1994 and in 1996, both, when that law was passed, isn't it true that the popular -- the popularly and the medically used terminology was "physician-assisted suicide"?

A. I believe that is true.

Q. And isn't it also fair to say that that phrase has been used, just within the last few years, in the literature on the subject?

A. It's been used with less frequency. And you may recall that I described a paper that a colleague of mine, David Smith, and I wrote that was published in 1998 in which we said, "Here are reasons why we think 'assisted suicide' is an inappropriate term for this process, and 'aid in dying' or 'physician aid in dying' is more apt." If you look simply at some of the papers that one of my colleagues, Linda Ganzini, from the same department of psychiatry that I'm in at the Oregon Health and Science University has written -- I was reviewing papers, obviously, for this case and I noticed that in a paper she wrote in, I think, 2001 she used the term "physician-assisted suicide" fairly frequently.

In a more recent article in 2009, there was virtually no reference to that term and more reference to "aid in dying." And I think she and other researchers in the field have been shifting their terminology, some more promptly than others.

Q. But just to be clear, that shift in terminology is using the different phrase to describe the same conduct; is that correct?

A. Yes.

Q. It might express a slightly different idea, but it's describing the same conduct; correct?

A. It's describing the same conduct and saying, This actually is a more apt and --

Q. Sure.

A. -- descriptive, more accurate description of what has previously been called "physician-assisted suicide."

Q. No, and I understand that. Are you familiar with the article -- when you said you had reviewed articles in preparation of this case, by any chance is one of those articles, *Differentiating Suicide From Life-Ending Acts and End-of-Life Decisions: A Model Based on Chronic Kidney Disease and Dialysis*?

A. By Bostwick and Cohen?

Q. Yes, sir.

A. Yes.

Q. Published in, looks like, *Psychosomatics* in the January-February 2009 issue?

A. I read that paper.

MR. FUQUA: Your Honor, may I approach the witness?

THE COURT: Excuse me?

MR. FUQUA: May I approach the witness?

THE COURT: You may, yes.

MR. FUQUA: Counsel, this is the chart that I'm going to be talking about.

Q. (BY MR. FUQUA) I apologize, Doctor, in advance. I only have the one copy.

A. That's okay.

Q. It's my failure in preparation, but what it means is I may have to stand a little bit closer to you than you appreciate. Does this appear to you to be the article that we were just discussing?

A. It does.

Q. I just want to ask you a couple of quick questions. Now, actually, before I get too deep into the specific text, I want to point you to what the authors in this article did, which was construct a 2 by 2 matrix; all right? So you've got a four --

A. A four-quadrant grid.

Q. -- quadrant grid, and they put different kinds of

end-of-life scenarios into those four quadrants.

A. Uh-huh.

Q. And one of them -- one of those quadrants they describe -- here, make sure I'm reading this correctly -- "Deaths that occur after withdrawing or withholding treatment when the achievement of an acceptable quality of ongoing life is considered futile." Did I read that correctly?

A. Uh-huh.

THE COURT: Yes or no?

THE WITNESS: Yes, I'm sorry.

Q. (BY MR. FUQUA) So following along here, "Also in the fourth quadrant" -- the quadrant we were just describing -- "is the small number of deaths that follow assisted dying." Do you see that?

A. Yes, I see that.

Q. And they further describe that as: The term assisted dying "includes both voluntary euthanasia (which is illegal in the United States) and 'physician-assisted suicide' (which is presently only in Oregon and now in Montana and Washington state, where voters recently endorsed it in the 2008 election) in which the physician gives the patient a prescription for a lethal amount of medication after he or she has gone through a protocol" --

THE COURT: You're speaking too fast.

MR. FUQUA: I'm actually surprised that's the first time this has happened. Maybe it's because I haven't said much so far.

Do you need me to back up?

COURT REPORTER: If you'd back up a sentence.

MR. FUQUA: I'm sorry.

Q. (BY MR. FUQUA) Starting with confirming, "confirming that he or she is making a free and competent decision to hasten death." Did I read all that correctly?

A. You did.

Q. And finally, "Neither method of assisted dying should be confused with withdrawal or withholding of life-support treatments." Did I read that part correctly?

A. Yes. Can I see the front of the article for a second?

Q. Yes, of course.

A. Just to refresh my memory about it.

Q. In fact, I'll let you hang onto that.

A. Okay.

Q. So I understand you were testifying earlier that your colleague had written a paper in 2001 --

A. Uh-huh.

Q. -- that uses the phrase "physician-assisted suicide" with some liberality, and in 2009 there was a similar article that didn't use the phrase, or at least didn't use it nearly as frequently?

A. That's correct.

Q. But here in 2009, this same year, we do see an article that describes the conduct of aid in dying as physician-assisted suicide; correct?

A. That is correct.

Q. We've kind of talked about this a little bit before, but I understand -- I understand, Doctor -- at least I think I do -- the reason that you've given for why aid in dying is a more apt term to describe the conduct of physician-assisted suicide and that, of course, centers on using the phrase, or word rather, "suicide"; correct?

A. That's in large part correct.

Q. But, again, when your colleague wrote that paper in 2001 and then the second paper in 2009, she used two different terms to describe the same conduct; namely, the provision of medication to a patient so that the patient can take that medication to end his or her life; is that true?

A. That's correct.

MR. FUQUA: I have nothing further. If I could retrieve my exhibit.

THE COURT: If that's an exhibit, then I think we should mark it and leave it.

MR. FUQUA: I say "exhibit." That will be entirely up to them, Your Honor. I do not intend to enter it into evidence.

THE COURT: Okay. Then retrieve your article.

MR. FUQUA: Thank you.

Thank you. I appreciate your time.

THE COURT: Redirect.

RECROSS-EXAMINATION BY MS. SMITH

Q. Briefly, regarding the evolution of the terminology, are you aware that medical organizations have rejected the term "physician-assisted suicide"?

A. I believe so, yes.

Q. And can you -- and that some of these include the American Public Health Association?

A. Public Health Association. I believe there may be national healthcare organizations that either involve social workers or psychologists or state organizations that have taken a similar position. I can't name the precise ones, but I know a number of professional health-related organizations have taken positions, both on the terminology, as well as their position in relation to supporting the concept.

Q. And so how -- what -- how have they taken a stand on supporting the concept?

A. I think, for example, the American Public Health Association position paper they've developed has endorsed this as an appropriate policy for states to adopt to allow the option for people to have the right to engage in or accept aid in dying in these circumscribed cases where they're imminently going to die from a terminal illness.

MS. SMITH: Thank you.

THE COURT: So just so I can be, I don't know, sort of -- perhaps try and get a succinct definition in my mind, this -- it sounds like what you're describing is a -- what's the word I want to use? -- a change over time and an accepted terminology within the medical community. That's what -- if I understand it, that's what you're testifying you believe has happened or is happening?

THE WITNESS: Yes. That is true. I believe that when concepts emerge in healthcare practice, they may be similar to something that people have seen before and they may make a miscalculation in terms of what they call it, and then over time the community of clinicians will accept something as being a more effective term or definition for that concept or process. But I don't think these researchers in this paper or other clinicians who are thinking about, "What shall we call it?" are thinking in terms of "What should the legal term be?" They're thinking more in terms of the clinical process and what we describe as that. But the fact that one or more researcher uses the term "assisted suicide" in a paper doesn't mean, ah-ha, therefore, it's physician-assisted suicide for legal purposes.

THE COURT: I think the researchers would probably not really want to bother with what the legal term of it is.

THE WITNESS: Absolutely.

THE COURT: So I was actually thinking over lunch and I was trying -- because I was thinking about this whole topic of the term, and I was trying to come up, in my mind, with other examples. And sort of the only thing I could come up with that -- and I don't think it's a good analogy -- but I'm thinking of what we used to call "mentally retarded," now we have the word "developmental disabled" and we have all gradations as opposed to this broad category of someone who we would term "mentally slow." But I was just wondering, I mean, you're a bioethicist.

THE WITNESS: Yes.

THE COURT: But is there anything else that comes to your mind when you think about that concept?

THE WITNESS: Sure.

THE COURT: What?

THE WITNESS: There are a lot of terms that have fallen out of favor for a variety of reasons whether there were pejorative associations with them. Like the term "senility" is not used as much now and we talk about people who have dementing illnesses, and not everyone who is old is senile necessarily. And the lack of precision is associated with certain terms, and what does it really mean? And here's where -- you know, suicide is a lack of precision in terms of what's being used here in terms -- in relation to that. Similar things in regard to gender identity, sexual

orientation, there are terms that have been used in those areas that have been either flagrantly pejorative or have been confusing in their use. There are other areas, I imagine, as well, but those are examples.

THE COURT: Okay. And when we -- I think one of the first things you talked about was, I think, the DSM V. And the DSM V actually defines suicidal ideation as a --

THE WITNESS: Symptom.

THE COURT: Pardon?

THE WITNESS: As a symptom.

THE COURT: As a symptom. So it's not a diagnosis on its own; it's a symptom?

THE WITNESS: No, it's a symptom. It can be a symptom of a number of different conditions, a number of different diagnoses.

THE COURT: Okay.

THE WITNESS: You can have suicidal ideation as part of the symptom constellation --

THE COURT: Okay.

THE WITNESS: -- that makes it that diagnosis.

THE COURT: All right. Let me make sure I don't have any other questions. If you will just give me one second. And I just want to make sure -- I think I know the answer to this, but just for the record, you had talked -- when you were talking about -- let me find the word that you used. You talked about basically when somebody has what I would call a "durable healthcare power of attorney" for someone to make healthcare decisions. But that person who has that can't make this decision for them, can they?

THE WITNESS: No, I don't think so. There are circumstances where a person can construct what we either call an "advanced directive" --

THE COURT: Right.

THE WITNESS: -- or in the context of working with their physician there's a process that began in Oregon and spread to many other states called POLST, P-O-L-S-T, which stands for "Physician's Orders for Life-Sustaining Treatment," that the patient works out with the physician after a conversation about how they want to proceed with their end-of-life planning. And this is a specific form that they fill out and the physician signs, and it carries more weight than an advanced directive.

An advanced directive is simply a declaration that the patient makes about, "In the event I go to a hospital or I have this kind of circumstance, this is what I prefer to have happen." And what people have found is that in a lot of cases the hospital the person ends up at, they can't find the advanced directive, or if they get the advanced directive, they don't acknowledge it or honor it because of their concerns about medical/legal things.

THE COURT: Yeah.

THE WITNESS: So the POLST process has been one that has really gotten beyond that and it's really helped. Oregon actually has a central database they keep of the POLST forms for many people that our Center for Ethics in Healthcare helped to develop.

But back to your question about this. These are processes that might then include the appointment of someone as either a personal or medical representative or healthcare representative or having durable power of attorney, different terms used in different places for different functions, but that person would not have the ability to exercise the administration of medication for aid in dying. It's explicitly for the person who is the patient to administer, self-administer, take that medication. So they have to be in a place where they can still have the competence to both understand what they're doing and that the function of these medications will be to hasten their death and that they voluntarily and autonomously self-administer the medication.

THE COURT: Oregon, of course, has a statute that defines some of the parameters of this. I believe if I understood Dr. Morris' testimony correctly -- and you were here when she testified --

THE WITNESS: I came -- I was out in the antechamber for part of it, but I came in during the latter part, yes.

THE COURT: I believe she testified, if I'm not mischaracterizing her testimony, that she believes that there is a sufficient body of -- that's a bad word. I was going to say a sufficient body of medical protocol. I don't think that's what you-all would call it -- but there are sufficient protocols that have been developed over time that, because of the Oregon experience, I guess, that would define a physician's role in this without all the statutory parameters. Do you believe that?

THE WITNESS: Let me think about that. I think so, yeah. I think there's a common -- look, before we even had the issue in Oregon, there were kind of -- there was a process known as the "double effect." I don't know if it's been introduced here or not, but where physicians would, in a sense, treat the person with pain medication, because that was a symptom, knowing that there was a possibility that the side effect of that pain medication would oversedate them. And that was kind of a back-door way of people doing something that others felt should be more overt, and that if that's what we're doing, let's acknowledge it. And I think both before the Oregon law passed and since then, there has been more attention to: What is the physician's role? And that is part of why in Oregon, since 1994, we have had a dramatic improvement in end-of-life care by the provision of

both hospice care in facilities, as well as visiting hospice workers and palliative care processes and better attention to the alleviation of the symptoms that are associated with terminal illness, such that our medical board will sanction physicians for undertreating pain as much as they would for people overtreating certain symptoms. And that's a new behavior for a medical board around the country.

I am guessing that other medical boards are adopting that set of standards as well, although I don't know. So, yes, I think the evolution of standards of practice and clarification of what is a physician's role has spread beyond the borders of Oregon and other states who either statutorily have this or are considering it.

THE COURT: In your opinion, are most standards for physicians statutorily imposed or medically imposed?

THE WITNESS: I think they are more medically imposed.

THE COURT: Thank you.

THE WITNESS: Thank you.

THE COURT: You may step down.

Call your next witness, please.

MS. IVES: Plaintiffs call Adrienne Dare.

(NOTE: Witness is sworn.)

THE COURT: Please be seated.

Counsel, just so you know, I need to take a break right

"FLS-5"

Supreme Court, U.S.
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No. 04-623

IN THE
Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General, *et al.*,
Petitioners,

v.

STATE OF OREGON, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF *AMICUS CURIAE* COALITION OF MENTAL HEALTH PROFESSIONALS IN SUPPORT OF RESPONDENTS

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GLORIA D. MONTOYA

This is the annexure marked "FLS-5" referred to in the affidavit of Frank Lewis Spring affirmed at Albuquerque, New Mexico this 28day of April 2015 before me

Signature ......Gloria D. Montoya......
A person duly authorised to administer oaths in New Mexico, United States of America

Expires – March 8, 2017

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STATEMENT OF JURISDICTION

Amicus, Coalition of Mental Health Professionals, adopts Plaintiffs/Appellees' Statement of Jurisdiction.

STATEMENT OF ISSUES

Amicus, the Coalition, adopts Plaintiffs/Appellees' Statement of Issues.

STATEMENT OF THE CASE

Amicus, the Coalition, adopts Plaintiffs/Appellees' Statement of the case.

CONSENT OF THE PARTIES

This *amicus* brief is filed with the consent of the parties.

INTEREST OF AMICI[1]

This case presents the narrow but important question of whether the Attorney General of the United States has the authority to take an action that will render Oregon's twice-passed Death with Dignity Act ("ODWDA" or the "Act") ineffective. Under this Act, certain terminally ill patients who are Oregon residents may request, and if they meet all criteria, receive, medication that will hasten their death and allow them to

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[1] This brief has been authored in its entirety by undersigned counsel for the *amicus curiae*. No person or entity, other than the named *amicus* and its counsel, made any monetary contribution to the preparation and submission of this brief. The parties have consented to the filing of this brief and their letters of consent are being lodged herewith.

maintain their mental and emotional dignity in their last days. The Department of Justice ("DOJ"), however, asserts that the Controlled Substances Act (the "CSA") permits the federal government to prevent physicians from assisting patients' exercise of their rights under the ODWDA because the medications are not allegedly being prescribed for a "legitimate medical purpose." DOJ argues that patient utilization of the ODWDA is a threat to public health. DOJ's argument is based, in part, on the erroneous notion that patients choosing to exercise their rights under the ODWDA must be suffering from impaired judgment. This argument nevertheless presumes that mental health issues are an important part of the present case; therefore, the views of mental health professionals such as amici and the weight of research on mental health issues are highly relevant.

The Coalition urges affirmance of the Court of Appeals' decision, and submits that consideration of the question before the Court involves the related issues of the ability to assess: (i) whether adequate diagnostic tools exist to determine the absence or presence of mental capacity and/or impaired judgment, and (ii) whether a terminally ill patient who makes a request under the ODWDA can be capable of making a reasoned decision based on judgment that is unimpaired by a psychiatric or psychological disorder. Amici who submit this brief are an ad hoc group of individual social workers, psychologists, and psychiatrists and related professional groups working as academicians, private practitioners, agency clinicians, administrators, and consultants (the "Coalition"). These mental health professionals have relevant training and experience that makes it appropriate for them to offer their views on terminally ill patients' decision-making capacity in the context of this case.

All individual Coalition members have extensive experience providing psychotherapy, often to persons who are

Organizational members of the Coalition are: *Washington State Psychological Association ("WSPA")*, a non-profit professional association of approximately 900 doctoral-level psychologists and other related mental health practitioners. The

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associated text; American Counseling Association, *2005 ACA Code of Ethics* Draft, available at http://www.counseling.org/PDFs/ACA_Code_of_Ethics_2005_Draft.pdf; American Psychological Association, *infra* note 7; American Psychological Association, *infra* note 22 and associated text. For example, the National Association of Social Workers issued a policy statement in 1994, and reconfirmed it in 1999, entitled "Client Self-Determination in End-of-Life Decisions" which stated that

> social workers should not promote any particular means to end one's life but should be open to full discussion of the issues and care options. . . . Social workers should be free to participate or not participate in assisted-suicide matters or other discussions concerning end-of-life decisions depending on their own beliefs, attitudes, and value systems.

National Association of Social Workers, *infra* note 7, at 48. The American Counseling Association's draft revision of that organization's ethics code contains this section: Quality of Care. Counselors take measures to ensure that clients: (1) receive high quality end-of-life care for their physical, emotional, social, and spiritual needs, (2) have the highest degree of self-determination possible, (3) are given every opportunity possible to engage in informed decision making regarding their end-of-life care, and (4) receive complete and adequate assessment regarding their ability to make competent, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice; see also infra note 43 and accompanying text. A similar position was taken by Quill and Cassel, who argued that medical associations should take "a position of studied neutrality" on "physician-assisted suicide." *Professional Organizations' Position Statements on Physician-Assisted Suicide*, 138 ANN. INT. MED. 208, 210 (2003).

terminally ill, and/or strong records of research and writing on end-of-life decision-making, depression, grief, or suicide. As mental health professionals, they help patients explore, ameliorate, and/or cope with issues regarding the patient's quality of life. The Coalition submits, however, that supporting the provision of such services to individuals considering hastening death does not signify supporting the hastening of death itself. In fact, it has been argued that organizations comprised of professionals who provide services to clients should ***not take any position*** that explicitly argues for or against "assisted suicide,"[2] but should instead focus on the ways the group's members can help people improve their quality of life and make the best decisions possible given their individual and particular circumstances.[3] A list of Coalition members is attached to this brief as Appendix A.

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[2] We place assisted suicide in quotation marks here and elsewhere to indicate that we are using the term (or "rational suicide" when applicable) because it was used by the authors of the sources we cite. However, we agree in principle with the position taken by Quill, Coombs Lee, and Nunn who stated that: ". . . we do not believe the term 'suicide' accurately reflects the meaning of this action, nor does it necessarily differentiate this practice from other last-resort practices. . . . The term 'suicide' also connotes an act of self-destructiveness by a person with mental illness, whereas [in other end-of-life situations], death [can be] viewed by the patients as a form of self-preservation. We must ensure that politicized public discussion about the legalization of physician-assisted suicide does not lead to distortion of the issues and ultimately to uninformed decision making." Quill, Coombs Lee & Nunn, *Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative*, 132 ANN. INTERN. MED. 488, 489 (2000).

[3] Werth, *The Appropriateness of Organizational Positions on Assisted Suicide*, 10 ETHICS & BEHAV. 239 (2000). *See also*, National Association of Social Workers, *infra* note 7 and associated text; Washington State Psychological Association, *et al.*, *infra* note 4 and

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WSPA's mission is to support, promote, and advance the science and practice of psychology in the public interest. Many WSPA members work with clients who are considering end-of-life decisions and assist terminally ill patients and their families with their problems on a regular basis. WSPA members routinely assess the mental capacity, the possibility of impaired judgment, and the presence of clinical depression among many clients, including those who are terminally ill and those contemplating suicide. The WSPA filed an *amicus curiae* brief with the U.S. Supreme Court in the two "assisted suicide" cases, *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).[4]

Oregon Psychological Association ("OPA"). OPA is a non-profit professional association of approximately 840 doctoral-level psychologists and other related mental health practitioners. The OPA joins this Brief to underscore the scientific support for determining competence, impaired judgment, and clinical depression for patients who are terminally ill and for the subgroup of patients who may contemplate using the ODWDA. Many OPA members work with clients who are considering end-of-life decisions and assist terminally ill patients and their families with their problems on a regular basis. OPA members routinely assess the mental capacity, the possibility of impaired judgment, and the presence of clinical depression among many clients, including those who are terminally ill and those

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[4] Brief *Amici Curiae* for the Washington State Psychological Association, *et al.*, in *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997). The WSPA's briefs focused on the roles mental health professionals could play in situations involving "assisted suicide" (rather than arguing that it should be a constitutional right), because the mental capacity of terminally ill individuals can be reliably assessed – the same reasons why it has signed on to the present Brief.

contemplating suicide. By reason of the skills, training, and experience of its members, OPA can provide meaningful insight into the mental capacity of terminally ill patients and into the diagnostic and evaluative resources available to verify such capacity.

National Association of Social Workers. With 153,000 members, the National Association of Social Workers ("NASW") is the largest organization of professional social workers in the world. Created in 1955, the purposes of NASW include improving the quality and effectiveness of social work practice in the United States and developing and disseminating high standards of social work practice, concomitant with the strengthening and unification of the social work profession as a whole. In furtherance of these purposes, NASW promulgates professional standards and criteria. Additionally, NASW conducts research, prepares studies of interest to the profession, and enforces the NASW Code of Ethics, which NASW members are required to honor. NASW's members are highly trained and experienced professionals who counsel individuals, families, and communities in a variety of settings, including schools, hospitals, mental health clinics, senior centers, and private practices. The practice of social work requires knowledge of human development and behavior; social, economic and cultural institutions; and of the interaction of all of these factors. The NASW policy, Client Self-Determination in End-of-Life Decisions, states "Social workers have an important role in helping individuals identify the end-of-life-options available to them. . . . A key value for social workers is client self-determination. Competent individuals should have the opportunity to make their own choices but only after being informed of all options and consequences. . . . without coercion." Social Work Speaks: NASW Policy Statements (2003 - 2006).

Oregon Chapter, National Association of Social Workers. This is a professional association with approximately 1,700 members in Oregon, affiliated with the NASW. Most members have advanced degrees (at least master's level) in social work. Oregon Chapter NASW members are involved in hospice care and end-of-life decisions for their clients, including decisions related to ODWDA. The national association has adopted a strong policy statement in favor of client self-determination in end-of-life decisions, which is binding upon and supported by the Oregon Chapter. As advocates and counselors for their clients, Oregon Chapter NASW members have interest and expertise in issues concerning end-of-life decisions, including the mental status of terminally ill patients.

Clinical Social Work Federation ("CSWF"). A non-profit professional organization of approximately 3000 members, the CSWF membership is comprised of licensed or certified clinical social workers with MSW, or PhD./DSW degrees. Members of the CSWF provide mental health services for the diagnosis, treatment, and prevention of mental, behavioral, and emotional disorders. Members work in a variety of settings including those that serve terminally ill individuals and their families and those contemplating end-of-life decision making for other reasons. Clinical social workers have the ability to determine mental capacity, impaired judgment, and executive functioning, and to diagnose clinical depression. The CSWF does not adhere to the belief that either terminal illness or clinical depression prevents an individual from making informed decisions.

Amici offer the following observations to assist the Court in ruling on the important questions presented in this case.

SUMMARY OF ARGUMENT

The ODWDA was approved by the voters of Oregon to allow an opportunity for terminally ill patients to end their lives with dignity and respect. The DOJ assertion that the CSA permits the federal government to deprive the citizens of Oregon from exercising its rights under the ODWDA because such law presents a risk to the public health is seriously flawed. The DOJ's argument is based, in part, on the erroneous idea that patients choosing to exercise such rights must be suffering from impaired judgment. However, not all terminally ill patients are mentally impaired and it is possible for some terminally ill patients to make a reasoned decision that is not a product of depression or psychiatric illness to hasten their death and end their lives with dignity.

ARGUMENT

I. ADEQUATE DIAGNOSTIC TOOLS AND PROTOCOLS ARE AVAILABLE TO ASSESS THE MENTAL CAPACITY OF A TERMINALLY ILL PATIENT WHO DESIRES TO HASTEN DEATH

A. Qualified Personnel Have Adequate Diagnostic Tools to Evaluate Whether a Patient has the Mental Capacity to Exercise Their Rights Under the ODWDA.

In order to receive medication under the ODWDA, a terminally ill Oregon resident must follow a specific and detailed procedure and must be deemed "capable" by the attending physician and a consulting physician, or, if a referral is made by one of those physicians for further mental health evaluation, a licensed psychologist or psychiatrist. The Act clearly provides

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that any patient wishing to exercise their rights under the Act must demonstrate the requisite capacity and sets forth how this is to be shown. O.R.S. 127.805 § 2.01; 127.820 at § 3.02; 127.800 at § 1.01 (3). If there is any question about the patient's capacity to request medication under the ODWDA, because the patient may be suffering from impaired judgment, the statute explicitly requires that a licensed psychologist or psychiatrist be consulted, and prohibits any medication from being prescribed until a determination regarding the presence or absence of impaired judgment is made. O.R.S. 127.805 § 2.01. The statute itself builds in a first-level safeguard to ensure that if there is a question about mental capacity being impaired by psychological or psychiatric disorder, no medication shall be given until an assessment is performed by a licensed psychologist or psychiatrist.[5]

The Coalition respectfully submits that the weight of scientific and medical research supports the proposition that adequate diagnostic tools exist for mental health professionals to assess the mental capacity of a terminally ill patient. Detailed protocols are available for evaluating a patient's capacity and potentially impaired judgment, including guidance specifically for use with the ODWDA.[6] Such protocols and tools allow trained and qualified professionals to assess the accuracy of the patient's understanding of his or her medical condition, including

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[5] *Id.*; *see also Oregon v. Ashcroft*, 192 F. Supp.2d 1077, 1081-82 (D. Or. 2002).

[6] Farrenkopf & Bryan, *Psychological Consultation Under Oregon's 1994 Death with Dignity Act: Ethics and Procedures*, 30 PROF. PSYCHOLOGY: RESEARCH & PRACTICE 245 (1999); Werth, Benjamin & Farrenkopf, *Requests for Physician-Assisted Suicide: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 PSYCHOL., PUB. POLICY & L. 348 (2000).

the prognosis and treatment alternatives; review the quality of the patient's deliberative process; identify the presence of major depression or another psychological condition; and, therefore, evaluate the soundness of the patient's decision.[7]

Mental health professionals who have the requisite training, experience, and direct contact with an individual patient are in a position to make such an evaluation and assess whether a patient has the capacity to make a reasoned end-of-life decision.[8]

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[7] Reflective of the fact that many mental health professionals believe that people can make well-reasoned decisions that death is their best option, whether assisted by a physician or not, some of these assessment outlines have been developed by national mental health organizations or working groups of such organizations. *See* American Psychological Association Working Group on Assisted Suicide and End-of-Life Decisions, *Report to the Board of Directors of the American Psychological Association, Appendix F: Issues to Consider When Exploring End-of-Life Decisions*, in REPORT TO THE AMERICAN PSYCHOLOGICAL ASSOCIATION BOARD OF DIRECTORS 79-86 (2000); National Association of Social Workers, *Client Self-Determination in End-of-Life Decisions*, in SOCIAL WORK SPEAKS: NATIONAL ASSOCIATION OF SOCIAL WORKERS POLICY STATEMENTS, 2003-2006 46 (6th ed. 2003).

[8] This Court has commented that "the subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations." *Medina v. California*, 505 U.S. 437, 451 (1992), *quoting Addington v. Texas*, 441 U.S. 418, 430 (1979); *see also Cooper v. Oklahoma*, 517 U.S. 348, 365-66 (1996). In this context as in other areas of law (or medicine), however, the impossibility of certainty does not obviate the need to evaluate the mental state of the patient. *Id.* The nature of end-of-life decisions would certainly justify use of a standard under which close cases are resolved in favor of preserving the medical status quo. *See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 283 (1990). But the inevitability of close cases cannot, by itself, justify imposing a flat prohibition that will apply even in cases where the evidence of mental capacity is clear.

Such evaluations are typical and common in the practice of mental health professionals.[9] Indeed, "psychiatrists and other physicians [as well as psychologists, social workers, and other qualified mental health professionals] have been successfully conducting such evaluations for years when persons request discontinuation of life sustaining treatment."[10] Moreover, such assessments commonly arise in a variety of legal contexts, from

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[9] Many mental health professionals have extensive experience in making both formal written evaluations and ongoing, informal assessments of decision-making capacity and rationality during the course of psychotherapy, counseling, or psychiatric consultation in medical settings. Indeed, professional evaluation occurs continuously during therapy and within the context of hospital or outpatient consultations.

[10] Smith & Pollack, *A Psychiatric Defense of Aid in Dying*, 34 COMMUNITY MENTAL HEALTH J. 547 (1998). *See also* Kleespies & Mori, *Life-and-Death Decisions: Refusing Life-Sustaining Treatment*, in EMERGENCIES IN MENTAL HEALTH PRACTICE: EVALUATION AND MANAGEMENT at 145 (1998); Cohen, Steinberg, Hails, Dobscha & Fischel, *Psychiatric Evaluation of Death-Hastening Requests: Lessons from Dialysis Discontinuation*, 41 PSYCHOSOMATICS 195 (2000); Ganzini, Leong, Fenn, Silva & Weinstock, *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY 595, 597 (2000) (surveyed Board-certified members of the American Academy of Psychiatry and the Law and found that 74% of the respondents "had evaluated the competence of a patient whose refusal of treatment would have resulted in the patient's death"). Although it is certainly true that psychologists and psychiatrists may be asked to make assessments of mental capacity in situations where other end-of-life decisions are being made (*e.g.*, discontinuation of life support), in such situations there is no mandatory requirement for a mental health assessment nor that a diagnosable depression be ruled out before the patient's wishes can be acted upon.

competence to stand trial to competence to make a valid will.[11] In deciding the legal issue of "competence" in these contexts, courts have inevitably relied upon the training, experience, and expert judgment of qualified mental health professionals to assess a given individual's capacity to make reasoned decisions.[12]

Although the particular legal standard of competence varies depending upon the rights and interests at stake in a given context,[13] there is no dispute that such standard may appropriately be set at a high level for assessing decision-making capacity in the end-of-life context.[14] The mental health literature suggests that one appropriate standard for determining capability would require that a terminally ill patient be able to:

(a) understand and remember information relevant to an end-of-life decision;

(b) appreciate the consequences of the decision;

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[11] *See, e.g., Cooper,* 517 U.S. at 348 (competence to stand trial); *Addington* 441 U.S. at 418 (involuntary civil commitment).

[12] *See, e.g., Medina,* 505 U.S. at 450. *See also Addington,* 441 U.S. at 465 (Blackmun, J., dissenting).

[13] *See, e.g., Cooper,* 517 U.S. at 367-68 (contrasting standards for involuntary commitment and for competence to stand trial).

[14] *Cf. Cruzan,* 497 U.S. at 282-284 (1990); *Addington,* 441 U.S. at 423 ("The function of a standard of proof . . . is to 'instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.'") (quoting *In re Winship,* 397 U.S. 358, 370 (1970) (Harlan, J., concurring).

> (c) indicate a clearly held and consistent underlying set of values that provide some guidance in making the decision; and
>
> (d) communicate the decision and explain the process used for making it.[15]

Using these criteria, a mental health professional evaluating decision-making capacity would examine a patient's "chain of reasoning," and would seek to determine whether the patient can "indicate the major factors in his decisions and the importance assigned to them."[16] Similar requirements are set out multiple times under the Act, mandating that a patient, among other things, make "an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request" (O.R.S. 127.850 § 3.08, O.R.S. 127.840 § 3.08), and be given an opportunity to rescind the request (O.R.S. 127.845 § 3.07).

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[15] Werth, *et al.*, *supra* note 6. *See also, e.g.*, Drane, *The Many Faces Of Competency*, 15 HASTINGS CENTER REPORT No. 2, 17, 19 (1985); Freedman, *Competence, Marginal and Otherwise; Concepts and Ethics*, 4 INT'L J. L. & PSYCHIATRY 53, 59-60 (1981); Roth, *et al.*, *Tests Of Competency To Consent To Treatment*, 134 AM. J. PSYCHIATRY 279, 280-282 (1977); Sullivan, Ganzini & Youngner, *Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide*, HASTINGS CENTER REPORT 24 (July/Aug 1998); Sullivan & Youngner, *Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment*, 151 AM. J. PSYCHIATRY 971 (1994); Tepper & Elwork, *Competence To Consent To Treatment As A Psycholegal Construct*, 8 LAW & HUMAN BEHAVIOR 205; Werth, RATIONAL SUICIDE? IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS 94 (1996); Zaubler & Sullivan, *Psychiatry and Physician-Assisted Suicide*, 19 CONSULTATION-LIAISON PSYCHIATRY 413 (1996).

[16] Appelbaum & Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635, 1636 (1988).

Thus, the diagnostic tools for an effective evaluation exist, and qualified professionals are able to use them to make this evaluation regarding a terminally ill patient's mental capacity. The expertise of and tools available to physicians and mental health professionals work cohesively with the safeguards incorporated into the ODWDA to allow those terminally ill patients who possess unimpaired judgment to exercise their rights and maintain their dignity throughout their lives.

B. Oregon's Actual Experiences Establish that Mental Capacity Evaluations are Occurring And Not All Requests for Medication Are Being Approved And/ Or Used.

Oregon's actual experience with ODWDA demonstrates that capacity evaluations are being performed, and that not all requests for medication are approved, and of those approved, not all are ultimately used.[17] In a survey of Oregon physicians

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[17] The ODWDA has been in effect since late 1997 and seven annual official reports have been issued by the Oregon Health Division. In 2004, the most recent year for which the Oregon Health Division has released statistics, 60 physician prescriptions for such medication were written, but only 37 individuals ingested medication prescribed under the provisions of ODWDA. *See* Oregon Dept. of Human Services, Seventh Annual Report on Oregon's Death with Dignity Act (2005). Each of these individuals had to be screened by an attending physician and a consulting physician to ensure that the individual's judgment was not impaired by psychological or psychiatric disorder, as required by the statute. *Id. See also* Coombs Lee & Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 6(2) Psychol., Public Policy & L. 268 (2000); Ganzini, Nelson, Schmidt, Kraemer, Delorit & Lee, *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 New Eng. J. Med. 557 (2000); Reagan, *Helen*, 353 Lancet 1265 (1999); Ganzini, Harvath, Jackson, Goy, Miller & Delorit, *Experiences*

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who had experience with the ODWDA, responses indicated that 165 people had requested medication under the Act from these physicians during the first two years the law was in effect.[18] Of these 165, only 29 (18%) actually received a prescription, and of these 29, only 17 individuals used it.[19]

The survey also demonstrates that physicians are making determinations of ineligibility based on impaired judgment – they are not freely writing prescriptions to every patient who asks for it. Physicians reported that 17% of the individuals requesting medication had "a mental disorder such as depression which impaired his/her judgment." None of those patients were given a prescription under the Act. The results of the study led the authors to conclude that "[the] data simply do not support the hypothesis that among patients eligible for assistance with suicide under the [ODWDA], vulnerable groups, including mentally ill patients, request assistance with suicide

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of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide, 347 NEW ENG. J. MED. 582 (2002); Ganzini, Dobscha, Heintz & Press, *Oregon Physicians' Perceptions of Patients Who Request Assisted Suicide and Their Families*, 6 J. PALL. MED. 381 (2003); Wineberg & Werth, *Physician-Assisted Suicide in Oregon: What are the Key Factors?*, 27 DEATH STUDIES 501 (2003); Werth & Wineberg, *A Critical Analysis of Criticisms of the Oregon with Dignity Act*, 29 DEATH STUDIES 1 (2005); Tolle, *et al.*, *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, 15 J. CLIN. ETHICS 111 (2004); Ganzini & Dobscha, Clarifying Distinctions between Contemplating and Completing Physician-Assisted Suicide, 15 J. CLIN. ETHICS, 119 (2004).

[18] Ganzini, Nelson, *et al.*, *supra* note 17.

[19] *Id.*

disproportionately or receive lethal prescriptions in place of palliative care."[20]

ODWDA creates a system in which only adults who are capable of making a reasoned judgment about their desire to make a request under the Act and the consequences thereof are eligible for the option provided thereunder, and those with impaired judgment may be determined and screened from receiving the requested medication.

II. A TERMINALLY ILL PATIENT CAN BE CAPABLE OF MAKING A REASONED DECISION TO HASTEN DEATH

Defendants' argument regarding an alleged threat to public health rests upon an erroneous comparison of hastened death under the ODWDA to "suicide," and an erroneous assumption that a terminally ill patient's decision to hasten death must be the result of a mental disorder which impairs judgment.

A. End-of-Life Decisions by Terminally Ill Patients Are Not Equivalent to Suicide by Depressed Individuals.

Using a model of suicide as the proxy for a desire to hasten death is extremely problematic, given the assumption of irrationality due to mental illness in instances of suicide. Even those who oppose "assisted suicide" acknowledge that a blanket statement cannot be made about people who may want to hasten death when they are dying of a terminal illness.[21]

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[20] Ganzini, Lee & Schmidt, *Letter to the Editor*, 343 New Eng. J. Med. 152, 152 (2000).

[21] *See, e.g.*, Hendin & Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 143, 145 (1993) ("We are likely to find that those who seek to die in the last days of terminal illness are a quite different population from those whose first response to the knowledge of serious illness is to turn to suicide.").

End-of-life decisions by terminally ill patients are not akin to what is commonly termed "suicide," which is considered to be a self-destructive act often related to feelings of depression. These decisions to hasten death are more accurately paralleled to a patient's thoughtful decision to decline life-sustaining measures: a product of judgment and reason, based on the desire to maintain one's dignity in a period where death in pending. A working group of the American Psychological Association stated that: "It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."[22] In contrast to suicide, refusal of life-sustaining treatment by terminally ill patients is often seen as an affirmation of their dignity in a fully lived life, a concept that many states, including Oregon, have already deemed worthy of legal recognition.[23]

Thus, medical and scientific research have found that many individuals facing certain death, along with the possibility of physical pain and loss of dignity – which are not factors for those who choose to commit suicide in response to emotional and mental distress – may desire to hasten death free from judgment impaired by depression or other mental disorder. The comparison to "suicide" is simply inapposite.

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[22] American Psychological Association, TERMINAL ILLNESS AND HASTENED DEATH REQUESTS: THE IMPORTANT ROLE OF THE MENTAL HEALTH PROFESSIONAL 1 (1997).

[23] *See, e.g.*, *Compassion in Dying v. Washington*, 79 F.3d 790, 817-20 (9th Cir.), *cert. granted*, 518 U.S. 1055 (1996), *rev'd*, 521 U.S. 793 (1997); *Vacco v. Quill*, 80 F.3d 716, 727-28 (2d Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 518 U.S. 1057 (1996), *rev'd*, 521 U.S. 702 (1997).

B. Many Terminally Ill Patients Are Not Clinically "Depressed."

The weight of medical and mental health research and experience indicates that terminally ill people who have a desire for death in general, or, more particularly, who wish to hasten death through use of the ODWDA, are not incapable of making healthcare decisions, suffering from impaired judgment, or experiencing major depression.[24] In fact, research and experience demonstrate that a personal sense of autonomy, control, and dignity are typically the most influential reasons why terminally ill people in general want to hasten death[25] and why terminally ill Oregonians want to use the ODWDA.[26] Based on their

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[24] Werth, *The Relationships Among Clinical Depression, Suicide, and Other Actions that may Hasten Death*, 22 BEHAV. SCI. & L. 627 (2004).

[25] Back, Wallace, Starks, & Pearlman, *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 J. AM. MED. ASSOC. 919 (1996); Lavery, Boyle, Dickens, Maclean & Singer, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*, 358 LANCET 362, 362 (2001) (for 32 people with HIV disease "Euthanasia and assisted suicide were seen by participants as a means of limiting loss of self."); Wilson, Viola, Scott & Chater, *Talking to the Terminally Ill About Euthanasia and Physician-Assisted Suicide*, 5 CANADIAN J. CLINICAL MED. 68 (April 1998); Back, Starks, Hsu, Gordon, Bharucha, & Pearlman, *Clinician-Patient Interactions About Requests for Physician-Assisted Suicide: A Patient and Family View*, 162 ARCH. INT. MED. 1257 (2002); Bharucha, Pearlman, Back, Gordon, Starks, & Hsu, *The Pursuit of Physician-Assisted Suicide: Role of Psychiatric Factors*, 6 J. PALL. MED. 873 (2003); Werth, supra note 24.

[26] Ganzini, Nelson, *et al.*, *supra* note 17; Ganzini, Harvath, *et al.*, *supra* note 17; Ganzini, Dobscha, *et al.*, *supra* note 17; Coombs

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experience with many individuals who have died of terminal illnesses, and upon the scientific and medical research available, the Coalition strongly opposes the assertion that a terminally ill patient's desire to hasten death necessarily involves depression or other mental disorder.[27]

Indeed, medical and scientific studies confirm that unlike with suicide, many terminally ill patients can and do make "rational" decisions, free of depressive or other mental disorder, regarding whether or not to hasten death. For example,[28] in one

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Lee & Werth, *supra* note 17; Reagan, *supra* note 17; Wineberg & Werth, *supra* note 17; Werth & Wineberg, *supra* note 17; Oregon Dept. of Human Services, *supra* note 16; Kade, *Death with Dignity: A Case Study*, 132 ANN. INTERN. MED. 504 (2000); Ganzini & Dobscha, *If it isn't Depression . . .*, 6 J. PALL. MED. 927 (2003); Bascom & Tolle, *Responding to Requests for Physician-Assisted Suicide*, 288 J. AM. MED. ASSOC. 91 (2002); L. Ganzini, personal communication by e-mail to J. Werth, Jr., January 7, 2002.

[27] Thus, the description of the case of Michael P. Freeland, set forth in an appendix to the amicus brief of Physicians for Compassionate Care Educational Foundation, is fundamentally flawed for at least two reasons. First, there is no external verification of incapacity or impaired judgment; in fact, several physicians determined Mr. Freeland had capacity, and an attempt to have him ruled incompetent was dropped after the discovery phase. Second, the description glosses over the fact that Mr. Freeland died of natural causes, without taking the medication prescribed under ODWDA – the very choice the ODWDA is intended to provide. We are confident that more thorough rebuttals of the claims in that Appendix will appear in the professional literature.

[28] For examples of other recent studies that examined the presence of diagnosable depression among terminally ill individuals who desired a hastened death – all of which found that a significant percentage were

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study, only 31 of 159 terminally ill patients who had an interest in "physician-assisted suicide" or euthanasia were considered to be depressed; only 2 of 11 patients who had discussed euthanasia or "physician-assisted suicide," collected medication for "assisted suicide," or had caregivers discuss euthanasia with physicians had "depressive symptoms."[29] In one survey of 39 HIV-positive individuals, researchers concluded that more than two-thirds had rationally contemplated ending their life and that the desire to hasten death was not directly related to clinical depression as measured by the Beck Depression Inventory (the most widely used rapid screening test for the presence of major depression).[30] Depression is a distinct and serious disorder that

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not depressed – *See* Breitbart, Rosenfeld, Pessin, Kaim, Funesti-Esch, *et al., Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer,* 284 J. AM. MED. ASSOC. 2907 (2000); Chochinov, Wilson, Enns, Mowchun, Lander, *et al., Desire for Death in the Terminally Ill,* 152 AM. J. PSYCHIATRY 1185 (1995); Rosenfeld, Breitbart, Stein, Funesti-Esch, Kaim, *et al., Measuring Desire for Death Among Patients with HIV/AIDS: The Schedule of Attitudes Toward Hastened Death,* 156 AM. J. PSYCHIATRY 94 (1999); Wilson, Scott, Graham, Kozak, Chater, *et al., Attitudes of Terminally Ill Patients Toward Euthanasia and Physician-Assisted Suicide,* 160 ARCH. INTERN. MED. 2454 (2000). *See also* Mishara, *Synthesis of Research and Evidence on Factors Affecting the Desire of Terminally Ill or Seriously Chronically Ill Persons to Hasten Death,* 39 OMEGA 1 (1999); Rosenfeld, *Assisted Suicide, Depression and the Right to Die,* 6 PSYCHOL., PUB. POLICY & L. 467 (2000).

[29] Emanuel, Fairclough & Emanuel, *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers,* 284 J. AM. MED. ASSOC. 2460, 2464, 2467 (2000).

[30] Jones & Dilley, *Rational Suicide and HIV Disease,* 8 FOCUS: A GUIDE TO AIDS RESEARCH AND COUNSELING 5 (July 1993).

can be identified and diagnosed.[31] The American Psychiatric Association's DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS lists nine criteria for identifying a Major Depressive Episode.[32] Under the diagnostic model, five of these criteria — one of which must be either depressed mood or loss of interest or pleasure — must manifest during any single two-week period. If fewer than five criteria are present, or they do not occur within this time frame, then "depression," as a psychological disorder, is not present.[33]

Scientific and medical research establish that it is not appropriate to assume that any decision to hasten death must be motivated by depression or other mood disorders. Indeed, in a variety of studies of terminally ill patients, a majority of those studies found that less than half of the terminally ill patients studied could be diagnosed with major depression.[34] At the very least, a large group of individuals who might medically qualify under the ODWDA were not suffering from judgment impaired by depression. Moreover, a recent study of hospice nurses and social workers in Oregon led the lead author to conclude that "the data do not support that depression is an important

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[31] For example, the literature shows that clear distinctions can be made between depression and grief. *See* Block, *Assessing and Managing Depression in the Terminally Ill Patient*, 132 ANN. INTERN. MED. 209 (2000).

[32] American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 327 (4th ed. 1994).

[33] Billings & Block, *Palliative Medicine Update: Depression*, 11 J. PALLIATIVE CARE 48, 48 (1995).

[34] Block, *supra*, note 31.

contributor in patients who received a lethal prescription."[35] Similarly, a study in Washington examining the role of clinical depression and other psychiatric conditions on a person's pursuit of physician-assisted suicide found that depressive symptoms did not appear to be an influential factor in decision-making and none of the participants appeared to have depression-related decisional incapacity.[36]

Thus, an assumption that all terminally ill patients are per se suffering from major depression is simply unsupportable and no blanket statements regarding their judgment properly can be made.

III. INVOLVEMENT OF MENTAL HEALTH PROFESSIONALS IN SITUATIONS INVOLVING END-OF-LIFE DECISION-MAKING, INCLUDING SERVING IN THE ROLE OUTLINED IN THE ODWDA, IS CONSIDERED TO BE APPROPRIATE

Because psychologists and psychiatrists are specified in the ODWDA as the professionals to whom the attending or consulting physician must refer a person if either of them has concerns about the possible presence of impaired judgment, the viewpoints of Oregon psychologists and psychiatrists concerning the ODWDA are important to consider. A survey of Oregon

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35. L. Ganzini, personal communication by e-mail to J. Werth, Jr., January 7, 2002. *See* Ganzini, Harvath, *et al.*, *supra*, note 17 at 582 ("A very important reason for the request [to use the ODWDA] was to control the circumstances of death. The least important reasons included depression, lack of social support, and fear of being a financial drain on family members.").

36. Bharucha et al, *supra*, note 25; Ganzini & Dobscha, *supra*, note 26.

psychiatrists found that two-thirds of the respondents "endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for a medication whose sole purpose would be to allow a patient to end his or her life."[37] A more recent survey of Oregon psychologists found that 78% supported the enactment of the ODWDA and 91% supported both "rational" and physician-"assisted suicide" more generally.[38] Thus, a significant percentage of psychologists and psychiatrists in Oregon believe that a decision by a terminally ill patient to hasten his or her own death may be carefully considered and fully rational.[39]

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[37] Ganzini, Fenn, Lee, Heintz & Bloom, *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 AM. J. PSYCHIATRY 1469, 1469 (1996).

[38] Fenn & Ganzini, *Attitudes of Oregon Psychologists Toward Physician-Assisted Suicide and the Oregon Death with Dignity Act*, 30 PROF. PSYCHOLOGY: RESEARCH & PRACTICE 235, 236, 237 (1999).

[39] These attitudes are similar to those found in other surveys of psychologists, counselors, and social workers. *See, e.g.*, DiPasquale & Gluck, *Psychologists, Psychiatrists, and Physician-Assisted Suicide: The Relationship Between Underlying Beliefs and Professional Behavior*, 32 PROF. PSYCHOLOGY: RESEARCH & PRACTICE 501 (2001) (75% of responding psychologists and psychiatrists in New Mexico thought physician-"assisted suicide" should be legal); Ganzini, *et al.*, *supra* note 10 at 597 (80% of respondents thought suicide was ethical in some or all circumstances, 66% believed physician-"assisted suicide" was ethical); Werth & Liddle, *Psychotherapists' Attitudes Toward Suicide*, 31 PSYCHOTHERAPY: THEORY, RESEARCH & PRACTICE 440 (1994) (81% of the respondents from a national sample of the American Psychological Association's Division of Psychotherapy stated that they believed that an individual could make a rational decision to die by "suicide"); Werth, *supra* note 15 at 47 (86% of the respondents to a survey of members of the National Register of Health Service Providers in Psychology believed

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In addition, Oregon mental health professionals believe that they can provide appropriate and effective services under the ODWDA and guidelines have been provided for their use in such situations.[40] Similarly, several organizations representing mental health professionals have taken positions that support the involvement of their members in providing services to individuals who are making end-of-life decisions, including considering whether to request and receive medication such as is offered under the ODWDA; however, as noted at the beginning of this Brief, supporting involvement should not be necessarily interpreted as support for assisted suicide in general or the ODWDA in particular.

In 1998, the American Psychological Association ("APA") convened a Working Group on Assisted Suicide and End-of-Life Decisions which issued an extensive Report to the Board

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in "rational suicide"); Rogers, Guellette, Abbey-Hines, Carney & Werth, *Rational Suicide: An Empirical Investigation of Counselor Attitudes*, 79 J. COUNSELING & DEVELOPMENT 365 (2001) (surveyed members of the American Mental Health Counselors Association and found 81% of respondents believed in the idea of "rational suicide"); Ogden & Young, *Euthanasia and Assisted Suicide: A Survey of Registered Social Workers in British Columbia*, 28 BRITISH J. SOC. WORK 161 (1998) (nearly 80% of responding social workers believed that "assisted suicide" should be legal in some circumstances); Ganzini, Harvath, *et al.*, *supra* note 17 (66% of hospice social workers support or strongly support the ODWDA, only 12% oppose or strongly oppose); Miller, Mesler & Eggman, *Take Some Time to Look Inside Their Hearts: Hospice Social Workers Contemplate Physician Assisted Suicide*, 35(3) SOC. WORK IN HEALTH CARE 53 (2002).

[40] Farrenkopf & Bryan, *supra* note 6; Werth, *et al.*, *supra* note 6; Bascom & Tolle, *supra* note 26.

of Directors two years later.[41] In 2001, the APA passed a resolution, which neither endorsed nor opposed "assisted suicide," but stated that "psychologists have many areas of competence, including assessment, counseling, teaching, consultation, research, and advocacy skills that could potentially enlighten the discourse about "assisted suicide," end-of-life treatment, and support for dying persons and their significant others."[42]

Similarly, in the American Counseling Association's *2005 ACA Code of Ethics Draft*, there is a new section entitled "End-of-Life Care for Terminally Ill Clients" that includes sections on Quality of Care; Counselor Competence, Choice, and Referral; and Confidentiality.[43] Regarding competence, the organization stated, "Recognizing the personal, moral, and competence issues related to end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. . . ." Specifically related to assisted death, in the Confidentiality section, the draft code

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[41] Available at http://www.apa.org/pi/aseolf.html.

[42] In the "assisted suicide" resolution, it was further resolved that the APA should

> Encourage psychologists to identify factors leading to assisted suicide requests (including clinical depression, levels of pain and suffering, adequacy of comfort care, and other internal and external variables) and to fully explore alternative interventions (including hospice/palliative care, and other end-of-life options such as voluntarily stopping eating and drinking) for clients considering assisted suicide.

Id.

[43] American Counseling Association, *supra* note 3; see also note 3 for the entire Quality of Care section.

specifies that, "Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option of breaking or not breaking confidentiality, depending on the specific circumstances of the situation and after seeking consultation or supervision."

It is clear that individual mental health professionals and several of their professional associations allow involvement in situations where clients are considering end-of-life issues, including "assisted suicide." A mental health professional can not only conduct an evaluation for capacity or impaired judgment to satisfy the letter of the law, but can also assist in identifying and ameliorating issues that are compromising the quality of life of the dying person and her or his loved ones.[44] Professionals can, for example, help patients address issues such as pain, depression, dignity, tranquility, financial concerns, and the effectiveness or futility of available medical treatments; communicate with other health care providers, family members, social service providers, or others concerning the patient's needs, concerns, and preferences, to help ensure that the patient receives necessary support and that the treatment provided comports with the patient's wishes; and promote and monitor appropriate involvement by significant others in a patient's end-of-life decisions. This position was endorsed by Supreme Court Justice Stevens in his concurrence for both *Washington v. Glucksberg* and *Vacco v. Quill*, when he wrote:

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[44] American Psychological Association Working Group, *supra* note 7; Cohen, *Suicide, Hastening Death, and Psychiatry*, 158 ARCH. INTERN. MED. 1973 (1998); Ganzini & Lee, *Psychiatry and Assisted Suicide in the United States*, 336 NEW ENG. J. MED. 1824 (1997); Werth & Holdwick, *A Primer on Rational Suicide and Other Forms of Hastened Death*, 28 COUNSELING PSYCHOLOGIST 511 (2000).

> I agree that the State has a compelling interest in preventing persons from committing suicide because of depression, or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying. Although, as the New York Task Force report discusses, diagnosing depression and other mental illness is not always easy, mental health workers and other professionals expert in working with dying patients can help patients cope with depression and pain, and help patients assess their options.[45]

Thus, although the Coalition does not take a position here on either the general issue of "physician-assisted suicide" or the more particular issue of the legitimacy of prescribing controlled substances under the ODWDA, its members strongly believe the Court will gain substantial benefit by taking into account the substantial literature and experience set forth herein, as elsewhere, which demonstrates that the desire for death is not necessarily pathological. Moreover, the literature establishes that if there is impaired judgment or lack of capacity, these individuals or symptoms can be detected and interventions can be implemented.

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[45] *Washington v. Glucksberg*, 521 U.S. at 735-36; *Vacco v. Quill*, 521 U.S. at 746-47.

CONCLUSION

The Coalition respectfully submits that the DOJ's reasoning for how the ODWDA's implementation leads to a threat to public health is flawed and misinformed. Many terminally ill patients are capable adults who are able to make a decision regarding use of the ODWDA free from impaired judgment, and adequate diagnostic tools are available for use in screening out those individuals who are not capable of making such a judgment.

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