IN THE SUPREME COURT OF THE STATE OF MONTANA
Case No. DA 09-0051

ROBERT BAXTER, STEVEN STOELB, STEPHEN PECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES.,

Plaintiffs-Appellees,

v.

STATE OF MONTANA and STEVE BULLOCK,

Defendants-Appellants

On Appeal from the Montana First Judicial District Court
The Honorable Dorothy McCarter

AMICUS BRIEF OF THE DISABILITY*AMICI CURAIE*: NOT DEAD YET, ADAPT, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, NATIONAL COUNCIL ON INDEPENDENT LIVING AND NATIONAL SPINAL CORD INJURY ASSOCIATION IN SUPPORT OF APPELLANTS THE STATE OF MONTANA AND STEVE BULLOCK

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STATEMENT OF ISSUES PRESENTED FOR REVIEW

The District Court held that the application of the homicide statutes to physician-assisted suicide was unconstitutional because the Plaintiffs had a right in Montana's Constitution to obtain lethal drugs, what the District Court euphemistically labeled "aid in dying," a/k/a assisted suicide and euthanasia. The Disability *amici curiae*, five national disability organizations, with Montana members, support the state's appeal that Montana's homicide statutes applied to physician-assisted suicide do not violate any Montana constitutional provisions.

This case does not concern the settled issue of the individual's right to refuse treatment, even if it might result in death. Certainly, people have a "right to die" by removing life supports and letting nature take its course. This case concerns only whether there is a Montana constitutional right to have active "assistance" in committing suicide. Before this Court is the question of the affirmative involvement of third parties – doctors.

Were this Court to uphold the District Court's decision, it would also soon face a number of related issues in future cases:

- Why should the Constitutional right be limited to providing only lethal medications? Why not lethal injections? What if the lethal medication does not work quickly enough? Why not assistance smothering the person?
- If such a constitutional right exists, why should a person's right be limited to "aid" only from doctors? What about family members, friends, assisted suicide advocates?
- Why should it be limited to only people who have a disabling condition that is labeled "terminal?" Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?

STATEMENT OF THE CASE

Plaintiffs claim that "competent terminally ill" patients must be permitted the assistance of physicians to obtain and (presumably) self administer a lethal dose of drugs, based on rights of individual privacy, personal dignity, and equal protection which are granted in the Montana constitution.

Whether there is a Montana constitutional right to "assisted suicide" must be addressed and understood from the perspective of the only class of people who will be adversely affected and impacted were such a right to be found — people with disabilities. Your *amici* represent a very broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people whose disabilities were from birth or acquired during our lifetimes. Many are now or at some point have been labeled “terminal” by a physician. Many have had doctors threaten to remove life sustaining treatment on an involuntary basis and have had to fight to receive continued care.

Many people who favor legalization of assisted suicide object to the involvement of disability rights organizations in the public debate. After all, they say, assisted suicide is about terminal illness, not disability.

People who are labeled "terminal," based on a medical prediction that they will die within six months, are invariably disabled. Furthermore, virtually all "end-of-life care" issues — access to competent health care, adequate pain relief, in-home personal care, peer counseling, family support — have been disability rights issues for decades.

In fact, although intractable pain has often been given as the primary reason for enacting assisted suicide laws, the reasons doctors actually report for issuing lethal prescriptions are the patient's "loss of autonomy" and "feelings of being a burden" and that "[p]atients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors."[1]

Major issues include the inadequacy of symptom control, difficulties in the person's relationships with family, and psychological disturbances, especially grief, depression, anxiety.[2]

> *'The desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self. . . . Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: "I'm inconveniencing, I'm still inconveniencing other people who look after me and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't, I wouldn't. No, I'd rather die.""*[3]

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[1] William Breitbart, MD, Barry D. Rosenfeld, PhD & Steven D. Passik, PhD, Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients, Am J Psychiatry 1996; 153:238-242.

[2] Block SD & Billings JA, Patient requests to hasten death. Evaluation and management in terminal care, Archives of Internal Medicine. 154(18):2039-47, 1994 Sep 26.

[3] James V. Lavery, B.M. Dickens, H. Maclean, & P.A. Singer (2001). Origins of the desire for euthanasia and assisted suicide in people with HIV-1 or AIDS: A qualitative study. Lancet, 358 (9279), 362-7. See also, Dr. E. Emanuel, Chairman, Bioethics Department at the Clinical Center of the National Institutes of Health, was reported to have challenged "a common stereotype of patients expressing interest in euthanasia. In most cases, he found, the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones." Robert Pear, A Hard-Charging Doctor on Obama's Team, N.Y. Times, April 18, 2009 at A14.

These are quintessential disability issues, and your disability *amici* are here to say that these feelings are not inevitable, that their causes can be successfully addressed and that, most importantly, these emotions do not justify a lethal response.

Assisted suicide empowers doctors to decide who is eligible – whose condition is "terminal" and whose desire to commit suicide is "rational" – in the context of our current health-care system, a system with no constitutional or even statutory right for patients to receive health services, with profit motives of insurance and managed care companies, as well financial and other pressures on family members and individuals. With these interests at play, the risks of subtle and even blatant coercion are great.

No one, whether disabled or currently able-bodied, is immune from the pervasive societal assumptions that affix to the disability label. Fear, bias, and prejudice against disability are inextricably intertwined in these assumptions and play a significant role in assisted suicide. Our society values and desires "healthy" bodies and minds. The idea that any person with a disability could be a happy, contributing member of society, a vibrant family member, is outside the experience or mind-set of most non-disabled persons. Severe disability is viewed as worse than death, thus justifying carving out the deadly exception to laws for suicide prevention and laws against homicide. These views and assumptions are strongly opposed by people with disabilities.

Assisted suicide advocates use the term "death with dignity" to justify assisted suicide, but when asked what "indignities" concern them, they invariably describe the need for assistance in daily activities like bathing and toileting, and other disability realities, as reasons everyone should accept for setting up a societal double standard for who gets suicide assistance while everyone else gets suicide prevention. Like derogatory racist and sexist language, the equation of disability and indignity is anti-disability, or "able-ist," thinking. Not surprisingly, these negative assumptions are sometimes shared by people whose disability status has not been life-long, but has been acquired by traumatic accidents and chronic diseases. However, people with disabilities rate our own quality of life as high or higher than the general public rates their own.[4]

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[4] 60% of paraplegics reported feeling more positively about themselves since becoming disabled (C Ray & J West, Social, Sexual and Personal Implications of Paraplegia, Paraplegia, Paraplegia, vol. 22, 75-86 (1984); 86% of spinal cord injured high-level quadriplegics rated their quality of life as average or better than average. Only 17% of their emergency-room doctors, nurses, and technicians thought they would have an average or better quality of life if they acquired quadriplegia (KA Gerhart et al., Quality of Life Following Spinal Cord Injury; Knowledge and Attitudes of Emergency Care providers, Annals of Emergency

STATEMENT OF THE STANDARD OF REVIEW

The District Court granted summary judgment in this matter based on both findings of fact and conclusions of law. Your *amici* assert that assisted suicide constitutes unlawful discrimination as a matter of law. However, if this is not viewed as dispositive, numerous factual matters cannot be resolved without trial.

SUMMARY OF ARGUMENT

There is no legitimate state interest, let alone a compelling one, for finding a constitutional right to assisted suicide for all or some (e.g. “terminal”) people with disabilities. It degrades the value and worth of people with disabilities and violates the antidiscrimination rights, protections and mandates of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq*.

ARGUMENT

I. ASSISTED SUICIDE SERVES NO LEGITIMATE PURPOSE NOR A COMPELLING MONTANA STATE INTEREST, BECAUSE IT DISCRIMINATES AGAINST AND DEGRADES THE LIVES OF PEOPLE WITH DISABILITIES

Medicine, 1994, vol. 23, 807-812). No differences were found between 190 physically disabled persons and 195 "able bodied persons on ratings of life satisfaction, frustration with life or mood (P Cameron et al., Journal of Consulting and Clinical Psychology, 1973, vol. 41, 207-214).

A. The District Court Decision Will Deny People with Disabilities the Benefits of Suicide Prevention Protections

Assisted suicide singles out some people with disabilities, those labeled “terminal” or very severely impaired, for different treatment than other suicidal people receive. This lethal discrimination is viewed as justified based on the mistaken belief that a severe disability – which may cause, for example, use of a wheelchair or incontinence, or may require assistance bathing, eating, or toileting – is worse than death.

The District Court’s decision, immunizing physicians for assisting the suicides of persons with "terminal" disabilities or conditions, turns on its head the general assumption that suicide is irrational and is a “cry for help.” For certain people who are disabled, suicide will be viewed as understandable and acceptable. According to assisted suicide advocates, an incurable disability is sufficient for eligibility, while others require a “terminal” label, however unreliable and slippery such predictions may be. The ruling permits doctors to affirmatively facilitate suicide, an act that would be a crime but for the person's disability. Persons with severe health impairments will be denied the benefit of Montana’s suicide prevention laws and programs. Mo. Rev. Stat. §630.900. Indeed, the District Court’s holding guarantees these suicide attempts will succeed - unlike those of the majority of other persons with suicidal ideation who are not disabled. A practice that the State would otherwise expend public health resources to prevent is instead actively facilitated as long as the person has a "terminal" or disability label.

The United States Supreme Court has recognized that suicide is a practice that American society actively discourages through laws and prevention programs. Washington v. Glucksberg, 521 U.S. 702, 711 (1997). By asserting 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 a disabled person's life.

For *amici*, perhaps no other attitude strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, surrounding barriers and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living.[5] As the U.S. Supreme Court has recognized:

> The State's interest here [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled

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[5] *See* Carol J. Gill, Suicidal Intervention for People with Disabilities: A Lesson 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.")

> 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.[6]

B. Assisted Suicide and Euthanasia 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-sanctioned discrimination against the disabled. The Supreme Court has acknowledged that at least one of the forms of this discrimination, the practice of withholding lifesaving medical assistance by medical professionals from children with severe disabilities, demonstrates a "history of unfair and often grotesque mistreatment" arising from a legacy in this country of "prejudice and ignorance" and continuing well into the 20th century.[7]

Throughout history, state officials, with the support of the medical community, have authorized the sterilization of people with disabilities.[8] People with disabilities were placed in "massive custodial institutions ... built to

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[6] Glucksberg, 521 U.S. at 732.

[7] City of Cleburne, Texas v. Cleburne Living Center, 105 S. Ct. 3249, 3262 (1985) (Stevens, J., joined by Burger, C.J., concurring), 3266 (Marshall, joined by Brennan & Blackmun, JJ., concurring).

[8] Buck v. Bell, 274 U.S. 200, 207 (1927).

warehouse the retarded for life; the aim was to halt reproduction of the retarded and 'nearly extinguish their race.'"[9]

Such attitudes, unfortunately, are not completely in the past.[10] Prominent ethicists such as Peter Singer of Princeton University have advocated 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.[11]

C. Denying People with Disabilities the State Benefit of Suicide Prevention and Enforcement of Homicide Laws Will Violate the ADA

Congress clearly understood this history when, in 1990, it enacted the ADA, the basic civil rights statute for people with disabilities. After extensive hearings, Congress made several Findings, including:

> historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination continue to be a serious and pervasive social problem;

42 U.S.C. Sections 12101(a)(2).

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[9] City of Cleburne, 105 S.Ct at 3265-66 (Marshall, J., concurring & dissenting) (citations omitted).

[10] See 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)).

[11] Peter Singer, Rethinking Life and Death: The Collapse of Our Traditional Ethics 197-98 (1994).

To address and remedy this pervasive and relentless discrimination, Congress substantively required that "no qualified individual with a disability shall . . . be excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity...." 42 U.S.C. § 12132. See 28 C.F.R. section 35.130(b)(discrimination includes denying or not affording an opportunity for people with disabilities to benefit from services either equal to or as effective as those afforded nondisabled persons).

Providing assisted suicide only for people with disabilities and denying them suicide prevention services, based on a doctor's prediction of terminal status or other justification, violates the ADA because the presence or absence of disability determines whether state and local governments:

- enforce laws requiring health professionals to protect individuals who pose a danger to themselves;
- respond to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities;
- investigate and enforce abuse and neglect and homicide statutes in cases reported as assisted suicides.

The doctor's determination of someone's eligibility for assisted suicide confers absolute legal immunity on the doctor, and all normal suicide-related procedures are set aside. The existence of a disability should never be the basis for these distinctions.

D. Assisted Suicide Serves No Legitimate Public Interest Because the Threat It Poses to People with Disabilities Is So Great

As the Supreme Court has recognized, assisted suicide is contrary to well-established medical ethics.[12] This rejection is firmly grounded in the potential harm the lower court's decision poses to the lives of people with disabilities.

1. The Uncertainty of Diagnosing a "Terminal Illness"

The diagnosis and prognosis of a "terminal condition" is inherently uncertain.[13] Because terminal conditions are so often misdiagnosed, the lower court's decision opens the door to assisted suicide to many people with disabilities who are not terminally ill. The medical profession's predictions of the capabilities and life spans of people with disabilities have been historically unreliable. The

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[12] Glucksberg, 521 U.S. at 731 (quoting American Medical Association, Code of Ethics section 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).

[13] 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]").

risks to newly disabled people, such as those with significant spinal cord injuries, are particularly great. 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."[14] Evan Kemp, Director of the Equal Employment Opportunity Commission under President George H.W. Bush, wrote:

> 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.[15]

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

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[14] National Council on Disability, Assisted Suicide: A Disability Perspective at 27-28.

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

U.S. at 730. The Court continued, "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." Id. Pain is rarely the reason people consider assisted suicide. Most people do so because they fear they will be dependent and a burden on their families. A study of cancer patients showed that those with depression were four times more likely to want to die.[16]

In a survey of 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."[17] 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]….[T]here 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. [18]

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[16] See William Breitbart et al., Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907, 2909 (Dec. 13, 2000).

[17] Linda Ganzini et al., Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists, 157 Am. J. Psychiatry 595 (Apr. 2000).

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

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 consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, or 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." <u>Assisted Suicide: A Disability Perspective</u> 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. Assisted suicide, however, assumes that a medical condition inherently makes life unworthy of continuation. Its availability causes medical practitioners to ignore other measures and services 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."[19]

The question how to address the psychological and social needs that underlie the desire to die, however, is typically lost in a simplistic mental "competency" determination. “The focus of competence may distract from adequate attention and resources on the person and their circumstances....”[20] Another study concluded that competency determinations "do not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide." Lavery, supra at 366.

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

Evidence exists that some persons killed under assisted suicide laws may "choose" suicide under pressure from others. In the Oregon 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

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[19] Kathleen M. Foley, Competent Care for the Dying Instead of Physician-Assisted Suicide, 336 New Eng. J. Med.54 (Jan. 2, 1997).

[20] Linda Ganzini et al., Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists, 157 Am. J. Psychiatry 595, 600 (Apr. 2000).

opinion from a second psychologist, who determined Ms. Cheney was competent. Ms. Cheney was accordingly prescribed lethal medication and died on August 29, 1999.[21]

There is no way to ensure that persons are not unduly pressured by family members, because of financial, emotional, or other reasons. Similarly, given the extraordinary high cost of health care, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not unduly pressuring a person to request "aid in dying" for financial reasons. Many states already permit involuntary passive euthanasia to be imposed by physicians. (See, e.g. Tex. Code Ann. § 166.046)[22] Doctors must not be similarly immunized for active measures to cause death.

II. THE CREATION OF A MONTANA CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE FOR A CLASS OF PEOPLE BASED ON THEIR HEALTH AND DISABILITY STATUS IS A LETHAL FORM OF DISCRIMINATION

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[21] Evelyn Hoover Barnett, Is Mom Capable of Choosing to Die? The Oregonian, Oct. 16, 1999, at G1-2.

[22] "If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment,…The physician and the health care facility are not obligated to provide life-sustaining treatment after the10th day after the written decision…"
Tex. Code Ann. § 166.046 (Vernon 2004).

A. People with Disabilities Are the Class Of Persons Affected by the Proposed Right to Assisted Suicide.

The issue before the court goes far beyond the 1980's cases in which Courts dismissed the state interest in protecting the lives of these disabled individuals and found a "right to die" through the withdrawal of routine life-sustaining treatment.[23] With appropriate treatment and services, many of them would be alive today. However, even in those cases, the courts specifically distinguished any right involving active physician-assisted suicide. Before this Court is the request to obliterate this distinction. It is against the backdrop of these and other cases that your *amici* request protection from the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

B. Adequate Safeguards Cannot Be Adopted to Protect People with Disabilities from Assisted Suicide Threat and Therefore an Unequivocal Rule Must Be Established Prohibiting Assisted Suicide.

1. Any Purported Limitation of the Right to Assisted Suicide to Terminally Ill Persons Will Not Protect People with Disabilities

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[23] See *e.g.*, Bouvia v. Superior Court, 179 Ca. App. 3d 1127, 255 Cal. Rptr. 297 (1986), reviewed denied (June 5, 1986); McKay v. Bergstedt, 106 Nev. 808, 801 P.2d 617 (1990); State v. McAfee, 259 Ga. 579, 385 SE2d 651 (1989).

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected, 42 U.S.C. section 12101 (a)(7), assisted-suicide “safeguards” cannot prevent abuse against people with disabilities. History demonstrates that assisted suicide has not and will not be limited to terminally ill persons.[24]

At issue is nondisabled peoples' intense fear of becoming disabled. When a person with a disability states a desire to die, nondisabled people believe the request is reasonable because they project their own biases and believe that living with a severe disability is a life of dependency, indignity and helplessness; in short, worse than death. The wish to die is based on the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids. Medical professionals, jurists and the public consistently ignore underlying treatable depression, lack of health care or other supports, and exhaustion from confronting systemic discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless," "suffering needlessly," and "quality versus quantity of life," purportedly in a humanistic and compassionate way, they are really expressing fear of severe disability and a very

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[24] See, H. Hendin and K. Foley, Physician-Assisted Suicide in Oregon: A Medical Perspective, 106 Michigan Law Review 1613 (2008).

misguided condemnation, "I could never live like that." Society translates these emotions into a supposedly rational social policy of assisted suicide. Whenever permanent disability is [defined] as the problem, death is the solution.... [T]he wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from [the same] emotional disturbance or illogical despair [that nondisabled persons face]."[25]

The medical profession is not immune to these erroneous assumptions. Research shows that doctors frequently project the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-prolonging treatment."[26] It is particularly important to note that research on suicidal feelings among people with terminal illnesses demonstrates that such feelings are remediable through other means, including pain management, hospice services and counseling.[27] As long as physicians believe that a person with a severe disability has a "life unworthy of living." lethal errors and abuses will occur.

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[25] C.J.Gill, Suicide Intervention for People With Disabilities: A Lesson in Inequality, 8 ***Issues in Law & Med.*** 37, 39 (1992).

[26] S. Miles, Physicians and Their Patients' Suicides, 271 ***J.A.M.A.*** 1786 (1994).

[27] Most death requests, even in terminally ill people are propelled by despair and treatable depression. Herbert Hendin and Gerald Klerman, Physician-Assisted Suicide: The Dangers of Legalization, 150 ***Am. J. of Psych.*** 143 (Jan.1993).

Safeguards cannot protect one from family pressures due to financial burdens which may accompany a disability, especially when the health care system may not pay for assistance in daily living activities. Nor can safeguards stop families from doctor-shopping, when one doctor says the person is not “terminal” or acting “voluntarily,” from finding another doctor who will. Nor can a state ensure that the medical professionals have prescribed adequate antidepressant and pain medications before providing lethal drugs.

2. Any Purported Limitation of a Right to Assisted Suicide Only in Cases of "Voluntary" Requests Will Not Protect People with Disabilities from Abuse

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary but is a forced "choice." The Disability *Amici* are profoundly disturbed by the finding of a constitutional right for assisted suicide in a society which refuses to find a concomitant right to adequate health care to stay alive. Now managed health care, with its emphasis on cost containment, further abridges the choices and endangers the lives of people with disabilities. Until society is committed to providing life supports, including in-home personal assistance services and technology supports, then there is not voluntary choice.

Without health care and consumer-directed personal care services, people with disabilities do not receive what they need to live as independently and with as much autonomy as possible. Without the professional commitment to help make living worthwhile for people with disabilities, which is the core of suicide prevention, people with disabilities, including those whose conditions are terminal, will not receive the support necessary for informed and voluntary decisions. There are no safeguards that can protect against these prejudices and realities.

Finally, no system of safeguards can control conduct which results in the death of the primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all citizens equally. If physicians are granted full legal immunity for assisted suicide, no meaningful barrier to active involuntary euthanasia will exist to protect the lives of members of this minority group.

III. CONCLUSION

People with disabilities in Montana are seriously threatened by physician-assisted suicide. *Amici* ask the Court to believe them when they state that disability-based discrimination in this culture is deep-seated, pervasive and overwhelming. People with disabilities request this Court to recognize that cloaked in the false rhetoric of "death with dignity," physician assisted suicide threatens the civil rights of a profoundly oppressed and marginalized people.

Respectfully submitted this ____ day of April, 2009:

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11(4)(d) of the Montana Rules of Appellate Procedure, I certify that this BRIEF OF THE DISABILITY*AMICI CURAIE* is printed with proportionately spaced Times New Roman text typeface of 14 points; is double spaced; and the word count calculated by Microsoft Office Word 2003 is 4,996 words, excluding table of contents, table of authorities, certificate of service and certificate of compliance.

Donald Ford Jones, Attorneys for
Amicus Curiae

CERTIFICATE OF SERVICE

I, Donald Ford Jones, do hereby certify I served a copy of the foregoing BRIEF OF THE DISABILITY*AMICI CURAIE* upon all parties of record on the 30h day of April, 2009, by mailing a copy thereof to:

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APPENDIX

I. James V. Lavery, et al, Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study. Lancet, 358 (9279), 362-7 (2001)

II. Carol J. Gill, Suicidal Intervention for People with Disabilities: A Lesson in Inequality, 8 Issues in L.& Med. 37 (1992)

III. American Medical Association, Code of Ethics section 2.211 (1994)

IV. National Council on Disability, Assisted Suicide: A Disability Perspective (1997)

V. William Breitbart et al., Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907 (Dec. 13, 2000)

VI. H. Hendin and K. Foley, Physician-Assisted Suicide in Oregon: A Medical Perspective, 106 Michigan Law Review 1613 (2008)