26-2414

UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BROOKLYN CENTER FOR INDEPENDENCE OF THE DISABLED, JOSÉ HERNANDEZ, ANITA CAMERON, SELF-INITIATED LIVING OPTIONS, INC., INDEPENDENT LIVING CENTER OF HUDSON VALLEY, REGIONAL CENTER FOR INDEPENDENT LIVING, NOT DEAD YET, UNITED SPINAL ASSOCIATION, NATIONAL COUNCIL ON INDEPENDENT LIVING, and INSTITUTE FOR PATIENTS' RIGHTS,

Plaintiffs and Appellants,

v.

THE HONORABLE KATHY HOCHUL, in her official capacity as Governor of the State of New York, NEW YORK STATE DEPARTMENT OF HEALTH, THE HONORABLE JAMES V. DONALD, M.D. in his official capacity as Commissioner of the New York State Department of Health, NEW YORK STATE BOARD FOR MEDICINE, THE HONORABLE AMIT M. SHELAT, D.O. in his official capacity as Chair of the New York State Board for Medicine, NEW YORK STATE OFFICE OF MENTAL HEALTH, THE HONORABLE ANN MARIE T. SULLIVAN, M.D. in her official capacity as Commissioner of the New York State Office of Mental Health,

Defendants and Appellees.

On Appeal from the United States District Court, Eastern District of New York
Case No. 1:26-cv-03492-OEM-JAM | Hon. Orelia E. Merchant

AMICUS BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND FIFTEEN OTHER DISABILITY RIGHTS ORGANIZATIONS IN SUPPORT OF PLAINTIFFS-APPELLANTS AND REVERSAL

Maria Michelle Uzeta*
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210, Berkeley, CA 94703
Tel: 510.644.2555
Counsel for *Amici Curiae*

*Admitted to the bar of the United States Court of Appeals for the Second Circuit

COMPLETE LIST OF AMICI

1. Disability Rights Education and Defense Fund
2. AIM Independent Living Center
3. American Association of People with Disabilities
4. Association of Programs for Rural Independent Living
5. Autistic People of Color Fund
6. Autistic Self-Advocacy Network
7. Autistic Women & Nonbinary Network
8. Center for Public Representation
9. Deaf Equality
10. Finger Lakes Independence Center
11. Harlem Independent Living Center
12. National Association of the Deaf
13. National Organization of Nurses with Disabilities
14. New York Association on Independent Living
15. Northern Regional Center for Independent Living
16. Southern Tier Independence Center

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.

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Conn. Fair Hous. Ctr. v. CoreLogic Rental Prop. Sols., LLC, 167 F.4th 605 (2d Cir. 2026).....16

Conn. Parents Union v. Russell-Tucker, 8 F.4th 167 (2d Cir. 2021).....16

Disabled in Action of Pa. v. Se. Pa. Transp. Auth., 539 F.3d 199 (3d Cir. 2008) ..18

Engesser v. McDonald, No. 25-CV-1689, 2025 WL 2371078 (E.D.N.Y. Aug. 14, 2025).....8

Engesser v. McDonald, No. 25-CV-1689, 2025 WL 2552602 (E.D.N.Y. Aug. 12, 2025).....8

FDA v. All. for Hippocratic Med., 602 U.S. 367 (2024).....16

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Havens Realty Corp. v. Coleman, 455 U.S. 363 (1982).....16

Heckler v. Mathews, 465 U.S. 728 (1984).....15, 21

Hickson v. St. David's Healthcare P'ship, L.P., L.L.P., 168 F.4th 282 (5th Cir. 2026).....7

Kinney v. Yerusalim, 812 F. Supp. 547, aff'd, 9 F.3d 1067 (3d Cir. 1993) (E.D. Pa. 1993).....18

Lujan v. Defs. of Wildlife, 504 U.S. 555 (1992).....15

Lujan v. Nat'l Wildlife Fed'n, 497 U.S. 871 (1990).....15

Miss. Univ. for Women v. Hogan, 458 U.S. 718 (1982).....15, 21

Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville, 508 U.S. 656 (1993).....15, 17

Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999) 21

Sch. Bd. of Nassau Cnty. v. Arline, 480 U.S. 273 (1987).....21

Washington v. Glucksberg, 521 U.S. 702 (1997).....24

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42 U.S.C. § 12102 5

42 U.S.C. § 12131 18

42 U.S.C. § 12182 18

42 U.S.C. §§ 12101–12213 1

Act of July 4, 2025, Pub. L. No. 119-21, 139 Stat. 72 8

N.Y. Mental Hyg. Law§ 9.41 (McKinney 2026) 20

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N.Y. Penal Law § 125.15(3) (McKinney 2026).....21

N.Y. Penal Law § 260.34 (McKinney 2026) 21

N.Y. Pub. Health Law § 2899-d(3) (McKinney 2026) 27

N.Y. Pub. Health Law § 2899-e(1) (McKinney 2026).....27

N.Y. Pub. Health Law § 2899-f(1) (McKinney 2026) 27

N.Y. Pub. Health Law § 2899-f(1)(d)–(f) (McKinney 2026) 27

N.Y. Pub. Health Law § 2899-f(2)–(3) (McKinney 2026) 27

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N.Y. Pub. HealthLaw § 2899-n (McKinney 2026) 7, 21

Or. Rev. Stat. § 127.810(2) (2025).....26

Or. Rev. Stat. § 127.825 (2025) 26

Or. Rev. Stat. § 127.865 (2025) 26

Or. Rev. Stat. §§ 127.800–.995 (2025) 25

Tex. Health & Safety Code Ann. § 166.046 (West 2025).....12

Other Authorities

Amit A. Gopal, *Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry*, 43 J. Am. Acad. Psychiatry & L. 183 (2015) 24

Caring Across Generations, *Federal Cuts, State Choices, and the Future of Aging and Disability Care* (July 2026).....8

Catherine A. Okoro et al., *Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults—United States, 2016*, 67 Morbidity & Mortality Wkly. Rep. 882 (2018).....9

Dan Goodley, *Dis/Ability Studies: Theorising Disablism and Ableism* (2014) 3

David Carlson, Cindy Smith & Nachama Wilker, Nat'l Disability Rts. Network, *Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights* (2012).....10

Deborah Edwards, Dikaios Sakellariou & Sally Anstey, *Barriers to, and Facilitators of, Access to Cancer Services and Experiences of Cancer Care for Adults with a Physical Disability: A Mixed Methods Systematic Review*, 13 Disability & Health J. 100844 (2020) 10

Elizabeth Barnes, *The Minority Body: A Theory of Disability* (2016).....20

Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JAMA 2460 (2000) 23

Ferdinando L. Mirarchi et al., *TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders*, 42 J. Emergency Med. 511 (2012).....12

Gale G. Whiteneck et al., *Rocky Mountain Spinal Cord Injury System Report* (Nat'l Inst. of Handicapped Rsch. 1985) 29

Herbert Hendin & Gerald L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 143 (1993).....23

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).....22

James V. Lavery et al., *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*, 358 Lancet 362 (2001) 24

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. 16, 2025) ..8

Joseph Shapiro, One Man's COVID-19 Death Raises the Worst Fears of Many People with Disabilities, NPR (July 31, 2020).....7

Lisa I. Iezzoni et al., *Physicians' Perceptions of People with Disability and Their Health Care*, 40 Health Affs. 297 (2021).....10, 11

Lisa I. Iezzoni et al., *U.S. Physicians' Knowledge About the Americans with Disabilities Act and Accommodation of Patients with Disability*, 41 Health Affs. 96 (2022) 11

Lisa I. Iezzoni, *Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities*, 30 Health Affs. 1947 (2011).11

Liz Essley Whyte, *State Policies May Send People with Disabilities to the Back of the Line for Ventilators*, Ctr. for Pub. Integrity (Apr. 8, 2020).....6

Maiss Mohamed, Alice Burns & Molly O'Malley Watts, *Medicaid Home Care (HCBS) in 2025*, KFF (Jan. 5, 2026).....8

Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 Disability & Health J. 16 (2010) 25

Marjolein Bannink et al., *Psychiatric Consultation and Quality of Decision Making in Euthanasia*, 356 Lancet 2067 (2000) 25

Merle Spriggs, *Ashley's Interests Were Not Violated Because She Does Not Have*

Necessary Interests, 10 Am. J. Bioethics 52 (2010) 6

Myron G. Eisenberg & Constance C. Saltz, *Quality of Life Among Aging Spinal Cord Injured Persons: Long Term Rehabilitation Outcomes*, 29 Paraplegia 514 (1991) 29

Nat'l Council on Disability, *Medical Futility and Disability Bias* (2019).....9

Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (2019).....11

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).....28

Nina Shapiro, *Terminal Uncertainty*, Seattle Weekly (Jan. 14, 2009).....28

Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 89 Fed. Reg. 40,066 (May 9, 2024).....18

Or. Health Auth., Pub. Health Div., Ctr. for Health Stat., *Oregon Death with Dignity Act: 2025 Data Summary* (2026) 23, 28

Pauline W. Chen, *Disability and Discrimination at the Doctor's Office*, N.Y. Times: Well (May 23, 2013) 11

Peter Singer, *Practical Ethics* (2d ed. 1993).....6

Richard Stensman, *Severely Mobility-Disabled People Assess the Quality of Their Lives*, 17 Scandinavian J. Rehab. Med. 87 (1985) 29

Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 Annals Internal Med. 743 (2003).....12

Robyn M. Powell & Michael Ashley Stein, *Persons with Disabilities and Their Sexual, Reproductive, and Parenting Rights: An International and Comparative Analysis*, 11 Frontiers L. China 53 (2016) 5

Sara Goering, *Rethinking Disability: The Social Model of Disability and Chronic Disease*, 8 Current Rev. Musculoskeletal Med. 134 (2015) 20

Tara Lagu et al., *"I Am Not the Doctor for You": Physicians' Attitudes About Caring for People with Disabilities*, 41 Health Affs. 1387 (2022).....10

Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment: A Survey*, 158 Annals Internal Med. 441 (2013).....11

The Arc, *Physician-Assisted Suicide Position Statement* (rev. 2017).....22

Timothy E. Quill, Christine K. Cassel & Diane E. Meier, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380(1992).....28

William Breitbart, Barry D. Rosenfeld & Steven D. Passik, *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238 (1996) 23

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28 C.F.R. §35.130(b)(1)(ii)–(iv) (2025).....18

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

This amicus curiae brief is filed with the consent of Ernest Galvan, counsel for Plaintiffs-Appellants, and Andrea W. Trento, counsel for Defendants-Appellees.

IDENTITIES AND INTERESTS OF AMICI CURIAE[1]

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, 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. Several Amici are membership organizations whose members, like the individual Plaintiffs here, live with life-threatening disabilities and depend on physicians to counsel them about the benefits and burdens of beginning or continuing life-sustaining treatment.

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 submit this brief to address the question on which the district court dismissed this case: whether Plaintiffs have alleged an injury in fact. The district court treated New

[1] 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 person other than Amici, their members, or their counsel, contributed money that was intended to fund preparing or submitting this brief.

York's Medical Aid in Dying Act (the "Act"), N.Y. Pub. Health Law §§ 2899-d to 2899-s (McKinney 2026), as a dormant benefit that touches no one until a physician certifies a six-month prognosis. JA 14, 22. That characterization ignores the lived realities of disabled people, for whom the clinical conversations that shape end-of-life decisions begin long before any terminal certification. The Act does not add a neutral option to a neutral health care system. It operates on a medical profession whose attitudes toward disabled lives are already documented and already harmful, and it does so for every patient whose disability a physician might one day deem "terminal."[2]

The individual Amici are described in the attached Addendum.

SUMMARY OF ARGUMENT

The district court dismissed this case on the premise that the Act cannot injure anyone who has not yet been certified as having six months to live. That premise is wrong as a matter of documented history, not speculation. People with life-threatening disabilities do not encounter the Act for the first time when a physician signs a terminal certification. They encounter it every time they sit across from a physician to decide whether to begin or continue a difficult, costly,

[2] Amici write principally in support of Plaintiffs' standing. The history of medical discrimination described in Parts I and II is not background to the merits; it is the factual predicate that makes Plaintiffs' present injury concrete and their future injury substantially likely.

or life-sustaining treatment—a conversation that depends entirely on the physician's assessment of the benefits and burdens of living with the patient's disability. The medical profession's assessments of that question were badly distorted before the Act. The Act now tells those same physicians that the State regards loss of function, dependence on others, and the need for intimate care as conditions for which death is an appropriate medical response. That message alters the standard of care for disabled patients now, whether or not they ever qualify for a lethal prescription. This is a concrete, present, disability-based injury the district court never considered.

New York's Act sits squarely within this nation's long history of disability discrimination in health care. It carves disabled people out of longstanding legal protections against abuse, neglect, and homicide while denying them the full force of state suicide-prevention efforts—a double standard the ADA forbids.

These laws also codify ableist[3] assumptions about whose lives are worth living. They operate in a 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

[3] On the meaning of "ableist" and "ableism," *see, e.g.*, Dan Goodley, *Dis/Ability Studies: Theorising Disablism and Ableism* 21 (2014) (explaining that ableism "privileges able-bodiedness" and "encourages an institutional bias towards autonomous, independent bodies").

ideation—untreated depression, unmanaged pain, isolation, and lack of supports—assisted suicide statutes accept those conditions as fixed. In that context, the promise of a "choice" is illusory.

The Act's purported statutory safeguards do not cure these structural defects. Nearly three decades in Oregon demonstrate that 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. Those realities—including the well-documented unreliability of six-month prognoses and the ease with which a person with a life-threatening disability can be brought within the Act's eligibility criteria—make the risk that Plaintiffs will be deemed eligible under the Act substantial rather than speculative.

The problem, then, is not autonomy itself. Amici do not oppose autonomy. We oppose false choices constructed atop inequity. Real autonomy requires real options: accessible and comprehensive rehabilitative services, voluntary mental health treatment, adequately funded home- and community-based supports, and high-quality palliative and hospice care. Expanding access to assisted suicide while those 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. Plaintiffs have alleged concrete, present injury from a system that already treats them as candidates for death rather than for care, and they are entitled to have that claim heard.

ARGUMENT

I. The Act Adds to the United States' Long History of Discrimination and Bias Against Disabled People in Health Care, and That History Is Why the Act Injures Plaintiffs Now.

Assisted suicide statutes must be understood—and allegations that such statutes injure disabled people must be assessed—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 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

[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. *See* 42 U.S.C. § 12102; 28 C.F.R. § 35.108(c) (2026).

[5] *See* Robyn M. Powell & Michael Ashley Stein, *Persons with Disabilities and Their Sexual, Reproductive, and Parenting Rights: An International and Comparative Analysis*, 11 Frontiers L. China 53, 60–68 (2016); *see also Buck v. Bell*, 274 U.S. 200, 207 (1927) (legitimizing early 20th century eugenic sterilization practices).

disabilities.[6]

These views are not relics of the past. 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, of the thirty state crisis standards of care it analyzed, at least twenty-five contained provisions that could deprioritize people with disabilities for ventilators and other life-saving treatment.[7] These protocols—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]

The crisis standards of care are instructive for a further reason: judgments that disabled lives are worth less do not stay in written protocols; they reach the

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[6] *See, e.g.*, Merle 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, *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] Liz Essley Whyte, *State Policies May Send People with Disabilities to the Back of the Line for Ventilators*, Ctr. for Pub. Integrity (Apr. 8, 2020), https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/.

[8] *Id.*

bedside. In June 2020, Michael Hickson, a 46-year-old man with quadriplegia and a brain injury, was hospitalized in Austin with suspected COVID-19. Although he had been given a 70% chance of survival, his physicians allegedly recommended comfort care based on his perceived quality of life and withdrew food and fluids; he died on June 11.[9] As one physician put it in a recorded conversation, "his quality of life—he doesn't have much of one."[10] The Act's message—that suicide prevention is not for disabled patients—will reach the bedside the same way.

New York's Act 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 nondisabled people. Only disabled people are removed from the protections of generally applicable laws on abuse, neglect, and homicide. *See* N.Y. Pub. Health Law § 2899-n. And only disabled people are offered assisted suicide in response to suicidal ideation.

This unequal treatment is particularly alarming now, when the services that enable disabled people to live in the community face persistent fiscal and political pressure. At both the federal and state levels, Medicaid funding cuts and financing

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[9] *See Hickson v. St. David's Healthcare P'ship, L.P., L.L.P.*, 168 F.4th 282, 285–287 (5th Cir. 2026) (vacating dismissal of Section 504 and Section 1557 claims).

[10] Joseph Shapiro, *One Man's COVID-19 Death Raises the Worst Fears of Many People with Disabilities*, NPR (July 31, 2020), https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities.

restrictions threaten optional benefits such as home- and community-based services, attendant care, and family caregiver supports.[11] New York is no exception: the State's 2025 transition of its Consumer Directed Personal Assistance Program to a single statewide fiscal intermediary disrupted attendant services for disabled New Yorkers who, like Plaintiff Hernandez, depend on in-home care to survive. *See* JA 40, 70.[12] States confronting budget shortfalls have likewise implemented or considered freezes, rate reductions, and limits on personal assistance and developmental disability services.[13]

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[11] *See* Act of July 4, 2025, Pub. L. No. 119-21, §§ 71107, 71115–71117, 71119, 139 Stat. 72, 295–96, 301–15 (codified at scattered sections of 42 U.S.C.); Maiss Mohamed, Alice Burns & Molly O'Malley Watts, *Medicaid Home Care (HCBS) in 2025*, KFF (Jan. 5, 2026), https://www.kff.org/medicaid/medicaid-home-care-hcbs-in-2025/ (explaining that nearly all Medicaid home care is optional for states and that the 2025 law is estimated to cut federal Medicaid spending by $911 billion over a decade); Caring Across Generations, *Federal Cuts, State Choices, and the Future of Aging and Disability Care* (July 2026), https://caringacross.org/wp-content/uploads/2026/07/July-2026-Federal-Cuts-State-Choices-and-the-Future-of-Aging-and-Disability-Care-Google-Docs.pdf (documenting home-care cuts in at least eighteen states).

[12] *Engesser v. McDonald*, No. 25-CV-1689, 2025 WL 2552602, at *9 (E.D.N.Y. Aug. 12, 2025), *objections overruled*, No. 25-CV-1689, 2025 WL 2371078 (E.D.N.Y. Aug. 14, 2025) (approving class settlement after the court entered successive injunctions to keep services in place during the transition).

[13] 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. 16, 2025), https://www.healthaffairs.org/content/forefront/history-repeats-faced-medicaid-cuts-states-reduced-support-older-adults-and-disabled.

The Act thus does not operate in a neutral health care system, but in one 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 Act revives the very hierarchies of worth disability civil rights statutes were enacted to abolish. That is why this history matters to standing. The district court asked only whether Plaintiffs are presently eligible for a lethal prescription. JA 14. But the injury Plaintiffs allege—an inferior standard of medical care, JA 76–77, 111–12—does not depend on eligibility. It depends on what the Act communicates to physicians about disabled patients, and on what those physicians already believed. Part II addresses the second point; Part III explains why, together, they establish a present, concrete injury.

II. Systemic Medical Bias Means the Act Degrades the Medical Care of People with Life-Threatening Disabilities Now, Whether or Not They Ever Qualify for a Lethal Prescription.

Disability status heavily shapes life-sustaining health care decisions.[14]

[14] *See, e.g.*, Catherine A. Okoro et al., *Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults—United States, 2016*, 67 Morbidity & Mortality Wkly. Rep. 882 (2018); Nat'l Council on Disability, *Medical Futility and Disability Bias* (2019), https://www.ncd.gov/report/medical-futility-and-disability-bias/.

People with disabilities are frequently denied necessary treatment due to pervasive biases about their quality of life and the value of their lives.[15] 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 produced what its authors called "troubling findings": 82.4% believed that people with significant disabilities have a worse quality of life than nondisabled people.[16] 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.[17] Qualitative research further shows that clinicians often make erroneous assumptions about disabled patients' values and preferences, narrowing treatment options and compromising care.[18]

The National Council on Disability has highlighted the troubling double

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[15] *See*, *e.g.*, David Carlson, Cindy Smith & Nachama Wilker, Nat'l Disability Rts. Network, *Devaluing People with Disabilities: Medical Procedures that Violate Civil Rights* (2012).

[16] Lisa I. Iezzoni et al., *Physicians' Perceptions of People with Disability and Their Health Care*, 40 Health Affs. 297, 297 (2021).

[17] Tara Lagu et al., *"I Am Not the Doctor for You": Physicians' Attitudes About Caring for People with Disabilities*, 41 Health Affs. 1387 (2022).

[18] Deborah Edwards, Dikaios Sakellariou & Sally Anstey, *Barriers to, and Facilitators of, Access to Cancer Services and Experiences of Cancer Care for Adults with a Physical Disability: A Mixed Methods Systematic Review*, 13 Disability & Health J. 100844 (2020), https://doi.org/10.1016/j.dhjo.2019.100844.

standard in suicide prevention reflected in laws like the Act: 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.[19] These risks are compounded by widespread legal ignorance. In the same survey, over a third of physicians knew little or nothing about ADA obligations, more than two-thirds misidentified who determines accommodations, and fewer than half felt very confident providing equitable care.[20]

These biases translate into tangible disparities: disabled patients face lower preventive screening rates, limited access to care, and in some cases outright refusal of treatment.[21] Jurisdictions that allow physicians to unilaterally withhold "futile" care exacerbate these risks, as subjective judgments about quality of life

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[19] Nat'l Council on Disability, *The Danger of Assisted Suicide Laws* (2019), https://www.ncd.gov/assets/uploads/docs/ncd-assisted-suicide-report-508.pdf.

[20] Lisa I. Iezzoni et al., *U.S. Physicians' Knowledge About the Americans with Disabilities Act and Accommodation of Patients with Disability*, 41 Health Affs. 96 (2022), https://doi.org/10.1377/hlthaff.2021.01136; *see also* Iezzoni et al., *supra* note 16, at 297 (reporting that only 40.7% of physicians were very confident about their ability to provide the same quality of care to patients with disability).

[21] *See* Lisa I. Iezzoni, *Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities*, 30 Health Affs. 1947 (2011); Pauline W. Chen, *Disability and Discrimination at the Doctor's Office*, N.Y. Times: Well (May 23, 2013), https://well.blogs.nytimes.com/2013/05/23/disability-and-discrimination-at-the-doctors-office/ (citing Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment: A Survey*, 158 Annals Internal Med. 441 (2013), https://doi.org/10.7326/0003-4819-158-6-201303190-00003).

and misunderstanding of advance directives can result in premature or inappropriate treatment limitations.[22]

Because the medical profession often fails to value disabled lives equally, laws like the Act can only 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.

III. The History of Medical Discrimination Is What Makes Plaintiffs' Injury Concrete and Present, Not Speculative.

The district court held that neither the individual Plaintiffs nor the organizations' members had alleged an injury in fact because none was presently eligible for lethal medication under the State's reading of the Act. JA 14, 22. Amici do not repeat Plaintiffs' arguments about the substantial risk that they will become eligible, or about the court's error in adopting the State's statutory construction at the pleading stage. Amici write instead to explain why the injury the district court

[22] *See, e.g.*, Tex. Health & Safety Code Ann. § 166.046 (West 2025). Even more concerning are futility policies that grant physicians immunity for denying care expressly requested by patients or their lawful surrogates. *See* Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 Annals Internal Med. 743 (2003); Ferdinando L. Mirarchi et al., *TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders*, 42 J. Emergency Med. 511 (2012), https://www.jem-journal.com/article/S0736-4679(11)00853-5/fulltext.

acknowledged, JA 12, but never analyzed—the Act's immediate degradation of the medical care Plaintiffs receive, JA 76–77, 111–12—is real, and why a court cannot assess that injury while disregarding the history set out above.

People with life-threatening disabilities depend on physicians in a way most patients do not. Mr. Hernandez has limited breathing capacity and no control of his diaphragm, and would die without around-the-clock care. JA 39–40. Ms. Cameron lives with progressive, degenerative conditions and has lung tumors that her providers failed to disclose to her. JA 42–43. For patients like them, nearly every significant medical decision—whether to accept a ventilator or a feeding tube, undergo surgery, pursue rehabilitation, fight an insurance denial, or continue an expensive or burdensome therapy—turns on a physician's counsel about the benefits and burdens of the treatment. And that counsel turns, inescapably, on the physician's assessment of what life with the patient's disability is worth.

That assessment was already distorted before the Act took effect. More than four in five physicians believe that people with significant disabilities have a worse quality of life than nondisabled people; physicians view accommodations as burdensome, deny care, and provide lesser treatment; and clinicians routinely make erroneous assumptions about disabled patients' values and preferences that narrow the options they present. *See supra* Part II. The individual Plaintiffs have lived this. A provider proposed amputating Mr. Hernandez's toe because he "was not using

it." JA 40. Providers treated Ms. Cameron as drug-seeking when she reported pain. JA 43. These are not isolated indignities. They are the ordinary texture of medical care for people with significant disabilities.

The Act operates on precisely this terrain. By making a lethal prescription a State-sanctioned medical response for patients with "incurable and irreversible" conditions, N.Y. Pub. Health Law § 2899-d(17), the Act tells physicians that the circumstances disabled patients live with every day—loss of autonomy, dependence on others for intimate care, loss of bodily control, the sense of being a burden—are conditions for which death is an appropriate clinical answer. Those are not Amici's characterizations; they are the reasons patients in Oregon give, year after year, for requesting assisted suicide. *See infra* Part V. A physician who already doubts that a ventilator-dependent patient's life is worth living, and who now practices under a law that treats such a life as a candidate for medically assisted death, counsels that patient differently about whether to accept a tracheostomy or contest an insurance denial. The physician need never mention the Act. The distortion enters the benefit-burden calculus itself.

That is why the injury is not speculative and does not wait for eligibility. The Supreme Court has long recognized that discrimination inflicts cognizable injury on those "personally denied equal treatment," including by "stigmatizing members of the disfavored group as 'innately inferior' and therefore as less worthy

participants in the political community." *Heckler v. Mathews*, 465 U.S. 728, 739–40 (1984) (quoting *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 725 (1982)); *see also Ne. Fla. Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656, 666 (1993) (holding that the injury in fact "is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit"); *Allen v. Wright*, 468 U.S. 737, 755 (1984). The Act's message that disabled lives are candidates for death is delivered, in the first instance, not to the patient but to the physician—the person on whose judgment the patient's access to life-sustaining care depends. A patient whose physician has received that message is "personally denied equal treatment" in the most literal sense: the standard of care applied to that patient differs, on the basis of disability, from the standard applied to everyone else. Plaintiffs allege exactly this, with expert support. JA 111–13, 118, 125. At the pleading stage the Court must accept those allegations and must "presum[e] that general allegations embrace those specific facts that are necessary to support the claim." *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992) (alteration in original) (quoting *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 889 (1990)).

The district court never engaged with this injury. It treated the Act as a benefit that touches no one until a physician certifies a six-month prognosis, and the medical system into which the Act is introduced as neutral. Neither premise

survives the history recounted above. A court that disregards the documented reality of medical bias against disabled people, and then holds that a law premised on that bias cannot injure them until the moment it kills them, has not applied Article III; it has repeated the discrimination the ADA was enacted to end. Amici respectfully urge this Court not to do the same.

The same history explains why the organizational Plaintiffs are injured now. Organizations such as United Spinal Association exist to counter the message that life after a catastrophic injury is not worth living. Its peer mentors work with newly injured people during precisely the period of despair and depression that, as the research shows, is typically followed by adaptation and renewed life satisfaction. JA 58–59, 83–84; *see infra* Part VI.B. That work is a core activity "by which the organizational mission has historically been carried out," *Conn. Parents Union v. Russell-Tucker*, 8 F.4th 167, 175 (2d Cir. 2021), and it is perceptibly impaired when the State tells the same newly injured people, through their physicians, that dependence and loss of dignity have a sanctioned medical solution in death. *See FDA v. All. for Hippocratic Med.*, 602 U.S. 367, 395 (2024) (organizational injury where defendant's conduct "directly affected and interfered with" the organization's "core business activities"); *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 379 (1982); *cf. Conn. Fair Hous. Ctr. v. CoreLogic Rental Prop. Sols., LLC*, 167 F.4th 605, 618 (2d Cir. 2026) (distinguishing advocacy and

informational programming from the counseling services at issue in *Havens*). The district court treated this injury as mere "[f]rustration of an organization's mission." JA 17. It is more than that. Whether the Act impairs United Spinal's peer mentoring of a twenty-year-old with a new spinal cord injury depends on what that young person's physicians are likely to believe about his future, and that is a matter of documented history, not conjecture.

IV. The Act Violates the Spirit and Letter of the Americans with Disabilities Act.

The district court did not reach the merits. But a court assessing standing must "accept as valid the merits of [the plaintiffs'] legal claims," *FEC v. Cruz*, 596 U.S. 289, 298 (2022), and discriminatory treatment is itself an Article III injury, *see Ne. Fla. Chapter*, 508 U.S. at 666. The nature of the discrimination the Act works therefore bears directly on the question before this Court.

A. The Act Denies People with Disabilities the Equal Benefit of Protective Laws and Programs.

Congress enacted the ADA in 1990 to remedy the "serious and pervasive social problem" of discrimination against individuals with disabilities. 42 U.S.C. § 12101(a)(2). 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.[23]

The Act's discrimination goes beyond withholding of suicide-prevention services. JA 113. New York'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 individuals with aids, benefits, or services that are "not equal to that afforded others," "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 Pa. v. Se. Pa. Transp. Auth.*, 539 F.3d 199, 208–09 (3d Cir. 2008) (quoting *Kinney v. Yerusalim*, 812 F. Supp. 547, 551, *aff'd*, 9 F.3d 1067 (3d Cir. 1993) (E.D. Pa. 1993)). *See also* 42 U.S.C. § 12101(b)(1) (ADA's purpose is "to

[23] *See* 42 U.S.C. §§ 12131, 12182; 28 C.F.R. §§ 35.130(b), 36.202(b)–(c). *See also* 45 C.F.R. § 84.56(b)(1)(i)–(iii) (2025) (prohibiting recipients of federal funds from denying or limiting medical treatment based on bias or stereotypes about a patient's disability, judgments that the patient will be a burden on others, or a belief that life with a disability is not worth living); Nondiscrimination on the Basis of Disability in Programs or Activities Receiving Federal Financial Assistance, 89 Fed. Reg. 40,066, 40,083 (May 9, 2024) (codified at 45 C.F.R. pt. 84) (explaining that § 84.56 reaches suicide-prevention services).

provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities"). A law that offers death as a state-sanctioned response to the health care and support needs of disabled individuals—and 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 preventive care and supportive services.

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 Act Is Predicated on Disability-Based Judgments About Quality of Life

Assisted suicide statutes like the Act 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.[24]

This premise 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. *See* N.Y. Mental Hyg. Law § 9.41 (McKinney 2026); JA 113. When expressed by a person who meets statutory disability criteria, however, the same intent becomes grounds for state-authorized medical assistance in ending 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.[25] 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

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[24] Despite its persistence, this assumption has been consistently rejected. *See, e.g.*, Elizabeth Barnes, *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").

[25] *See* Sara 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.

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 Act therefore do more than create a narrow medical exception. They establish a disability-triggered carveout from generally applicable prohibitions on homicide, assisting suicide, and endangering vulnerable persons. *See* N.Y. Penal Law §§ 120.30, 125.15(3), 260.34 (McKinney 2026); N.Y. Pub. Health Law § 2899-n; JA 95, 103. 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 lives are less worthy of the State's protective efforts.

The ADA was enacted precisely to repudiate governmental decision-making grounded in "myths," "archaic and stereotypic notions," "unwarranted assumptions," and "unfounded fear" about disability.[26] It prohibits not only explicit exclusion, but also policies that embody or perpetuate judgments that disabled

[26] *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273, 284, 287 (1987) ("society's accumulated myths and fears"; "prejudice, stereotypes, or unfounded fear"); *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999) (isolation "perpetuates unwarranted assumptions" that persons are "incapable or unworthy"); *Heckler*, 465 U.S. at 739 ("archaic and stereotypic notions") (quoting *Hogan*, 458 U.S. at 725).

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.

These dangers are acute for people with intellectual disability, who have long been subjected to assumptions that their lives are of lesser value, and who may be especially vulnerable to subtle or overt pressure from the physicians, caregivers, guardians, and family members on whom they depend for daily supports.[27] Expressions of voluntariness may be shaped by those power imbalances, by fear of burdening others, or by concern about losing essential services.[28] Formal consent requirements do not account for these relational dynamics, and no procedural safeguard can reliably ensure that a decision to end life is voluntary, informed, and free from coercion or discrimination.

V. Requests for Assisted Suicide Reflect Structural Inequality and Unmet Support Needs.

Although fear of pain is often raised as the primary reason for enacting assisted suicide laws, the top five reasons for requesting assisted suicide are

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

[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.

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] Each describes the daily lives of Plaintiffs Hernandez and Cameron—who depend on others for daily and intimate care—long before any six-month prognosis. *See* JA 40, 75–76. Studies confirm that interest in assisted suicide is more a function of psychological distress and social factors than physical ones.[30] Qualitative research likewise shows 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

[29] These figures are drawn from Oregon, the state where assisted suicide has been legal the longest. *See* Or. Health Auth., Pub. Health Div., Ctr. for Health Stat., *Oregon Death with Dignity Act: 2025 Data Summary* 9, 16 tbl.1 (2026), https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year28.pdf.

[30] *See* William Breitbart, Barry D. Rosenfeld & Steven D. Passik, *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238 (1996); Ezekiel J. Emanuel et al., *Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers*, 284 JAMA 2460 (2000); *see also* Herbert Hendin & Gerald L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 143 (1993) (explaining that 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 death because of stigma, isolation, or lack of disability-related services, society should respond with services and supports, not accept that choice as "voluntary" and facilitate suicide.

Many candidates for assisted suicide could benefit from counseling, peer support, pain medication, or in-home personal assistance. These measures lessen suffering and perceived burdens on family and restore independence and control. Access to quality mental health care is particularly important.[32] "[T]hose who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders."[33] "Research indicates . . . that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated."[34]

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[31] James V. Lavery et al., *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*, 358 Lancet 362, 366 (2001).

[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. 702, 730 (1997); *see also* Amit A. Gopal, *Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry*, 43 J. Am. Acad. Psychiatry & L. 183 (2015), http://jaapl.org/content/jaapl/43/2/183.full.pdf

[34] *Glucksberg*, 521 U.S. at 730; *see also* Marjolein Bannink et al., *Psychiatric*

VI. Purported Safeguards Are Structurally Inadequate.

Amici's constituents bear the greatest risks from the fragile safeguards and prognostic uncertainty inherent in assisted suicide statutes. The lessons from Oregon also bear on standing: the ease with which a person with a life-threatening disability can be brought within the Act's eligibility criteria, and the unreliability of the prognosis on which eligibility turns, make the risk that Plaintiffs will be deemed eligible substantial rather than conjectural.

A. Oregon's Experience Reveals Structural Design Failures.

Proponents of laws such as New York's Act frequently cite Oregon as proof that assisted suicide can be confined within meaningful safeguards. Nearly three decades under the Oregon Death with Dignity Act demonstrate otherwise. The statutory scheme relies almost entirely on physician self-reporting and provides no independent mechanism to detect coercion, mistake, or abuse.[35]

These weaknesses are structural. The statute does not prevent heirs or financially interested caregivers from encouraging, facilitating, or orchestrating a

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Consultation and Quality of Decision Making in Euthanasia, 356 Lancet 2067, 2067–68 (2000) (reporting that, when psychological issues are explored, the request for assisted suicide may be withdrawn).

[35] *See generally* Or. Rev. Stat. §§ 127.800–.995 (2025). *See also* Marilyn Golden & Tyler Zoanni, *Killing Us Softly: The Dangers of Legalizing Assisted Suicide*, 3 Disability & Health J. 16 (2010), https://doi.org/10.1016/j.dhjo.2009.08.006 (providing an overview of the weaknesses with Oregon's statute).

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. *See* Or. Rev. Stat. § 127.810(2). 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. *See id.* § 127.865. 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.[36] There is no requirement for routine psychological assessment, even though requests often stem from psychosocial distress—fear of dependence, loss of autonomy, or feeling like a burden.

New York's Act replicates these flaws, and in some respects goes further. Like Oregon's law, it entrusts the eligibility determination entirely to clinician

[36] Moreover, in most cases, no psychiatric referral is made. In the most recent reporting year, 2025, only 0.5% of the patients who died under Oregon's law (2 of 400) had been referred for psychiatric evaluation. Only 2.9% (83 of 3,691) have been referred over all reporting years—dating back to 1998. *See* Or. Health Auth., *supra* note 29, at 10, 15. Referral is required only if a physician believes the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment. *See* Or. Rev. Stat. § 127.825.

attestation without independent oversight.[37] A prescription for lethal drugs may be filled five days after the patient's request, and sooner—"within hours or even minutes of the first request"—if the physician believes the patient has less than five days to live. JA 99, 122; N.Y. Pub. Health Law §§ 2899-e(1), 2899-f(2)–(3). The attending physician may also dispense with the in-person examination, and proceed entirely by telehealth, on the physician's own finding of "extraordinary hardship." N.Y. Pub. Health Law § 2899-f(1); JA 101, 128. Although the Act now requires a mental-health evaluation, that evaluation is confined to decision-making capacity; it requires no assessment of the patient's psychiatric or psychological condition, including any history of depression or suicidality. N.Y. Pub. Health Law §§ 2899-d(3), 2899-i(1); JA 99–100. And although palliative care and end-of-life options must be discussed, nothing requires that disability-related supports, home- and community-based services, or mental health care were actually offered, secured, or even available. N.Y. Pub. Health Law § 2899-f(1)(d)–(f); JA 101–02. The promise of "safeguards" is therefore largely aspirational—while the consequence of death is irreversible.

[37] *See generally* N.Y. Pub. Health Law §§ 2899-d to 2899-s.

B. 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.[38] Clinicians routinely over- or under-estimate life expectancy, particularly in non-cancer conditions.[39] 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.[40] Plaintiffs allege the same from their own lives: Mr. Hernandez's mother was told she had six months to live and lived thirteen more years. JA 40. For people with significant disabilities, prognostic error is compounded by bias—people with spinal cord injuries, for example, are especially likely to be perceived as terminally ill. JA 106. The risk that Plaintiffs will be deemed eligible under the Act by mistake or

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[38] Nina 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* Timothy E. Quill, Christine K. Cassel & Diane E. Meier, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380, 1381 (1992) ("[W]e acknowledge the inexactness of such prognosis [of imminent death]").

[39] *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%).

[40] *See* Or. Health Auth., *supra* note 29, at 7, 15, 18 (reporting that 172 patients since 1998, including 24 in 2025, outlived the six-month prognosis, and that time from first request to death has ranged as high as 2,529 days).

prejudice is therefore not a "speculative chain of possibilities," *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 414 (2013); it is the documented, ordinary operation of six-month prognoses applied to disabled patients.

Prognostic uncertainty is especially acute for individuals with newly acquired disabilities, such as spinal cord injuries or stroke, who often experience an initial period of despair followed by adaptation and renewed life satisfaction.[41] A legal framework that authorizes death during a period of crisis risks making permanent decisions based on temporary conditions. Newly injured people in that period are the population United Spinal's peer mentors serve, JA 58–59, 83–84, which is why the Act impairs that work now, not at some future date.

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

[41] *See* Richard Stensman, *Severely Mobility-Disabled People Assess the Quality of Their Lives*, 17 Scandinavian J. Rehab. Med. 87 (1985); Gale G. Whiteneck et al., *Rocky Mountain Spinal Cord Injury System Report* 29–33 (Nat'l Inst. of Handicapped Rsch. 1985); Myron G. Eisenberg & Constance C. Saltz, *Quality of Life Among Aging Spinal Cord Injured Persons: Long Term Rehabilitation Outcomes*, 29 Paraplegia 514 (1991).

inequality as voluntary consent. Nor does Article III permit a court to treat the documented effects of medical bias as speculation. For these reasons, Amici respectfully urge this Court to reverse the district court's dismissal of Plaintiffs' complaint for lack of standing and remand for further proceedings.

Respectfully submitted,

DISABILITY RIGHTS EDUCATION AND DEFENSE FUND

By: s/ Maria Michelle Uzeta
Maria Michelle Uzeta

Attorney for Amici Curiae

Dated: October 30, 2026

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitations of Fed. R. App. P. 29(a)(5) and Local Rule 29.1(c) because it contains 7000 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f), as counted using Microsoft Word for Mac, Version 16.113.4. This brief complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in a proportionally spaced typeface using 14-point font.

DISABILITY RIGHTS EDUCATION AND DEFENSE FUND

By: s/ Maria Michelle Uzeta
Maria Michelle Uzeta

Attorney for Amici Curiae

Dated: October 30, 2026

ADDENDUM

The Disability Rights Education and Defense Fund ("DREDF") based in Berkeley, California, is a national law and policy center dedicated to protecting and advancing the civil rights of people with disabilities. Founded in 1979, DREDF pursues its mission through education, advocacy, and law reform efforts, and is nationally recognized for its expertise in the interpretation of federal disability civil rights laws.

AIM Independent Living Center is a nonprofit organization that provides supportive services to people with disabilities, seniors, veterans, the unhoused, those with food insecurity, and any others with an unmet need. AIM's services include supportive housing, supported employment, consumer-directed homecare, assistive technology, case management, service coordination, food and nutrition support, and recovery programming. AIM serves people across New York State, with a primary focus on the western New York, Southern Tier and Finger Lakes regions.

The American Association of People with Disabilities ("AAPD") works to increase the political and economic power of people with disabilities, and to advance their rights. A national cross-disability organization, AAPD advocates for full recognition of the rights of over 60 million Americans with disabilities.

The Association of Programs for Rural Independent Living ("APRIL") is a national membership organization dedicated to advancing the rights and responsibilities of people with disabilities in rural America. APRIL provides leadership and resources on rural independent living through a national network of rural centers for independent living, programs and individuals concerned with the unique aspect of rural independent living. The goal of APRIL is to work together to find solutions to common problems and to bring rural issues in independent living into focus on the national level.

The Autistic People of Color Fund ("APOC Fund") is an organization that upholds the principles of Disability Justice through economic redistribution and policy advocacy. APOC Fund's innovative microgrant program supports autistic people of color who are seeking financial support for basic needs, enjoyment, and community belonging. APOC Fund also works for systemic change through policy advocacy, work with and within coalitions, and by publishing policy materials to advance the inclusion, belonging, and liberation of disabled people nationwide.

Autistic Self Advocacy Network ("ASAN") is a national, private, nonprofit organization, run by and for autistic individuals. ASAN provides public education and promotes public policies that benefit autistic individuals and others with developmental or other disabilities, including housing and independent living

issues. ASAN's advocacy activities include combating stigma, discrimination, and violence against autistic people and others with disabilities, promoting access to long-term supports in integrated community settings, and educating the public about the access needs of autistic people. ASAN takes a strong interest in cases that affect the right of autistic individuals and others with disabilities to choose a community in which to live.

The Autistic Women & Nonbinary Network ("AWN") provides community support, and resources for Autistic women, girls, transfeminine and transmasculine nonbinary people, trans people of all genders, Two Spirit people, and all people of marginalized genders or of no gender. AWN is committed to recognizing and celebrating diversity and the many intersectional experiences in our community. AWN's work includes solidarity aid, community events, publications, fiscal support, and advocacy to empower disabled and autistic people in their fight for disability, gender, and racial justice.

The Center for Public Representation ("CPR") is a public interest law firm that has been assisting people with disabilities for fifty years. As a statewide and national legal backup center, CPR supports public and private attorneys who represent people with disabilities in Massachusetts and around the country. It has litigated systemic cases on behalf of persons with disabilities in more than twenty

states, and authored amici briefs to the United States Supreme Court and many courts of appeals, in order to enforce the constitutional and statutory rights of persons with disabilities, including the right to be free from discrimination under the Americans with Disabilities Act (ADA) and the Rehabilitation Act.

Deaf Equality is a non-profit legal services organization committed to achieving true equality for Deaf, DeafBlind, DeafDisabled, Hard of Hearing, and Late Deafened (collectively, "Deaf and Hard of Hearing") individuals across the United States and worldwide. As an organization led by and for Deaf and Hard of Hearing individuals, Deaf Equality offers unique expertise and first-hand knowledge of the lived experience of these communities. Deaf Equality strives to challenge and dismantle oppressive attitudes and systemic discrimination. In alignment with these values, Deaf Equality joins this amicus brief in strong support of the arguments presented.

Finger Lakes Independence Center ("FLIC"), located in Tompkins County, is a non-profit organization dedicated to empowering individuals of all ages with disabilities to live as independently as possible. Established in 1988 the center works to create an inclusive community by actively breaking down social, attitudinal, and architectural barriers. To support self-determination for people with disabilities, they provide free services including peer counseling, disability benefits advisement, employment supports, housing assistance equipment loan closets,

advocacy, and personal care options. Finger Lakes Independence Center opposes assisted suicide because it creates a discriminatory double standard where able-bodied individuals receive suicide prevention while disabled or terminally ill individuals receive suicide assistance. Profit-driven healthcare systems will incentivize cheap lethal prescriptions over expensive long-term home care, pushing disabled people toward death due to a lack of robust community support.

The Harlem Independent Living Center ("HILC"), incorporated in May 1990, is a peer-led, consumer-directed nonprofit dedicated to advancing the rights and independence of people with disabilities. Founded to expand access to independent living services for underserved New Yorkers, particularly in communities of color, HILC has served Upper Manhattan for more than 36 years. Today, HILC serves New Yorkers of all ages and disabilities citywide, providing free, culturally and linguistically appropriate assistance with housing, public benefits, and independent living skills. HILC combines direct services with systems advocacy to remove barriers to accessibility and promote full participation in community life. HILC is affiliated with the New York Association on Independent Living and the New York State Independent Living Council and collaborates with disability rights organizations across New York City to advance equal opportunity.

The National Association of the Deaf ("NAD"), founded in 1880 by deaf and hard of hearing leaders, is the oldest national civil rights organization in the United States. As a nonprofit serving all deaf and hard of hearing individuals within the United States, the NAD's mission is to preserve, protect, and promote the civil, human, and linguistic rights of over 48 million deaf and hard of hearing people. The NAD is supported by affiliated state organizations in 48 states and the District of Columbia and affiliated nonprofits within the deaf and hard of hearing community. Led by deaf and hard of hearing people on its Board and staff leadership, the NAD is dedicated to ensuring equal access in every aspect of life, including, but not limited to, healthcare and mental health services, education, employment, entertainment, personal autonomy, voting rights, access to professional services, and legal and court access, technology, and telecommunications.

The National Organization of Nurses with Disabilities ("NOND") is a 501(c)3 nonprofit organization founded in Chicago, Illinois in 2003, and is an open membership, cross-disability, professional organization that works to promote equity for people with disabilities and chronic health conditions in nursing through education and advocacy by promoting best practices in education and employment; providing resources to individuals, nursing organizations, and educational and healthcare institutions; influencing the provision of culturally responsive nursing

practice; and creating systemic improvement and change.

The New York Association on Independent Living ("NYAIL") is a statewide, disability-led not-for-profit membership association created by and composed of Independent Living Centers (ILCs) across New York State. NYAIL's mission is to lead statewide ILC efforts to advance the civil rights of people with disabilities and promote the full participation of people with disabilities in their communities. New York's Independent Living Centers work directly with thousands of New Yorkers with disabilities, providing cross-disability services and supports that empower individuals to direct their own lives and live with dignity. As an organization dedicated to protecting the rights, autonomy, and equal treatment of people with disabilities, NYAIL has a substantial interest in ensuring that laws affecting end-of-life decision-making do not undermine access to community-based supports or reinforce discriminatory assumptions about the value and quality of disabled lives.

Northern Regional Center for Independent Living ("NRCIL") is a disability rights and resource center run by and for people with many different disabilities. Through NRCIL, people with disabilities discover choices to live more independently, with enhanced dignity. NRCIL empowers consumers by connecting them with knowledge so they can confidently make choices and decisions about their life. By supporting our community and other grass-roots

organizations, we promote community efforts to end disability discrimination and prejudice, create accessibility, and achieve lasting change for a fully inclusive society.

Southern Tier Independence Center ("STIC") is an Independent Living Center that has advocated for the rights, independence, and self-determination of people with disabilities since 1983. We have seen firsthand how inadequate access to healthcare, home and community-based supports, and accessible, affordable housing limits meaningful choice for people with disabilities. Our support for DREDF's amicus brief reflects our commitment to equal access and to the right of people with disabilities to live with dignity, free from coercion and discrimination.

CERTIFICATE OF SERVICE

I hereby certify that on October 30, 2026, I electronically filed the foregoing Brief of Amici Curiae Disability Rights Education and Defense Fund and Fifteen Other Disability Rights Organizations in Support of Plaintiffs-Appellants and Reversal with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system.

I certify that all the participants in the case are registered CM/ECF users, and that service will be accomplished by the appellate CM/ECF system.

DISABILITY RIGHTS EDUCATION AND DEFENSE FUND

By: s/ Maria Michelle Uzeta
Maria Michelle Uzeta

Attorney for Amici Curiae

Dated: October 30, 2026