No. 26-1001

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

SEAN CURRAN, ET AL.

Plaintiffs-Appellants

v.

GOVERNOR OF DELAWARE, ET AL.

Defendants-Appellees.

On Appeal from the United States District Court
for the District Court of Delaware
Case No. 1:25-cv-01475
Hon. Gregory B. Williams

BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND ELEVEN OTHER DISABILITY RIGHTS ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLANTS

Maria Michelle Uzeta* (CA SBN 164402)
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
510-644-2555
muzeta@dredf.org

Counsel for *Amici Curiae*

*Admitted to the Third Circuit Court of Appeal

COMPLETE LIST OF AMICI

1. Disability Rights Education and Defense Fund
2. American Association of People with Disabilities
3. The Arc
4. Autistic People of Color Fund
5. Autistic Self-Advocacy Network
6. Autistic Women & Nonbinary Network
7. Center for Public Representation
8. Deaf Equality
9. Independent Resources, Inc.
10. United States International Council on Disabilities
11. National Association of the Deaf Law and Advocacy Center
12. National Organization of Nurses with Disabilities

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CONSENT OF THE PARTIES TO THE FILING PURSUANT TO FEDERAL RULE OF APPELLATE PROCEDURE 29(b)(2)

This amicus curiae brief is filed with the consent of Michael Bien and Theodore Kittila, counsel for Plaintiffs-Appellants, and Victoria Sweeney, counsel for Defendants-Appellees.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29(a)(4)(A) of the Federal Rules of Appellate Procedure, counsel for Amici Curiae certify that no Amicus has a parent corporation and that no publicly held corporation owns 10 percent or more of any Amicus's respective stock.

STATEMENT PURSUANT TO FEDERAL RULE OF APPELLATE PROCEDURE 29(a)(4)(E)

The undersigned certifies that no party's counsel authored this brief in whole or in part, and that no party, party's counsel, or any other person other than Amici, their members, or their counsel, contributed money that was intended to fund preparing or submitting this brief.

IDENTITIES AND INTERESTS OF AMICI CURIAE

Amici curiae are nationally recognized authorities in disability rights who oppose euthanasia, the expansion of assisted suicide laws, and efforts to weaken safeguards in such laws. Amici have extensive experience in policy advocacy and litigation under federal civil rights statutes, including the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101–12213,[1] and represent a broad spectrum of people with disabilities, including many who have faced discrimination in health care, pressure to decline life-sustaining treatment, and denials of essential services and supports.

Amici have a substantial interest in ensuring that disability civil rights laws are properly enforced, preventing coercion and bias in medical decision-making, and protecting the dignity and legal rights of people with disabilities. Amici respectfully submit that the Court's characterization of the Delaware End of Life Options Act ("EOLOA"), *Del. Code Ann*. tit. 16, ch. 25C (West 2025), as an "entirely voluntary" option "fails to reflect the lived realities of many disabled people. For those facing shortages of home- and community-based services and

[1] Plaintiff also brought claims under Section 504 of the Rehabilitation Act and the Affordable Care Act, but as all three statutes are analyzed similarly, only the ADA is discussed herein. *See Jones v. CVS Pharmacy, Inc*., No. 21-157, 2022 WL 4536124, at *5 n.2 (M.D. Pa. Sept. 28, 2022) (noting the pleading requirements for all three laws to be "virtually identical.").

supports, pervasive health care disparities, inadequate attendant care, inaccessible housing, unmanaged pain, poverty, and social isolation, "voluntary" end-of-life decisions are often shaped by systemic inequities. Unlike services that promote independence and community integration, the EOLOA offers a lethal option in a context where essential supports are too often denied and thus cannot be fairly described as a neutral expansion of benefits.[2]

SUMMARY OF ARGUMENT

Delaware's EOLOA sits squarely within this nation's long and well-documented history of discrimination and bias against people with disabilities in health care settings. Laws authorizing assisted suicide do more than create a new medical option—they carve disabled people out of longstanding legal protections against abuse, neglect, and homicide, while simultaneously denying them equal access to the full force of state suicide-prevention efforts. That double standard collides directly with the ADA's guarantees of equal protection, equal access to public services, and freedom from discriminatory medical decision-making.

[2] Amici take no position on the question of Plaintiffs' standing. However, should the Court affirm the District Court's determination that Article III jurisdiction is lacking, Amici urge the Court to nevertheless vacate the District Court's erroneous holding on the merits of Plaintiffs' anti-discrimination claims, which was unnecessary and superfluous given that jurisdiction is dispositive.

These laws also codify and legitimize ableist[3] assumptions about whose lives are worth living. They operate in a health care system where disabled people routinely confront low expectations, undertreatment, and judgments about "quality of life" that devalue their existence. Rather than addressing the documented drivers of suicidal ideation—untreated depression, unmanaged pain, social isolation, lack of home- and community-based supports, and coercive or dismissive medical environments—assisted suicide statutes accept those conditions as fixed. In that context, the promise of a "choice" is illusory.

The EOLOA's purported statutory safeguards do not cure these structural defects. Experience in jurisdictions such as Oregon, California, Canada, and the Netherlands demonstrates that eligibility expansions, limited oversight, and heavy reliance on physician self-reporting fail to protect people with disabilities from error, coercion, or the subtle pressures of bias and abandonment. Given these realities, the EOLOA cannot credibly be said to safeguard voluntary choice.

[3] On the meaning of "ableist" and "ableism," *see, e.g.*, Paul Goodley, *Dis/Ability Studies: Theorizing Disablism and Ableism* 21 (2014) (explaining that ableism "privileges able-bodiedness; promotes smooth forms of personhood and smooth health; creates space fit for normative citizens; encourages an institutional bias towards autonomous, independent bodies; and lends support to economic and material dependence on neoliberal and hyper- capitalist forms of production").

We oppose false choices constructed atop inequity. Real autonomy requires real options: accessible and comprehensive rehabilitative services, robust mental health treatment, adequately funded home- and community-based supports, and high-quality palliative and hospice care. Expanding access to physician-assisted suicide while these essential services and supports remain uneven, underfunded, or inaccessible does not expand freedom—it entrenches inequality. At a moment when the nation continues to reckon with profound disparities in health care, the response should be to strengthen life-sustaining supports and services, not widen access to state-facilitated death.

ARGUMENT

I. The EOLOA Adds To The United States' Long History Of Discrimination And Bias Against Disabled People In Health Care.

Assisted suicide statutes must be understood against the backdrop of the United States' long and troubling history of state-sanctioned discrimination against people with disabilities in health care.[4] For decades, disabled people were subjected to forced sterilization and other government policies designed to prevent

[4] 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).

them from forming families or reproducing.[5] Within the bioethics community, some scholars have argued—and continue to argue—that concepts such as dignity, autonomy, and even basic rights do not fully apply to people with certain disabilities.[6]

These views are neither isolated nor relics of the distant past. Recent history confirms that discrimination against disabled people in health care remains embedded in policy and practice. During the COVID-19 pandemic, health care rationing systems provided a stark example. An April 2020 investigation by the Center for Public Integrity revealed that, in the early months of the pandemic, at least twenty-five states adopted crisis standards of care that deprioritized people with disabilities for ventilators and other life-saving treatment.[7] These protocols—

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[5] *See* Geoffrey Powell & Alan 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) (legitimizing early 20th century eugenic sterilization practices).

[6] *See, e.g.,* Spriggs, *Ashley's Interests Were Not Violated Because She Does Not Have Necessary Interests*, 10 *Am. J. Bioethics* 52, 52–54 (2010) (opining that a young disabled girl subjected to involuntary surgery 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* Peter Singer, *Taking Life: Humans*, in *Practical Ethics* 175–217 (2d ed. 1993) (advocating for actively killing infants and others with severe disabilities in the belief that they will not lead "good" lives and will burden their parents and society.").

[7] Daniel Whyte, *State Policies May Send People With Disabilities to the Back of the Line for Ventilators*, Ctr. for Pub. Integrity, Apr. 13, 2020,

which relied on predicted life expectancy, need for assistance with activities of daily living, perceived resource intensity, or diagnoses such as dementia or cystic fibrosis—systematically disadvantaged disabled patients.[8]

Delaware's EOLOA adds to this sordid history. It establishes a discriminatory double standard for how health care providers, government authorities, and others treat disabled individuals compared to others. Only disabled people are removed from the protections of generally applicable laws on abuse, neglect, and homicide. And only disabled people are offered assisted suicide in response to suicidal ideation.

This unequal treatment is particularly alarming in the current policy climate, where essential services that enable people with disabilities to live in the community face persistent fiscal and political pressure. At both the federal and state levels, Medicaid—the primary payer of long-term services and supports—has been subject to funding reduction proposals, financing restrictions, and administrative barriers that threaten optional benefits such as home- and community-based

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https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/.

[8] *Id*.

services, attendant care, and family caregiver supports.[9] States confronting budget shortfalls have likewise implemented or considered freezes, rate reductions, and limits on personal assistance and developmental disability services.[10]

It is clear from this context that the EOLOA does not operate in a neutral health care system. It functions within a system that has historically devalued disabled lives and, in recent memory, has formally deprioritized disabled people for life-sustaining treatment. By carving out a lethal exception to otherwise applicable protections and treating death as an acceptable clinical response to disability-related needs and circumstances, the EOLOA revives the very hierarchies of worth disability civil rights statutes were enacted to abolish.

II. Systemic Medical Bias Renders The EOLOA Inherently Dangerous For People With Disabilities.

Disability status heavily shapes life-sustaining health care decisions.[11]

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[9] Maiss Mohamed, Alice Burns & Molly O'Malley Watts, *Medicaid Home Care (HCBS) in 2025* (Kaiser Family Foundation, Jan. 25, 2026), https://www.kff.org/medicaid/medicaid-home-care-hcbs-in-2025/.

[10] Jessica Schubel, Alison Barkoff, H. Stephen Kaye, Marc A. Cohen & Jane Tavares, *History Repeats? Faced With Medicaid Cuts, States Reduced Support for Older Adults and Disabled People*, Health Affs. Forefront (Apr. 14, 2025), https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and.

[11] *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, 67 *Morb. Mortal. Wkly. Rep.* 882, 882–87 (2018).

People with disabilities are frequently denied necessary treatment due to pervasive biases about their quality of life and the value of their lives.[12] Studies consistently show that health care providers underestimate disabled individuals' well-being and assume their lives are inherently less valuable.

A 2021 national survey of over 700 physicians found such perceptions "disturbing" and widespread: 82.4% believed that people with significant disabilities have a worse quality of life than nondisabled people.[13] Similarly, a 2022 study documented that some physicians view accommodations as burdensome, have denied care, or provided lesser treatment to disabled patients, confirming disparate treatment.[14] Qualitative research further shows that clinicians often make erroneous assumptions about disabled patients' values and preferences, narrowing treatment options and compromising care.[15]

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[12] *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.

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

[14] Lagu, Haywood, Reimold, DeJong, Walker Sterling & Iezzoni, *'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities*, 41, no. 10 *Health Affs. (Project Hope)* 1387, 1387–1395 (2022).

[15] Edwards, Sakellariou & Anstey, *Barriers to, and Facilitators of, Access to Cancer Services and Experiences of Cancer Care for Adults with a Physical*

The National Council on Disability has highlighted the troubling double standard in suicide-prevention reflected in laws like the EOLOA: disabled individuals expressing a desire to die are more likely to have that desire treated as rational, whereas nondisabled individuals are more likely to receive suicide-prevention interventions.[16] These risks are compounded by widespread legal ignorance. In the 2021 survey, over a third of physicians knew little or nothing about ADA obligations, two-thirds misidentified who determines accommodations, and fewer than half felt confident providing equitable care.

These biases translate into tangible disparities: disabled patients face lower preventive screening rates, limited access to care, and in some cases outright

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Disability: A Mixed Methods Systematic Review, 13, no. 1 *Disability & Health J.* 100844 (2020), https://doi.org/10.1016/j.dhjo.2019.100844; Varkey, Manwell, Williams, Ibrahim, Brown, Bobula, Horner-Ibler, Schwartz, Konrad, Wiltshire, Linzer & MEMO Investigators, *Separate and Unequal: Clinics Where Minority and Nonminority Patients Receive Primary Care*, 169, no. 3 *Arch. Intern. Med.* 243, 243–250 (2009). https://doi.org/10.1001/archinternmed.2008.559.

[16] 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

[17] Iezzoni, Rao, Ressalam, Bolcic-Jankovic, Agaronnik, Lagu, Pendo & Campbell, *U.S. Physicians' Knowledge About the Americans With Disabilities Act And Accommodation Of Patients With Disability*, 41, no. 1 *Health Affs. (Project Hope)*96, 96–104 (2022), https://doi.org/10.1377/hlthaff.2021.01136.

refusal of treatment.[18] Jurisdictions that allow physicians to unilaterally withhold "futile" care exacerbate these risks, as subjective judgments about quality of life and misunderstanding of advance directives can result in premature or inappropriate treatment limitations.[19]

Because the medical profession often fails to value disabled lives equally and to uphold nondiscriminatory care, assisted suicide laws like Delaware's EOLOA will only serve to exacerbate existing inequities. Where physician bias exists and access to care is already unequal, the risk that decisions about eligibility, voluntariness, or prognosis will be shaped by assumptions about whose lives are worth living is predictable and dangerous. Absent the prohibition of laws like the

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[18] *See* Chen, *Disability and Discrimination at the Doctor's Office*, N.Y. Times, May 23, 2013, https://well.blogs.nytimes.com/2013/05/23/disability-and-discrimination-at-the-doctors-office/ (citing Lagu, Hannon, Rothberg et al., *Access to Subspecialty Care for Patients With Mobility Impairment: A Survey*, 158 *Ann. Intern. Med.* 441, 441–446 (2013), https://doi.org/10.7326/0003-4819-158-6-201303190-00003).

[19] *See, e.g.*, *Tex. Health & Safety Code Ann*. § 166.046 (West 2021). Even more concerning are futility policies that grant physicians immunity for denying care expressly requested by patients or their lawful surrogates. Fine & Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 *Ann. Intern. Med.* 743, 743–746 (2003); Mirarchi, Costello, Puller, Cooney & Kottkamp, *TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders*, 42, no. 5 *J. Emerg. Med.* 511, 511–520 (2012), https://www.jem-journal.com/article/S0736-4679(11)00853-5/fulltext.

EOLOA, vulnerable members of the disability and aging communities remain at serious risk of coercion, differential treatment, and premature death.

III. The EOLOA Violates The Spirit And Letter Of The Americans With Disabilities Act

A. The EOLOA 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 protections, the ADA prohibits the use of disability as a qualification—or disqualification—for the receipt of services and benefits, including health care services provided by both public and private entities. It guarantees people with disabilities full and equal access to health care and related services.[20]

The district court rejected Plaintiff's ADA claim based solely on whether the EOLOA could "be read to deny people with disabilities under the ADA with access to suicide prevention services." A21. Amici submit that this framing is unduly narrow. Delaware's sanctioning of assisted suicide for disabled people—and only disabled people—constitutes differential treatment based expressly on disability. And the ADA's implementing regulations prohibit providing disabled

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

individuals with aids, benefits, or services that are "unequal," "not as effective," or "different or separate" from those provided to others. *See* 28 C.F.R. § 35.130(b)(1)(ii)–(iv).

Nothing in the ADA's text, its regulations, or its interpretive case law limits its prohibitions to circumstances in which services are withheld altogether. To construe the statute so narrowly would contravene the principle that the ADA, as a remedial statute, "be broadly construed to effectuate its purposes." *Disabled in Action of Pennsylvania v. Se. Pennsylvania Transp. Auth.*, 539 F.3d 199, 208–09 (3d Cir. 2008). A law that offers death as a state-sanctioned response to the health care and support needs of disabled individuals—and again, only disabled people—while offering suicide prevention and protective intervention to others falls squarely within the ADA's prohibition on unequal, different, and not-as-effective services. A facilitated death is self-evidently not "as effective" in addressing suicidal ideation as the provision of preventative care and supportive services.

For Amici, the issue is straightforward: disability status should not determine whether an individual receives the protections of laws prohibiting abuse, neglect, and homicide, or whether expressions of suicidal intent are met with intervention and prevention rather than assistance in carrying out lethal measures. Where the presence of a disability is the predicate for this disparate treatment, the statute violates the ADA.

B. The EOLOA is Predicated On Disability-Based Judgments About Quality Of Life

Assisted suicide statutes like the EOLOA are built upon an ableist premise: that disability itself renders life diminished, burdensome, or not worth sustaining. By conditioning eligibility for state-authorized suicide on the presence of a qualifying disability or terminal diagnosis, these laws do not merely regulate end-of-life decision-making. They embed into statutory design the assumption that suffering is inherent in disabled existence and that death may be an appropriate response to it.[21]

This premise is not abstract; it structures how the State responds to suicidal ideation. Under these laws, suicidal intent triggers fundamentally different governmental interventions depending on whether the individual has a qualifying disability. When expressed by a nondisabled person, suicidal intent is treated as a psychiatric crisis warranting intervention, prevention, and the full protection of generally applicable criminal laws. The State mobilizes its resources to preserve life. When expressed by a person who meets statutory disability criteria, however, the same intent becomes grounds for state-authorized medical assistance in ending

[21] Despite its persistence, this assumption has been consistently rejected. *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").

life. Disability status thus determines whether the State prevents suicide or facilitates it.

The disability rights movement has long rejected the notion that suffering is inherent in disability.[22] Disadvantage and distress frequently stem not from diagnosis itself, but from discrimination, social isolation, inadequate pain management, and barriers to services and supports. By medicalizing distress that may be socially and structurally produced, assisted suicide statutes misidentify the source of suffering. Instead of remedying inequities—lack of home- and community-based services, economic insecurity, or bias in clinical settings—the law offers death as a sanctioned solution.

Statutes such as the EOLOA therefore do more than create a narrow medical exception. They establish a disability-triggered carveout from generally applicable homicide prohibitions. Conduct that would constitute criminal assistance in suicide in any other context becomes lawful when the individual satisfies statutory medical criteria tied to disability. The State thereby creates two classes of suicidal individuals: those entitled to prevention and protection, and those eligible for facilitation. That distinction rests on—and reinforces—the premise that disabled

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[22] Samuel Goering, *Rethinking Disability: The Social Model of Disability and Chronic Disease*, 8 *Current Rev. Musculoskeletal Med.* 134. (2015), https://doi.org/10.1007/s12178-015-9273-z.

lives are less worthy of the State's protective efforts.

The Americans with Disabilities Act was enacted precisely to repudiate governmental decision-making grounded in "archaic attitudes," "myths," and "stereotypes" about disability. It prohibits not only explicit exclusion, but also policies that embody or perpetuate judgments that disabled lives are inherently tragic, undignified, or of lesser value. A statutory framework that withdraws suicide prevention protections once disability is present codifies the very type of discriminatory assumption the ADA was designed to eliminate. Equal and effective services cannot coexist with a system that conditions the State's commitment to preserving life on whether the individual is disabled.

C. Assisted Suicide Laws Present Particular Risks To People With Intellectual Disability

Physician-assisted suicide poses particular and grave risks to people with intellectual disability, who have long faced discrimination, devaluation, and unequal treatment in medical and social systems. As recognized by Amicus The Arc, safeguards embedded in assisted suicide statutes are insufficient to protect people with intellectual disability from coercion, bias, and systemic pressures that can shape life-ending decisions.[23]

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[23] The Arc, *Physician-Assisted Suicide Position Statement* (Revised 2017), https://thearc.org/wp-content/uploads/2021/05/Physician-Assisted-Suicide.pdf.

People with intellectual disability have historically been denied equal protection in medical decision-making and subjected to assumptions that their lives are of lesser value.[24] That history informs present-day health care interactions, where implicit bias and structural inequities persist. In this context, procedural safeguards cannot fully mitigate the risk that discriminatory judgments about "quality of life" will influence assessments of suffering, capacity, or eligibility for assisted suicide.

These structural inequities operate not only at the level of broad societal bias, but also within the day-to-day relationships on which many people with intellectual disability depend. Individuals with intellectual disability may be especially vulnerable to subtle or overt pressure from authority figures, including physicians, caregivers, service providers, guardians, and family members.[25] Research shows that people with intellectual disability often perceive their autonomy as diminished and that decisions are made on their behalf without meaningful input, underscoring their susceptibility to external influence in

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[24] The Arc, *"He Isn't Worth Helping" – Devastating Stories of Medical Ableism* (Jan. 3, 2024) (describing pervasive medical ableism and denial of appropriate treatment for people with intellectual and developmental disabilities), https://thearc.org/blog/he-isnt-worth-helping-devastating-stories-of-medical-ableism/

[25] *See* The Arc, *Physician-Assisted Suicide Position Statement* (Rev'd 2017).

health-related decisions.[26] Clinical studies also document gaps in clinician knowledge and comfort in treating patients with intellectual disability, which can increase reliance on third parties and further marginalize the individual's voice.[27] Moreover, because many people with intellectual disability depend on others for daily supports, expressions of voluntariness may be shaped by power imbalances, fear of burdening others, or concern about losing essential services.[28] Formal consent requirements, standing alone, do not adequately account for these

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[26] James Sheerin et al., *Perceptions of People With Intellectual Disabilities on Autonomy and Decision-Making in Daily Life: A Systematic Review and Synthesis of Qualitative Studies*, 70 *J. Intellect. Disabil. Res.* 225, 233-34 (2026).

[27] *See, e.g.*, Nicole Agaronnik et al., *Communicating with patients with disability: Perspectives of Practicing Physicians*, 34 *Journal of General Internal Medicine* 1139–1145 (2019) (finding many physicians treating patients with intellectual disability rely on caregivers and fail to engage the patients themselves in decision-making); Lisa Iacono et al., *A Systematic Review of Hospital Experiences of People with Intellectual Disability*, 55 *BMC Health Servs. Res.* 1, 6–8 (2014) (finding that health professionals frequently report inadequate training, low confidence, and discomfort in treating patients with intellectual disability, contributing to reliance on caregivers and reduced patient participation in decision-making); and Alice Bacherini et al., *Physicians' Attitudes about Individuals with Intellectual Disability and Health Care Practices*, Psychiatr. Danub. (2021) (finding physician knowledge to often be incomplete, especially regarding the rights and capabilities of individuals with intellectual disabilities and best practices for their healthcare).

[28] *See, e.g.*, Irene Tuffrey-Wijne et al., *Euthanasia and Physician-Assisted Suicide in People with Intellectual Disabilities and/or Autism Spectrum Disorders: Investigation of 39 Dutch Case Reports (2012–2021)*, 9 *BJPsych Open* e87 (2023), https://doi.org/10.1192/bjo.2023.69.

relational dynamics or ensure that decisions are truly voluntary.

These interpersonal vulnerabilities are compounded by systemic deficiencies in health and long-term care systems. In under-resourced health and long-term care systems, assisted suicide may be presented—explicitly or implicitly—as an alternative to unavailable or inadequate supports. Where access to high-quality medical care, palliative care, and disability-related services is uneven, offering assisted suicide risks converting systemic failures into life-ending outcomes. Against a backdrop of persistent societal misperceptions about the quality of life of people with intellectual disability, the danger that bias or economic pressures will influence decisions is acute.

For these reasons, assisted suicide laws present exceptional dangers to people with intellectual disability, and statutory safeguards cannot reliably ensure that decisions to end life are truly voluntary, informed, and free from coercion or discrimination.

IV. Requests For Assisted Suicide Reflect Structural Inequality And Unmet Support Needs.

A. The Primary Reasons For Requesting Assisted Suicide Are The Functions Of Psychological And Social Distress.

There are misconceptions about the role pain plays in individuals choosing assisted suicide. Although the desire to avoid pain and fear of pain are often raised as the primary reason for enacting assisted suicide laws, the top five reasons for

requesting assisted suicide are disability-related: loss of autonomy; decreasing ability to participate in activities that make life enjoyable; loss of dignity; losing control of bodily functions; and burden on family, friends/caregivers.[29] Studies of patient attitudes toward assisted suicide and euthanasia confirm that patients' interest in physician assisted suicide are more a function of psychological distress and social factors than physical factors.[30] Additionally, research has shown that:

> [t]he 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

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[29] Based on the data from Oregon, the state where assisted suicide has been legal the longest. *See* Oregon Health Authority, Public Health Division, Center for Health Statistics (2025). *2024 Oregon Death with Dignity Act data summary (Year 27). Oregon Health Authority*. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.pdf.

[30] Breitbart, Rosenfeld & Passik, *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 *Am. J. Psychiatry* 238, 238–242 (1996); Gillet E. Pear, *A Hard Charging Doctor on Obama's Team*, N.Y. Times (Apr. 18, 2009), at A14 (noting that pain is "a common stereotype of patients expressing interest in euthanasia. In most cases… the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones"). *See also* Hendin & Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 *Am. J. Psychiatry* 143, 143–150 (1993) (Most death requests, even in terminally ill people, are propelled by despair and treatable depression.)

> 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.'[31]

When people choose to end their lives because of social stigma, isolation, or lack of access to disability-related services, society should not accept this choice as "voluntary" and actively facilitate suicide. Instead, it should respond with the provision of services and supports.

Many people identified as candidates for assisted suicide could benefit from supportive care or treatment, such as counseling, peer support, pain medication, or in-home consumer-directed personal assistance. These measures lessen pain, suffering, and perceived burdens on family members, and restore independence, control, and choice. Access to quality mental health care is particularly relevant to lessening the desire to commit suicide.[32] "[T]hose who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders."[33] "Research

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[31] Block & Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 *Arch. Intern. Med.* 2039, 2039–47 (1994).

[32] By "quality mental health care" Amici mean voluntary mental health treatment and services that are comprehensive, community-based, recovery-oriented, and culturally and linguistically competent. Nothing in this brief should be construed as recommending or supporting involuntary treatment of any kind.

[33] *Washington v. Glucksberg*, 521 U.S. 701, 703 (1997).
Gopal, *Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry*, 43 *J. Am. Acad. Psychiatry Law* 183, 183–190 (2015), available at http://jaapl.org/content/jaapl/43/2/183.full.pdf

indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated."[34]

B. For People In Pain, Alternatives To Assisted Suicide Exist And Should Be Made Equally And Meaningfully Available.

The movement for the legalization of assisted suicide is driven by anecdotes of people who suffer greatly in the period before they die. But the overwhelming majority of these anecdotes describe situations for which legal alternatives exist.

It is legal in every U.S. state for an individual to create an advance directive that requires the withdrawal of treatment under any conditions the person wishes and for a patient to refuse any treatment or to require any treatment to be withdrawn.[35] It is also legal to receive sufficient painkillers to be comfortable, and research has shown this will not hasten death.[36] And perhaps least understood, for anyone who is dying in discomfort, it is currently legal in all states to receive

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[34] *Id*. *See also* Bannink et al., *Psychiatric Consultation and Quality of Decision Making in Euthanasia*, 356 *Lancet* 2067, 2067–68 (2000) (when psychological issues are explored, the request for assisted suicide may be withdrawn).

[35] Am. Bar Ass'n Comm'n on L. & Aging, *Health Care Advance Directives: State Laws* (50-State Survey) (2018), https://www.americanbar.org/content/dam/aba/administrative/law_aging/2018-triggering-chart.authcheckdam.pdf.

[36] *See* Hendin & Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 *Mich. L. Rev.* 1613, 1613–1640 (2008), available at https://repository.law.umich.edu/mlr/vol106/iss8/7

palliative sedation to relieve discomfort during the dying process.[37] Thus, there is already a legal recourse for painful deaths. These alternatives do not raise the serious difficulties of legalizing assisted suicide.

V. Purported Safeguards Are Structurally Inadequate And Erode Over Time.

Amici's constituents are among the most likely to be exposed to the risks created by the fragile safeguards, diluted protections, and prognostic uncertainty inherent in assisted suicide statutes. The lessons from Oregon and California therefore speak directly to the real-world threats laws like the EOLOA pose to the disability community.

A. Oregon's Experience Reveals Structural Design Failures.

Proponents of laws such as Delaware's EOLOA frequently cite Oregon as proof that assisted suicide can be confined within meaningful safeguards.[38] Nearly three decades under the Oregon Death with Dignity Act demonstrate otherwise.

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[37] *See* Richard Liu & Thaddeus Pope, *Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration: An International Review*, 35 *Ind. Int'l & Comp. L. Rev.* 67, 82–83 (2025) (discussing palliative sedation as an established, lawful end-of-life practice in the United States).

[38] Oregon's law, passed in 1997, is the oldest in the country.

The statutory scheme relies almost entirely on physician self-reporting and provides no independent mechanism to detect coercion, mistake, or abuse.[39]

These weaknesses are structural. The statute does not prevent heirs or financially interested caregivers from encouraging, facilitating, or orchestrating a request. Witnesses to the written request need not know the patient and are not required to meaningfully assess coercion; one witness may be an heir. Once the prescription is written, no physician or health professional need be present at ingestion, and no neutral party confirms voluntariness at the moment of death. The State lacks authority to independently investigate undue influence or complications beyond information supplied by the prescribing physician. In practice, the safeguards function largely on paper.

The psychiatric safeguard is particularly illusory. Referral for mental health evaluation occurs only if a physician subjectively questions the patient's decisional capacity.[40] There is no requirement for routine psychological assessment, even

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[39] *See generally Or. Rev. Stat.* §§ 127.800–127.897 (2023). *See also* Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 *Disability & Health J.*16, 16–22 (2010), https://doi.org/10.1016/j.dhjo.2009.08.006 (providing an overview of the weaknesses with Oregon's statute).

[40] Moreover, in the large majority of cases, no psychiatric referral is made. In the most recent reporting year, 2024, Oregon physicians referred less than 1% of persons who requested assisted suicide for a consultation to determine whether their judgment was impaired. Only 2.5% have been referred over all reported

though requests often stem from psychosocial distress—fear of dependence, loss of autonomy, or feeling like a burden. Nor must the State ensure that supportive services, disability accommodations, or mental health treatment were meaningfully offered or provided before a lethal prescription issues.

Moreover, even where referral is made, studies have shown that more than half of psychiatrists were "not at all confident" they could assess whether a psychiatric condition impaired a person's judgment in a single consultation; only six percent were "very confident" that they could.[41] 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 [physician-assisted suicide] ... There are no clinical criteria to guide such an assessment - just as there are no criteria to assess the rationality of any person's decision to commit suicide.[42]

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years—dating back to 1998. *See Oregon Death with Dignity Act - 2020 Data Summary*, *supra* note 29 at 15.

[41] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 *Am. J. Psychiatry* 595 (2000). *See also* Sulmasy et al., *Physician-Assisted Suicide: Against Medical Neutrality*, 34 *J. Gen. Intern. Med.* 1372 (2019), https://doi.org/10.1007/s11606-019-05019-1 (explaining how "[i]t is beyond the ken and expertise of the physician to judge whether such suffering is adequate to fulfill the criteria for the provision of lethal drugs.")

[42] Kelly & McLoughlin, *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box*, 181 *Br. J. Psychiatry* 278, 278–79 (2002) https://doi.org/10.1192/bjp.181.4.278

Delaware's EOLOA replicates these flaws. Like Oregon's law, it entrusts life-ending determinations to clinician attestations without independent oversight.[43] Interested individuals may participate in facilitating requests, witness requirements do not demand meaningful inquiry into coercion, no health professional must be present at ingestion, and mental health referral remains contingent on subjective suspicion rather than mandatory evaluation. Although palliative and hospice care must be discussed, neither statute requires documentation that disability-related supports, home- and community-based services, or mental health care were actually secured. The promise of "safeguards" is therefore largely aspirational—while the consequence of death is irreversible.

B. Legislative Experience Demonstrates That Safeguards Are Readily Diluted.

Experience shows that even initially described "guardrails" are unstable. In 2021, California amended its End of Life Option Act through Senate Bill 380, reducing the waiting period from fifteen days to forty-eight hours and eliminating the final attestation requirement—protections previously characterized as essential.[44] These changes occurred only a few years after enactment.

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[43] *See generally Del. Code Ann*. tit. 16, ch. 25C (West 2025).

[44]

Subsequent legislative and administrative efforts have continued to streamline access. The trajectory has been toward expansion and simplification, not heightened oversight. California's experience demonstrates that statutory safeguards are mutable policy choices, vulnerable to steady erosion over time.

C. Terminal Prognosis Is Inherently Uncertain.

Eligibility for assisted suicide in U.S. jurisdictions turns on a six-month terminal prognosis—an estimate widely acknowledged to be imprecise.[45] Clinicians routinely over- or under-estimate life expectancy, particularly in non-cancer conditions.[46] Oregon's own reports indicate that some individuals who received prescriptions lived well beyond the statutory prognosis; the data cannot capture how many might have survived longer absent ingestion.

Prognostic uncertainty is especially acute for individuals with newly acquired disabilities, such as spinal cord injuries or stroke, who often experience

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[45] Shapiro, *Terminal Uncertainty*, *Seattle Weekly* (Jan. 14, 2009), https://www.seattleweekly.com/news/terminal-uncertainty/ (exploring both the clinical and statistical uncertainty in terminal prognoses). *See also* Daniel Quill et al., *Sounding Board: Care of the Hopelessly Ill*, 327 *N. Engl. J. Med.* 1380, 1381 (1992) ("[W]e acknowledge the inexactness of such prognosis [of imminent death]").

[46] *See, e.g.,* Nicola White et al., *A Systematic Review of Predictions of Survival in Palliative Care: How Accurate Are Clinicians and Who Are the Experts?*, 11 *PLoS One* e0161407 (2016), https://doi.org/10.1371/journal.pone.0161407 (accuracy of categorical prognostic estimates ranged widely from 23% to 78%).

an initial period of despair followed by adaptation and renewed life satisfaction.[47] A legal framework that authorizes death during a period of crisis risks making permanent decisions based on temporary conditions.

D. Substantive Expansion Follows Normalization.

Although assisted suicide is often introduced as limited to the terminally ill, international experience demonstrates that eligibility criteria expand over time.

Since legalizing Medical Assistance in Dying in 2016, Canada broadened access in 2021 to include persons with disabilities whose deaths were not terminally foreseeable.[48] Assisted deaths now account for a significant percentage of annual deaths nationwide,[49] and the overwhelming majority involve clinician-

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[47] Stensman, *Severely Mobility-Disabled People Assess the Quality of Their Lives*, 17 *Scand. J. Rehab. Med.* 87, 87–99 (1985); Whiteneck et al., *Rocky Mountain Spinal Cord Injury System Report*, Nat'l Inst. Handicapped Research 29–33 (1985); Eisenberg & Saltz, *Quality of Life Among Aging Spinal Cord Injured Persons: Long Term Rehabilitation Outcomes*, 29 *Paraplegia* 1, 1–12 (1991).

[48] Canada, Bill C-7, An Act to Amend the Criminal Code (Medical Assistance in Dying), 43rd Parl., 2nd Sess., 2021.

[49] Most recent data from Canada reports 15,343 assisted deaths in 2023—an increase of over 15.8% over 2022. Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada*, 2023, ch. 2.2, "MAID Provisions" (Dec. 11, 2024), https://www.canada.ca/en/health-canada/services/publications/health-system-services/annual-report-medical-assistance-dying-2023.html.

administered euthanasia.[50] Government data reflect that many recipients cite isolation, inadequate supports, and feeling like a burden as contributing factors.

A similar pattern is evident in the Netherlands. What began as a practice defended for competent, terminally ill patients has expanded to encompass chronic illness, psychiatric disorders, cognitive impairment, and other non-terminal conditions. Oversight remains retrospective rather than prospective. Over time, the limiting principle has shifted from imminence of death to subjective assessments of "unbearable" suffering—an elastic standard that invites further expansion. As the late Dr. Herbert Hendin, one of the world's foremost suicide experts, explained in Congressional testimony:

> Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia.[51]

Hendin further testified:

> The notion that . . . American doctors . . . would follow guidelines if assisted suicide were legalized is not borne out by the Dutch experience; nor is it likely given the failure of American practitioners of assisted suicide to

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[50] *Id*. (Reporting that in 2023 "MAID was administered by a practitioner in nearly all cases" and "self-administered in fewer than five instances.")

[51] National Council on Disability, *supra* note 16 at 45 (quoting MD, *Suicide, Assisted Suicide and Euthanasia: Lessons from the Dutch Experience*, Testimony Summary, U.S. House of Representatives, Subcomm. on the Constitution, Apr. 29, 1996).

follow elementary safeguards in cases they have published.[52]

Expansionary pressures are not limited to foreign jurisdictions. In 2024, legislation was introduced in California[53] that would have extended eligibility for assisted suicide to individuals diagnosed with dementia, irrespective of terminal prognosis. Although the proposal did not advance, its introduction reflects ongoing efforts to decouple eligibility from a six-month terminal requirement and anchor it instead to progressive cognitive disability. It illustrates the instability of limiting principles once physician-assisted death becomes embedded in statutory law.

Recent scholarship also highlights serious risks where assisted suicide intersects with psychiatric vulnerability. A 2024 systematic review identified over sixty documented cases of assisted suicide and euthanasia involving patients with eating disorders in Belgium, the Netherlands, and the United States, including adolescents and young adults—many of whom had not received comprehensive treatment before assisted death.[54] These cases raise significant concerns about the

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[52] *Id*.

[53] *See* S.B. 1966, 2023–2024 Reg. Sess. (Cal. 2024) (introduced Apr. 9, 2024) (proposing amendments to extend eligibility to certain individuals diagnosed with dementia), introduced by Sen. Catherine Blakespear.

[54] Catherine Roff & Amanda Cook-Cottone, *Assisted Death in Eating Disorders: A Systematic Review of Cases and Clinical Rationales*, 15 *Frontiers in Psychiatry* 1431771 (2024), https://doi.org/10.3389/fpsyt.2024.1431771.

adequacy of safeguards in protecting individuals with psychiatric conditions from premature or coerced decisions.

CONCLUSION

Assisted suicide cannot meaningfully be characterized as a matter of "choice" when people with disabilities lack equitable access to appropriate medical care and the supports necessary to live with dignity. Decisions to die—made in the shadow of inaccessible services and institutional bias—cannot be disentangled from discrimination; the ADA does not permit the State to treat the effects of inequality as voluntary consent. Accordingly, Amici respectfully urge this Court to vacate the District Court's erroneous holding on the merits of Plaintiffs' anti-discrimination claims.

Respectfully Submitted,

DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND

s/ Maria Michelle Uzeta

Maria Michelle Uzeta (CA SBN 164402)
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
510-644-2555
muzeta@dredf.org

Attorney for Amici Curiae

Dated: March 2, 2026

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1. Certificate of Bar Admission: The attorney who appears on this brief is a member of the bar of this Court.

2. Certificate of Type Style Compliance: This brief complies with the type style requirements of Fed. R. App. P. 32(a) (5) and (6) because it has been prepared using Times New Roman, a proportionally spaced typeface, and 14-point font.

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4. Certificate of Service: On March 2, 2026, I electronically filed the foregoing Brief of *Amici Curiae* Disability Rights Education and Defense Fund and Eleven Other Disability Rights Organizations in Support of Plaintiffs-Appellees with the Clerk of the Court for the United States Court of Appeals for the Third Circuit by using the appellate CM/ECF system. The participants in this case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND

s/ Maria Michelle Uzeta

Maria Michelle Uzeta (CA SBN 164402)
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
510-644-2555
muzeta@dredf.org

Attorney for Amici Curiae

Dated: March 2, 2026