IN THE SECOND JUDICIAL DISTRICT COURT
COUNTY OF BERNALILLO
STATE OF NEW MEXICO

KATHERINE MORRIS, M.D.,
AROOP MANGALIK, M.D., and AJA RIGGS

Plaintiffs,

vs. **No.** CV 2012-02909

KARI BRANDENBERG, in her official capacity as District Attorney for Bernalillo County, New Mexico, and GARY KING, in his official capacity as Attorney General of the State of New Mexico,

Defendants.

BRIEF OF AMICUS NEW MEXICO PSYCHOLOGICAL ASSOCIATION IN SUPPORT OF THE PLAINTIFFS

INTEREST OF AMICUS

The New Mexico Psychological Association (NMPA) is the largest organization of professional doctorate-level psychologists in New Mexico and the leading source of professional standards and policy for psychologists who practice within the state. It has been established to promote quality research and the highest level of qualified professional practice in psychology, to improve the qualifications and usefulness of psychologists by upholding and maintaining the highest standards of professional ethics, conduct, education, and achievement, and to increase and diffuse psychological knowledge throughout New

Mexico. N.M. Psychological Ass'n., *Constitution and Bylaws, Section 2* (2005). It is the primary authority to speak on behalf of psychologists and their patients, and those who provide related mental health services and their patients, in New Mexico, and it is concerned with assuring that the law in New Mexico permits and encourages the highest level of psychological practice.

The NMPA is committed to providing high quality mental health care to all New Mexicans. In doing so, members often provide services to those who are contemplating suicide, and to family members and friends of those who have committed suicide. Its members have also provided services to competent adults who are terminally ill and facing imminent death, and to their friends and family members. Some of these terminally ill patients are also considering asking their physicians for Aid in Dying (AID)[1] if their

---

[1] In adopting the term "Aid in Dying," the New Mexico Psychological Association joins its sister organization, the Washington State Psychological Association, which has stated: "A person with a terminal illness is going to die even with, or despite, the best medical treatment available. The designation of suicide is disrespectful to individuals with terminal illness who wish to have choice regarding death with dignity, and can be distressing and problematic emotionally, socially, psychologically, and financially, for family members and loved ones of dying individuals." Judith R. Gordon, *New WSPA Policy on Value-Neutral Language Regarding End-of-Life Choices*, Wash. State Psychological Ass'n. (Jan. 8, 2007), http://www.wapsych.org/resource/resmgr/Docs/New_WSPA_Policy_on_Value-Ne.docx. The term has been adopted by several other organizations and most academic writers. Even those who do not choose that terminology do not use "suicide" or "assisted suicide" to describe the AID process. See, for example, the new edition of the leading Health Law casebook, Furrow et al., *Health Law* (7th ed. 2013), which refers to "medically assisted dying."

While several years ago terms like "assisted suicide" had been used to describe a competent, terminally ill patient's decision to seek a physician's help in prescribing medication that could hasten the dying process, over the last several years responsible health care providers, lawyers, academics and others have stopped referring to this process as any form of "suicide." The general consensus is that "aid in dying" is more accurate, sensitive, and consistent with the professional literature in the field. "Aid in dying" is the better descriptive term, and it avoids presuming any sets of values. Consistent with the propriety of "aid in dying," the American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine (the organization of JD-MDs), the American Student Medical Association, and the American Medical Women's Association have all recently rejected using the term "assisted suicide," mostly in suffering during the dying process becomes too difficult to bear, and some of these patients have been referred to psychologists for counseling by the physicians from whom they sought AID. The NMPA recognizes that if a psychologist is required to treat a patient considering AID like a patient considering suicide, that psychologist cannot possibly provide adequate care that is consistent with the psychologist's professional standard of care.

The NMPA and its members recognize that AID and suicide are fundamentally different psychological phenomena, and that these different categories of patients must be treated differently by the law for their patients to be able to get adequate psychological support at the end of life. Psychologists think of suicide as their greatest challenge, and they work tirelessly to prevent their patients from committing suicide. They also recognize that AID involves almost no substantive theoretical overlap with suicide. Being required to treat competent terminally ill patients seeking AID as potential suicide "victims" will undermine the quality of care they can provide just when dying patients need their help the most. This view of psychologists on this issue is especially important because psychologists are experts on mental health care related to suicide in this country. They are uniquely well positioned to understand the actual consequences of the determination of the issues before this Court on those who are at risk for suicide and those who seek access to aid in dying from their physicians.

The Board of the New Mexico Psychological Association, after protracted and serious discussion over several months, decided by consensus to support the Plaintiffs in this case,

---

favor of "aid in dying." For the most part, the only individuals and organizations continuing to refer to the practice using the word "suicide" are those who, for political, religious or philosophical reasons, advocate against it. In short, "assisted suicide" now is a pejorative term used primarily by those who believe it to be morally wrong.

and to seek permission from the Court to file an amicus brief on behalf of the Plaintiffs, because of the importance of the resolution of this case to the quality practice of psychology in New Mexico.

I. PSYCHOLOGISTS RECOGNIZE THAT SUICIDE IS FUNDAMENTALLY DIFFERENT FROM AID IN DYING. THOSE WHO CHOOSE SUICIDE REJECT LIFE; THOSE WHO CHOOSE AID IN DYING EMBRACE LIFE.

A. SUICIDAL IDEOLOGY ARISES FROM IMPAIRED COGNITION OF TEMPORARY PROBLEMS THAT ARE ACTUALLY TREATABLE; AID IN DYING, ON THE OTHER HAND, ARISES FROM ACCURATE COGNITION OF PHYSICAL CONDITIONS THAT ARE TRULY INCURABLE.

Psychologists are trained to assess suicide risk and, as a matter of course, to consider that risk in every patient. The State of New Mexico has long authorized licensed psychologists and physicians (and lately other mental health care professionals) to certify that a patient should be detained and evaluated in the event that the patient presents a risk of serious harm to him or herself. N.M.Stat.Ann., § 43-1-10(A)(4). Psychologists figure prominently in suicidology and research into the causes and prevention of suicide. *See, e.g.*, Edwin .S. Shneidman, *The Suicidal Mind* (1998). Determining whether a patient poses a risk of suicide and how to address that risk are central to the practice of psychology in New Mexico, as elsewhere.

One substantial difference between suicidal patients and those who seek AID is that suicidal patients do not realize that their condition is amenable to treatment, and that they can overcome their urge to commit suicide. Their mental health pathology can be treated. *See* Thomas Reisch et al., *Efficacy of Crisis Intervention*, 20(2) Crisis: J. of Crisis Intervention and Suicide Prevention, 78-85 (1999). Those who seek access to AID, on the other hand, are actually suffering life-ending illnesses that cannot be cured. They have no misunderstanding of their condition, and the reason they seek access to AID is because no medical treatment can make the continuation of life possible; that is exactly what makes them terminally ill. Suicidal patients react to their misunderstood condition by applying distorted logic; those seeking AID react to their fully and correctly understood terminal condition by applying well reasoned logic that is consistent with the values that they have embraced for years or decades.

Suicide motivation arises from an emotional crisis which interferes with logic and planning. Thomas Joiner, *Myths About Suicide* 39 (2010). Suicidal patients tend to be severely depressed such that they are unable to contemplate a future without the intense emotional anguish from which they currently suffer. Such crises may derive from loss of a loved one, a business reversal, a personal humiliation, or any number of factors. The unifying response is a misplaced cognition that the situation will never improve; that there is no hope to right the ship. In suicidal patients, negative emotion narrows cognitive focus. *Id.* at 34. The suicide motive is deeply irrational. The psychologist treating a suicidal patient seeks to restore reason and thus restore hope, as is reasonable for persons with a long life ahead of them.

By contrast, the problem confronting the terminally ill patient arises from an irreversible physical calamity. She or he is dying of an incurable disease. The recognition that there is no hope for future physical improvement is accurate, not irrational. To treat a mentally competent terminally ill patient who seeks access to AID to avoid unbearable suffering as equivalent to a lovesick teenager or a homeowner losing the family home to foreclosure would be to completely misunderstand the psychological condition and the therapeutic role in each of those cases. It is for this reason that it is so offensive for those who have finally come to grips with their terminal condition, sometimes after a great deal of psychotherapy, and who thus seek access to AID, condescendingly to be told that they are demonstrating mental health pathology and that they are suicidal.

B. IN CASES OF SUICIDE, RATIONAL CONTROL IS INTERRUPTED BY DEFICIENCIES IN IMPULSE CONTROL. IN CASES OF AID IN DYING, THE PATIENT'S RATIONAL CONTROL PREVAILS.

The suicidal patient's functioning is characterized not only by impaired cognition, as described above, but by disrupted impulse control. See, *e.g.*, Roy Baumeister, *Suicide as Escape from Self* 90-133 (1990). In evaluating the risk of suicide in any new patient, the psychology practitioner is taught to look for the "three P's": pain, pressure, and perturbation. "Pain" stands for emotional anguish, "pressure" stands for a feeling of being overwhelmed, and "perturbation" stands for agitation. Edwin S. Shneidman, *Autopsy of a Suicidal Mind* (2004). This "pain, pressure and perturbation" precipitate sudden, unannounced, lethal and often violent acts, like suicide. They are the quintessence of irrationality and loss of personal control. The three P's analysis describes virtually every real suicide, and it suggests why we are so concerned when there is a risk of suicide.

Fifteen years of data from Oregon regarding an open practice of AID show that patients who choose AID act as a result of a careful, fully vetted deliberation, always after a period long enough to establish the enduring nature of the desire, usually in consultation with their families and other personal and religious advisors, and always after discussion with their physicians. This is the opposite of deficient impulse control; this is truly deliberative action. The physician plaintiffs in this case point out that they would require a carefully reasoned, voluntary, informed and enduring request for a prescription for AID before they would consider writing one. Further, as you might expect from the self-selected group of patients who ask their doctors about aid in dying, they are carefully deliberative and well educated. In Oregon and Washington, almost half of those employing the Death with Dignity Act have graduated from college, and almost all have education beyond high school. Or. Pub. Health Div., *Oregon's Death with Dignity Act 2012* (2013), http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf. For information on Washington state, see http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2012.pdf . This subset of the population seeking to act in a self-determined and autonomous manner at their death is well able to understand their options and choose among them. The question of how much suffering to bear before death arrives is intensely personal and will turn on values and beliefs an individual has developed over the course of a lifetime. Empowering the individual with control over this question preserves an essential sense of autonomy. Even though progressive illness has robbed the patient of much, being empowered to deliberate and determine how this final bit of the life journey will unfold enhances the patient's mental state. *See* Kathy Cerminara and Alina Perez, *Therapeutic Death, A Look at Oregon's Law*, 6(2) Psychol. Pub. Pol'y & L. 511-518 (2000).

The collaboration between physician and patient over time reflects a deliberative, rational process, the antithesis of impulse-driven behavior. The nature of the deliberative process in every case of AID is made even more impressive by the fact that all of those choosing AID have made the decision to do so while in the course of regularly seeing health care providers, other than psychologists, who are treating other physical disease conditions, most often cancer, which afflicts more than 80% of those who choose AID under the Oregon statute. *See* Or. Pub. Health Div., *Oregon's Death with Dignity Act 2012* (2013). Poor impulse control is a defining characteristic of suicide; it is not present in those choosing aid in dying. AID and suicide are at the opposite extremes of the continuum of rational thought and conduct, and ought not be conflated.

C. SUICIDE LEAVES FAMILY MEMBERS DISTRAUGHT, OFTEN DESTROYED, AND VIRTUALLY ALWAYS EMOTIONALLY TRAUMATIZED. AID IN DYING BRINGS FAMILIES TOGETHER AND ALLOWS FAMILIES TO DEAL SUCCESSFULLY WITH GRIEF.

The act of suicide is usually lonely and alienated, leaving in its wake a distraught family. *See* Thomas Joiner, *Myths About Suicide* 123 (2010). Psychologists see countless family members who struggle to make sense of an irrational, final act planned and committed without their knowledge, support or consultation. At the least, family members feel abandoned and disempowered after a suicide. They feel utterly without control, and they also feel they failed their suicidal family member. They are also likely to feel resentment resulting in complex grief. *See* Ann M. Mitchell et al., *Complicated Grief in Survivors of Suicide*, 25(1) J. of Crisis and Suicide Prevention 12-18 (2004).

The experience of family members following AID is very different. At the Seattle Cancer Care Alliance, families of patients who opted for AID frequently expressed gratitude after the patient obtained the prescription, regardless of whether the patient ever ingested the medication. They felt they could support their family member by supporting the decision to access AID. They referenced an important sense of patient control and family support in an uncertain situation. *See* Elizabeth Trice Loggers et al., *Implementing a Death with Dignity Program at a Comprehensive Cancer Center*, 368 New Eng. J. Med. 1417 (2013). In these cases the patient’s acquisition of some sense of control over his time and manner of death, whether the medication is ingested or not, may well have a positive emotional effect on the family, sharing in the pain and loss, as well as on the patient himself. There is little doubt that recognizing the patient's right to control the timing of his or her death has given Washington families greater ability to join together for support of their loved ones at that crucial moment. Similar findings in Oregon show that the family survivors of patients who choose AID do not suffer the adverse mental health impacts suffered by family members of suicide victims. *See* Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. of Pain and Symptom Management 807 (2009).

D. SUICIDAL PATIENTS WHO ARE SAVED FROM SUICIDE OFTEN GO ON TO LEAD LONG AND PRODUCTIVE LIVES, THANKFUL THAT THEIR SUICIDES WERE AVERTED. THOSE WHO ARE DENIED AID IN DYING GENERALLY LIVE ONLY A BIT LONGER, OFTEN WITH HORRIFIC SUFFERING, FRUSRATED BY THE DENIAL OF CONTROL AND AUTONOMY AT THE END OF LIFE.

As an impulse-driven event, the act of suicide irrationally aims to permanently end its victim's intense anguish by ending his biological life. Thomas Joiner, *Myths About Suicide* 7 (2010). Psychologists sometimes ruefully refer to suicide as "a permanent solution to a temporary problem," since the patient sees no hope in a circumstance where a rational person would be able to find hope. That is often the very purpose of therapy. Research into suicide shows that persons restrained from suicide by jumping off a bridge, for example, often go on to lead productive lives. In one leading study, virtually all bridge jumpers who survived recalled experiencing profound regret during the four seconds it took to reach the water. Richard Seiden, *Where Are They now? A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 Suicide and Life-Threatening Behavior 1-13 (1978).

Psychologists sometimes use Reasons For Living (RFLs) as a therapy technique with suicidal patients. *See* David Jobes, *Managing Suicidal Risk* 22-23 (2006). These include plans and goals for the patient's future, family, friends, responsibilities to others, enjoyable trips, and anything else which gives the patient affirmative reasons to fight through a lethal depression. The evocation of hope can be one of the most important and central elements of healing. See C. E. Yahne, and W. R. Miller, *Evoking Hope*, in American Psychological Association, Integrating Spirituality into Treatment: Resources for Practitioners 217-233 (1999). As Dr. Chuck Elliott, a prominent Albuquerque psychologist teaches, "It is our job to give our patients hope." If that hope can be restored and the patient saved from a suicide that would later be the source of terrible regret, the psychologist or other person who managed to do so can count that as an important success – effectively, the saving of a life.

The result of denying AID is far different. No life is saved. No suffering is averted; indeed, the patient's physical suffering will most likely last longer and perhaps grow even more horrific before the final ravages of the cancer or other disease culminate inevitably in death. The psychological suffering at being denied the autonomy to determine how much agony to endure before death arrives will often be profound. The meaning of a terminal diagnosis is that death will come soon, regardless of medical treatment. From a physiological point of view, and from the perspective of the progression of the underlying disease, it will make little difference whether a patient has access to AID; the patient is going to die soon in any case. From a psychological perspective, though, the utter and final lack of control that comes from being denied the opportunity to avoid unbearable suffering at the end of life is extremely important. It can lead to resentment, frustration, a sense of being powerless and captive of a miserable final stage of dying. The patient's frustration is also likely to extend to the patient's family members, who feel that they failed the patient when she needed their help the most and when she was helpless to act without medical assistance to end her suffering. *See* Barbara Coombs Lee and James L. Werth, *Observations on the First Year of Oregon's Death with Dignity Act*, 279-280 (2000)

When a psychologist intervenes to prevent suicide, that intervention helps his patient, both physically and mentally, in the short run and in the long run. An intervention to prevent AID will not have such a salutary effect. It will exacerbate physical pain and mental suffering in the short term, and will have no effect on the long term because the patient will die of the underlying disease whether a psychologist intervenes or not. It is simply wrong to consider AID to be a species of suicide when evaluating the consequence of the provision of mental health services.

II. PSYCHOLOGISTS HAVE THE TRAINING AND ABILITY TO DETERMINE THE MENTAL CAPACITY OF TERMINALLY ILL PATIENTS TO CHOOSE AID IN DYING. THERE ARE ESTABLISHED GUIDELINES FOR ASSESSMENT OF DECISIONAL CAPACITY OF THE TERMINALLY ILL.

Virtually everybody recognizes that refusing to allow AID will force some decisionally capable and terminally ill people to endure suffering they find intolerable at the end of life. Some, however, are willing to accept this to avoid the risk that some terminally ill patients might be incorrectly determined to have decisional capacity to choose AID when, in fact, they do not have that capacity. That concern is unfounded.

The practice of psychology has developed clear standards of care for capacity determinations. Psychologists are often called upon to determine a patient's capacity under the Uniform Health Care Decisions Act, N.M.Stat.Ann., § 24-7A-11. For the New Mexico statutory definition of capacity, see N.M.Stat.Ann., § 24-7A-1(C). Mental health professionals in New Mexico and across the nation recognize best practices to make such determinations, and those professionals are routinely trained in making exactly this kind of determination. See James L. Werth, G. Benjamin and T. Farrenkopf, *Requests for Physician Assisted Death: Guidelines for Assessing Mental Capacity and Impaired Judgment*, 6 Psych., Pub. Pol. & L. 348 (2000), and Charles H. Baron, *Competency and Common Law: Why and How Decision-Making Capacity Criteria Should be Drawn from the Capacity-Determination Process*, 6 Psych., Pub. Pol. & L. 373 (2000). In fact, over the last several years special attention has been given to the determination of decisional capacity in those who face terminal illness and, more generally, in the elderly (from whom the terminally ill are disproportionately drawn). By way of immediate example, the Amicus has offered programs to its members and other health care professionals over the last two months in Albuquerque on working with patients with dementia (September 27, 2013) and in suicide risk assessment (November 8, 2013), and in Santa Fe on dealing with depression and despair, including end of life despair (September 27, 2013). For a current schedule of the active NMPA education program touching on these issues *see* New Mexico Psychological Association, *Upcoming NMPA Workshops,* http://www.nmpsychology.org/displaycommon.cfm?an=1&subarticlenbr=25. Where they have been called upon to do so, professional mental health associations have developed nationally respected standards specifically for assessing a person's capacity to choose AID. *See, e.g.,* Washington State Psychological Association, *The Washington Death with Dignity Act: WSPA Guidelines For Mental Health Professionals* (2010), *available at* http://www.wapsych.org/resource/resmgr/Docs/DWD_Guidelines_6-3-09.pdf. *See also* Tony Farrenkopf and James Bryan, *Psychological Consultation Under Oregon's 1994 Death With*

Dignity Act: Ethics and Procedures, 30(3) Prof. Psychol.: Research and Practice, 245-249 (1999).

A mental health professional will not always be required to evaluate the capacity of a terminally patient that chooses AID, of course. Under the Uniform Health Care Decisions Act, a patient is presumed to have decisional capacity to make a health care decision (like choosing AID, if her physician believes that is among her appropriate choices). N.M.Stat.Ann., § 24-7A-11(B). If there is any question, though, physicians can consult with a mental health professional to avoid any uncertainty about the patient's capacity. See N.M.Stat.Ann., § 24-7A-11(C). As the experience in Oregon and Washington suggests, physicians occasionally do so. There may have been a time when mental health professionals were not trained to make such determinations in the terminally ill, and there was a time when those professionals had no professional standards to apply in making those decisions, but that time is long past. Making capacity determinations at the end of life is now a regular function of psychologists and other mental health professionals. There are adequate tools for professionals to make these determinations, and these professionals are well trained to do so.

III. PSYCHOLOGISTS HAVE SPECIAL LEGAL AND ETHICAL OBLIGATIONS WITH REGARD TO SUICIDE. IT WOULD UNDERMINE THE WORK OF PSYCHOLOGISTS TO REQUIRE THEM TO TREAT AID IN DYING AS SUICIDE, AND IT WOULD DESTROY PSYCHOLOGISTS' ABILITY TO COUNSEL TERMINALLY ILL PATIENTS WHEN THEIR ASSISTANCE IS MOST DESPERATELY NEEDED.

It is extremely important that psychologists be able to treat suicidal patients and prevent suicides. It is equally important for psychologists to be able to counsel family members and friends of those who have committed suicide, or are threatening to do so. As a matter of law, psychologists and other mental health workers are permitted to issue certificates authorizing a law enforcement officer to detain by force and hospitalize a patient who is threatening suicide, and the standard of care requires that psychologists issue such certificates when the threat is one of imminent harm. A psychologist would be at risk of civil liability to both the patient and to others, including the patient's family members, if the psychologist were to breach this legal obligation.

At the same time, psychologists also have a duty to provide counseling to those who are approaching death due to terminal illness and to their family members. Many physicians – oncologists, geriatricians and others – refer their patients to mental health providers for counseling when they are diagnosed as terminally ill. In order to provide adequate care and support to these patients, a psychologist needs to be able to respond appropriately to a patient's mental state and address their issues with flexibility and with respect for the values, beliefs and physical situation of the patient.

It would be inappropriately condescending and it would undermine the psychologist-patient relationship for a mental health professional to treat a rational and entirely non-pathological decision of a patient to inquire into AID as an expression of suicidal ideation. Treating the decision to inquire about AID the same as one to ruminate about suicide would require application of an entirely inappropriate form of analysis and counseling. The standard of care for treating a suicidal patient would require issuance of a certificate which would authorize a law enforcement officer to detain the dying patient who was considering AID. This would utterly and completely destroy the trust necessary to make the psychologist-patient relationship useful, and, as a practical matter, it would end the psychologist-patient relationship, thus depriving the patient of an opportunity to benefit from the professional knowledge of the psychologist. Further, requiring psychologists to treat AID as suicide would discourage oncologists and others from referring their patients for mental health services, and it would discourage patients from seeking out mental health services on their own as well.

The practice of good professional psychology in New Mexico requires that the law recognize the fundamental distinction between AID and suicide, and that the law recognize that AID is not a form of suicide.

CONCLUSION

For the reasons stated above, the Amicus New Mexico Psychological Association requests that the Court grant the Plaintiffs the relief sought in their Complaint in this case.

Respectfully submitted,

/s/ Frank L. Spring
Frank L. Spring
Duhigg, Cronin, Spring & Berlin, P.A.
620 Roma NW
Albuquerque, NM 87103
(505) 243-3751

/s/ Robert Schwartz
Robert Schwartz
1117 Stanford NE
Albuquerque, NM 87131
(505) 277-3119

Counsel for Amicus,
New Mexico Psychological Association

CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of December, 2013, I electronically filed the foregoing pleading through the *Odyssey File & Serve System*, which caused all parties or counsel registered to receive electronic service to be served by electronic means.

/s/ Frank Spring