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15 **SUPERIOR COURT OF THE STATE OF CALIFORNIA**
16 **COUNTY OF RIVERSIDE**

17 DR. SANG-HOON AHN, DR. LAURENCE
BOGGELN, DR. GEORGE DELGADO, DR.
18 PHILIP DREISBACH, DR. VINCENT
FORTANASCE, DR. VINCENT NGUYEN,
19 and AMERICAN ACADEMY OF MEDICAL
ETHICS d/b/a of CHRISTIAN MEDICAL
20 AND DENTAL SOCIETY,

21 Plaintiffs,

22 v.

23 MICHAEL HESTRIN, in his official capacity
as District Attorney of Riverside County,

24 Defendant,

25 ATTORNEY GENERAL OF THE STATE
OF CALIFORNIA, KAMALA D. HARRIS,
26 and the STATE OF CALIFORNIA by and
through the CALIFORNIA DEPARTMENT
27 OF PUBLIC HEALTH,

28 Defendants/Intervenors.

FILED
SUPERIOR COURT OF CALIFORNIA
COUNTY OF RIVERSIDE

JUL 19 2016
K. Garcia

Case No. RIC 1607135

Hon. Daniel A. Ottolia

~~PROPOSED~~ **BRIEF OF AMICUS
CURIAE COMPASSION & CHOICES
IN OPPOSITION TO PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

Complaint filed: June 8, 2016

Hearing Date: July 25, 2016
Hearing Time: 8:30 a.m.
Courtroom: Dept. 4

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1 **I. INTEREST OF THE AMICUS CURIAE**

2 Compassion & Choices is the leading nonprofit organization working to improve care and
3 expand choices at the end of life. For over thirty years, Compassion & Choices has strived to
4 increase people’s quality of life and to provide some peace of mind in their final days, even when
5 an injury or illness robs them of their voice. Compassion & Choices provides free consultation,
6 planning resources, referrals, and support to patients across the country through an End of Life
7 Consulting Program. Compassion & Choices also advocates for policies that empower people to
8 be in charge of their own healthcare decisions at the state and federal levels, to enable patients
9 facing the end of life to access information and options needed for more control and comfort
10 during their final days.

11 The interests of Compassion & Choices in preserving the rights accorded by the End of
12 Life Option Act are profound. The members of Compassion & Choices who are terminally ill
13 have pressing interests in securing the freedom to make all critical healthcare decisions that
14 impact their bodily integrity and sense of self, including the option of physician aid in dying.
15 They also need the security of knowing they can exercise their choices safely, effectively, legally,
16 and in a humane manner with the professional assistance of their physicians, as is afforded by the
17 End of Life Option Act.

18 **II. ARGUMENT**

19 **A. Preliminary Injunction Standard**

20 In deciding whether to issue a preliminary injunction, a trial court weighs two interrelated
21 factors—the likelihood that the moving party ultimately will prevail on the merits, and the
22 relative interim harm to the parties from the issuance or nonissuance of the injunction. *Butt v.*
23 *State of California* (1992) 4 Cal.4th 668, 677-78. In balancing hardships, “the trial court must
24 determine which party is the more likely to be injured by the exercise of its discretion . . . and it
25 must then be exercised in favor of that party.” *Cont’l Baking Co. v. Katz* (1968) 68 Cal.2d 512,
26 528. Although Compassion & Choices recognizes plaintiffs’ face an insurmountable burden in
27 order to prevail on the first part of the test, this brief focuses on the hardship inquiry because of
28 amicus curiae’s unique perspective. Ultimately, if for no other reason, plaintiffs’ request for a

1 preliminary injunction should be denied because the balance of harms weighs heavily in favor of
2 terminally ill patients who will face certain harm if the injunction is granted, and against
3 Plaintiffs' unsubstantiated and speculative allegations of harm to hypothetical victims of
4 substandard healthcare.

5 **B. The Balance Of Hardship Favors Denial Of A Preliminary Injunction**

6 **1. Grant of a preliminary injunction will cause severe hardship for**
7 **terminally ill patients who would be forced to suffer a painful and**
8 **prolonged death**

9 In the absence of medical aid in dying allowed by the End of Life Option Act ("the Act"),
10 patients and families will be forced to live through painful and prolonged deaths and will rob
11 patients of the peace of mind knowing they will not have to suffer as they approach death even if
12 they ultimately choose to not use their prescription for medical aid in dying. This is so even when
13 other palliative medical support, such as terminal sedation, is available. The example of what
14 California residents Jennifer Glass experienced and what her sister Mavis Prall witnessed, both
15 Compassion & Choices supporters, illustrates the pain and suffering to which patients and
16 families are subjected absent the options afforded by the Act. Jennifer was diagnosed with the
17 most common form of lung cancer among non-smokers in January 2013. She underwent
18 chemotherapy and radiation in order to have an additional two years with her loved ones. In June
19 2015, she learned that the cancer had metastasized from her lungs to her brain, pelvis, cervix, and
20 liver.

21 Jennifer was an advocate for medical aid in dying. In her words, "I'm doing everything I
22 can to extend my life, but no one has the right to prolong my death." Jennifer Glass, *At Last: I*
23 *Want The Last Word As To How My Story Ends*, The Huffington Post, April 27, 2017¹; see also
24 George F. Will, *Affirming A Right To Die With Dignity*, Washington Post, August 28, 2015.²
25 Mavis recalls that Jennifer wanted to die at home, surrounded by those who loved her, but that
26 Jennifer did not want her family to watch her suffer because it would cause her family additional

27 ¹ Available at http://www.huffingtonpost.com/jennifer-glass/i-want-the-last-word-in-h_b_7147716.html, attached as
28 Exhibit 1.

² Available at https://www.washingtonpost.com/opinions/distinctions-in-end-of-life-decisions/2015/08/28/b34b8f6a-4ce7-11e5-902f-39e9219e574b_story.html, attached as Exhibit 2.

1 pain.

2 In August 2015, Jennifer's lungs filled with fluid as a result of her advancing cancer,
3 literally drowning her from within, and her headaches became too great to manage with
4 medication. Because medical aid in dying was not legally available to her, she requested
5 palliative sedation, a medical practice in which a patient is sedated, often into a coma, to alleviate
6 pain. Nutrition and fluids are often then withheld until the patient dies, either from the disease or
7 dehydration. For Jennifer, the process of palliative sedation began the afternoon of August 6,
8 2015, and ended with her death on August 11, 2015, at the age of 52. During those five days,
9 Mavis stood vigil with loved ones as Jennifer slowly died. Jennifer was heavily sedated and
10 mostly lay in a deep sleep, yet she groaned and grimaced when she was turned to prevent
11 bedsores. Because a side effect of morphine is difficulty passing urine, Jennifer's bladder became
12 distended to three times its normal size. During the third day of palliative sedation, Jennifer's
13 breathing became loud and labored, and she began to flail her arms and to roll herself over in bed.
14 She opened her eyes and appeared to be aware of her surroundings, desperate for air and in a state
15 of panic. Mavis, along with Jennifer's other sisters and Jennifer's husband Harlan, desperately
16 tried to soothe her. Jennifer never regained consciousness, but she again registered awareness
17 before she died. In that instance, when a catheter was used to relieve her distended bladder, she
18 struggled against its insertion. At times during those final days, she became very agitated,
19 foaming at the nose and mouth for hours on end. See S. Lupkin, *California Right-to-Die*
20 *Advocate Dies, But Not the Way she Wanted*, Vice News, August 20, 2015³; see also, Samantha
21 Weigel, *Right-To-Die Advocate Dies Without Reprieve: San Mateo Resident Jennifer Glass*
22 *Fought For New Legislation*, The Daily Journal, August 14, 2015.⁴

23 These sights and sounds of Jennifer's needless and prolonged suffering haunt Mavis,
24 leading her to share her experience. To this day, Mavis is deeply saddened that her sister Jennifer
25 had to suffer for no comprehensible reason. If medical aid in dying as authorized by the End of

26 ³ Available at <https://news.vice.com/article/california-right-to-die-advocate-dies-but-not-the-way-she-wanted>,
27 attached as Exhibit 3.

28 ⁴ Available at <http://www.smdailyjournal.com/articles/news/2015-08-14/right-to-die-advocate-dies-without-reprieve-san-mateo-resident-jennifer-glass-fought-for-new-legislation/1776425148475.html>, attached as Exhibit 4.

1 Life Option Act were available to Jennifer at that time, Jennifer’s passing likely would have
2 occurred within half an hour. See Oregon Public Health Division, *Oregon Death with Dignity*
3 *Act: 2015 Data Summary*.⁵ Mavis regrets that Jennifer had to undergo palliative sedation for five
4 days until she finally died. Although Mavis is sad that Jennifer was unable to take advantage of
5 the law she fought so hard to pass, Mavis takes comfort in knowing that others will be able to
6 access medical aid in dying in order to achieve piece of mind and, if they so wish, a peaceful,
7 quick, and humane death.

8 The End of Life Option Act allows California citizens who are terminally ill to control
9 some circumstances of their death and reduce suffering during the final stages of their lives. If a
10 preliminary injunction is granted, those terminally ill patients who want the option of medical aid
11 in dying, and their families, will be left to suffer as Jennifer and Mavis did. For some patients,
12 such intense suffering is unbearable and leaves them no option but to request medical assistance
13 as they approach their inevitable deaths. Moreover, these terminally ill patients have, by
14 definition, fewer than six months to live. Thus, an injunction granted for the limited duration of
15 the pendency of this case will cause severe hardship—by the time the Court decides the merits of
16 this case, many of these terminally ill patients will likely have died without the reassurance and
17 comfort made possible by the Act.

18 In addition to avoidance of prolonged and agonizing pain, terminally ill patients seek
19 medical aid in dying because they wish to die at home, they seek to avoid loss of autonomy, loss of
20 freedom, and the inability to enjoy the activities that made life enjoyable, and they fear future poor
21 quality of life and inability to care for themselves. See Ganzini et al., *Why Oregon Patients Request*
22 *Assisted Death: Family Members’ Views* (2007) 23 J. Gen. Intern. Med. 154, 155⁶ (reporting that “the
23 most important reasons” for requesting physician assisted death were “wanting control of the
24 circumstances of death; loss of dignity; wanting to die at home and concerns about loss of
25 independence, quality of life, ability to care for self in the future.”); Loggers et al., *Implementing a*

26 ⁵ Available at <https://public.health.oregon.gov/Provider>
27 [PartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf](https://public.health.oregon.gov/Provider/PartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf) (2016), at 7 (reporting median
28 time between ingestion and death as 25 minutes), attached as Exhibit 5.

⁶ Attached as Exhibit 6.

1 *Death with Dignity Program at a Comprehensive Cancer Center* (2013) 368 New Eng. J. Med.
2 1417⁷ (“the most common reasons for participation were loss of autonomy (97.2%), inability to
3 engage in enjoyable activities (88.9%), and loss of dignity (75.0%).”).

4 Still other terminally ill persons seek medical aid in dying because treatments such as
5 palliative sedation or withdrawal of life support are not available to them. For example, some
6 patients, such as Christie O’Donnell, are morphine-intolerant and thus cannot receive palliative
7 sedation to avoid their suffering. *See Donorovich-Odonnell v. Harris* (2015) 241 Cal.App.4th
8 1118, 1125. Christie was diagnosed with stage IV adenocarcinoma—the most advanced stage—
9 and was given a terminal diagnosis of less than six months. *Id.* The invasive tumors in her lungs
10 had spread to other tissues and organs, metastasizing to her brain, liver, spine, and rib. *See id.*
11 Because she could not alleviate her pain and suffering through palliative sedation due to her
12 morphine intolerance, and because the End of Life Option Act was not available at the time,
13 Christie took the extraordinary measure of bringing a lawsuit to win the right to receive medical
14 aid in dying. *Donorovich-O’Donnell v. Harris*, Case No. 37-2015-00016404-CU-CR-CTL (San
15 Diego Super. Ct. filed May 15, 2015). In *Donorovich-O’Donnell*, the Hon. Gregory Pollack
16 recognized the need for legislative intervention, stating that “the legislature ought to be fixing the
17 law so that the legitimate needs of terminally-ill patients and their physicians are recognized,
18 respected and protected.” *Donorovich-O’Donnell v. Harris*, July 24, 2015 Order at p. 19⁸

19 Although Judge Pollack’s call for a legislative remedy was answered in the form of the
20 End of Life Option Act, Christie died before the Act went into effect. Granting preliminary
21 injunctive relief in this case will put many other terminally ill persons in the same position as
22 Christie—left to suffer through a prolonged and painful death in the face of a legislative policy
23 that would afford recognition, respect, and protection to these patients, their families, and their
24 physicians.

25
26
27 ⁷ Attached as Exhibit 7.

28 ⁸ Attached as Exhibit 8.

1 2. **Grant of preliminary injunction will cause hardship by forcing**
2 **terminally ill patients and their families to seek options outside of**
3 **California**

3 Granting a preliminary injunction would also force terminally ill patients and their
4 families to make a difficult choice between enduring a painful death or uprooting their lives to
5 obtain medical aid in dying in states that afford their residents this option.

6 The experience of Dan Diaz and his wife Brittany Maynard illustrates this tragic
7 circumstance. In Spring 2014, then-29-year-old Brittany learned she had terminal brain cancer.
8 After careful assessment of her prognosis and end-of-life options, Brittany and her family
9 determined that she could not obtain the peaceful end that she desired in California at the time. In
10 the Fall of 2014, Brittany and her family reluctantly moved from their Bay Area home to Oregon.
11 *See* Brittany Maynard, *My Right To Death With Dignity at 29*, CNN.com, November 2, 2014.⁹
12 Medical aid in dying has been available in Oregon since 1997, when the Oregon Death with
13 Dignity Act first went into effect. As Brittany moved closer to death, she was besieged by
14 frequent seizures and debilitating headaches caused by her brain tumor. Brittany died on
15 November 1, 2014, after self-administering her medical aid in dying prescription. She died
16 peacefully at home surrounded by loved ones. *See* Catherine E. Shoichet, *Brittany Maynard,*
17 *Advocate For 'Death With Dignity' Dies*, CNN.com, November 3, 2014.¹⁰ Brittany recognized
18 that the vast majority of people cannot access medical aid in dying because they do not have the
19 resources and wherewithal to uproot their family to seek medical care and establish a support
20 system in a different state. This was, in part, what led her and her husband to advocate for a full
21 range of end-of-life options in California, including medical aid in dying.

22 Even for those patients who have the means and support of family to obtain medical aid in
23 dying by moving to another state, granting a preliminary injunction will force them to make
24 difficult decisions away from their homes, disrupt their lives during their final days, and face the
25 uncertainty of having to seek medical care in a different state. For other patients who lack the

26 _____
27 ⁹ Available at <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/>, attached as Exhibit
28 9.

¹⁰ Available at <http://www.cnn.com/2014/11/02/health/oregon-brittany-maynard/>, attached as Exhibit 10.

1 ability to relocate to a state that permits medical aid in dying, issuing an injunction here would
2 leave them with few alternative options to suffering the ravages of their disease—(1) resort to
3 palliative sedation, which is sometimes unavailable and may not be a viable or desired option, or
4 (2) enlist the aid of friends and family members, who may later be subjected to criminal
5 prosecution. The grant of a preliminary injunction will only lead to greater suffering for the
6 terminally ill and devastating consequences for family and friends.

7 **3. Grant of preliminary injunction will cause hardship in reducing the**
8 **quality of care available to terminally ill patients**

9 The End of Life Option Act facilitates open discussion of end-of-life options between
10 patients and physicians insofar as it exempts medical aid in dying from criminal liability under
11 Penal Code § 401. Numerous studies in Oregon and Washington, along with a host of national
12 surveys, link the availability of medical aid in dying as a palliative care option to more positive
13 outcomes for end-of-life care. Patients' questions about medical aid in dying can also prompt in-
14 depth conversations between doctors and patients about the full range of end-of-life care,
15 including hospice, pain management, and emotional support, in addition to medical aid in dying.
16 One study of end-of-life care concluded that "it is possible that the Oregon Death with Dignity
17 Act has resulted in or at least reflects more open conversation and careful evaluation of end-of-
18 life options, more appropriate palliative care training of physicians, and more effort to reduce
19 barriers to access to hospice care and has thus increased hospice referrals and reduced potentially
20 concerning patterns of hospice use in the state." Wang et al., *Geographic Variation of Hospice*
21 *Use Patterns at the End of Life* (2015) 18 J. of Palliative Med. 771, 778¹¹; see also Smith et al.,
22 *Quality of Death and Dying in Patients Who Request Physician-Assisted Death* (2011) 14 J.
23 *Palliative Med.* 445¹² (patients requesting life-ending prescriptions were more satisfied with their
24 symptom control, control over surroundings, and preparedness for death than those who did not
25 pursue prescription).

26 Indeed, Plaintiff Dr. Vincent Nguyen himself acknowledges the importance of open

27 ¹¹ Attached as Exhibit 11.

28 ¹² Attached as Exhibit 12.

1 communications between terminally ill patients and their physicians regarding end-of-life care
2 options and the Act’s ability to facilitate such communications. In an op-ed article published in
3 the Los Angeles Times on July 1, 2016, Dr. Nguyen stated: “Regardless of one’s personal beliefs
4 on [the End of Life Option Act], I am hopeful that it will ultimately serve an important role in
5 beginning a critical conversation about death, dying and what it means to retain autonomy over
6 the final days of our lives.” Dr. Vincent Nguyen, *Commentary: End of Life Option Act requires*
7 *rigorous physician review*, L.A. Times, July 1, 2016.¹³ The End of Life Option Act allows
8 terminally ill patients just that—the opportunity for open discussions with their physicians
9 regarding available options for their end-of-life care. Granting a preliminary injunction will chill
10 open discussion between terminally ill Californians and their physicians of available end-of-life
11 options.

12 **C. The Alleged Hardship To The Plaintiffs Is Insubstantial and Speculative**

13 Plaintiffs claim they and their patients “will suffer severe prejudice as the Act’s
14 immunities come into effect, up to and including the irreversibility of lives lost to currently
15 unlawful acts of assisting suicide.” (P’s Am. Appl. at 18.) But they offer no evidence—none—
16 that these speculative harms will occur in the absence of a preliminary injunction. At most,
17 Plaintiffs offer only assertions that (1) in the past, there have been instances in which aid in dying
18 medications have failed to work as intended; (2) physicians conceivably may act “negligently,
19 incompetently, or maliciously”; and (3) people suffering from depression are more likely to
20 commit suicide. (P’s Am. Appl. at 5–7.) This is not enough.

21 Plaintiffs have failed to support their application with any credible evidence that they—or
22 anyone—will be harmed if the Act goes into effect. “An injunction cannot issue in a vacuum
23 based on the proponents’ fears about something that may happen in the future. It must be
24 supported by actual evidence that there is a realistic prospect” that the proponent will experience
25 irreparable harm. *Korean Phila. Presbyterian Church v. Cal. Presbytery* (2000) 77 Cal.App.4th
26 1069, 1084, as modified (Feb. 9, 2000). “An injunction properly issues only where the right to be

27 ¹³ Available at [http://www.latimes.com/socal/daily-pilot/opinion/tn-dpt-me-commentary-nguyen-20160702-](http://www.latimes.com/socal/daily-pilot/opinion/tn-dpt-me-commentary-nguyen-20160702-story.html)
28 [story.html](http://www.latimes.com/socal/daily-pilot/opinion/tn-dpt-me-commentary-nguyen-20160702-story.html), attached as Exhibit 13.

1 protected is clear, injury is impending and so immediately likely as only to be avoided by
2 issuance of the injunction.” *E. Bay Mun. Utility Dist. v. Dep’t of Forestry & Fire Prot.* (1996) 43
3 Cal.App.4th 1113, 1126. Plaintiffs’ thought experiments about hypothetical mentally ill patients
4 and their incapable teams of physicians do not come close to constituting the “substantial
5 evidence” needed to support the issuance of injunctive relief. *Nelson v. Pearson Ford Co.* (2010)
6 186 Cal.App.4th 983, 1020–21 (reversing award of injunctive relief that was not supported by
7 substantial evidence); *see also Epstein v. Superior Court* (2011) 193 Cal.App.4th 1405, 1410
8 (denying writ of mandate where superior court properly denied a preliminary injunction where
9 there was no “substantial basis” to conclude irreparable harm would occur).

10 Plaintiffs fail to meet their burden in two ways. First, Plaintiffs have not identified how
11 the Act will harm them. At most, they assert the act will harm patients who are under the care of
12 other, imaginary doctors who will ignore the signs of mental illness, or who will fail to adhere to
13 procedures required under the Act in treating their patients. But the Act does not force the hands
14 of Plaintiffs or any other physicians in the state of California to prescribe aid in dying
15 medications or to act outside their best medical judgment. Medical aid in dying is purely
16 voluntary. *See* Cal. Health & Safety Code § 443.14(e). The Act serves only to provide terminally
17 ill patients with more options at the end of life—no one is required to participate in the process of
18 medical aid in dying as contemplated under the Act. Plaintiffs are free to act consistent with their
19 own moral or professional reservations about medical aid in dying and will not be harmed by the
20 Act’s immunity provisions.

21 Second, Plaintiffs do not make a credible showing of how the Act will hurt anyone.
22 Plaintiffs admit—as they must—that the Act was designed with ample procedures that protect
23 patients from exactly those harms that Plaintiffs are concerned with. (P’s Am. Appl. at 4–6.)
24 Indeed, Plaintiff Nguyen states in his op-ed article published in the Los Angeles Times on July 1,
25 2016, that “[the Act] is hardly ‘the easy way out’” because its numerous safeguards make it
26 “[o]ne of the most rigorous in the nation.” Nguyen, Ex. 13. Under the Act, only competent
27 adults are allowed to request the prescription for themselves. Cal. Health & Safety Code § 443.2.
28 Two independent physicians—that is, doctors who are not related to the terminally ill patient and

1 who do not stand to gain from the patient’s estate—must confirm the patient’s terminal diagnosis.
2 *Id.* § 443.17(d). And each patient who requests medical aid in dying must make three separate
3 requests—two oral requests, at least fifteen days apart, and one written request signed by the
4 patient in the presence of two witnesses, one of whom cannot be either the attending physician or
5 someone who could benefit from the terminally ill patient’s estate. *Id.* § 443.3. Finally, under the
6 Act each terminally ill patient must execute a final attestation form less than 48 hours before self-
7 administering the aid in dying medication. *Id.* § 443.5(a)(12).

8 Plaintiffs’ application rests on a foundation of speculation. They surmise that some
9 terminally ill people might suffer from depression, that some people might not follow the law,
10 and that the Act provides insufficient deterrents for some physicians who might be negligent or
11 malicious. But a recent analysis of nearly two decades’ worth of reported physician data in
12 Oregon shows that the availability of medical aid in dying under that state’s Death with Dignity
13 Act has not had a negative impact on end of life care, including the availability and use of hospice
14 and palliative care. Ganzini, *Legalised Physician-Assisted Death in Oregon* (2016) 16 QUT L.
15 Rev. 76, 79.¹⁴ Medical aid in dying has been “rarely chosen by terminally ill patients” in Oregon,
16 in part because the requirements under the Oregon statute “require planning and foresight” on the
17 part of patients.¹⁵ *Id.* In short, none of the Oregon opponents’ public policy fears came true.

18 Plaintiffs contend the Act will direct people to end their lives because terminal diagnoses
19 make people “fearful and depressed” and depression causes suicides. (P’s Am. Appl. at 7–8.)
20 Not so. Plaintiffs’ simplistic logic conflates clinical depression, a serious disease that undermines
21 a person’s judgment and autonomy, with colloquial uses of the term “depressed.” While
22 Plaintiffs characterize those who request medical aid in dying as vulnerable, impressionable, and
23 even suicidal, surveys of people who actually requested medical aid in dying show that they are
24 not motivated by depression, but by a desire to maintain independence and control, to minimize
25

26 ¹⁴ Attached as Exhibit 14.

27 ¹⁵ The low rates of aid in dying prescriptions also reflect an unwillingness of some doctors to prescribe the
28 medication, either as a result of personal conviction or contractual obligations to religious health care systems.
Ganzini, *supra*, at 79, 81 (Exhibit 14). This established, long-standing ability of doctors to opt-out of medical aid in
dying further emphasizes that these Plaintiff physicians face no harm or threat of harm from the Act’s provisions.

1 dependence on others, and to die at home. See Ganzini et al., *supra*, at 155¹⁶; Ganzini, *supra*, at
2 80¹⁷; Loggers et al., *supra*, at 1417¹⁸. The rate of depression in those who request medical aid in
3 dying is not significantly higher than in terminally ill patients who do not request medical aid in
4 dying. Ex. 14 at 83. It is simply untrue that the availability of medical aid in dying permits
5 patients suffering from depression to hastily end their lives. See Pearlman et al., *Motivations for*
6 *Physician-assisted Suicide* (2004) 20 J. Gen. Intern. Med. 234, 238¹⁹ (“[P]atients considered a
7 hastened death over prolonged periods of time and repeatedly assessed the benefits and burdens of
8 living versus dying. None of the participants cited responding to bad news, such as the diagnosis of
9 cancer, or a depressed mood as motivations for interest in hastened death.”).

10 It is conceivable that a terminally ill person, suffering from depression, will one day
11 request medical aid in dying, but the Act has built-in protections that ensure such a person is
12 healthy and competent enough to make a reasoned, well-considered judgment about whether to
13 receive medical aid in dying. See, e.g., Cal. Health & Safety Code §§ 443.2, 443.1(k) (patient
14 competence and mental health assessments). Similar requirements have been successful in
15 Oregon at preventing people suffering through major depressive disorders from obtaining medical
16 aid in dying. See Ex. 14 at 82. Plaintiffs’ concerns about terminally ill patients with depression
17 are overstated and unsubstantiated.

18 Plaintiffs’ separate, and even more fanciful, concern is that the Act provides a “wide
19 swath of criminal and civil immunity” that gives doctors carte blanche to act “negligently,
20 incompetently, or maliciously and still enjoy near complete immunity, so long as the Act’s
21 formalities of observed.” (P’s Am. Appl. at 6.) First, Plaintiffs provide absolutely no evidence
22 showing physicians would abandon their medical ethics and professional standards because the
23 Act provides them with some kind of immunity. Their alleged harm is pure imagination. Second,
24 the only provision in the Act that Plaintiffs’ cite for this “near complete immunity” is Section
25 443.14(c), which reads in full:

26 ¹⁶ Attached as Exhibit 6.

27 ¹⁷ Attached as Exhibit 14.

28 ¹⁸ Attached as Exhibit 7.

¹⁹ Attached as Exhibit 15.

1 Notwithstanding any other law, a health care provider shall not be
2 subject to civil, criminal, administrative, disciplinary, employment,
3 credentialing, professional discipline, contractual liability, or
4 medical staff action, sanction, or penalty or other liability for
5 participating in this part, including, but not limited to, determining
6 the diagnosis or prognosis of an individual, determining the
7 capacity of an individual for purposes of qualifying for the act,
8 providing information to an individual regarding this part, and
9 providing a referral to a physician who participates in this part.
10 Nothing in this subdivision shall be construed to limit the
11 application of, or provide immunity from, Section 443.16 or
12 443.17.

13 Cal. Health & Safety Code § 443.14(c). Section 443.14(c) expressly incorporates and does not
14 limit the application of section 443.16, which provides that “[a] health care provider may not be
15 sanctioned for . . . [m]aking an initial determination *pursuant to the standard of care* that an
16 individual has a terminal disease.” *Id.* § 443.16(a) (emphasis added). In other words, a physician
17 can still be sanctioned if the determination that a patient has a terminal disease is not made
18 pursuant to the standard of care, contrary to Plaintiffs’ assertion that physicians will have complete
19 immunity even when they act “negligently, incompetently, or maliciously and still enjoy near
20 complete immunity.” (P’s Am. Appl. at 6.) In addition, Section 443.17 provides for criminal
21 penalties for various acts related to the provision of medical aid in dying, *e.g., id.* §§ 443.17(a)
22 (felony to alter or forge a written request for medical aid in dying), 443.17(b) (felony to exert
23 undue influence on an individual to request medical aid in dying), 443.17(d) (felony for physician
24 to participate in medical aid in dying where physician is related to the patient or is entitled to a
25 portion of the patient’s estate). These provisions are plainly inconsistent with Plaintiffs’ broad
26 reading of the “immunity” afforded under the act to physicians. Not only is Plaintiffs’ purported
27 harm unsupported by the facts, but it is unsupported by the statute itself.

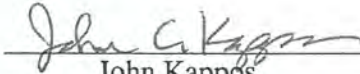
28 **III. CONCLUSION**

For the foregoing reasons, Compassion & Choices respectfully requests that the Court
denies plaintiffs’ motion for preliminary injunction.

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Dated: July 18, 2016

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