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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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

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

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

(Cont'd)

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

(Cont'd)
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).

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

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

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

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* (Cont'd)

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

(Cont'd)

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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