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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Lonny Shavelson, M.D.; Alex Sajkovic; Robert Uslander, M.D.; Gary Pasternack, M.D.; Richard Mendius, M.D.; and End of Life Options California; on behalf of themselves and all others similarly situated; Plaintiffs, v. State of California; Robert Bonta, Attorney General of the State of California, in his official capacity; Nancy O'Malley, Alameda County District Attorney, in her official capacity; Defendants.	Case No. 3:21-cv-06654-VC Brief of Disability Rights Education and Defense Fund, American Association of People with Disabilities, Association of Programs for Rural Independent Living, Autistic Self Advocacy Network, Autistic Women and Nonbinary Network, Disability Rights Legal Center, National Council on Independent Living, Not Dead Yet, National Organization of Nurses with Disabilities, Patients' Rights Action Fund, United Spinal Association and World Institute on Disability as *Amici Curiae* in Support of Defendants' Motions to Dismiss

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IDENTITIES AND INTERESTS OF *AMICI CURIAE*

Amici are authorities in the field of disability rights who oppose euthanasia, the expansion of assisted suicide laws, and efforts to weaken critical protections in assisted suicide laws, including California's End of Life Options Act ("ELOA").[1] *Amici* have extensive policy and litigation experience and are nationally recognized for their expertise in the interpretation of civil rights laws affecting individuals with disabilities including the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101-12213.

Amici include organizations with members with disabilities in California and organizations whose members regularly represent the disability community in advocacy under state and federal anti-discrimination statutes. *Amici* represent the broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people whose disabilities existed from birth or were acquired during their lifetimes. Many have experienced discrimination in the health care setting, had medical professionals pressure them to discontinue life-sustaining treatment and/or had to fight to receive the care, services and supports necessary to keep them alive.

Collectively and individually, *Amici* have a strong interest in ensuring that the ADA is properly interpreted and enforced, and not appropriated for purposes inconsistent with Congress's remedial intent to eliminate discrimination unequal treatment in health care. 42 U.S.C. § 12101. *Amici* also have a strong interest in combatting implicit bias and preventing coercion and abuse in the delivery of health care services and ensuring that the lives of disabled people are valued and respected.

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[1] The 12 *Amici* are individually described in the concurrently filed Motion for Leave to File Brief as *Amici Curiae* in Support of Defendants' Motion to Dismiss.

Plaintiffs' misguided attempt to use disability rights laws to eliminate ELOA's self-administration requirement – *the Act's most essential and fundamental safeguard* – by characterizing it as a "reasonable accommodation" is of immense concern to *Amici.* As this Court has already acknowledged, the modification that Plaintiffs seek "open[s] a window during which there would be no way of knowing whether the patient had changed their mind" about ending their life.[2] Such a modification would significantly undermine the protections included in the ELOA to prevent abuse and coercion by traversing the "sharp boundary" between allowing an individual to end their own life and euthanasia[3], transform the benefit available under the Act, and compromise it's "essential nature".[4] This "fundamental alteration" is not cured by the Plaintiffs' narrowing of their proposed modification or the change in class representatives.

SUMMARY OF ARGUMENT

Assisted suicide statutes are part of the United States' tragic history of state-sanctioned discrimination and bias against people with disabilities and chronic illnesses in health care settings.[5] They violate anti-discrimination laws by treating disabled people differently and convey the message that disabled lives are less worthy. Under assisted suicide laws, the presence or absence of disability alone determines whether an individual receives the protections of state laws prohibiting abuse, neglect, and homicide, and

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[2] ECF No. 79 at 8.

[3] ECF No. 79 at 7, 8.

[4] ECF No. 79 at 8-10.

[5] Although not all disabled people have a terminal prognosis, *all* patients with a terminal prognosis are disabled: that is, substantially limited in major life activities such as caring for oneself and the operation of the major bodily functions implicated by the medical condition presenting a terminal prognosis. 42 U.S.C. § 12102; 28 C.F.R. § 35.108(c).

whether expressions of suicidal intent are responded to with intervention and preventative measures or aid in employing lethal measures. Where states have nonetheless authorized this practice, like California, it is critical that existing statutory eligibility requirements, particularly one as fundamental as the self-administration requirement, be preserved.

ARGUMENT

I. Assisted Suicide is Part of a Long History of Discrimination and Bias Against Disabled People in Health Care Settings.

A. The United States' History of Discrimination in Health Care.

The United States has a long and tragic history of state-sanctioned discrimination against people with disabilities in health care settings. For decades people with disabilities have endured forced sterilization and other governmental policies to prevent them from creating and maintaining families.[6] Many in the bioethics community have advocated, *and continue to advocate*, that the concepts of dignity and rights do not apply to people with certain disabilities.[7] Sadly, these are not isolated or antiquated views.

The utilization of health care rationing systems in response to the COVID pandemic is a recent example of this discrimination and health inequity in practice. An April 2020

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[6] *See* Powell & Stein, Persons with Disabilities and Their Sexual, Reproductive, and Parenting Rights: An International and Comparative Analysis, 11 FRONT. L. CHINA 53, 60–68 (2016). *See also, Buck v. Bell*, 274 U.S. 200, 207 (1927) (a not yet overturned Supreme Court opinion legitimizing early 20th century eugenic sterilization practices).

[7] *See, e.g.,* Spriggs, Ashley's Interests Were Not Violated Because She Does Not Have Necessary Interests, 10 AM. J. BIOETHICS, 52-54 (2010) (opining that a young girl with disabilities subjected to involuntary surgery to prevent her growth was "not deprived of anything that she values because she does not have the capacity to value her own existence, let alone to miss anything taken from her."). *See also,* Singer, Taking Life: Humans, PRACTICAL ETHICS, 175-217 (2d ed. 1993) (advocating for actively killing infants with severe disabilities in the belief that they will not lead "good" lives and will burden their parents and society and opining that these "justifications" for death equally "apply to older children or adults whose mental age is ... that of an infant.").

investigation by the Center for Public Integrity revealed that in the early months of the pandemic, at least 25 states had crisis standards of care that deprioritized people with disabilities for ventilators and other critical care based on factors such as a patient's expected lifespan; need for assistance with activities of daily living or resources; or specific diagnoses, such as dementia or cystic fibrosis.[8] Elimination of the ELOA's self-administration requirement would only add to the above-described history of discrimination.

B. Bias in the Medical Profession is Pervasive and Unavoidable.

Disability status is an important factor affecting decisions about life sustaining health care.[9] Many disabled people are denied necessary treatment because of implicit biases in the medical profession regarding the quality of life and inherent worth of people with disabilities.[10] The pervasiveness of this bias cannot be overstated. Studies have consistently demonstrated that health care providers hold negative views of people with disabilities and fail to fully appreciate the value and quality of life with a disability.

For example, a 2021 survey found that negative perceptions of patients with disabilities were widespread among physicians—to a degree researchers described as

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[8] Whyte, State Policies May Send People With Disabilities to the Back of the Line for Ventilators, Ctr. for Pub. Integrity, Apr. 13, 2020, https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/ (last visited Oct. 20, 2022).

[9] *See, e.g.,* Okoro, Hollis, Cyrus & Griffin-Blake, Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults—United States, 2016. Volume 67, Issue 32, MORB. MORTAL. WKLY. REP., 882–87 (2018).

[10] *See, e.g.,* Carlson, Smith & Wilker, Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights (2012), http://ndrn.org/images/Documents/Resources/Publications/Reports/Devaluing_People_with_Disabilities.pdf (last visited Oct. 20, 2022).

"disturbing."[11] Of over 700 practicing US physicians surveyed, 82.4 percent reported that people with significant disability have worse quality of life than nondisabled people[12], affirming prior research demonstrating healthcare providers' implicit beliefs about the low quality of life of persons with significant disabilities.[13]

In a similar study, published in October 2022, participating physicians revealed an array of negative attitudes about people with disabilities.[14] Many implied that providing accommodations to disabled patients was burdensome, and one described disabled people as "an entitled population."[15] Some admitted to denying care to people with disabilities or attempting to discharge them from their practices.[16] Others described care that they *would have* provided if a patient *did not have a disability*, confirming their disparate treatment.[17]

This bias results in actual and significant barriers to care. In 2019, the National Council on Disability released a series of reports exploring how people with disabilities are impacted by bias in critical health care areas including organ transplantation, assisted suicide and determinations of medical futility.[18] The assisted suicide report describes,

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[11] Iezzoni, Rao, Ressalam, Bolcic-Jankovic, Agaronnik, Donelan, Lagu & Campbell, Physicians' Perceptions of People With Disability And Their Health Care, Volume 40, No. 2, HEALTH AFFAIRS (Project Hope), 297–306 (2021).

[12] *Id.*

[13] *See, e.g.,* Crossley, Ending-Life Decisions: Some Disability Perspectives, 33 GA. STATE UNIV. L. REV. 893, 900–01 (2017) (reviewing studies).

[14] Lagu, Haywood, Reimold, DeJong, Walker Sterling & Iezzoni, 'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities, Volume 41, No. 10, HEALTH AFFAIRS (Project Hope), 1387-1395 (2022).

[15] *Id.*

[16] *Id.* at 1392.

[17] *Id.*

[18] National Council on Disability, Bioethics and Disability Report Series, (2019) https://ncd.gov/publications/2019/bioethics-report-series (last visited Oct. 20, 2022).

among other things, a double standard in the provision of suicide prevention efforts where people with disabilities are concerned.[19]

It is not an exaggeration to say that disabled people are at disproportionately high risk of being killed as the result of medical bias and the barriers it creates. In Texas, physicians and hospitals already have the ability to discontinue life-sustaining care they believe to be futile even if a patient or patient's family desires to continue treatment.[20] In a study published in 2011 in the Journal of Emergency Medicine, over 50% of physician respondents misinterpreted a living will as synonymous with a "do not resuscitate" (DNR) order, and a similar percentage over-interpreted DNR orders as meaning "comfort care" or "end-of-life" care only, when such orders may coexist with the patient receiving aggressive treatments.[21] In his book "A Chosen Death", plaintiff Shavelson himself describes witnessing the murder of a disabled man who had changed his mind about wanting to die by a Hemlock Society chapter head.[22]

In these and countless other ways, the medical community has failed to fully appreciate the value and quality of disabled lives. Sanctioning euthanasia will only exacerbate this already troubling situation.

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[19] National Council on Disability, The Danger of Assisted Suicide Laws 221 (2019) https://www.ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf (last visited Oct. 20, 2022).

[20] See Tex. Health & Safety Code Ann. § 166.046. *See also* Fine & Mayo, Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act, 138 ANN. INTERN. MED. 743-746 (2003).

[21] Mirarchi, Costello, Puller, Cooney & Kottkamp, TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders, Volume 42, Issue 5, J. EMERGENCY MED., 511-520 (2012), https://www.jem-journal.com/article/S0736-4679(11)00853-5/fulltext (last visited Oct. 20, 2022).

[22] Shavelson, A Chosen Death: The Dying Confront Assisted Suicide. University of California Press (1998) at p. 94 (recounting the killing of "Gene" by "Sarah").

II. Assisted Suicide Violates the ADA by Treating Disabled People Differently and Conveying the Message that Disabled Lives are Less Worthy

A. Assisted Suicide Denies People with Disabilities the Equal Benefit of Protective Laws and Programs.

Congress enacted the ADA in 1990 to address and remedy the "serious and pervasive social problem" of discrimination against individuals with disabilities. 42 U.S.C. § 12101(a)(2). Among other things, the ADA bars the use of disability as a (dis)qualification for the receipt of services and benefits from the government and medical providers, both public and private, and requires that health care providers provide people with disabilities full and equal access to health care services.[23]

Sanctioning assisted suicide for disabled people, and only disabled people, violates the ADA by treating such persons differently based on explicit disability classifications. Sanctioning euthanasia violates the law in a similar, yet more insidious way. The presence or absence of disability should not determine whether an individual receives the protections of state laws prohibiting abuse and neglect, and homicide, or whether expressions of suicidal intent are responded to with intervention and preventative measures or aid in implementing lethal measures. Although this case does not challenge the legality of the ELOA statute, the discrimination innate in assisted suicide laws must be understood and considered when deliberating this case.

B. Assisted Suicide Promotes Ableist Beliefs about Disabled Lives and Fails to Address the Primary Reasons People Choose Death.

Policies favoring assisted suicide and the expansion of assisted suicide statutes are based on the ableist premise that it is rational for a disabled person to end their own life.

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[23] *See* 42 U.S.C. §§ 12132 and 12182; 28 C.F.R. §§ 35.130(b) and 36.202(b) and (c).

They send the false and harmful message that the lives of disabled people are intrinsically less valuable than the lives of people without disabilities, and that it is logical for them to want to die. So logical, in fact, that others want to actively assist in their death.

Central to the disability rights movement is the idea that a disabling condition does not inherently diminish one's life and that a life with a disability is not qualitatively worse than life without a disability.[24] To the extent people with disabilities do experience disadvantage, it is the result of pervasive prejudice, stereotypes, and barriers that prevent access to necessary services and supports. Assisted suicide laws only compound this injustice, by singling disabled people out for differential treatment. A practice (suicide) that the State would otherwise expend resources to prevent as a matter of public health policy, is instead actively facilitated when a disabled life is at issue.

Assisted suicide laws also fail to address the real reasons terminally ill people chose death. Although concerns about pain are often raised as the primary reason for enacting assisted suicide laws, data shows that the top five reasons people request assisted suicide are: loss of autonomy; decreasing ability to participate in activities that make life enjoyable; loss of dignity; burden on family, friends/caregivers; and losing control of bodily functions.[25] When people choose to end their lives because of social

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[24] *See, e.g.,* Barnes, E., The Minority Body: A Theory of Disability 71 (2016) (explaining that "there is a vast body of evidence that suggests that non-disabled people are extraordinarily bad at predicting the effects of disability on perceived well-being"); Bagenstos & Schlanger, Hedonic Damages, Hedonic Adaptation, and Disability, 60 VAND. L. REV. 745 (2007) (discussing hedonic damages and noting that "people who experience disabling injuries tend to adapt to their disabilities. To the extent that they experience continuing hedonic loss, it is physical pain and loss of societal opportunities--not anything inherent in the disability--that is the major contributor").

[25] Based on data from Oregon, the state where assisted suicide has been legal the longest. *See* Oregon Health Authority, Public Health Division, Oregon Death with

stigma, isolation, or lack of access to resources, we should not accept this "choice" as voluntary and actively facilitate suicide. We should respond with services and supports.

III. California has Already Rolled Back a Number of the ELOA's Protections, Making Retention of the Self-Administration Requirement Critical.

In October 2021, California enacted Senate Bill 380, removing a number of key protections that the Legislature included in the ELOA only a few years prior. Among other things, SB 380 reduced the mandatory 15-day waiting period between requests for assisted suicide drugs to a mere 48 hours[26] and eliminated the requirement that an individual make a final attestation affirming their choice before drugs are administered.[27] These requirements were important guardrails against erroneous or coerced requests for assisted suicide. Without them, the risks of coercion and abuse of people with disabilities have increased, making retention of the ELOA's self-administration requirement—*requiring that patients complete the final act themselves*—that much more critical.

IV. The Modification Proposed Would Result in a Fundamental Alteration.

The California Legislature's purpose in passing the ELOA was to provide terminally ill and competent Californians with the option of receiving a prescription for an aid-in-dying drug to end their life at their own hand if certain conditions are met.[28] The inclusion of "strong provisions to safeguard patients from coercion" was intentional,

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Dignity Act - 2021 Data Summary 13 (2022), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf (last visited Oct. 21, 2022). Notably, the State of California does not collect such data.

[26] Cal. Health & Safety Code § 443.3(a).

[27] SB-380 End of Life (Cal. Stats. 2021, ch. 542, eff. Jan. 1, 2022).

[28] *See* Rob Bonta, Chair, ABx2-15, Assemb. Public Health and Developmental Servs., cmt. 1 (Sept. 1, 2015), https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520162AB15

and crucial to the statute's enactment.[29] These safeguards include the requirement that the patient seeking to end their life have "the physical and mental ability to self-administer the aid-in-dying drug."[30] The self-administration requirement was introduced into the ELOA as an eligibility criteria for the *express purpose* of averting lethal injection, mercy killings, and euthanasia.[31] It is an essential eligibility requirement that has been adopted by all eleven United States jurisdictions in which assisted suicide is authorized.[32]

The goal of the self-administration requirement is simple: to ensure that patients are not coerced into taking lethal medication or killed against their wishes if they change their minds as their end-of-life reality nears. This is the predominant factor in any self-administration requirement; that a patient must manifest their desire to die by completing the final act of ingesting the life-ending medication themselves.

As this Court has recognized, the "multi-year process during which the California Legislature, Governor, and public debated the options that should be available to the terminally ill" has resulted in a reasoned framework that draws a sharp boundary between aid-in-dying and euthanasia.[33] The ELOA allows a person to take their own life with aid-in-dying medication, while absolutely forbidding the taking of anyone else's.[34]

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[29] *Id.*

[30] Cal. Health & Safety Code § 443.2(a)(5). *See also* Cal. Health & Safety Code § 443.1(p) (defining self-administration as "a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death."

[31] *See* Bonta, *supra* note 28, at 6.

[32] Oregon, Washington, Montana, Vermont, California, Colorado, Washington D.C., Hawai'i, New Jersey, Maine and New Mexico.

[33] ECF No. 79 at 7.

[34] *Id.*

The modification sought by Plaintiffs—that physicians be permitted to complete the final act of administering aid-in-dying medication—would traverse this boundary, transforming the benefit available under the ELOA from the ability to end one's own life to the ability to have someone else end it for you. This is a fundamental alteration of the ELOA and ignores the Legislature's sound judgment that no person's life should be ended unless they are fully committed to ending it – something that can never be truly clear unless they complete the final act themselves. While not ideal for everyone, the self-administration requirement affirms and secures an essential moral and legislative line between assisted suicide and euthanasia and remains a necessary barrier to coercion and abuse. Requiring California to cross that line would compromise the essential nature of the regulated end-of-life program the state created and increase existing threats to the civil rights, and the very lives, of profoundly oppressed and already marginalized people.

V. There is Meaningful Access to the ELOA's End-of-Life Benefit.

In *Alexander v. Choate*, 469 U.S. 287 (1985), the Supreme Court outlined a test to determine whether meaningful access to a public benefit program has been provided. In *Choate,* Medicaid recipients challenged a proposed reduction in the number of inpatient hospital days covered by Tennessee's Medicaid program from 20 to 14.[35] The plaintiffs argued the reduction would disproportionately affect people with disabilities, who typically required more in-patient care, and thus discriminated against people with disabilities in violation of Section 504.[36] To determine whether disabled persons were being denied "meaningful access" to Tennessee's state-Medicaid program, the Court

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[35] *Id.* at 289.

[36] *Id.* at 290.

considered the purposes of the underlying program and the evidence of exclusion of disabled people.[37] As to purpose, the Court reasoned that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs."[38] The Court further found no evidence that the in-patient limitation would have the effect of systematically excluding people with disabilities.[39]

Plaintiffs' ADA claim should be assessed under the standard articulated in *Choate*.[40] Looking to the legislative history and statutory source of California's end-of-life benefit, the there is no requirement or statutory purpose that everyone have access to end-of-life medications, or that the benefit be provided to people on their preferred terms. Rather, the benefit is explicitly defined by the California Legislature as having certain eligibility requirements including, among other things, that the individual be diagnosed with a terminal disease, that the individual voluntarily express the wish to receive a prescription for aid-in-dying medication and that the individual have the "physical and mental ability to self-administer the aid-in-dying drug."[41] Because of the controversy around assisted suicide, these eligibility criteria were critically important to the ELOA's end-of-life benefit being adopted.[42] Although there may be individuals eligible for the ELOA's end-of-life benefit who might need or prefer something different (just as the

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[37] *Id.* at 302.

[38] *Id.* at 303.

[39] *Id.*

[40] There is no significant difference in analysis of the rights and obligations created by the ADA and Section 504. *See* 42 U.S.C. § 12133 "[C]ourts routinely look to [Section 504] case law to interpret the rights and obligations created by the ADA." *Zukle v. Regents of the University of California*, 166 F.3d 1041, 1046 n.11 (9th Cir. 1999).

[41] Cal. Health & Safety Code § 443.2.

[42] *See* Bonta, *supra* note 28, at 6; cmt 1.

plaintiffs in *Choate* needed more than 14 days), the fact remains that there is meaningful access to the benefits of the ELOA for everyone as defined, using facially neutral terms.

The assisted suicide of former plaintiff Sandy Morris illustrates how individuals with terminal, degenerative diseases that may (or may not) result in an eventual loss of the ability to self-administer lethal mediation are not denied access to the benefit offered by the ELOA.[43] Although Ms. Morris may have personally preferred to access the benefit later in her dying process, the fact remains that she was eligible for, and successfully availed herself of the ELOA's benefit. Not everyone qualifies for the end-of-life benefit the ELOA provides, nor does the Act guarantee an individual's preferred date and time of death. The progression of one's illness and decline in health and mental and physical functioning are unpredictable factors and somber considerations for *every* individual choosing exactly when to end their life using the ELOA's end-of-life benefit.

VI. End of Life Choices California Does Not Have Organizational Standing.

Plaintiffs' Third Amended Complaint adds End of Life Choices California ("EOLCC") as an organizational plaintiff.[44] Organizations can assert standing on behalf of their own members, *see Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 181 (2000), or in their own right, *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 378-79 (1982). As explained below, EOLCC does not have organizational standing under either standard. Nor does EOLCC represent or reflect the community of disabled people threatened by Plaintiffs' unrelenting efforts to eliminate or circumvent the essential eligibility criteria and safeguards of the ELOA or cure the deficiencies with this lawsuit.

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[43] ECF No. 87 at ¶ 5.

[44] ECF No. 89.

A. EOLCC is Not a Membership Organization.

To establish representational standing, an organization must show that "(a) its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purposes; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Hunt v. Wash. State Apple Advertising Comm'n*, 432 U.S. 333, 343 (1977). Here, EOLCC does not allege it is a membership organization. Nor has EOLCC plausibly alleged that they have clients with standing in their own right, *i.e.,* who: (1) can start administering lethal medication on their own and are unable to complete the process; and (2) have a physician failing to step in and help due to the threat of criminal liability.[45] For this reason, and because it's purpose is to provide information and support as to current law, not to expand or change the law (*see* section B, *infra*), EOLCC cannot claim representational standing.

B. Without a Direct Injury, EOLCC Lacks Direct Standing.

As the Supreme Court recognized in *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982), direct organizational injury is typically cognizable in two ways: (A) a diversion of organizational resources to identify or counteract the allegedly unlawful action, or (B) frustration of the organization's mission. In the Ninth Circuit, organizations are required to show both forms of injury, *Fair Hous. of Marin v. Combs*, 285 F.3d 899, 905 (9th Cir. 2002), through a "concrete and demonstrable injury" to their activities—with a "consequent drain on [their] resources—[that] constitutes far more than simply a setback to the organization's abstract social interests". *Havens* at 379. An organization must actually alter

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[45] Newly added individual plaintiff Alex Sajkovic lacks standing for similar reasons.

their resource allocation to combat the challenged practices and not "simply go[] about their 'business as usual.'" *National Council of La Raza v. Cegavske*, 800 F.3d 1032, 1040-41 (9th Cir. 2015). EOLCC fails to allege facts sufficient to make this showing.

EOLCC is not an advocacy or policy organization working to change or enforce the law. Their mission is to "provide Californians information and support to successfully navigate their legal end-of-life options"[46]; a mission that has not been frustrated by ELOA's self-administration requirement. EOLCC has not focused any resources on counteracting the self-administration requirement of ELOA.[47] They are staffed by one volunteer[48] focused on "ensur[ing] that all Californians *who are eligible for the law* are able to access the law."[49] This "business" is unaffected by the practices challenged by Plaintiffs' lawsuit.

CONCLUSION

On the basis of the foregoing, *Amici* support Defendants' motions to dismiss and ask that they be granted.

Dated: October 24, 2022

DISABILITY RIGHTS EDUCATION
& DEFENSE FUND

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[46] https://endoflifechoicesca.org/who-we-are/mission-statement/ (last visited Oct. 20, 2022).

[47] https://endoflifechoicesca.org/what-we-do/ (last visited Oct. 20, 2022).

[48] https://endoflifechoicesca.org/staff/ (last visited Oct. 20, 2022).

[49] https://endoflifechoicesca.org/what-we-do/ (last visited Oct. 20, 2022) (emphasis added).