2005

Brief of Amici Curiae Not Dead Yet, Adapt, Center on Disability Studies, Law and Policy at Syracuse University, Center for Self-determination, Hospice Patients Alliance, Mouth Magazine/ Freedom Clearinghouse, National Council on Independent Living, National Spinal Cord Injury Association, Self-Advocates Becoming Empowered, Society for Disability Studies, Tash and the World Institute on Disability in Support of Petitioners, Gonzalez v. Oregon, 126 S.Ct. 904 (Supreme Court of the United States of America 2006) (No. 04-623)

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Supreme Court of the United States

October Term, 2004

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 *AMICI CURIAE* NOT DEAD YET, ADAPT, CENTER ON DISABILITY STUDIES, LAW AND POLICY AT SYRACUSE UNIVERSITY, CENTER FOR SELF-DETERMINATION, HOSPICE PATIENTS ALLIANCE, MOUTH MAGAZINE/FREEDOM CLEARINGHOUSE, NATIONAL COUNCIL ON INDEPENDENT LIVING, NATIONAL SPINAL CORD INJURY ASSOCIATION, SELF-ADVOCATES BECOMING EMPOWERED, SOCIETY FOR DISABILITY STUDIES, TASH AND THE WORLD INSTITUTE ON DISABILITY IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE

Amici are among the nation's leading organizations representing people with disabilities. Most are governed and staffed by a majority of people with disabilities of all types. They played a key role in enacting the nation's civil rights laws for people with disabilities, including the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12181. Based on their shared experience as people with disabilities, including conditions judged to be "terminal," *Amici* strongly oppose the legalization of assisted suicide.[1]

In the United States, as in most other nations, a person who attempts or desires to commit suicide will typically be rushed to the nearest emergency room, as one-half million Americans are each year. *The Surgeon General's Call to Action to Prevent Suicide 1999* 1. The person will be subject to numerous laws, programs, and medical and therapeutic interventions designed to convince him or her not to commit suicide, or to prevent him or her from doing so. *Id.*

It seems axiomatic that society's response to a person who attempts suicide should not differ based on that person's race, ethnicity, gender, religion or disability. Yet Oregon's "Death with Dignity" Act, Or. Rev. Stat. §§ 127.800 – 127.995, encourages, rather than discourages, certain people to die solely because of their disability. Indeed, the law *guarantees* that the suicide attempts of the severely disabled will succeed. Although the Surgeon General has stated that suicide prevention policies "must recognize and affirm the value, dignity and importance of each person," *Surgeon General's Call to Action* at 13, Oregon's assisted suicide law implicitly states that some people's lives are worth saving

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[1] The parties have consented to the filing of this brief. No counsel for a party has authored this brief, in whole or in part, and no person other than *amici* and their counsel has made any monetary contribution for its preparation.

and others are not. For *amici*, this debate is not about the "choice" of someone who is suicidal. Rather, it is about demanding a uniform legal and societal response to those who want to kill themselves. *Amici*'s experience as people with disabilities is that the false assumption that suicide is a rational solution to the barriers and discrimination they face devalues them as human beings and sanctions their unequal treatment under law.

Supporters of physician-assisted suicide laws such as Oregon's claim they are limited only to competent people who face imminent death as a result of terminal illness. Yet neither Oregon's system of physician-assisted suicide nor any other – whether *de jure* (the Netherlands)[2] or *de facto* (Dr. Kevorkian)[3] – has operated within these boundaries. Physician-assisted suicide invites anyone involved in the decision to die, including the physician, to make monumental judgments on the relative value of a person's life – or, as one Oregon reporter noted, to act as "the gatekeepers of death." Evelyn Hoover Barnett, *Is Mom Capable of Choosing to Die?* The Oregonian, Oct. 16, 1999, at G1. It is no coincidence, then, that this Court has refused to recognize assisted suicide as a fundamental right, *see Washington v. Glucksberg,* 521 U.S. 702, 735 (1997), the medical profession has eschewed it as a legitimate practice, *see* American Medical Association, Code of Ethics § 2.211, and every other state besides Oregon has refused to allow it shelter under their laws, *Glucksberg,* 521 U.S. at 710. And, as *Amici* here submit, it is condemned by the vast majority of people with disabilities. *See* National Council on Disability, *Assisted Suicide: A Disability Perspective* (1997, re-released 2005).

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[2] *See* Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* (1997), cited in *Washington v. Glucksberg,* 521 U.S. 702, 730 (1997).

[3] *See* Lori A. Roscoe *et al., Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998*, 343 New Eng. J. Med. 1735 (Dec. 7, 2000).

A. Not Dead Yet

Not Dead Yet is a national grassroots organization of people with disabilities formed in response to the movement to permit physician-assisted suicide and euthanasia in the United States and around the world. Not Dead Yet's mission is to protect the civil rights of people with disabilities by advocating against discriminatory legalization of physician-assisted suicide and euthanasia and to bring a disability-rights perspective and awareness of the effects of discrimination to the legal and sociological debate surrounding these practices. Not Dead Yet has worked to educate, support, coordinate and lead the disability community's effort to stop the "right to die" from becoming a duty to die or a right to kill. This Court cited Not Dead Yet's *amicus* brief in *Washington v. Glucksberg*, 521 U.S. 702, 733 n.23 (1997). Not Dead Yet has also testified before the U.S. Congress three times on the subject of physician-assisted suicide.

B. ADAPT

ADAPT is a national disability rights organization comprised primarily of people with disabilities. ADAPT has a long history and record of enforcing the civil rights of people with disabilities. In addition to being one of the key organizations that helped enact the Americans with Disabilities Act, ADAPT has been a plaintiff in numerous civil rights lawsuits. *See e.g. ADAPT v. Skinner,* 881 F.2d 1184 (3d Cir. 1989); *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), *cert. denied sub nom., Secretary of Publ. Welf. v. Idell S.*, 516 U.S. 813 (1995); *ADAPT v. Philadelphia Hous. Auth.,* 2000 U.S. Dist. LEXIS 5380 (E.D. Pa. Apr. 14, 2000); *ADAPT v. SkyWest Airlines*, 762 F. Supp. 320 (D. Ut. 1991).

C. Center on Disability Studies, Law and Human Policy at Syracuse University

The Center on Disability Studies, Law and Human Policy is an interdisciplinary disability research and policy institute at Syracuse University. Established in 1971, the Center's work focuses on people with cognitive disabilities. The Center's research has included studies of institutions, schools, and community services, the history of the treatment of people with disabilities in America, disability law and policy, images of disability in the media and popular culture, and the politics and ethics of treatment.

D. Center for Self-Determination

The Center for Self-Determination is a national organization comprised of individuals with disabilities, family members, and professionals committed to the principles of self-determination: freedom to choose where and with whom one wants to live, as well as what one will do with one's life; authority and control over the dollars necessary for long term supports; designing and providing individual, community-based supports for people with disabilities; and responsibility for both the wise use of public dollars and for contributing to one's community.

E. Hospice Patients Alliance

The Hospice Patients Alliance, Inc. is a charitable nonprofit patient advocacy organization that works to promote excellence in end-of-life care and to protect the rights of patients. It provides information about hospice services, directly assists patients, families and caregivers in resolving difficulties they have with current hospice services, and promotes better quality hospice care.

F. Mouth Magazine/Freedom Clearinghouse

Mouth Magazine, published by Free Hand Press, Inc., is a magazine run by and dedicated to issues concerning people with disabilities. Its mission is to promote the lives and freedoms of all people with disabilities through magazines, books, handbooks, speeches, pamphlets, and electronic media. The mission statement of Freedom Clearinghouse is to publicize and implement the right of people with disabilities to live in the community.

G. National Council on Independent Living

The National Council on Independent Living (NCIL) represents over 700 advocacy organizations and people with disabilities of all types. The independent living philosophy, which NCIL and its members advance, holds that people with disabilities have the right to live with dignity and appropriate supports in their own homes, participate in their communities, and control and make decisions about their lives, regardless of the degree of disability.

H. National Spinal Cord Injury Association

Founded in 1948, the National Spinal Cord Injury Association (NSCIA) is the largest organization in the United States dedicated to improving the quality of life of persons with spinal cord injuries and diseases. The NSCIA's mission is to enable people with spinal cord injuries to make choices and take actions to achieve their highest level of independence and personal fulfillment. Spinal cord injury has been cited as the type of impairment warranting a desire to hasten death. The NSCIA believes that expediting one's death because they have a disability is immoral and unwise, both for society at large and members of the disability community in particular.

I. Self-Advocates Becoming Empowered

Self-Advocates Becoming Empowered is a national organization comprised of and directed by people with developmental disabilities, including intellectual disabilities or mental retardation, cerebral palsy and autism. First established in 1974, Self-Advocates Becoming Empowered now has over 900 chapters in 46 states (known locally as "People First" organizations), with an estimated 20,000 members. Many members have been unnecessarily institutionalized and have experienced discrimination by medical practitioners.

J. Society for Disability Studies

The Society for Disability Studies is an international non-profit organization that promotes the exploration of disability through research, artistic production, and teaching.

K. TASH

TASH (formerly the Association for Persons with Severe Handicaps) is an international advocacy organization of people with disabilities, their families, advocates and professionals in the disability field. It has over 30 chapters covering 37 states and members in 34 nations. TASH has adopted a resolution opposing physician-assisted suicide.[4]

L. World Institute on Disability

The World Institute on Disability (WID) is a nonprofit research, public policy and advocacy center dedicated to promoting the civil rights and full societal inclusion of people with disabilities. WID is governed and staffed by a majority of people with disabilities.

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[4] www.tash.org/resolutions/res02assistedsuicide.htm.

SUMMARY OF ARGUMENT

Amici support the Attorney General's interpretive ruling that assisted suicide is not a "legitimate medical practice" under the Controlled Substances Act, 21 U.S.C. §§ 801-971, and its implementing regulations, 21 C.F.R. § 1306.04(a). When applied only to people with significant or even "terminal" health impairments, Oregon's assisted suicide law encourages the disabled to end their lives – and guarantees such efforts will be successful – while other state laws concurrently discourage non-disabled persons from doing so. Assisted suicide laws deny people with disabilities the benefit of programs and laws that prevent suicide and are the ultimate legal judgment that the life of a person with a disability is not as worthwhile as that of a non-disabled person.

Assisted suicide also raises serious ethical concerns regarding the medical profession's treatment of the disabled. It requires doctors to make difficult, if not impossible, determinations of a person's competency and life expectancy, the consequences of which are both ultimate and irreversible. The availability of assisted suicide also distracts from the determination whether a person's desire to die might be lifted with improved treatment, community-based health care or other measures that improve a person's independence and dignity.

Thus, given the Attorney General's latitude to interpret federal statutes that Congress has authorized him to enforce, *see Chevron U.S.A. v. Natural Resources Defense Council,* 467 U.S. 837, 844 (1982), this difference in treatment, based solely on the presence of a severe disability, justifies the Attorney General's action here. Additionally, Congress and the Attorney General are not precluded from acting to protect the rights of people with disabilities simply because such protection regulates the practice of medicine. The Court of Appeals' erroneous reliance on *Gregory v.*

Ashcroft, 501 U.S. 452 (1991), and its imposition of the "clear statement" rule to an area that is not a "fundamental" state function, unduly impairs Congress' ability to legislate against state infringements on the civil rights of people with disabilities.

ARGUMENT

I. Assisted Suicide Serves No Legitimate Medical Purpose Because It Discriminates Against and Degrades the Lives of People with Disabilities

A. Laws, Programs and Services Operate to Prevent People from Committing Suicide

Suicide is a practice that American society disapproves of and actively discourages through laws and prevention programs. *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997) ("[F]or over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide."). The U.S. Surgeon General has called suicide "a serious health problem." *The Surgeon General's Call to Action to Prevent Suicide 1999* at 1. Every year, 500,000 people in the United States use emergency room services as a result of suicide attempts. *Id.* In almost every state, helping someone commit suicide is a crime. *Glucksberg,* 521 U.S. at 710-11. In Oregon, intentionally causing or aiding another person to commit suicide is second-degree manslaughter. Or. Rev. Stat. § 163.125. Oregon law also authorizes physical force to prevent someone from committing suicide. Or. Rev. Stat. § 161.205(4).[5] Additionally, many states statutorily mandate

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[5] *See also* Ariz. Rev. Stat. § 13-403; Del. Code Ann. tit. 11, § 467; 9 Guam Code Ann. § 7.92; Haw. Rev. Stat. § 703.308; Neb. Rev. Stat. § 28.1412; N.H. Rev. Stat. Ann. § 627.6; N.J. Stat. Ann. § 2C:3-7; N.D. Cent. Code § 12.1-05; 18 Pa. Cons. Stat. § 508; Tenn. Code Ann. § 39-11-613; Wis. Stat. § 939.48.

suicide prevention plans, hotlines, or other intervention programs.[6]

According to the World Health Organization (WHO), depression and anxiety are often associated with suicide and over 80 percent of suicide victims had severe depression. WHO, *World Report on Violence and Health* 192 (2002). Oregon law reflects this assumption that persons who commit suicide do not act rationally. For life insurance purposes, Oregon law creates a presumption against suicide, under the reasoning that "it is common knowledge that sane persons do not ordinarily kill themselves." *Wyckoff v. Mutual Life Ins. Co.,* 147 P.2d 227, 229 (Or. 1944); *see also* Or. Rev. Stat. § 656.310 (for worker's compensation claims, worker's death presumed not to be suicide). Oregon also presumes that the will of one who commits suicide is invalid and the product of a "deranged" mind. *In re Kober's Will,* 285 P. 1032 (Or. 1930).[7]

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[6] *See e.g.* Alaska Stat. S§ 44.29.300-44.29.390; Ariz. Rev. Stat. § 36.3415; Ark. Code Ann. § 6-18-1005; Cal. Gov. Code § 53110; Cal.Welf. & Inst. Code §§ 4098 - 4098.5; Conn. Gen. Stat. § 7-294g; 410 Ill. Comp. Stat. 53/5-15; La. Rev. Stat. Ann. § 17.282.4; Md. Code Ann., Health-General § 10-1403(a)(1)(iii); Mass. Ann. Laws ch. 40, § 36C; Minn. Stat. § 146.56; Mo. Rev. Stat. § 630.900; Nev. Rev. Stat. §§ 439.511 – 439.513; N.H. Rev. Stat. § 186.67-a; N.J. Stat. Ann. §§ 30:9A-13 – 30:9A-27; N.D. Cent. Code § 57-40.6-10; Okla. Stat. Ann. §§ 12-101 – 12-105; 24 P.R. Laws Ann. §§ 3241 – 3244; R.I. Gen. Laws § 16-22-14; Va. Code Ann. § 32.1-73.7.

[7] Other ways in which Oregon law discourages suicide include: the exclusion of suicide threats from a state law mandating confidentiality of statements made during counseling sessions, Or. Rev. Stat. § 181.860(8)(a); establishing a statewide team to investigate youth suicides, Or. Rev. Stat. § 418.748; establishing a Youth Suicide Prevention Coordinator, Or. Rev. Stat. § 418.756; and mandating that hospitals refer children who attempt suicide to crisis intervention services, Or. Rev. Stat. § 441.750.

B. The Oregon Assisted Suicide Law Denies People with Disabilities the Benefits of Suicide Prevention Laws and Measures

The Oregon "Death with Dignity" Act, Or. Rev. Stat. §§ 127.800 – 127.995, modifies the assumption that suicide is irrational and undesirable – but only as to persons with "terminal" disabilities or conditions. For these people, Oregon law does not assume that suicide is irrational or a practice that should be discouraged. Rather, the law allows doctors and others to facilitate suicide, an act that would be a crime but for the person's disability. Persons with severe health impairments are therefore denied the benefit of suicide prevention laws and programs. Indeed, state law guarantees their suicide attempts will succeed – unlike those of other persons with suicidal ideations. A practice that the State would otherwise expend public health resources to prevent is instead allowed to occur. This differing response is based solely on a person's disability.[8]

If a state overtly excluded people with "terminal" disabilities from suicide prevention laws and programs, it would undoubtedly violate federal civil rights laws such as the Americans with Disabilities Act, 42 U.S.C. §§ 12132, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a). Yet that is precisely the design and effect of the Oregon assisted-suicide law. A more devastating form of discrimination would be difficult to imagine. By assuming that it is irrational for a non-disabled person to end his or her life, but rational for a disabled person to do so, the law assumes that the non-disabled person's life is intrinsically more valuable and worthwhile than that of a disabled person.

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[8] *Amici* do not advocate here for forced treatment or against the right of people with disabilities to refuse treatment. *Amici* include persons with psychiatric disabilities who have been subject to unwanted treatment. *Amici* are concerned solely with the Oregon assisted suicide law's unequal treatment of the disabled. *See* www.mindfreedom.com.

For *amici*, perhaps no other attitude strikes closer to the heart of the disability civil rights movement to which they have dedicated themselves for the past three decades. Central to this movement is the idea that a disabling condition does not inherently diminish one's life; rather, surrounding barriers and prejudices do so. Assisted suicide takes the opposite approach – it gives official sanction to the idea that life with a disabling condition is not worth living.[9] As this Court has recognized:

> The State's interest here [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference ..." The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same as everyone else's.

Glucksberg, 521 U.S. at 732.

C. Euthanasia and Assisted Suicide Are Part of the Long and Tragic History of Discrimination Against People with Disabilities

Assisted suicide must be seen against the background of the United States' long and tragic history of state-

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[9] *See* Carol J. Gill, *Suicidal Intervention for People with Disabilities: A Lesson in Inequality,* 8 Issues in L. & Med. 37 (1992) ("When a culture values human life conditionally, suicide intervention becomes selective. Devalued populations fail to receive rigorous protection, assessment and treatment.")

sanctioned discrimination against the disabled, which five members of the Supreme Court have called "grotesque." *City of Cleburne v. Cleburne Living Center,* 473 U.S. 432, 454-55 & 461 (1985). *Amici*'s experience is that this history continues to haunt the everyday lives and realities of people with disabilities, particularly when making so-called "end-of-life" decisions.

Throughout history, state officials, with the support of the medical community, have authorized the sterilization of people with disabilities. *Buck v. Bell*, 274 U.S. 200, 207 (1927) ("It is better for all the world, if ... society can prevent those who are manifestly unfit from continuing their kind ... Three generations of imbeciles are enough").[10] People with disabilities were placed in "massive custodial institutions ... built to warehouse the retarded for life; the aim was to halt reproduction of the retarded and 'nearly extinguish their race.'" *City of Cleburne*, 473 U.S. at 461-62 (Marshall, J., concurring & dissenting) (citations omitted). The disabled were deemed "uneducable" and excluded *en masse* from public schools. *See School Comm. of Burlington v. Massachusetts Dep't of Educ.*, 471 U.S. 359, 373 (1985). These practices, like Jim Crow laws in the south, were carried out by elected officials with the support of the voters. This did not make them any more legitimate or constitutional.

Euthanasia played a key role in this history. In the 1940s, medical professionals sought the involuntary euthanasia of the severely disabled. In a 1941 presentation to the American Psychiatric Association, which was later

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[10] *See also In re Simpson,* 180 N.E. 2d 206 (Ct. Common Pleas Oh. 1962) (ordering sterilization of woman with retardation because of "probability that [her] offspring will be mentally deficient and become a public charge for most of their lives."); H. Laughlin, *Eugenic Sterilization in the United States* 369 (1922) ("[D]efectives who are practically certain to breed principally defectives, owe a debt to the community that can be discharged only by an adequate guarantee that they shall not contribute to the next generation.").

published in the Association's journal, Dr. Foster Kennedy, the President of the American Neurological Association, stated:

> [T]he place for euthanasia, I believe, is for the completely hopeless defective: nature's mistake; something we hustle out of sight, which should never have been seen at all. These should be relieved of the burden of living ... to allow them to continue such a living is sheer sentimentality, and cruel too; we deny them as much solace as we give our stricken horse. Here we may most kindly kill.

M. Louis Offen, *Dealing with "Defectives": Foster Kennedy and William Lenox on Eugenics,* 61 Neurology 668 (Sept. 2003) (quoting Foster Kennedy, *The Problem of Social Control of the Congenital Defective*, 99 Am. J. Psychiatry 13, 16 (1942)). In 1935, a Nobel Prize-winning fellow at the Rockefeller Institute similarly urged that "sentimental prejudice ... not obstruct the quiet and painless disposition of incurable ... and hopeless lunatics." *The Right to Kill*, Time, Nov. 18, 1935, at 53-54.[11]

Such attitudes, unfortunately, are not completely in the past. Prominent ethicists such as Peter Singer of Princeton University have sanctioned the killing of infants with severe disabilities based on a belief that they will not lead a "good" life and will burden their parents and society. Peter Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics* 197-98 (1994). Professor Singer has also written that it is impossible to kill people with severe cognitive disabilities "against their will" "because they are not capable of having a will on such a matter." *Id.*

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[11] *See also* Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (1986).

Amici do not claim that Oregon's assisted suicide law was intended to "extinguish" the disabled. Nevertheless, given this history and the slippery slope it exemplifies, federal safeguards are appropriate and necessary to ensure that euthanasia against the disabled is not, once again, sanctioned as a "legitimate medical practice" as it was for so many years.

D. Assisted Suicide Contravenes Medical Ethics and Practice Because of the Abuse It Poses to People with Disabilities

As this Court has recognized, assisted suicide is contrary to well-established medical ethics. *Glucksberg*, 521 U.S. at 731 (quoting American Medical Association, Code of Ethics § 2.211 (1994)); *see also Vacco v. Quill*, 521 U.S. 793, 801 n.6 (1997) (discussing medical profession's distinction between withholding treatment and assisted suicide). This rejection is firmly grounded in the potential harm the Oregon assisted suicide law poses to the lives of people with disabilities.

1. The Uncertainty of Diagnosing a "Terminal Illness"

First, the diagnosis and prognosis of a "terminal condition" – defined under the Oregon law as a condition likely to cause death within the next six months – is inherently uncertain. Timothy E. Quill *et al., Sounding Board: Care of the Hopelessly Ill*, 327 New Eng. J. Med. 1380, 1381 (Nov. 5, 1992) ("[W]e acknowledge the inexactness of such prognosis [of imminent death]"). Oregon's own reports on the implementation of its assisted suicide law confirm this uncertainty. In 2004, 60 patients were determined "terminally ill" and prescribed lethal medication, but only 35 ingested the medication. Of the 25 who did not, 12 – almost half – were still alive at the end of 2004. One patient who was prescribed medication in 2003, and thus determined to have less than six months to live, did not ingest the medication and was nevertheless still alive by the end of 2004. Oregon Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act* 12 (2005).

Assisted suicide has not been limited to persons facing imminent death. In the Netherlands, whose assisted suicide law was a model for Oregon, a governmental report confirmed that many people have been killed who did not have a "terminal" illness. Peter Van der Maas *et al.*, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 The Lancet 669, 672 (1991).[12] Similarly, only one in four of the people whom Dr. Jack Kevorkian helped commit suicide had a terminal illness; others simply had physical or neurological disabilities. Lori A. Roscoe *et al.*, *Dr. Jack Kevorkian and Cases of Euthanasia in Oakland County, Michigan, 1990-1998*, 343 New Eng. J. Med. 1735, 1736 (Dec. 7, 2000).

The medical profession's predictions of the capabilities and life spans of people with disabilities have been historically unreliable. As the National Council on Disability has reported, "people with disabilities are aware of enough instances of dramatic mistakes that many of them have a healthy skepticism of medical predictions, particularly as it relates to future life quality." *Assisted Suicide: A Disability Perspective* at 27-28. Evan Kemp, Director of the Equal Employment Opportunity Commission under President George H.W. Bush, wrote:

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[12] Not all such cases involve unintentional misdiagnosis. In one Dutch case, a court acquitted a psychiatrist who helped a physically healthy 50-year old woman – who was unquestionably not terminally ill – commit suicide. The woman had been diagnosed with leukemia and had a history of depression. Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 Issues in L. & Med. 123, 123-26 (1994).

> As a disabled person, I am especially sensitive to the "quality of life" rationale that is frequently introduced in the debate [over assisted suicide]. For the past 47 years I have lived with a progressive neuromuscular disease that first began to manifest itself when I was 12. My disease, Kugelberg Weylander Syndrome, has no known cure, and I have no hope for "recovery." Upon diagnosis, my parents were informed by the physicians treating me that I would die within two years. Later, another group of physicians was certain that I would live only to the age of 18. Yet here I am at 59, continuing to have an extraordinarily high quality of life.

Evan J. Kemp, *Could You Please Die Now?* Wash. Post, Jan. 5, 1997, at C1.

2. The Law's False Assumption that Suicide is "Rational" When Committed by a Person with a Disability

As the *Glucksberg* Court recognized, "those who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." 521 U.S. at 730.[13] The Court continued, "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Id.* For example, a study of cancer patients showed that those with depression were four times more likely to want to die. William Breitbart *et al., Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA 2907, 2909 (Dec. 13, 2000).

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[13] Ninety-five percent of those who commit suicide have been found to have a diagnosable psychiatric illness in the months preceding suicide. Herbert Hendin *et al., Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 14 (Jan. 1993).

Although the Oregon law mandates that doctors must determine that patients are "not suffering from a psychiatric or psychological disorder or depression causing impaired judgment" before prescribing lethal drugs, and must refer such patients for counseling, *see* Or. Rev. Stat. § 127.825, in practice such determinations are extremely problematic. In a survey of Oregon *psychiatrists*, over half were "not at all confident" they could assess in a single consultation whether a psychiatric condition impaired a person's judgment; only six percent were "very confident." Linda Ganzini *et al.*, *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psychiatry 595 (Apr. 2000). This is because such assessments are inherently subjective and unreliable. As one research analysis concluded:

> There is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting PAS [physician-assisted suicide]. More worryingly, there are no clinical criteria to guide such an assessment – just as there are no criteria to assess the rationality of any person's decision to commit suicide.

Brendan D. Kelly *et al.*, *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box*, 181 British J. Psychiatry 278, 279 (2002).

Perhaps for these reasons, counseling referrals in assisted suicide cases under the Oregon law are alarmingly rare. In 2004, only five percent of patients seeking assisted suicide were referred for a psychiatric evaluation. *Seventh Annual Report on Oregon's Death with Dignity Act* at 24. In the Netherlands, whose assisted suicide law similarly asks doctors to determine whether a person's judgment is impaired by a psychiatric disability, only three percent of assisted suicide patients were so referred. Kelly, *supra* at 278.

3. The Law's False Assumption that Disability Intrinsically Deprives Life of Dignity and Value

Many people identified as candidates for assisted suicide could benefit from supportive care or treatment, such as counseling, pain medication, or in-home personal assistance. These measures lessen their pain and suffering, their perceived burden on family members, or their lack of independence and choice. The National Council on Disability has found that "improving laws, policies, programs and services for people with disabilities ... would go a long way toward assuring that any self-assessment or decision about the quality of life of an individual with a disability would be made in an optimal context of independence, equality of opportunity, full participation, and empowerment." *Assisted Suicide: A Disability Perspective* at 13.

Research demonstrates the lack of this type of assistance and support, rather than any intrinsic aspect of a person's disability, is the primary motivation for suicide. For example, one study found that people who experience serious pain are no more likely to want to kill themselves than those who do not. This finding was attributed to "the quality of pain management" provided to terminal patients in the study. Breitbart, *supra* at 2910. In a study of euthanasia in the Netherlands, only ten of 187 patients listed pain as the reason they wanted to die. Van der Maas, *supra* at 672. Depression is also a condition that can be treated with therapy or counseling, which often leads the patient to withdraw his or her request to die. Kelly, *supra* at 279; Herbert Hendin *et al., Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 14, 15 (Jan. 1993).

Assisted suicide, however, assumes that a disability or medical condition inherently makes life unworthy of continuation. Its availability causes medical practitioners to ignore other measures, services and modifications that might cause someone to reconsider their desire to die. As a doctor at New York's Memorial Sloan-Kettering Cancer Center has observed, assisted suicide "runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care." Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 New Eng. J. Med. 54 (Jan. 2, 1997).

The desire to die of people with disabilities is often driven by a temporal or situational depression that arises from the perception that their lives lack value or that they are a burden on their loved ones. In a study of HIV and AIDS patients, one participant said, "I'm still inconveniencing other people who look after me and stuff like that ... No, I'd rather die." Another described himself as "a bag of potatoes to be moved from spot to spot ..." James V. Lavery *et al.*, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*, 358 The Lancet 362, 364-64 (Aug. 4, 2001).[14]

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[14] Oregon's experience also confirms these findings. Physicians who administered assisted suicide under the Oregon law were asked whether "end of life concerns" contributed to the patient's desire to die:

> In all cases, physicians reported multiple concerns contributing to the request. Eleven (41%) patients included at least four specific concerns: becoming a burden, losing autonomy, decreasing ability to participate in activities that make life enjoyable, and losing control of bodily functions. Another 15 (56%) patients included at least two or three of these concerns. Most frequently noted across all three years were loss of autonomy ... and participation in activities that make life enjoyable ... Patients have increasingly

Another study linked suicidal ideation to unnecessary institutionalization. It found that most terminally ill patients who have a sense of "fractured dignity" were inpatients, "suggesting that the degree of autonomy and independence that can be maintained in a home setting with community based care, as opposed to care enabled by an institution, is an important mediator of one's sense of dignity." This loss of dignity, and the corresponding feelings of depression and hopelessness, are "strong predictors of desire for death and suicidal ideation ..." Harvey Max Chochinov *et al.*, *Dignity in the Terminally Ill: A Cross-Sectional, Cohort Study*, 360 The Lancet 2026 (Dec. 28, 2002).

These medical findings mirror this Court's recognition of the deleterious effects of institutionalization. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Court held that unjustified institutionalization was a form of discrimination under the Americans with Disabilities Act because it "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life" and "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 600.

The question how to address the needs that underlie the desire to die, however, is typically lost in the wake of the law's "competency" determination. As one Oregon psychiatrist stated:

> The focus of competence may distract from adequate attention and resources on the

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> expressed concern about becoming a burden to family, friends or caregivers.

Oregon Department of Human Services, *Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted Suicide* 11-12 (2001).

> person and their circumstances ... we may spend thousands of dollars on assessing competence and little in care directed to the day-to-day life and morale of the person.

Ganzini, *supra* at 600. Another study concluded that the Oregon law's competency determination "do[es] not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide." Lavery, *supra* at 366.

The case of Kenneth Bergstedt exemplifies how external concerns that could be remedied drive the desire to die for people with disabilities. Mr. Bergstedt, a 30-year old Nevada man with quadriplegia, wanted to die because his father, who cared for him, was himself dying of cancer. Mr. Bergstedt, though not in physical pain, feared he would be institutionalized without his father's support. *See McKay v. Bergstedt,* 801 P.2d 617, 628, 637 (Nev. 1990); Stanley S. Herr, *No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities*, 8 Issues in L. & Med. 3, 10-13 (1992).

A psychiatric evaluation submitted to the trial court found that Mr. Bergstedt was depressed, but that this was irrelevant because "the quality of life for this man is ... forever profaned by a future which offers no relief and only the possibility of worsening." Herr, *supra* at 12. Based on his poor "quality of life," the Nevada Supreme Court upheld his decision to die. *Bergstedt,* 801 P.2d at 824-25. No consideration was given to measures that might have helped Mr. Bergstedt restore his sense of dignity and independence, such as non-institutional, in-home health care.

A dissenting Nevada Supreme Court Justice observed that "[w]ith this kind of support it is no wonder that he decided to do himself in." *Bergstedt,* 801 P.2d at 637 (Springer, J., dissenting). He added, presciently:

> It is critical that the court not put its judicial stamp of approval on negative stereotypes about disability. This would result if it were to allow the state to assist an individual to die only because he or she had a disability. Judicial decisions which are based on societal prejudices merely reinforce those prejudices, making them even more difficult to eradicate.

Id. at 836.

Because it rests on false assumptions and stereotypes of the disabled, Oregon's assisted suicide law enshrines these debilitating attitudes under the protection of state law.

4. The Difficulty in Ensuring Decisions to Die Are Not Coerced or Made By Others

Finally, evidence exists that some persons killed under assisted suicide laws may "choose" suicide under pressure from others. In the case of Kate Cheney, an 85-year old woman with cancer, her psychologist was concerned that Ms. Cheney was not competent to make the decision to die and that her daughter was unduly pressuring her to choose assisted suicide. The daughter simply obtained an opinion from a second psychologist, who determined Ms. Cheney was competent. Ms. Cheney was accordingly prescribed lethal medication and died on August 29, 1999. Evelyn Hoover Barnett, *Is Mom Capable of Choosing to Die?* The Oregonian, Oct. 16, 1999, at G1-2. A Dutch study confirmed that some people administered lethal drugs in that country did not ask to die. Van der Maas, *supra* at 672.

II. The Attorney General's Determination that Assisted Suicide is Not a "Legitimate Medical Practice" is a Permissible Construction of the Controlled Substances Act

A. The Attorney General's Interpretive Ruling is Entitled to Deference

In *Chevron U.S.A. v. Natural Resources Defense Council,* 467 U.S. 837 (1982), this Court set forth the standard under which courts must defer to an Executive Branch agency's interpretation of a statute. When Congress has authorized the agency to enforce the statute, the court must make a twofold inquiry:

> First … whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter … If, however, the court determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction of the statute, as would be necessary in the absence of administrative interpretation. Rather, if a statute is silent or ambiguous with respect to a specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-43.

The Court clarified that "permissible construction" was not "the only one [the agency] permissibly could have adopted … or even the reading the court would have reached if the question initially had arisen in a judicial proceeding." *Id.* at 843 n.11.

Under this standard, an agency's interpretative rulings "are given controlling weight unless they are arbitrary, capricious or manifestly contrary to the statute." *Id.*; *see also Barnhart v. Walton,* 535 U.S. 212, 218 (2002). Even when this standard has not been applied, this Court has nevertheless relied on "the well-reasoned views of the agencies implementing a statute," which "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance." *Bragdon v. Abbott,* 524 U.S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.,* 323 U.S. 134, 139-40 (1944)); *see also Olmstead v. L.C.,* 527 U.S. 581, 598 (1999).

Under the Controlled Substances Act, 21 U.S.C. §§ 801 – 971, Congress authorized the Attorney General to register medical practitioners to dispense controlled substances, 21 U.S.C. § 822(b), and designated the Attorney General as the officer responsible for the Act's enforcement. 21 U.S.C. § 871(a). The Attorney General may revoke such registration if he "determines that the issuance of such registration would be inconsistent with the public interest." 21 U.S.C. § 823(f). In making this determination, the Attorney General may consider, among other factors, "any conduct which may threaten the public health and safety." *Id.* Although preventing drug abuse is one of Congress' goals under the Act, its plain language does not limit itself to that goal; rather, the Act seeks to prohibit any use of prescription drugs that may have a "detrimental effect on the health and general welfare of the American people." 21 U.S.C. § 801(2).

In 1971, the Attorney General promulgated a regulation under the Act that states that prescriptions for controlled substances are valid only if issued for a "legitimate medical purpose" as part of "professional treatment." 21 C.F.R. § 1306.04(a). This Court has affirmed the validity of this regulation. *United States v. Moore,* 423 U.S. 122, 140 (1975).

Under this regulation, the Attorney General issued an interpretive ruling that assisted suicide is not a "legitimate medical practice" for "treatment" within the meaning of this regulation, thereby rendering any prescriptions made for this purpose invalid. Given the well-documented medical concerns over the harm and invidious discrimination the Oregon assisted suicide law poses to people with disabilities, *see* Sec. I, *supra,* the Attorney General's ruling is undoubtedly a valid interpretation of the Act, which does not specifically foreclose this interpretation. *Chevron,* 467 U.S. at 843; *Barnhart*, 535 U.S. at 218.

B. The "Clear Statement" Rule Does Not Apply to Regulation of the Practice of Medicine

The Court of Appeals avoided this analysis by holding that the Attorney General's directive on prescriptions for assisted suicide "interferes with Oregon's authority to regulate medical care within its borders..." *Oregon v. Ashcroft,* 368 F.3d 1118, 1124 (9th Cir. 2004). Relying on *Gregory v. Ashcroft,* 501 U.S. 452 (1990), the Appeals Court held the Attorney General had infringed on an area of law "traditionally reserved for state authority, such as regulation of medical care." *Id.* at 1125. Thus, the Court of Appeals turned the usual test for deference to agency interpretations of federal law on its head: Congress had to make a "clear statement" that it was prohibiting assisted suicide to authorize the Attorney General to act. Because it had not, the Appeals Court held, the Attorney General's ruling was invalid. *Id.* at 1125-26.

Under *Solid Waste Agency v. Army Corps of Engineers*, 531 U.S. 159 (2001), the "clear statement rule" is applied only when "an administrative interpretation of a statute invokes the outer limits of Congress' power ..." *Id.* at 172. It is clear that prohibiting prescriptions made for the purpose of assisted suicide does not place the Controlled

Substances Act outside the boundaries of Congress' Constitutional authority. Congress has always had the power, under the Commerce Clause, to regulate medication prescribed by doctors. *See Minor v. United States,* 396 U.S. 87, 98 n.13 (1969); *Reina v. United States,* 364 U.S. 507, 511 (1960); *In re Grand Jury Proceedings,* 801 F.2d 1164, 1169 (9th Cir. 1986) ("[T]he Commerce Clause empowers the federal government to regulate prescription drugs"). Indeed, given the magnitude of the discrimination posed by Oregon's assisted suicide law, *Amici* here submit that the Fourteenth Amendment, as well as the Commerce Clause, provides a basis for the Attorney General's interpretive ruling. *Cf. Tennessee v. Lane,* 541 U.S. 509, 124 S. Ct. 1978, 1989-93 (2004); *City of Cleburne,* 473 U.S. at 461 (striking down, on rational-basis grounds, law that prohibited home for people with disabilities).

The Appeals Court's underlying reasoning that regulation of the practice of medical infringes upon "a decision of the most fundamental sort for a sovereign entity," as establishing qualifications for state judges was held to be in *Gregory,* 501 U.S. at 460, is patently flawed. There is no support, legal or otherwise, for the Appeals Court's conclusion that regulating the practice of medicine "go[es] to the heart of representative government." *Id.* at 461 (quoting *Sugarman v. Dougall,* 413 U.S. 634, 647 (1973)). *See e.g. Equal Employment Opportunity Comm'n v. Massachusetts,* 987 F.2d 64, 67 (1st Cir. 1993) (distinguishing *Gregory* because "[t]he Missouri constitutional provision was concerned, *not with regulating health care*, but with ensuring the qualifications of the highest state officials.") (emphasis added).

If any federal restriction on the practice of medicine infringed upon a "fundamental" state function, it would call into question Congress' entire regulatory scheme for prescription medication, which has been in effect for three decades and has been repeatedly upheld and enforced. *See*

Moore, 423 U.S. at 139. Indeed, it is difficult to understand how the practice of medicine could be considered solely a state function, given that the federal government has regulated in this area for at least the past 67 years. *See e.g.* Food, Drug and Cosmetic Act, 21 U.S.C. §§ 301-397.

The Court of Appeal's holding is of significant concern to *amici* beyond its implications for assisted suicide. Congress and federal agencies often regulate "medical care" to prevent abuse of or discrimination against people with disabilities. If every decision affecting the medical practice were within a state's sovereign power and subject to the "clear statement" rule, Congress' ability to prohibit states from sanctioning disability discrimination in the medical field would be severely undermined.

For example, in *Olmstead,* this Court held that the unnecessary institutionalization of people with disabilities by states was discrimination under Title II of the Americans with Disabilities Act (ADA). Although Title II's definition of discrimination did not explicitly identify unnecessary institutionalization, the Court relied in part upon the Attorney General's regulations and interpretations of the Act in discerning Congress' intent. 527 U.S. at 598. Although this interfered with a "medical" decision approved under state law (and carried out by the State itself), it was nevertheless understood as appropriate federal action. *Id.* [15]

Similarly, in *Bragdon,* this Court ruled that a patient with HIV could bring a claim under Title III of the ADA against a dentist who refused to serve him because of his disability. 524 U.S. at 647. The Court relied on agency determinations that Congress had intended to cover persons

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[15] *Atascadero State Hosp. v. Scanlon,* 473 U.S. 234 (1985), while involving the rights of institutionalized people with disabilities, is distinguishable because it involved a state's waiver of sovereign immunity under the Eleventh Amendment, not the underlying challenged practices in the institution. *Id.* at 242.

with HIV under Title III, which applied to medical practitioners. Although this decision involved Congressional regulation of the practice of dentistry, this Court did not invoke the "clear statement" rule or find that Title III encroached upon a "fundamental" state function. *Id.* at 642.[16]

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to reverse the Court of Appeals' decision and affirm the Attorney General's interpretive ruling.

Respectfully submitted,

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[16] In the District Court below, the defendant dentist challenged application of Title III to him on grounds that "the practice of dental medicine is an area of law reserved to the states, and thus beyond the scope of Congress' Commerce Clause authority." *Abbott v. Bragdon,* 912 F. Supp. 580, 592 (D. Me. 1995), *aff'd,*, 107 F.3d 934 (1st Cir. 1997), *vacated & remanded on other grounds*, 524 U.S. 624 (1998). The Court rejected this proposition and held Congress could regulate defendant's dental practice because it was "an economic enterprise". *Id.* at 593-94 & n.15.