SUPERIOR COURT OF WASHINGTON FOR THURSTON COUNTY

COALITION AGAINST ASSISTED SUICIDE, DUANE FRENCH, Petitioners/Appellants, v. STATE OF WASHINGTON; SAM REED, in his official capacity as Secretary of State; and ROB MCKENNA, in his capacity as Washington Attorney General, Respondents/Defendants.	*The Honorable Gary R. Tabor* NO. 08-2-00265-6 ***Amicus Curiae* Brief in Support of Petitioners/Appellants**

AMICUS CURIAE BRIEF ON BEHALF OF JOHN E. PEYTON, JR., AND PATRICIA PEYTON, AND WASHINGTON STATE CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS/APPELLANTS

I. INTRODUCTION

Amici are Washington resident John E. Peyton, Jr., a patient suffering from ALS who will in the future qualify for physician-assisted suicide (PAS) under Ballot Initiative 1000; Washington resident Patricia Peyton, who, as John Peyton's wife of nearly 40 years, will not be notified under Ballot Initiative 1000 should Mr. Peyton choose PAS; and Washington State Catholic Medical Association, an organization incorporated in Washington and consisting of physician members seeking to protect the dignity of both their patients and their profession.

Amici are particularly concerned that the ballot summary describing Ballot Measure 1000 fails to inform Washington residents that neither a mental health evaluation nor family notification are required before a patient uses PAS. As this Court is well aware, the State's proposed ballot title and summary are subject to review by this Court to ensure that its wording complies with RCW 29A.72.050 and Article II, Sections 19 and 37 of the Washington

Constitution. Importantly, the summary should make voters aware of the general effect of new legislation and the specific impact the legislation will have on existing laws. *See Washington Citizens Action of Washington v. State*, 171 P.3d 486, 493 (Wash. 2007); *Amalgamated Transit Union Local 587 v. State*, 142 Wn.2d 183, 246 (2000). *Amici* are concerned that, because the current ballot summary does not alert Washington residents of the fact that no mental health evaluation or family notification is required before PAS, it fails to alert the public to the general effect of the initiative and the future impact on existing state law.

The Defendants argue that the Plaintiffs are requesting that the summary state what is not contained in the measure; but the Defendants fail to take into account that what is not in the measure will have a drastic effect on the lives of those who, like Mr. and Mrs. Peyton, are targeted by the initiative. The Defendants also fail to take into account the fact that summarizing the general effect of new legislation and the impact it will have includes alerting the public to what is not contained in an initiative.

As demonstrated herein, and as communicated by the United States Supreme Court, patients facing the end of life suffer from depression, lack important decision-making capacities, and benefit from the presence and support of family members. Because of these facts, it is important that residents of Washington fully understand what Ballot Initiative 1000 will not do—*i.e.*, require evaluation for mental health issues or family notification—before they vote.

II. ARGUMENT

A. The United States Supreme Court and its cited resources are clear that depression is a substantial risk in physician-assisted suicide

In *Washington v. Glucksberg*, the United States Supreme Court held that there is no right to physician-assisted suicide. 521 U.S. 702 (1997). In doing so, the Court acknowledged that "[t]hose who attempt suicide—terminally-ill or not—often suffer from depression or other

mental disorders." *Id*. at 731.[1] Citing to the New York State Task Force on Life and the Law, discussed *infra* Part I.A.(i), the Court stated that 95 percent of those who commit suicide have a major psychiatric illness at the time of death. *Id*. The Court went on to state that "[r]esearch indicates … that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Id*. (citing H. Hendin, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE 24-25 (1997); New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT 177-78 (May 1994)).

The Court also acknowledged that, because depression is difficult to diagnose, physicians and medical professionals fail to adequately respond to the needs of terminally-ill patients. *Id*. at 175. As such, state-sanctioned PAS may make it more difficult for a state to protect depressed or mentally-ill persons. *Id*. at 731. This is a legislative effect of which Washington voters must be aware.

Two of the resources relied upon heavily for these statements—the New York State Task Force and psychiatrist Herbert Hendin—both reveal the grim likelihood of unwarranted suicides because depression is ignored or inadequately treated.

i. The New York State Task Force on Life and the Law

The New York State Task Force on Life and the Law (Task Force) was convened in 1985 by the Governor of New York. The 25-member task force, comprised of prominent physicians, nurses, lawyers, representatives of religious communities, and academics of varying opinions and beliefs, was formed to develop recommendations for public policy in New York for a host of

[1] In its *Amicus Curiae* brief, the National Legal Center for the Medically Dependent & Disabled informed the Court that terminally-ill patients who desire an early death are usually suffering from a treatable mental illness, most commonly depression. *Amicus Curiae Brief of the National Legal Center for the Medically Dependent & Disabled* in *Vacco v. Quill*, 521 U.S. 793 (1997), 1995 U.S. Briefs 1858, at *40.

issues arising from recent medical advances—including PAS. Due to its variation of members and their beliefs as well as the lengthy deliberation process involved, the Task Force is the preeminent resource on PAS and public policy.

In 1994, the Task Force unanimously concluded—despite the varied beliefs of its members—that existing law should not be changed to permit PAS. Pervasive in its 217-page report were comments, concerns, and conclusions about the mental health of the terminally-ill patients targeted by PAS.

Throughout the report, the Task Force continually noted that terminally-ill patients who desire suicide generally suffer from a treatable mental disorder, commonly depression. Task Force, *supra*, at x, 13, 23, 25, 26. In one study of terminally-ill patients, those who expressed a desire to die all met diagnostic criteria for major depression. *Id*. at 13. After examining the resources and deliberating on the facts, the Task Force concluded that "[i]n most cases, the patient will withdraw the request when pain management, depression, and other concerns have been addressed…." *Id*. at 108.

Thus, important here is that treating patients for depression and pain reduces the desire for suicide. *Id*. at 26.[2] In one study, treatment for depression resulted in the cessation of suicidal ideation for 90 percent of the patients who had expressed a desire to die. Thus, not only can depression in the terminally-ill be treated, but such treatment reduces or completely obliterates the desire to die. *Id*. at 41. The Task Force concluded that physicians must respond to a request for PAS by investigating whether the patient is suffering from depression. *Id*. at 108.

[2] For more on the fact that treating depression reduces requests for PAS, *see Amicus Curiae Brief of National Hospice Organization* in *Vacco*, 1995 U.S. Briefs 1858, at *6, 15-16.

Sadly, Ballot Measure 1000 does not require such an investigation and fools Washington residents into thinking that it does.

Furthermore, the evaluation of "competence" ignores the frequent failure of physicians to diagnose depression and other mental disorders. While Ballot Initiative 1000 does require a physician to determine that a patient is "competent," it ignores evidence that the medical community continually fails to diagnose depression and other mental disorders. *Id*. at ix, xiii. In fact, the necessary screening for depression in terminally-ill patients and the subsequent offer of treatment are not standard care—meaning that the physicians who are being relied upon in Ballot Initiative 1000 for competency screening are not screening for depression. *Id*. at 127. *See also Amicus Curiae Brief of American Association of Homes and Services for the Aging* in *Vacco*, 1995 U.S. Briefs 1858, at *19 ("All agree that a decision to take one's life should not be made while incompetent or clinically depressed. But merely imposing competency requirements on assisted suicide decisions cannot prevent such errors. Both competency and depression exist along subtle continuums that are not susceptible to precise measurement.").

Most physicians are not trained to diagnose depression, especially in complex cases such as the terminally-ill. Task Force, *supra*, at xiv, 127. Depression is particularly difficult to diagnose in the terminally-ill because symptoms or medications may mask the depression. *Id*. at 26, 127, 176. Thus, depression in the terminally-ill is "grossly underdiagnosed and undertreated." *Id*. at xiv. Specialists in certain fields, such as oncology, are most likely to receive requests for PAS, but physicians in such areas "rarely have extensive training in treating or diagnosing depression." *Id*. at 127.

In reality, even "psychologists and psychiatrists who routinely treat and diagnose depression may have limited experience doing so for patients who are terminally-ill or

chronically ill." *Id*. at 127-28. Thus, routine psychiatric consultation for most terminally-ill patients is inadequate to reliably diagnose whether a patient is suffering from depression. *Id*. at 143.[3]

With all of this information in hand, the Task Force concluded that very few people fall into the category of "individuals who make an informed, competent choice to have their lives artificially shortened." *Id*. at 72. Instead, PAS would be "profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases." *Id*. at xii.

Finally, the Task Force concluded that family support is imperative at the end of life. The Task Force concluded that the proper response to a patient's personal and psychological needs is accomplished best with the participation of family members and others close to the patient. *Id*. at 180. Proper care at the end of life should focus on elimination of suffering—through treatment for depression and pain, as well as support from the family—and not on the elimination of the sufferer.

The lack of family notification also increases the risk that a physician will fail to diagnose depression or another mental disorder. When family members, who know the patient best, are intentionally left out of the PAS process, the physician lacks necessary input that will allow him to decide whether the patient is acting normally, or is instead acting in a depressed

[3] For more on the failure of physicians to diagnose and treat depression in the terminally-ill, *see Amicus Curiae Brief of American Suicide Foundation* in *Glucksberg*, 1996 U.S. Briefs 110, at *13-14 (citing NIH Consensus Development Panel on Depression in Late Life); *Amicus Brief of American Geriatrics Society* in *Vacco*, 1995 U.S. Briefs 1858, at *39; *Amicus Curiae Brief of Physicians for Compassionate Care* in *Glucksberg*, 1996 U.S. Briefs 110, at *19, 20 ([I]t is not an easy task to diagnose either psychiatric illness or suicidality… nonetheless [Oregon's Death with Dignity Act] asks just such busy, front-line, untrained physicians to perform this vital screening function. It will inevitably be done poorly….").

state not typical for that patient. Failing to notify a family member also prevents the family from demonstrating support and love for the patient—the exact response that the Task Force concluded was imperative.

Amicus Mrs. Peyton is particularly affected by the lack of family notification. Should Mr. Peyton choose PAS, he will be able to do so without notifying his loving wife of 40 years. He could commit suicide without ever informing Mrs. Peyton or allowing her the chance to support and love him through his illness. Likewise, Mr. Peyton is worried that, in a moment of weakness, terminally-ill patients like himself may seek PAS, never having the chance to know that their family would have loved and supported them to the end of life had their family been allowed the chance.

Yet Ballot Initiative 1000 fails to inform voters that family members will not be notified if a patient requests and utilizes PAS. The effect of the law is that the State will not ensure that patients receive the support of family at the end of life, as the Task Force suggested. Voters in Washington deserve the facts regarding both the lack of a mental health evaluation as well as the lack of family notification.[4]

ii. Dr. Herbert Hendin

In setting forth its statements that the terminally-ill often suffer from depression and mental disorders, the Supreme Court also relied upon resources from preeminent psychiatrist Dr.

[4] In 1997, the Task Force affirmed its 1994 findings. In the issuing SUPPLEMENT, the Task Force noted that its findings were grounded in ten years of efforts to promote patients' rights to control their medical care. Task Force, WHEN DEATH IS SOUGHT SUPPLEMENT 1 (April 1997). In listing the "risks of legalization" of PAS, the first risk listed was "undiagnosed and untreated mental illness." *Id*. at 4. Because physicians routinely fail to diagnose and treat mental disorders (particularly at the end of life), the legalization of PAS will mean that many requests based on mental illness are likely to be granted. *Id*. The Task Force again concluded that such profound dangers outweigh any benefits PAS might achieve in isolated cases. *Id*. at 6.

Herbert Hendin. As with the Task Force, Dr. Hendin states that "[t]he vast majority of requests for assisted suicide come from patients who are terrified and depressed." Herbert Hendin, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE 157 (1998).[5] Such patients are usually suffering from a treatable depressive condition. *Id* at 35. While other factors also contribute to the wish for death, research has confirmed that no factor is as significant as the presence of depression. *Id*. at 35. *See also Amicus Curiae Brief of American Suicide Foundation* in *Glucksberg*, 1996 U.S. Briefs 110, *10-11.

As cited in *Glucksberg*, terminally-ill patients usually respond well to treatment for pain and depressive illness and are grateful to be alive. Hendin, *supra*, at 15. Yet physicians continually fail to diagnose depression. *Id*. at 25. While half of all patients who commit suicide see a doctor in the month prior to suicide, often requesting treatment for symptoms of depression, the depression that underlies these symptoms goes unrecognized. *Id*. at 246; *see also id*. at 35-36.

Comparisons between the United States and the Netherlands fly between both proponents and opponents of PAS. Yet despite the "slippery slope" to euthanasia that many critics cite in the Netherlands, the Dutch actually have one safeguard that Americans do not: the relative absence of the family doctor in America eliminates what the Dutch perceive as a major source of patient protection. *Id*. at 213.

Dr. Hendin also emphasizes that, while trained to recognize depression, many psychiatrists have little experience in treating the terminally-ill or in treating the often covert depression that coexists with physical illness. *Id*. at 157.

[5] This publication was an updated version of that cited by the Supreme Court in *Glucksberg*.

Voters must be informed that safeguards protecting patients are not present in Ballot Initiative 1000.

B. Other resources also make clear that, because of the high likelihood of depression, physician-assisted suicide poses dangers for terminally-ill patients

The foregoing facts have been demonstrated and reiterated time and time again throughout medical studies, law review articles, and *amicus curiae* briefs to the Supreme Court. For example, a Massachusetts study of cancer patients found that "patients who had seriously considered and prepared for euthanasia or physician-assisted suicide were significantly more likely to be depressed." Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455, 466 (1996) (citing E. Emauel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805, 1809 (1996)). Likewise, a New York study of HIV patients found that those who expressed an interest in PAS reported significantly more depressive symptoms. *Id*. at 467 (citing W. Briebart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238 (1996)). Furthermore, both Dutch and U.S. studies have indicated that depression and nonphysical factors are more important in motivating patients to request PAS than pain and other physical symptoms. *Id*. at 468.

Moreover, depression impairs the ability to make sound judgments. The fact that patients requesting PAS are substantially likely to be suffering from depression is dangerous because depression can impair the ability to understand information, to weigh alternatives, and to make judgments that are stable over time and consistent with the patient's wishes. E.R. Grant & P.B. Linton, *Relief or Reproach?: Euthanasia in the Wake of Measure 16*, 74 OR. L. REV. 449, 532 (1995) (citing the Task Force). When depressed, patients lose the ability to compare suicide with alternative solutions. *Amicus Curiae Brief of National Hospice Organization* in *Vacco*,

1995 U.S. Briefs 1858, at *12. Yet physicians with inadequate training in diagnosing depression will have the authority to declare such patients "competent." It is necessary for Washington residents to understand that "competence" does not mean a patient has undergone a mental health evaluation.

In *Glucksberg*, Physicians for Compassionate Care, an Oregon-based non-profit organization of healthcare providers, explained the difference between competency and mental health. "[M]any people with the major life stress of a diagnosis of terminal illness will suffer from depression, whether or not it rises to the level of clinical or major depression, and will have impaired judgment for making life and death decisions, even though legally competent." *Amicus Curiae Brief of Physicians for Compassionate Care* in *Glucksberg*, 1996 U.S. Briefs 110, at *17. Thus, a terminally-ill person can appear legally competent but be suffering from depression that impairs his or her ability to make life-ending decisions. Yet the proposed ballot summary only alerts Washington voters that competency will be judged, while ignoring the fact that mental evaluations are not required.

Determining competency itself—let alone mental health—is also "extraordinarily challenging, requiring subtle evaluations of thought process and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices. Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential." *Id*. at *21 (quoting Harvard psychiatrists). By simply informing voters that

patients must be competent before utilizing PAS, the State fails to inform the residents of Washington that no psychiatric input is required.[6]

Moreover, by failing to require family involvement in the decision, the family's perception of the patient's mental health is missing from the physician's determination. Thus, voters must also be informed that family input is excluded as well.

To summarize, "[w]e now know, as past ages could not, that there is a nearly perfect coincidence of suicidal ideation and the presence of severe mental illness or clinical depression." Grant & Linton, 74 OR. L. REV. at 501. Yet failing to inform voters of the lack of a mental health evaluation and family notification masks the true effect of Ballot Measure 1000.

C. The experience in Oregon demonstrates that physicians fail to adequately diagnose depression

Ballot Initiative 1000 is identical in substance to Oregon's Death With Dignity Act. Like Ballot Initiative 1000, the Death With Dignity Act does not require a mental health examination. Physicians are to refer for psychiatric evaluation only when they feel it necessary. Yet as demonstrated above, physicians often fail to diagnose depression and other mental health disorders. Thus, it is not surprising that very few patients have been referred for psychiatric counseling in Oregon prior to physician-assisted suicide.

In the latest report for year nine of the Death With Dignity Act, Table 1 displays startling statistics.[7] Despite the fact that the foregoing studies and statistics indicate that large numbers of terminally-ill patients are in fact suffering from depression, only four percent of patients (or two

[6] Physicians for Compassionate Care also informed the Court that Oregon's 15-day waiting period—also present in Ballot Initiative 1000—was inadequate because depression cannot be treated in only 15 days. Physicians for Compassionate Care, *supra*, at *13-14.

[7] Table 1 as well as every annual report published to date are located at http://www.oregon.gov/DHS/ph/pas/ar-index.shtml (last visited Feb. 14, 2008).

patients) who used physician-assisted suicide in 2006 were referred for psychiatric evaluation. In the years 1998 through 2005, only 14 percent of patients (or 34 patients) were referred for psychiatric evaluation. While the New York State Task Force concluded that "very few people" can make a competent decision regarding PAS, the reality in Oregon is that "very few people" are truly evaluated for depression or other mental health disorders. In light of the studies and conclusions discussed above, Oregon is failing to ensure that patients are free from depression and other mental incapacities before making the suicide decision.

III. CONCLUSION

Evidence demonstrates that most terminally-ill patients who request PAS are in reality suffering from depression or another mental disorder. When treated for depression, the desire for PAS disappears. Yet Ballot Initiative 1000 does not require physicians to evaluate for depression or mental disorders, nor does it require family notification of the PAS decision. Washington residents must be informed that such safeguards are missing in Ballot Initiative 1000. The ballot title and measure summary must be altered to reflect the changes proposed by Petitioners/Plaintiffs. According to Art. II, §§ 19 and 37 of the Washington Constitution and RCW 29A.72.080, 29A.72.050, and 29A.72.060, this Court holds the authority to amend the proposed ballot title and summary to comply with constitutional and statutory mandates—mandates that will not be met if the title and summary remain in the current form.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

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