State of New Mexico

Interim Legislative Health and Human Services Committee Informational Hearing on *Morris v NM*, and Aid in Dying in NM.

November 8, 2013
Remarks of Kathryn L. Tucker, J.D.

Chair and Members of the Committee, thank you for allowing me to share information with you this morning.

## I. *Morris v NM* and Aid in Dying in NM

I am Kathryn Tucker, Director of Legal Affairs and Advocacy with Compassion & Choices, and Co-Counsel to the plaintiffs in *Morris v New Mexico*.[1] A description of my 2 decades of work relating to protecting and expanding the rights of terminally ill patients and the work of Compassion & Choices is provided below in Part II. A brief overview of the great body of data and research demonstrating that when aid in dying is an openly available option, patients are benefitted, suffer no harm, and end of life care is improved is provided in Part III. I appreciate the opportunity to speak today about *Morris v New Mexico*, what the case seeks to establish, the status of the case, and what might be expected in the wake of a decision in plaintiffs' favor.

Aid in dying refers to the practice of a physician providing a prescription to a mentally competent terminally ill patient which the patient may ingest to achieve a peaceful death if he or she finds their dying process unbearable.

*Morris* is brought by 2 physicians who treat cancer patients and a cancer patient, asking the court to recognize that physicians who provide a prescription for aid in dying to patients who request it are not subject to criminal prosecution.

The case includes 2 kinds of claims: Statutory and Constitutional. The statutory claim argues that the NM statute making a crime of assisting suicide, NMSA § 30-2-4, says nothing about the conduct of a physician providing aid in dying to a mentally competent terminally ill patient, that the choice of such a patient for a peaceful death is no sort of "suicide", and thus a physician

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[1] My Co-Counsel is Laura Ives, Legal Director of the New Mexico ACLU.

prescribing for aid in dying would not be subject to prosecution under the "assisted suicide" statute.

Should the court find the statute encompasses aid in dying, Plaintiffs argue that it is constitutionally impermissible to prohibit patients from choosing this option. Plaintiffs assert that if the term "suicide," as used in New Mexico Assisted Suicide Statute, is interpreted to include the action of a physician who provides aid in dying, then the statute

- Is impermissibly vague, depriving Plaintiffs of due process of law in violation of the Due Process Clause of the New Mexico Constitution.
- Violates patient rights to privacy and other fundamental liberties without due process of law in violation of the Due Process Clause of the New Mexico Constitution.
- Deprives patients' who seek aid in dying equal protection in violation of the New Mexico Constitution.
- Constitutes a deprivation of the freedom of speech guaranteed in the New Mexico Constitution.
- Deprives patients' of the inherent and inalienable right to seek safety and happiness in violation of the New Mexico Constitution.

If the court finds for plaintiffs on statutory grounds, the practice of aid in dying can emerge governed by guidance in the court's decision and by professional practice standards. [2]

In the wake of a statutory victory, those opposed to aid in dying might seek to outlaw the practice by introducing legislation sufficiently specific to prohibit it.[3]

In addition, in the wake of such a ruling, those supportive of aid in dying might seek to provide additional clarity to physicians about protection from civil and disciplinary sanction, in addition to protection from criminal sanction, by enacting legislation to create a clear 'safe harbor' for physicians.[4]

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[2] Should plaintiffs prevail on statutory grounds, the situation in NM will be much like in Montana in the wake of a ruling by the Montana Supreme Court in 2009, recognizing the right of Montanans to choose aid in dying . *Baxter v. Montana*, 224 P.3d 1211(Mont. 2009).

[3] Prohibitory legislation was introduced in Montana in the wake of *Baxter* in two successive legislative sessions. No such legislation was enacted.

[4] Regulatory and 'safe harbor' legislation was proposed in Montana following *Baxter*, but was not enacted. The practice of aid in dying in Montana is governed by the *Baxter* decision and professional practice standards..

Should the court rule for plaintiffs on constitutional grounds, the ability to constrain access to aid in dying through legislation would be considerably more limited and subject to constitutional bounds. Any restriction would need to show a rational relationship to a legitimate state interest, that it furthers an important state interest, and that it is the least restrictive means of advancing a compelling state interest.

This case is set for trial the week of December 9, 2013.[5] We anticipate a 4 day trial. It is likely that the trial court decision will be appealed and that the case will ultimately likely be decided by the New Mexico Supreme Court.

## II. INTRODUCTION OF KATHRYN TUCKER, JD, AND COMPASSION & CHOICES

Kathryn Tucker is an attorney and serves as Director of Legal Affairs and Advocacy for Compassion & Choices. She also serves as an Adjunct Professor of Law at Loyola Law School/Los Angeles, where she teaches Law, Medicine and Ethics at the End of Life. She has previously held appointments as Adjunct Professor of Law at the University of Washington, Seattle University and Lewis & Clark Schools of Law. She is Co-Counsel to the patient and physicians in the case known as *Morris v New Mexico*.

Compassion & Choices(C&C) is a national nonprofit organization with a proven record of protecting and expanding the rights of terminally ill patients. C&C advocates strongly on behalf of terminally ill persons to ensure that their wishes, whether for curative treatment, palliative care or to cease life-prolonging treatment, will be respected.

Compassion & Choices has been in the forefront of efforts to:

- Ensure that terminally ill patients are able to receive adequate pain and symptom management;[6]

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[5] The State has filed a motion to dismiss, which plaintiffs have opposed. The court has not yet heard argument on this motion nor issued any ruling.

[6] For example, Compassion & Choices developed and litigated the first case in the nation to establish that failure to treat pain associated with terminal illness constitutes elder abuse, holding the provider accountable. *Bergman v Eden Medical Center*, No. CH205732-1 (Cal. Sup. Ct., June 13, 2001). Compassion & Choices has litigated a number of other cases seeking accountability for inadequate pain and symptom management. See Kathryn Tucker, *Medico-Legal Case Report and Commentary: Inadequate Pain Management in the Context of Terminal Cancer. The Case of Lester Tomlinson*, 5 PAIN

- Provide comprehensive counseling regarding end-of-life options;[7]
- Ensure that patient wishes are respected;[8]
- Bring accountability in instances where inadequate or inappropriate end-of-life care was provided;[9]
- Expand end-of-life choice to include palliative sedation[10] and aid in dying.[11]

Ms. Tucker's involvement with aid in dying dates back to her service as Campaign Counsel to the Washington Citizens for Death with Dignity campaign in 1991, the first time Washington State considered enacting a measure to permit aid in dying. She subsequently served as lead counsel representing patients and

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MED. 214, 215 (2004); *Tolliver v. Visiting Nurse's Ass'n of Midlands,* 771 N.W.2d 908, 911 (Neb. 2009); *Hargett v Vitas*, No. RG10547255 (Cal. Super. Ct. July 6, 2011). Compassion & Choices drafted and sponsored landmark legislation requiring that physicians obtain Continuing Medical Education in pain and symptom management. CAL. BUS. & PROF. CODE § 2190.5 (West 2011); Compassion & Choices brought landmark federal cases establishing that dying patients have the right to aggressive pain management, including palliative sedation.*Vacco v. Quill, 521 U.S. 793(1997); Washington v. Glucksberg*, 521 U.S. 702(1997).

[7] Compassion & Choices drafted and sponsored introduction of statues requiring comprehensive counseling regarding end-of-life options. See, California Right to Know End-of-Life Options Act, CAL. HEALTH & SAFETY CODE §442.5; New York Palliative Care Information Act, N.Y. PUB. HEALTH LAW § 2997-c.

[8] For example, Compassion & Choices is pursuing accountability for failure to honor a patient's wishes as documented in a POLST, *DeArmond v Kaiser,* No. 30-2011-00520263 (Superior Court, Orange County, CA). In another case, Compassion & Choices represented a family in bringing into the public eye a situation where patient wishes to forego food and fluid were obstructed. See Span,"Deciding to Die, Then Shown the Door," *The New York Times*, Aug. 24, 2011, available at http://newoldage.blogs.nytimes.com/2011/08/24/deciding-to-die-then-shown-the door/? ref=health; Uyttebrouck, "Couple Transported Out of Facility After Refusing Food," *Albuquerque Journal*, Jan. 08, 2011, available at http://www.abqjournal.com/news/metro/08232859metro01-08-11.htm.

[9] See supra n. 6, Bergman, Tomlinson, Tolliver, Hargett; See supra n. 8, DeArmond.

[10] *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill,* 521 U.S. 793(1997); *Hargett v Vitas*, No. RG10547255 (Cal. Super. Ct. July 6, 2011).

[11] Compassion & Choices brought two federal cases to the United States Supreme Court urging recognition of a federal constitutional right to choose aid in dying. *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill, 521 U.S. 793(1997).* Compassion & Choices was in leadership in the campaigns to enact the Death with Dignity Acts in Oregon and Washington. OR. REV. STAT. § 127.800 (2007); WASH. REV. CODE ANN. § 70.245 (West 2011), and most recently was involved in the process to enact the Patient Choice at End of Life Act in Vermont in 2013. Compassion & Choices brought a landmark state statutory and constitutional case establishing the right to choose aid in dying in Montana. *Baxter v. Montana*, 224 P.3d 1211(Mont. 2009).

physicians in two landmark federal cases decided by the United States Supreme Court, *Washington v. Glucksberg* and *New York v. Quill*, asserting that mentally competent terminally ill patients have a constitutional right to choose aid in dying. The Supreme Court declined, at that time, to recognize a federal constitutional right to aid in dying, though reserving the possibility it might do so in future, and inviting the states, in the first instance, to grapple with this issue. Several states have done so.

The *Glucksberg* and *Quill* cases are widely acknowledged to have prompted much-needed attention to improving care of the dying, and to have established a federal constitutional right to aggressive pain management, including palliative sedation.

Ms. Tucker has also represented doctors and terminally ill patients in cases raising claims of a similar nature, including *Baxter v. Montana*, in which the Montana Supreme Court upheld the right of terminally ill Montanans to choose aid in dying.[12]

C & C has been a steward of implementation of the Death with Dignity Acts in Oregon and Washington and is now taking on that role in Vermont . Ms. Tucker was involved in the successful defense of the Oregon Death with Dignity Act from attack by the United States Department of Justice in *Oregon v. Gonzales.* [13]

## III. THE EXPERIENCE WITH AID IN DYING

The reality of modern medicine is that the dying process can be prolonged to a point where some patients, even with excellent pain and symptom management, find themselves trapped in suffering they experience as intolerable. For some of these patients having the option of aid in dying affords great comfort.

A great body of data collected in Oregon, where aid in dying has been openly available for more than 15 years, shows how the availability of aid in dying impacts end-of-life care, the patients who choose it and the practice of medicine.

Oregon's experience with aid in dying demonstrates that the option does not put patients at risk,[14] as evidenced by a comprehensive report that examined the

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[12] *Baxter v. Montana*, 224 P.3d 1211, 1214, 1222 (Mont. 2009).

[13] *Gonzales v. Oregon,* 546 U.S. 243, 275 (2006). *See also* Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law*, 2 NAT'L ACAD. ELDER L. ATT'YS. J. 291(2006).

[14] *See* Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands:Evidence Concerning the Impact on Patients in 'Vulnerable' Groups*, 33 J. MED. ETHICS 591, 593-95 (2007); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act*, 285 J. AM. MED. ASS'N 2363, 2368 (2001); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote:The Silver Lining*, 124 ANNALS INTERNAL

Oregon experience to assess whether vulnerable populations were at risk and concluded that there was no evidence of this.[15]

The Oregon data shows that the dire predictions of those initially opposed to the Dignity Act were unfounded, and that the option of aid in dying has not been unwillingly forced upon those who are poor, uneducated, uninsured or otherwise disadvantaged.[16] In fact, the data shows just the opposite: For example, the reports reflect that patients choosing aid in dying have a high level of education,[17] are overwhelmingly insured (100% of patients opting for aid in dying had either private health insurance, Medicare or Medicaid), and almost all (97%) were enrolled in hospice care.[18] Furthermore, the data demonstrates that aid in dying is rare: During the first fifteen years this option was openly available in Oregon, only 673 patients chose it.[19] Further, interestingly, more than one-third of patients who complete the process of seeking medications for aid in dying do not go on to

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MED. 267, 267–69 (1996); Quill & Cassel, Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide:A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208, 209 (2003); Kathryn A. Smith et al., *Quality of Death and Dying in Patients who Request Physician-Assisted Death*, 14 J. PALLIATIVE MED. 445, 446-47 (2011); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & CIV RTS. L. REV. 475, 479, 482 (2006); American Public Health Association, *APHA Policy on Patient Self-Determination at the End of Life* (2008) (During the policy development and consideration process at APHA, the Disability Section of that organization argued against adoption of the policy, claiming that it would put persons with disabilities at risk. This argument was thoroughly considered; indeed, it prompted APHA to consider the policy over a two-year policy cycle rather than a single-year cycle. After careful, evidence-based consideration of those arguments, the health policy professionals at APHA ultimately rejected them as unconvincing and adopted its policy in support of aid in dying.) Observers outside the U.S. examining the experience in the U.S. with an open practice of aid in dying have also found no evidence of harm. See, the Royal Society of Canada Expert Panel on End-of-Life Decision Making (RSC EOL Panel) ( Nov. 2011) ( "Despite the fears of opponents, it is also clear that the much-feared slippery slope has not emerged following decriminalization, at least not in those jurisdictions for which evidence is available. Nor is there evidence to support the claim that permitting doctors to participate in bringing about the death of a patient has harmed the doctor/patient relationship. What has emerged is evidence that the law is capable of managing the decriminalization of assisted dying and that state policies on this issue can reassure citizens of their safety and well-being." @ p. 90). A Canadian court, in considering a case about end of life choice, examined extensive data from the practice in the US with aid in dying and adopted factual findings that there was no evidence of risk or harm to patients, or to vulnerable populations including specifically persons with disabilities. *Carter v. Canada,* 2012 BCSC 886, Vancouver Registry, Docket Number S112688)(appeal pending).

[15] Battin et al., *supra.*

[16] Arthur Chin et al., *Oregon's Death with Dignity Act:The First Year'sExperience*, OR. HEALTH AUTH. 1999, at 7, *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf. "Patients who chose physician-assisted suicide were *not* disproportionately poor (as measured by Medicaid status), less educated, lacking in insurance coverage, or lacking in access to hospice care." *Id.*; Battin et al., *supra* at 591; Kant Patel, *Euthanasia and Physician-Assisted Suicide Policy in The Netherlands and Oregon: A Comparative Analysis*, 19 J. HEALTH SOC. POL'Y 37, 51-52 (2004) (finding no empirical evidence of slippery slope in Oregon, but more potential for a slide in the Netherlands). See APHA policy, Supra

[17] *See e.g.*, Or. Dept. of Human Servs., *Annual Report on Annual Oregon's Death With Dignity Act*, OR. HEALTH AUTH., at 2, *available at* http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. [hereinafter Annual Reports].

[18] *Id.*

[19] *Id.*

consume them.[20] Deriving comfort from having the option to control their time of death, these patients ultimately die of their disease without exercising that control.[21]

Overall, observers studying aid in dying in Oregon have concluded that the law poses no risk to patients. Leading scholars have concluded: "I [was] worried about people being pressured to do this ... But this data confirms ... that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy."[22]

Indeed, rather than posing a risk to patients or the medical profession, the availability of aid in dying galvanized significant improvements in the care of the terminally ill in Oregon. Oregon physicians report that since aid in dying has been openly available, they have worked hard to improve end-of-life care, taking educational courses in how to treat pain associate with terminal illnesses, how to recognize depression and other psychiatric disorders, more frequently referring patients to hospice, and making such referrals earlier.[23] Surveyed on their efforts to improve end-of-life care since aid in dying became available, 30% of physicians reported increased referrals to hospice care, 76% had made efforts to improve their knowledge of pain management.[24] Hospice nurses and social workers observed an increase in physician knowledge of palliative care and willingness to refer to hospice.[25]

The availability of the option of aid in dying has significant psychological benefits for both the terminally ill and the healthy.[26] The availability of the option

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[20] *See Annual Reports.*

[21] *Id.*

[22] William McCall, *Assisted-suicide Cases Down in '04; 37 Terminally Ill Oregonians Took Lethal Drug Doses*, THE COLUMBIAN, Mar. 11, 2005, at C. (quoting Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania School of Medicine). *See also* Straton, *supra* at 482.

[23] *See* Ganzini *et al.*, *supra*, at 2363, 2367-68; Lee & Tolle, *supra*, at 267-69; Quill & Cassel, *supra*; Lawrence J. Schneiderman, *Physician-Assisted Dying*, 293 J. AM. MED. ASS'N 501 (2005) (reviewing *PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE* (Timothy E. Quill, & Margaret P. Battin eds., 2004.) ("Indeed, one of the unexpected yet undeniable consequences of Oregon's Death with Dignity Act permitting physician aid in dying is that 'many important and measurable improvements in end-of-life care' occurred following the Act's implementation. Rather than becoming the brutal abattoir for hapless patients that some critics predicted, the state is a leader in providing excellent and compassionate palliative care.")

[24] Ganzini et al., *supra,* at 2363.

[25] Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past 5 Years,* 1 PALLIATIVE &SUPPORTIVE CARE 215, 218 (2003).

[26] Kathy L. Cerminara & Alina Perez, *Empirical Research Relevant to the Law:Existing Findings and Future Directions, Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL. PUB. POL'Y & L. 503, 512–13 (2000).

gives the terminally ill autonomy, control and choice, the overwhelming motivational factor behind the decision to request aid in dying.[27] Healthy Oregonians know that if they are confronted by a dying process they find unbearable, they have this additional end-of-life option. Survivors of patients who choose aid in dying suffer none of the adverse mental health impacts commonly experienced by survivors of those who commit suicide.[28]

Leading medical and health policy professional organizations which have taken a careful, evidence-based review of the experience in Oregon have adopted policy supportive of aid in dying, including the American Public Health Association, the nation's oldest and largest organization dedicated to protecting the public health of the nation.[29] The Oregon experience has caused even staunch opponents to acknowledge that continued opposition to aid in dying can only be based on personal, moral or religious grounds.[30]

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[27] *Id.* (data from Oregon justifies optimistic view); Smith et al., *supra*, at 445, 449. *See also* Linda Ganzini et al., *Oregon Physicians' Perceptions of Patients who Request Assisted Suicide and Their Families*, 6 J. Palliative Med. 381, 381 (2003) (finding physicians receiving requests for lethal medication perceive patients as wanting to control their deaths); Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, 347 New Eng. J. Med. 582, 582 (2002) (showing nurses and social workers rated desire to control circumstances of death as most important reason for requesting aid in dying).

[28] Linda Ganzini et al. Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying, 38 Journal of Pain and Symptom Management 807 (2009).

[29] *See* Am. Pub. Health Ass', *Patients' Rights to Self-Determination at the End of Life*, Pol'y Statement Database (Dec. 28, 2008) http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372 ("A small fraction of dying people confront a dying process so prolonged and marked by such extreme suffering that they determine hastening impending death to be the best alternative. Many Americans believe that the option of death with dignity should be open to those facing a terminal illness marked by extreme suffering."); Am. C, Legal Med.Policy on Aid in Dying (2008) ("[T]he ACLM recognizes patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death . . . ."); Am. Med. Student Ass'n 71, *available at* http://www.amsa.org/AMSA/Homepage/About/AMSAConstitution.aspx (follow "2011 AMSA Constitution, Bylaws and Internal Affairs" hyperlink) (last visited Jan. 13, 2012); Am. Med. Women's Ass'n, American Medical Women's Association Position Paper on Aid in Dying ¶¶ 1-2 (2007), *available at* http://www.amwa-doc.org/page3-8/PositionStatements (follow "Aid in Dying" hyperlink under "Ethical Issues" heading) (supporting the passage of aid-in-dying laws which empower mentally competent, terminally ill patients and protect participating physicians, such as that passed in Oregon, the Oregon Death with Dignity Act). See also, Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 Harv. Health Pol'y Rev. 45 (2009).

[30] Daniel E. Lee, *Physician-Assisted Suicide:A Conservative Critique of Intervention*, Hastings Ctr. Rep. 1, 1, 4 (2003).