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12
13 UNITED STATES DISTRICT COURT
14 CENTRAL DISTRICT OF CALIFORNIA

15 UNITED SPINAL ASSOCIATION; NOT DEAD YET;
16 INSTITUTE FOR PATIENTS’ RIGHTS;
17 COMMUNITIES ACTIVELY LIVING
INDEPENDENT AND FREE; LONNIE VANHOOK;
18 INGRID TISCHER,

19 Plaintiffs,

20 v.

21 STATE OF CALIFORNIA; GAVIN NEWSOM, in his
official capacity as Governor; ROBERT BONTA in his
official capacity as Attorney General; CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH; TOMAS J.
22 ARAGON, in his official capacity as Director and State
Public Health Officer; CALIFORNIA DEPARTMENT
23 OF HEALTH CARE SERVICES; MICHELLE BAASS,
in her official capacity as Director; MENTAL HEALTH
SERVICES OVERSIGHT AND ACCOUNTABILITY
24 COMMISSION; MARA MADRIGAL-WEISS, in her
official capacity as Chair; MEDICAL BOARD OF
25 CALIFORNIA; KRISTINA D. LAWSON, in her official
capacity as President; DISTRICT ATTORNEY’S
26 OFFICE FOR LOS ANGELES COUNTY; GEORGE
27 GASCON, in his official capacity as District Attorney;
and DOES 1 through 20, inclusive,

28 Defendants.

Case No. 2:23-cv-03107

**COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

- (1) Americans with Disabilities Act
- (2) Rehabilitation Act
- (3) 14th Amendment Equal Protection
- (4) 14th Amendment Due Process

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1 **INTRODUCTION¹**

2 1. The Plaintiff organizations and individuals bring this action to stop the
3 Defendant government agencies and officials from running a deadly system that
4 steers people with terminal disabilities² away from necessary mental health care,
5 medical care, and disability supports, and towards death by suicide under the guise
6 of “mercy” and “dignity” in dying.

7 2. Physician-assisted suicide is not only a revival of old eugenic
8 ideologies, it also violates federal disability rights laws and federal constitutional
9 provisions which protect persons with disabilities from discrimination, exclusion,
10 and life-threatening governmental laws and policies. Under federal law, a public
11 entity may not withhold services or make services available on unequal terms on the
12 basis of disability. The State and local government Defendant agencies and officials
13 named in this action fund and operate systems of public health, social services,
14 medical profession regulation, and law enforcement to provide protective services
15 for people who express suicidality, and to prevent medical professionals, caregivers,
16 and family members from taking advantage of or encouraging a person’s impulse
17 for self-harm or suicide. Through the State’s physician-assisted suicide law,
18 however, that entire protective network of services is withheld from the Plaintiffs
19 and their members—solely on the basis of a doctor’s “good faith” diagnosis of
20 terminal disability.

21 3. Nine U.S. states and the District of Columbia have passed laws
22 legalizing physician-assisted suicide (Montana also permits the practice through a
23

24 ¹ This lawsuit addresses suicide. Suicidal thoughts or actions (even in very young
25 children, older adults, and people with life-threatening illness/disability) are a sign
26 of extreme distress and should not be ignored. If you or someone you know needs
27 immediate help, call or text the Suicide & Crisis Lifeline at 988.

28 ² This complaint uses the term “people with terminal disabilities” to describe people
who have a medical condition that some doctors would describe as an incurable and
irreversible disease that has been medically confirmed and will, within reasonable
medical judgment, result in death within six months—with or without medical care.

1 state supreme court decision). All of these laws are modeled after the nation’s first
2 physician-assisted suicide law, Oregon’s Death With Dignity Act, which went into
3 effect in 1997. California’s End of Life Option Act (“EOLOA” or “the Act”), was
4 enacted in 2016. All of these laws permit physicians to prescribe lethal drugs to
5 people who, in the opinion of the physician, have six months or less to live. Under
6 EOLOA and all other similar laws, a person’s perceived physical health is the
7 critical legal determinant of whether their doctor may help them live or die.

8 4. Plaintiffs United Spinal Association, Not Dead Yet, Institute for
9 Patients’ Rights, Communities Actively Living Independent and Free, Lonnie
10 VanHook, and Ingrid Tischer bring this lawsuit challenging EOLOA’s
11 discriminatory scheme, which creates a two-tiered medical system in which people
12 who are suicidal receive radically different treatment responses by their physicians
13 and protections from the State depending on whether the person has what the
14 physician deems to be a “terminal disease”—which, by definition, is a disability
15 under the Americans with Disabilities Act. Plaintiffs are all organizations with
16 members who have disabilities, individual persons with disabilities, and/or
17 organizations that advocate for persons with disabilities.

18 5. EOLOA is situated within a long history of American state laws and
19 practices directly harming and discriminating against people with disabilities on the
20 grounds that *those peoples’ lives* are not as worthy of protecting as others.
21 Prominent disability activist and author Alice Wong has discussed how the COVID-
22 19 pandemic recently revealed how certain groups of people are considered
23 disposable by the State, such as older, disabled, and chronically ill people, as well as
24 how people are even more disproportionately impacted by State-based medical
25 discrimination policies if they are economically marginalized or a person of color.
26 Black people, for example, are particularly at risk from EOLOA because racist
27 health care policies lead to limited choices and poorer outcomes, and make it more
28 likely that doctors will “write off” patients as terminal and not worthy of life-

1 preserving care. As California’s official health care policy, EOLOA steers
2 vulnerable people to their deaths instead of providing care and supportive services.



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16 6. The vast majority of people with terminal disabilities who seek a
17 hastened death have depression, which often interferes with decision making.
18 People with new, or newly diagnosed, disabilities also often go through a period of
19 initial depression including suicidal feelings. For example, Plaintiff United Spinal’s
20 members with spinal cord injuries at times experience depression and suicidal
21 thoughts as they must adjust to living with their disability after injury. Most people
22 with life-threatening conditions who say that they want to die are actually asking for
23 assistance in *living*—that is, for help in dealing with the symptoms and practical
24 necessities common to living with a terminal disability: depression, anxiety about
25 the future, grief, inadequate care options, dependence, lack of control, fear about
26 physical suffering, and spiritual despair.³

27
28 ³ Susan D. Block, & J. Andrew Billings, *Patient Requests for Euthanasia and*

1 7. Publicly-reported data show that people in the United States who have
2 died by physician-assisted suicide sought suicide primarily out of fears related to
3 losing autonomy, loss of the ability to engage in enjoyable activities, loss of dignity,
4 losing control of bodily functions, and becoming a burden on caregivers.
5 Appropriate attention to fears about living with disabilities reduces suicidal ideation
6 and results in dramatic improvement in quality of life—even as people approach the
7 end of their lives.⁴

8 8. Defendant California agencies and officials are cynically “generous” in
9 providing the freedom to choose death by suicide, but drastically restrict the
10 provision of appropriate palliative, hospice, in-home care, and other supportive and
11 protective services such that the actual supply and availability of alternatives to
12 physician-assisted suicide is woefully inadequate to meet the demands of its aging,
13 disabled, and chronically ill population. Instead of ensuring viable, appropriate
14 mental and medical health care options that promote patient well-being and true
15 autonomy, EOLOA presents a false choice of living without necessary health care or
16 dying by suicide with the “help” of a physician.

17 9. EOLOA discriminates against people with terminal disabilities by
18 depriving them of protections afforded other persons under California law in
19 violation of the Americans with Disabilities Act (“ADA”) and Section 504 of the
20 Rehabilitation Act of 1973 (“Section 504”). The State’s suicide prevention
21 programs are designed to ensure that a person’s expression of suicidal ideation is
22 sufficient in itself to trigger mental health care, irrespective of whether they want
23
24

25 _____
26 *Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36
27 PSYCHOSOMATICS 445 (1995),
28 <https://www.sciencedirect.com/science/article/pii/S0033318295716255>.

⁴ Herbert Hendin, *Suicide, Assisted Suicide, and Medical Illness*. 60 J. CLIN. PSYCH.
(Suppl. 2) 46, (1999), <https://www.psychiatrist.com/read-pdf/20371/>.

1 treatment.⁵ EOLOA deprives Plaintiffs and their members access to these life-
2 preserving interventions because of their disabilities. Medical professionals are
3 immunized and cannot be held civilly liable nor criminally prosecuted for assisting
4 the suicide of a person with terminal disabilities so long as they comply with the
5 Act’s minimal requirements. Yet the same doctor is subject to criminal and civil
6 liability for providing a far less dangerous dose of opioids to a non-terminal patient
7 in pain who later overdoses and dies. EOLOA shields physician-assisted suicide
8 deaths from law enforcement investigation and prosecution, solely because the
9 person who died by suicide had a terminal disability.

10 10. EOLOA does not reasonably advance its claimed purposes of enabling
11 autonomous choices in dying and relieving suffering, and violates the Equal
12 Protection Clause of the Fourteenth Amendment by treating differently people with
13 terminal disabilities as compared to everyone else who expresses a wish to die to
14 their medical doctor (both groups include people who want to, and do, die by
15 suicide). There is no rational basis for EOLOA’s “terminal” classification given
16 that physicians often misdiagnose some patients as having terminal diseases,
17 physicians’ prognosis of six months to live is often fallible, and the “terminal”
18 classification includes people who can live a longer life span with treatment and
19 supports (i.e., a diabetic taking insulin) but not without them. EOLOA’s very
20 purpose and core requirement—providing an early death to someone who will die
21 from a terminal illness within six months—is irrational, unreliable, and
22 discriminatory, in violation of both the Due Process Clause and the Equal Protection
23 Clause of the Fourteenth Amendment.

24 11. EOLOA further violates the Due Process Clause of the Fourteenth
25

26 _____
27 ⁵ Plaintiffs support voluntary mental health treatment and services that are
28 comprehensive, community-based, recovery-oriented, and culturally and linguistically competent. Nothing in this complaint should be construed as recommending or supporting involuntary treatment of any kind.

1 Amendment by failing to include sufficient safeguards to ensure that a judgment-
2 impaired, or unduly influenced person does not receive and/or ingest lethal
3 physician-assisted suicide drugs without adequate due process in waiving their
4 fundamental right to live. The Act’s failure to require an exhaustion, or at least
5 evidence of an informed rejection, of less restrictive alternatives to assisted suicide—
6 —including suicide prevention services, palliative care, hospice care, and other
7 personal support services currently provided by the State—also violates the Due
8 Process Clause of the Fourteenth Amendment. The Act creates an unregulated zone,
9 which allows a free-for-all with no independent or public oversight into whether
10 people who die by physician-assisted suicide are actually close to death, have a
11 treatable mental disorder, are coerced into death by another person, or lack feasible
12 alternatives.

13 12. The U.S. Supreme Court has observed that the State has an “unquali-
14 fied interest in the preservation of life,” including “an interest in protecting vulner-
15 able groups—including the poor, the elderly, and disabled persons—from abuse,
16 neglect, and mistakes,” given “the real risk of subtle coercion and undue influence
17 in end-of-life situations.”⁶ This interest “goes beyond protecting the vulnerable
18 from coercion; it extends to protecting disabled and terminally ill people from
19 prejudice, negative and inaccurate stereotypes, and ‘societal indifference.’”⁷ By
20 implementing and enforcing EOLOA, Defendants have pinpointed the very
21 population they know to have the most risk factors for suicide—characterized by old
22 age, illness, and disability—and given them the equivalent of a loaded gun, instead
23 of providing the protective, supportive, and compassionate services that this
24 population requires to continue living.

25
26 _____
27 ⁶ *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (finding no constitutional
right to assisted suicide).

28 ⁷ *Id.* at 732.

1 13. Plaintiffs ask the Court to (1) declare EOLOA unlawful and
2 unconstitutional; and (2) enjoin Defendants from enforcing EOLOA.

3 **JURISDICTION**

4 14. An actual, present, and justiciable controversy exists between the
5 parties within the meaning of 28 U.S.C. § 2201(a).

6 15. This Court has jurisdiction over Plaintiffs’ claims arising under the
7 United States Constitution and 42 U.S.C. § 1983 pursuant to 28 U.S.C. §§ 1331 and
8 1343(a)(3).

9 16. This Court has jurisdiction over Plaintiffs’ claims arising under Title II
10 of the Americans with Disabilities Act (“ADA”), and Section 504 of the Rehabilita-
11 tion Act (“Rehab Act”) and the regulations promulgated thereunder, pursuant to 28
12 U.S.C. §§ 1331 and 1343(a)(3). 42 U.S.C. § 12202 (ADA, Title II) and 42 U.S.C.A.
13 § 2000d-7(a) (Rehab Act) both waive states’ Eleventh Amendment immunity and
14 provide that civil actions asserting claims under these statutes may be brought in
15 federal court.

16 17. Plaintiffs’ claims for declaratory and injunctive relief are authorized by
17 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil
18 Procedure, by 42 U.S.C. §§ 12101 *et seq.*, 29 U.S.C. § 794 and by the general legal
19 and equitable powers of this Court. This Court also has authority under the ADA
20 (42 U.S.C. § 12205), Section 504 of the Rehabilitation Act (29 U.S.C. § 794a(b))
21 and 42 U.S.C. § 1988 to award Plaintiffs their reasonable attorneys’ fees, litigation
22 expenses, and costs.

23 **VENUE**

24 18. Venue is proper in this Court pursuant to 28 U.S.C. §§ 1391(b) because
25 at least one plaintiff resides in this district, one or more defendants reside in this
26 district, and a substantial part of the events or omissions giving rise to the claims
27 occurred in this district.

28

THE PARTIES

1
2 19. Plaintiff United Spinal Association (“United Spinal”) is a national
3 501(c)(3) nonprofit membership organization that was founded by paralyzed
4 veterans in 1946. United Spinal is run by a Board of Directors, the majority of
5 whom are people with disabilities, and staff that includes people with spinal cord
6 injuries. United Spinal is dedicated to empowering and advocating for people living
7 with spinal cord injuries and disorders (“SCI/D”) and all wheelchair users, including
8 veterans, to obtain greater independence and quality of life. United Spinal expends
9 substantial time and resources on work to advance opportunities, social equity, and
10 disability rights for all people living with a spinal cord injury or disease. This
11 includes work on issues such as increasing access to quality affordable health care
12 and independent living services; enhancing and reforming government benefit
13 systems; and preserving social security benefits—including in California. United
14 Spinal has approximately 60,000 members nationally, and over 5,000 members in
15 California served by four chapters. More than 2,000 of United Spinal’s California
16 members self-identify as having a spinal cord injury.

17 20. Spinal cord injuries are devastating to the injured and their families.
18 Newly injured members of United Spinal have faced and will continue to face
19 significant challenges including loss of independence, depression, isolation, loss of
20 self-confidence, and anxiety about what the future will bring. Many have been
21 suicidal on occasion. Many have also been depressed after injury and while living
22 in the community. In response to these needs, United Spinal operates a peer mentor
23 support program that brings together people who have experience living with spinal
24 cord injuries with others who are navigating similar challenges. United Spinal peer
25 mentors provide information and support to members about suicide prevention.

26 21. While United Spinal helps its members live independently and
27 effectively in the community, some members are unable to do so because of
28 systemic problems in the healthcare and benefits systems as well as discrimination

1 on the basis of disability. Many of United Spinal’s members have directly
2 experienced discrimination by medical professionals, including denial and delay of
3 necessary medical services, by being told that their quality of life is poor, as well as
4 by being delayed or denied basic services and supports necessary for living at home
5 with paralysis. People with spinal cord injuries generally consider themselves as
6 having a static disability, one that can be addressed with the right care, services, and
7 supports. Some members have been told by doctors that their condition is
8 “terminal,” and that they have a limited amount of time to live—yet the dire
9 predictions proved wrong. As a result of being perceived as terminally ill by their
10 physicians, some of United Spinal’s members qualify for physician-assisted suicide
11 and are particularly vulnerable to (and United Spinal is fearful of) being steered
12 towards physician-assisted suicide in a state of despair or depression. United Spinal
13 members in California have discussed, considered, and on information and belief,
14 accessed lethal medications and/or committed suicide by means of EOLOA. The
15 Act places United Spinal’s members at risk of dying by using physician-assisted
16 suicide during a period of depression and difficulty. United Spinal brings this action
17 on behalf of its members because the interests at stake are germane to United
18 Spinal’s purpose of empowering and advocating for people living with spinal cord
19 injuries and disorders to obtain greater independence and quality of life.

20 22. United Spinal has been injured as a direct result of Defendants’ actions
21 and omissions alleged herein. In addition to placing United Spinal members at risk
22 of death by physician-assisted suicide, Defendants’ actions and omissions have
23 frustrated the organization’s mission to empower and advocate for people with
24 spinal cord injuries to obtain better quality of life and greater independence. United
25 Spinal has diverted resources to address and counteract concerns about physician-
26 assisted suicide in California as well as advocate for its members and constituents
27 who are placed at risk of harm by EOLOA and/or at risk of being steered toward
28 utilizing physician-assisted suicide. United Spinal has expended resources on

1 education and outreach campaigns targeted at addressing physician-assisted suicide.
2 This includes publishing a position statement opposing physician-assisted suicide
3 and a message from the organization’s CEO about the dangers of the practice.
4 United Spinal has held public information discussions to inform its members
5 concerning assisted suicide laws and their impact on equality, dignity, and access to
6 care for people with disabilities. United Spinal monitors reports from peer support
7 mentors concerning physician-assisted suicide, and has surveyed an online group of
8 individuals with spinal cord injuries about their experiences with the practice.
9 United Spinal is unable to devote these resources to its other critical programs. By
10 steering people with spinal cord injuries towards physician-assisted suicide, EOLOA
11 impedes United Spinal’s mission to support their members in obtaining greater
12 quality of life. Neither the claims asserted nor relief requested by United Spinal
13 requires the participation of individual members in the lawsuit.

14 23. Plaintiff Not Dead Yet (“NDY”) is a national disability rights
15 organization formed in 1996 to articulate and organize the disability rights
16 opposition to the legalization of physician-assisted suicide, to oppose public policies
17 that allow the involuntary withholding of life-sustaining medical treatment, and to
18 advocate for equal protection of the law in cases of homicides of disabled persons.
19 NDY is headquartered in Rochester, New York and operates under the fiscal
20 sponsorship of The Center for Disability Rights, Inc., a non-profit, community-
21 based advocacy and service organization for people with all types of disabilities.

22 24. NDY expends substantial time and resources on work to advance the
23 rights of people with disabilities. Its advocacy work includes advocating that the
24 withholding or withdrawal of life-sustaining medical treatment be truly voluntary
25 and based on informed consent with meaningful alternatives, including long-term
26 services and supports to live in the community; opposing futility policies involving
27 unilateral or involuntary health care provider decisions to withhold or withdraw life-
28 sustaining medical treatment; and advocating for equal protection of the law in

1 homicide cases when the victim is old, ill, or disabled.

2 25. NDY has been injured as a direct result of Defendants' actions and
3 omissions alleged herein. Defendants' actions have frustrated its mission to oppose
4 public policies that allow the involuntary withholding of life-sustaining medical
5 treatment, to oppose bioethics policies such as Quality Adjusted Life Years
6 ("QALY") that pose risks to the healthcare and lives of disabled people, to advocate
7 for equal protection of the law in cases of homicides of disabled persons, and
8 oppose assisted suicide bills in states that have not legalized the practice. NDY has
9 been forced to expend resources to address community concerns and advocate for
10 people with disabilities who are harmed by or at risk of harm by EOLOA, and is
11 therefore unable to devote these resources to its other critical efforts addressing the
12 impact of discriminatory health care policies on the lives of people with disabilities.
13 Not Dead Yet spent resources on press advocacy as well as organizing people with
14 disabilities in California to oppose EOLOA's passage. Since the enactment of
15 EOLOA, NDY has had to expend resources supporting people with disabilities in
16 California by advocating against, organizing against, and educating the public about
17 the ongoing removal of safeguards from EOLOA.

18 26. Plaintiff Institute for Patients' Rights ("IPR") is a national, 501(c)(3)
19 organization that conducts and supports research and public education on healthcare
20 disparities in the context of end-of-life issues. IPR advocates to protect individuals'
21 rights in numerous healthcare contexts, including by providing information about
22 the discriminatory effects of physician-assisted suicide laws and the dangers those
23 laws pose to vulnerable individuals; opposing discriminatory crisis standards of care
24 put in place during the COVID-19 pandemic that placed people with disabilities at
25 risk of harm; advocating against the use of the QALY metric, which discriminates
26 against and diminishes the value of the lives of people with disabilities; educating
27 the public about disparities in healthcare access and outcomes, including those based
28 on race, age, and/or disability; and advocating for improvements to the quality of

1 hospice and palliative care services, as well as for expanded access to these key
2 services. IPR staff and board members regularly give presentations on these issues
3 and engage with the press to raise awareness and educate the public on these topics.

4 27. IPR has been injured as a direct result of Defendants' actions and
5 omissions alleged herein. Defendants' actions have frustrated its mission by placing
6 at risk of death individuals that IPR seeks to educate and advocate on behalf of.
7 Defendants' actions have further frustrated IPR's mission by eliminating safeguards
8 that work to ensure equal access to healthcare. Due to the enactment and
9 implementation of EOLOA, IPR has been forced to expend resources addressing
10 community concerns and advocating for its constituents who are placed at risk of
11 harm by EOLOA. In response to EOLOA, IPR developed and obtained
12 accreditation for continuing legal and medical education courses specific to
13 EOLOA. IPR hired a consultant to assist in its development of a California-specific
14 advanced directive that is now used to protect Californians from the dangers of
15 EOLOA. IPR developed community workshop training materials about EOLOA.
16 By expending resources on these and other EOLOA-specific activities, IPR is
17 unable to devote these resources to its other critical programs addressing the impact
18 of discriminatory healthcare policies. For example, IPR was unable to comment on
19 recent congressional legislation that would have prohibited the use of QALYs in
20 federal programs because it was too busy opposing EOLOA and the potential
21 expansion of EOLOA.

22 28. IPR is a sister organization of the Patients' Rights Action Fund
23 ("PRAF"), a national, non-partisan single-issue 501(c)(4) organization that protects
24 the rights of patients, people with disabilities, older adults, and economically-
25 disadvantaged people from deadly harm and discrimination inherent in physician-
26 assisted suicide laws. PRAF lobbies and advocates in state legislatures and
27 Congress for patient access to high-quality multidisciplinary end-of-life care, and
28 works against efforts that devalue and deprioritize healthcare for vulnerable

1 people—such as QALYs and physician-assisted suicide.

2 29. Plaintiff Communities Actively Living Independent and Free
3 (“CALIF”) is an independent living center, non-profit 501(c)(3), community-based
4 organization that provides services and advocacy by and for people with disabilities,
5 including people with terminal disabilities, who reside in Los Angeles County.
6 CALIF was founded in 2001 by people with disabilities and is run by a Board of
7 Directors and staff, the majority of whom are people with disabilities. CALIF is
8 based in Los Angeles, California.

9 30. CALIF’s mission is to: (1) achieve greater input, participation, and
10 control over policies and services for people with disabilities; (2) address
11 discrimination against people with disabilities; (3) encourage the meaningful
12 participation of persons with disabilities in mainstream activities that enhance the
13 positive image and experience of disability; and (4) empower people with
14 disabilities by encouraging ongoing education and a broad knowledge of the history
15 and heritage of the Disability Movement.

16 31. CALIF expends substantial time and resources on work to advance the
17 rights of people with disabilities. Its advocacy work includes helping individuals
18 select, acquire, and use assistive technology; assisting individuals with disabilities in
19 resolving issues related to their applications and/or appeals for public services or
20 benefits; housing advocacy; and systems change advocacy which entails monitoring
21 government systems and programs, laws, and local ordinances that affect people
22 with disabilities in their formulation and implementation to ensure their access,
23 quality of life, participation, and independence in all parts of life. CALIF’s peer
24 counseling program provides one-on-one peer counseling as well and group
25 mentoring for individuals who are dealing with disability related issues and
26 problems. CALIF provides training in the day-to-day independent living skills
27 necessary for self-directed and empowered living. CALIF participates very closely
28 with the Personal Assistance Services Council, which helps people with disabilities

1 access the State’s In-Home Supportive Services Program and develop skills in
2 interviewing, hiring, management, and self-evaluation of personal assistants,
3 interpreters, readers, and drivers. CALIF connects people with disabilities with long
4 term care services and supports to allow them to stay in their homes and receive the
5 services required to support their needs. CALIF also provides various education,
6 training, and volunteer opportunities. In fiscal year 2021, CALIF provided direct
7 services to approximately 860 consumers with disabilities, over half of whom are
8 over the age of 60. CALIF further provided resources and support through its
9 Information and Referral Services Program to over 6,000 consumers with
10 disabilities.

11 32. CALIF has been injured as a direct result of Defendants’ actions and
12 omissions alleged herein. The interests CALIF seeks to protect through this
13 litigation are germane to its mission and purpose. By furthering the deaths of
14 constituents that would have sought out and benefitted from CALIF’s services,
15 Defendants’ actions and omissions have frustrated CALIF’s mission and
16 undermined the effectiveness of the programs and services they provide. Due to
17 EOLOA, CALIF has been forced to expend resources to address community
18 concerns and advocate for people with disabilities who are harmed by or at risk of
19 harm by EOLOA, and CALIF has therefore been unable to devote these resources to
20 its other critical programs. CALIF expended resources to oppose the passage of
21 EOLOA and to educate the public on the risks that physician-assisted suicide poses
22 to people with disabilities, including CALIF’s constituents. Following the passage
23 of EOLOA, CALIF provided additional educational programs to counteract the de-
24 valuing of disabled lives under EOLOA. In order to combat the impact of EOLOA,
25 CALIF has diverted already scarce resources to identify, investigate, and address its
26 impact on CALIF’s constituents, including by offering suicide prevention peer
27 support services as well as by providing presentations and other educational
28 materials on the value of the lives of people with disabilities. Because EOLOA

1 threatens the lives of people with disabilities, CALIF is compelled to spend
2 substantial time to provide enhanced peer counseling and case management to ease
3 the anxiety and fears regarding consumers’ end of life decisions. EOLOA’s “better
4 off dead than alive” mentality contributes to the frightening trend of bullying and
5 criminal behavior toward the disabled so much that CALIF found it necessary to
6 join “LA versus Hate,” a group that supports Los Angeles County residents and
7 communities targeted for hate acts, in 2022.

8 33. Plaintiff Lonnie VanHook is a resident of Oakland, California, a
9 veteran of the United States Navy, and a member of United Spinal. Diagnosed as a
10 C-5 quadriplegic as a result of a spinal cord injury, he has lost the ability to move
11 his arms and legs. Mr. VanHook has also previously been diagnosed with
12 Rhabdomyosarcoma, a rare form of cancer that forms in soft tissue including
13 skeletal muscle tissue and hollow organs such as the bladder. Subsequent to his
14 spinal cord injury and cancer diagnosis, both of his legs were amputated.
15 Mr. VanHook is a person with multiple disabilities as defined in 42 U.S.C. § 12102
16 and 29 U.S.C. § 705(9)(B).

17 34. Mr. VanHook’s ability to engage in major life activities is substantially
18 limited, and he is mostly dependent on in-home health services. He requires in-
19 person assistance with basic life activities including eating, drinking, and cleaning.
20 Mr. VanHook requires being physically turned by another person in order to avoid
21 having his skin break down. He lives with substantial, and at times, excruciating
22 pain. Mr. VanHook would rapidly die without medical treatments and home health
23 care supports. He has been told his conditions are “terminal,” and he believes the
24 medical system would prefer him dead. As a result of interactions with doctors and
25 medical professionals, Mr. VanHook removed the organ donor indication from his
26 driver’s license for fear he was being targeted for organ harvesting rather than
27 treatment. Pursuant to EOLOA, Mr. VanHook has a terminal disease and is eligible
28 for physician-assisted suicide.

1 35. Mr. VanHook has been diagnosed with chronic depression, and has
2 experienced suicidal thoughts during episodes of depression. Mr. VanHook has
3 been placed on emergency psychiatric holds pursuant to California Welfare and
4 Institutions Code Section 5150. After learning about the availability of physician-
5 assisted suicide in Oregon, Mr. VanHook took steps to travel to Oregon to request
6 and receive lethal drugs—including withdrawing money for the trip, physician-
7 assisted suicide services, and experiences for his final journey—but was ultimately
8 unsuccessful. During this same period of time while placed on a 5150 hold in
9 California when Mr. VanHook was experiencing depression, he requested that his
10 medical providers let him perish from ceasing to ingest water and food.
11 Mr. VanHook’s doctors agreed to this request. After a period of time not eating or
12 drinking, Mr. VanHook decided to continue living with the support of his long-time
13 physician who has followed Mr. VanHook’s medical care for over 33 years.

14 36. Mr. VanHook wants to continue living; he would not choose assisted
15 suicide while exercising sound judgment and does not want to die from physician-
16 assisted suicide even knowing that the process is readily available in California.
17 Mr. VanHook is an African American male with limited resources and substantial
18 medical, mental health, and in-home health care needs—a person at serious risk of
19 racism and ableism in his contacts with the medical system. He has experienced
20 discrimination by several of his medical providers and currently is unable to obtain
21 the level of in-home care support that is required due to insufficient allocation of in-
22 home health care resources by Defendant California Department of Health Care
23 Services. Based on past and ongoing medical discrimination, the ongoing risk of
24 lacking the balance of quality of life, and his continued inability to obtain critical in-
25 home supports, Mr. VanHook experiences anxiety and depression. Mr. VanHook
26 fears that he will again become suicidal while depressed, that he will seek and
27 obtain physician-assisted suicide services without making an informed choice, and
28 that he will be provided with and subsequently ingest lethal medication. He also

1 fears that medical providers who view his quality of life to be very low will steer
2 him towards physician-assisted suicide instead of provided life-sustaining treatment,
3 and that he will die after consuming lethal medication.

4 37. Plaintiff Ingrid Tischer is a resident of Berkeley, California and a
5 member of United Spinal. Ms. Tischer has been diagnosed with scoliosis, muscular
6 dystrophy, Dejerine-Sottas Subtype III and polyneuropathy that has caused
7 quadriplegia and led to sleep apnea/chronic respiratory insufficiency, depression,
8 and anxiety. Ms. Tischer was born with a type of muscular dystrophy, a progressive
9 neuro-muscular disease, that causes neurodegeneration and muscle weakness over
10 time and substantially limits her ability to breathe, the use of her arms and hands,
11 and her ability to walk and move about. Ms. Tischer uses a walker and a wheelchair
12 for mobility and uses a type of ventilator known as a bilevel positive airway
13 pressure (“BiPap”) machine to help her breathe at night. She is a person with a
14 disability as defined in 42 U.S.C. § 12102 and 29 U.S.C. § 705(9)(B).

15 38. Ms. Tischer, a White woman, has experienced medical discrimination
16 based upon her disability, including by her doctor affirmatively challenging her
17 quality of life and denying Ms. Tischer medical services on the basis of her
18 disability. Based in part on past and ongoing medical discrimination, Ms. Tischer
19 experiences anxiety and depression, and fears that she will die either at a hospital
20 due to improper care or misclassification as “medically futile,” or at a skilled
21 nursing facility where there is a substandard level of care. Ms. Tischer’s condition
22 is a progressive one and as she ages her medical needs and daily living supports will
23 increase. If Ms. Tischer loses access to her Bi-Pap machine, her condition would
24 immediately worsen due to the lack of oxygen, causing physical and mental
25 exhaustion and confusion, severe headaches, possibly pneumonia, and ultimately
26 death due to carbon dioxide narcosis. Ms. Tischer believes she qualifies and is
27 eligible for physician-assisted suicide pursuant to EOLOA because she would die
28 within six months without medical supports. Ms. Tischer would not choose assisted

1 suicide while exercising sound judgment and does not want to die from physician-
2 assisted suicide. Based upon her medical history and experience, she is fearful that
3 her medical providers will steer her towards physician-assisted suicide in lieu of
4 providing life-sustaining treatment during a time when she is has impaired judgment
5 due to anxiety and/or depression. During a previous medical crisis, she considered
6 physician-assisted suicide to be a desirable choice given the absence of meaningful
7 and appropriate alternatives.

8 39. Defendant State of California (“State” or “California”) is the legal and
9 political entity responsible for enacting and enforcing State laws and legislation,
10 including EOLOA.

11 40. Defendant Gavin Newsom is sued in his official capacity as Governor
12 of the State of California. He is vested with the supreme executive power of the
13 State and has the duty to see that the State’s laws are faithfully executed. Cal.
14 Const. art. V, § 1. He has the authority to direct the attorney general to assist any
15 district attorney in the discharge of the duties of that office, and the attorney general
16 exercises its duties subjected to the powers and duties of Governor Newsom. *Id.* art.
17 V, § 13. Governor Newsom possesses the authority to supervise and assign
18 functions among executive officers and agencies, other than elective officers and
19 agencies administered by elective officers. *See id.* art. V, § 6; Cal. Gov’t Code
20 § 12010. Governor Newsom is tasked with appointing thirteen of fifteen members
21 of the Medical Board of California, subject to Senate confirmation. *See* Cal. Bus. &
22 Prof. Code § 2001. Governor Newsom has authority to remove from office
23 members of the Medical Board of California for neglect of duty, incompetency, or
24 unprofessional conduct. *Id.* § 2011. Governor Newsom also has the power to
25 appoint twelve of sixteen commissioners to the Mental Health Services Oversight
26 and Accountability Commission.

27 41. Defendant Robert Bonta is sued in his official capacity as the Attorney
28 General of California. As the chief law officer of the State, one of his duties is to

1 enforce the laws of the State. Cal. Const. art. V, § 13. He has direct supervision
2 over various law enforcement officers, including every district attorney and sheriff
3 in the State. *Id.* art. V, § 13.

4 42. Defendant California Department of Public Health (“CDPH”) is a
5 department within the California Health and Human Services Agency. CDPH’s
6 mission is to advance the health and well-being of the people of California. CDPH
7 is responsible for enforcing various provisions of the Health and Safety Code,
8 Welfare and Institutions Code, and other State laws and regulations. CDPH’s Office
9 of Suicide Prevention (OSP) is responsible for coordinating statewide suicide
10 prevention efforts and resources through planning and collaboration across diverse
11 partners and systems. Cal. Health & Safety Code § 131300. By statute, OSP is
12 responsible for implementing suicide prevention efforts consistent with the Mental
13 Health Services Oversight and Accountability Commission’s Suicide Prevention
14 Report “Striving for Zero.” Cal. Health & Safety Code § 131315(a).

15 43. CDPH facilitates physician-assisted suicide in part by making available
16 on its website the forms physicians must complete when participating under the Act.
17 Cal. Health & Safety Code § 443.22. CDPH also collects and reviews
18 documentation submitted by physicians pursuant to EOLOA, including physician-
19 assisted suicide requests and physician forms, and publishes a report based on the
20 information collected. *Id.* § 443.19. CDPH receives federal funds and has received
21 such funds at all times relevant to this complaint.

22 44. Defendant Tomás J. Aragón is sued in his official capacity as the
23 Director of CDPH and State Public Health Officer. In these positions, he has
24 control over the CDPH. He is appointed by the Governor, and his authority is
25 delegated to him by California Health and Safety Code § 131005.

26 45. Defendant California Department of Health Care Services (“CDHCS”)
27 is a department within the California Health and Human Services Agency. CDHCS
28 finances and administers certain health care service delivery programs for low

1 income and underserved individuals, including the California Medical Assistance
2 Program (“Medi-Cal”). CDHCS is responsible for California suicide prevention
3 activities, including but not limited to providing resources to counties to establish
4 suicide prevention trainings and programs, connecting individuals with county
5 providers for local assistance, and connecting individuals in crisis to the CDHCS
6 Ombudsman to obtain immediate services. CDHCS facilitates EOLOA by setting
7 and administering billing codes for health care providers who treat and prescribe
8 physician-assisted suicide to patients receiving health care through Medi-Cal, which
9 enable those providers to seek reimbursement for lethal drugs under EOLOA.
10 CDHCS prepares regulations to interpret and provide greater specificity for Medi-
11 Cal services, which may include services provided by Medi-Cal providers under the
12 Act. CDHCS also provides policy and billing information and guidance for Medi-
13 Cal providers who participate in EOLOA.

14 46. Michelle Baass is sued in her official capacity as the Director of
15 CDHCS. She is appointed by the Governor, and in her role, leads a team of more
16 than 4,000 employees at CDHCS.

17 47. Defendant Mental Health Services Oversight and Accountability
18 Commission (“MHSOAC”) is an independent State agency that oversees the
19 implementation of the Mental Health Services Act (Proposition 63), which imposed
20 a 1% income tax on wealthy California residents to pay for mental health services
21 and to establish a framework for continuous improvement of mental healthcare in
22 the State. Partnering with public and private mental health agencies, MHSOAC
23 works to ensure that people obtain the mental health care they need in a timely,
24 comprehensive, effective, and culturally competent manner. MHSOAC is
25 responsible for the statewide suicide prevention plan, California’s Strategic Plan for
26 Suicide Prevention 2020-2025. MHSOAC publishes information advising that
27 people with terminal disabilities, including people who are older, with disabilities,
28 and with chronic illnesses, have elevated rates of suicide risk factors. MHSOAC’s

1 suicide prevention services explicitly and purposefully abandon people with
2 terminal illnesses who seek physician-assisted suicide. The 16-member
3 Commission is composed of one Senator, one Assembly member, the State Attorney
4 General, the State Superintendent of Public Instruction, and 12 public members
5 appointed by the Governor.

6 48. Defendant Mara Madrigal-Weiss is sued in her official capacity as the
7 Chair of MHSOAC. She was elected Chair by MHSOAC Commission members,
8 and is serving a one year term.

9 49. Defendant Medical Board of California (“MBC”) is a government
10 agency within the California Department of Consumer Affairs. The MBC’s mission
11 is to protect health care consumers through the proper licensing and regulation of
12 physicians, surgeons, and certain allied healthcare professionals, and through
13 enforcement of the Medical Practice Act, which governs the practice of medicine in
14 California. The MBC also aims to promote access to quality medical care through
15 its licensing and regulatory functions. The MBC is charged with enforcing the
16 disciplinary and criminal provisions of the Medical Practice Act. *See* Cal. Bus. &
17 Prof. Code § 2004. MBC publishes an overview of the requirements of EOLOA,
18 and provides an email address for EOLOA questions. MBC has the authority to
19 update the forms physicians must complete when participating under the Act, Cal.
20 Health & Safety Code § 443.22, although it reports that it has not done so. Upon
21 information and belief, MBC has not disciplined any health care provider who has
22 furnished lethal drugs to patients under EOLOA, with the purpose of facilitating
23 their death.

24 50. Defendant Kristina D. Lawson is sued in her official capacity as the
25 President of the MBC. Her duties include administering the licensing, regulatory,
26 and disciplinary functions of the MBC. *See* Cal. Bus. & Prof. Code §§ 2000 *et seq.*

27 51. Defendant District Attorney’s office for Los Angeles County (“DA’s
28 Office”) is a public entity duly organized and existing under the laws of the State of

1 California. The DA’s Office has the primary authority and responsibility for
2 prosecuting criminal and specific civil cases within its jurisdiction. The DA’s
3 Office receives State and federal funds and has received such funds at all times
4 relevant to this complaint. Upon information and belief, the DA’s Office has not
5 investigated or prosecuted any health care provider who has furnished lethal drugs
6 to patients under EOLOA, with the purpose of facilitating their death.

7 52. Defendant George Gascón is sued in his official capacity as the District
8 Attorney for Los Angeles County. He is charged with prosecuting criminal
9 violations of the laws of California. Cal. Gov’t Code § 26500.

10 53. Plaintiffs are ignorant of the true names and capacities of Defendants
11 sued in this complaint as DOES 1 through 20, inclusive, and therefore sue these
12 Defendants by such fictitious names. Plaintiffs will amend this complaint to allege
13 their true names and capacities when ascertained. Plaintiffs are informed and
14 believe, and thereon allege, that each of the fictitiously named Defendants is
15 responsible in some manner for the acts alleged in this complaint.

16 54. Defendants, collectively and through their respective duties and
17 obligations, are responsible for administering and/or enforcing the Act. Each
18 Defendant, and those subject to their direction, supervision, and control, has the
19 responsibility to intentionally perform, participate in, aid and/or abet in the
20 administration or enforcement of the Act.

21 FACTUAL ALLEGATIONS

22 I. **Suicidality Is a Common Human Condition that We Now Recognize as a 23 Mental Health Symptom that Should Be Addressed Clinically—Even Among People with Terminal Disabilities**

24 A. **Suicide Is a Public Health Concern, Particularly for Older People 25 and Those with Disabilities**

26 55. Suicide is “death caused by injuring oneself with the intent to die.”⁸
27

28 ⁸ *Facts about Suicide*, CENTERS FOR DISEASE CONTROL AND PREVENTION (“CDC”),

1 According to the World Health Organization, more than 800,000 people die due to
2 suicide annually and “[t]here are indications that for each adult who died of suicide
3 there may have been more than 20 others attempting suicide.”⁹ Death from suicide
4 disproportionately impacts “the most vulnerable of the world’s populations and is
5 highly prevalent in already marginalized and discriminated groups of society.”¹⁰

6 56. The Centers for Disease Control and Prevention (“CDC”) reports that
7 suicide is “[o]ne of the 10 leading causes of death in the United States.”¹¹

8 According to the Surgeon General, “suicide rates are rising across the country.”¹² “In
9 2020, an estimated 12.2 million American adults seriously thought about suicide,
10 3.2 million planned a suicide attempt, and 1.2 million attempted suicide.”¹³ In 2020,
11 there were nearly twice as many completed suicides (45,979) in this country as there
12 were homicides (24,576).¹⁴ When states legitimize physician-assisted suicide and
13 doctors recommend and normalize suicide as an appropriate “treatment” for
14 addressing end-of-life concerns, the number of suicides increase—not only for
15 individuals with terminal disabilities but for the entire community.¹⁵

16
17 <https://www.cdc.gov/suicide/facts/index.html> (last visited March 8, 2023).

18 ⁹ World Health Org., PREVENTING SUICIDE: A GLOBAL IMPERATIVE 9 (2014),
19 https://apps.who.int/iris/bitstream/handle/10665/131056/9789241564779_eng.pdf?sequence=1.

20 ¹⁰ *Id.* at 3.

21 ¹¹ U.S. Surgeon General & Nat’l Action Alliance for Suicide Prevention, THE
22 SURGEON GENERAL’S CALL TO ACTION TO IMPLEMENT THE NATIONAL STRATEGY FOR
23 SUICIDE PREVENTION (“Surgeon General’s Call to Action”) 11 (2020),
<https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf>.

24 ¹² *Id.*

25 ¹³ *Facts About Suicide*, *supra* note 8.

26 ¹⁴ *Suicide*, Statistics, NAT’L INST. MENTAL HEALTH,
<https://www.nimh.nih.gov/health/statistics/suicide> (last visited March 9, 2023).

27 ¹⁵ David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted*
28 *Suicide Affect Rates of Suicide?*, 108 S. MED. J. 599 (2015),
https://www.researchgate.net/publication/282609275_How_Does_Legalization_of

1 57. The CDC observes that “[a]dults aged 75 and older have the highest
2 suicide rate compared to any other age group.”¹⁶ Military veterans make up
3 approximately 14 percent of all suicides in the U.S., and more than half of all
4 veterans who die from suicide are 55 years of age or older.¹⁷ People with
5 disabilities are significantly more likely than those without disabilities to report
6 suicidal ideation, suicide planning, and suicide attempts.¹⁸ People with cognitive,
7 complex activity (defined as self-care and/or independent living tasks), and multiple
8 disabilities have the highest risk of suicidal thoughts, suicide planning, and suicide
9 attempts.¹⁹ In 2021, “adults with disabilities were three times more likely to report
10 suicidal ideation in the past month compared to persons without disabilities.”²⁰

11 58. Suicide is “a major public health concern in California,” according to
12
13

14 _____
15 Physician-Assisted Suicide Affect Rates of Suicide; see also David Albert Jones,
16 *Euthanasia, Assisted Suicide, and Suicide Rates in Europe*, 11 J. ETHICS MENTAL
17 HEALTH, 1, 27 (2022),
18 [https://jemh.ca/issues/open/documents/JEMH%20article%20EAS%20and%20suicid
e%20rates%20in%20Europe%20-%20copy-edited%20final.pdf](https://jemh.ca/issues/open/documents/JEMH%20article%20EAS%20and%20suicid%20rates%20in%20Europe%20-%20copy-edited%20final.pdf) (concluding that
17 “there have been very steep rises in suicide” [both physician-assisted suicides and
18 other suicides] after the legalization of physician-assisted suicide in four European
countries).

19 ¹⁶ *Disparities in Suicide*, CDC, [https://www.cdc.gov/suicide/facts/disparities-in-
suicide.html](https://www.cdc.gov/suicide/facts/disparities-in-suicide.html) (Nov. 2, 2022).

20 ¹⁷ Cal. Mental Health Servs. Oversight & Accountability Comm’n, *Striving for
21 Zero: California’s Strategic Plan for Suicide Prevention 2020-2025* (“California’s
22 Strategic Plan”) 62,
https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf.

23 ¹⁸ Nicole M. Marlow, Zhigang Xie, Rebecca Tanner, Ara Jo, & Anne V. Kirby,
24 *Association Between Disability and Suicide-Related Outcomes Among U.S. Adults*,
61 AM. J. PREVENTATIVE MED. 852 (2021).

25 ¹⁹ Nicole M. Marlow, Zhigang Xie, Rebecca Tanner, Molly Jacobs, Michaela K.
26 Hogan, Thomas E. Joiner, Jr., & Anne V. Kirby, *Association Between Functional
27 Disability Type and Suicide-Related Outcomes Among U.S. Adults with Disabilities
in the National Survey on Drug Use and Health, 2015-2019*. 153 J. PSYCHIATR. RES.
213 (2022).

28 ²⁰ *Disparities in Suicide*, *supra* note 16.

1 Defendant CDPH.²¹ “[A]n average of 1,115,000 Californians over the age of 18 –
2 about 3.8 percent of all adults – reported having serious thoughts of suicide in the
3 past year.”²² In 2017, “18,153 Californians visited or were admitted to an
4 emergency department for intentional self-harm.”²³ In California, people over the
5 age of 65 have historically had the highest rates of suicide,²⁴ and the 85 and older
6 age group has “the highest rates of suicide compared to any other age group.”²⁵

7 59. Serious illness²⁶ and chronic pain²⁷ are important risk factors for
8 suicide. Social factors, “such as isolation and the feeling of being a burden to
9 others,” may increase suicide risk.²⁸ Other risk factors include “a breakdown in the
10 ability to deal with acute or chronic life stresses, such as financial problems.”²⁹
11 California recognizes that very high suicide rates among older adults “may be driven
12 by factors such as use of highly lethal means; unmet health, mental health, and
13 substance use disorder needs, especially late-life onset of depression; personality
14

15 _____
16 ²¹ CDPH, *Older Adult Suicide in California in 2019* (2022), at 1,
17 https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/OlderAdultSuicideCADataBrief_2019.pdf.

18 ²² California’s Strategic Plan, *supra* note 17, at 56.

19 ²³ *Id.*

20 ²⁴ *Id.* at 61.

21 ²⁵ CDPH, *California Suicide and Self-Harm Trends in 2020* (Feb. 21, 2021), at 1,
22 <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/SuicideAndSelfHarmIn2020-DataBrief-ADA.pdf>.

23 ²⁶ *Risk and Protective Factors, Suicide Prevention*, CDC,
24 <https://www.cdc.gov/suicide/factors/index.html> (Nov. 2, 2022).

25 ²⁷ PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 40 (“Suicidal
26 behaviour has been found to be 2–3 times higher in those with chronic pain
compared to the general population”).

27 ²⁸ Surgeon General’s Call to Action, *supra* note 11, at 19.

28 ²⁹ PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 11.

1 traits and coping mechanisms; life stressors, such as the loss of loved ones; social
2 disconnection; and impairments in functioning and disability.”³⁰ Most often,
3 “several risk factors act cumulatively to increase an individual’s vulnerability to
4 suicidal behavior.”³¹ Depression is the common culprit: “[E]very study that has
5 looked for an association between depression and the desire for death has found
6 one.”³²

7 60. A suicide attempt is often referred to as a “cry for help.” “[I]ndividuals
8 who are thinking about suicide, even when they experience strong intent, are often
9 ambivalent about their wish to die.”³³ The World Health Organization and the U.S.
10 Surgeon General (“Surgeon General”) agree that suicide is preventable.³⁴ Many
11 people who die by suicide do so within weeks or months of seeing a health
12 provider.³⁵ Such visits are opportunities to detect risk, address safety, and connect
13 patients with sources of care and support.³⁶ Restricting access to the lethal means
14 for suicide is also an effective strategy.³⁷

15 61. Suicidal crises are often short-lived, and even when there are chronic
16 factors present, a suicidal person can desist from self-harm with help from a health
17 provider.³⁸ People who survive suicide attempts are unlikely to later die by suicide.

18 _____
19 ³⁰ California’s Strategic Plan, *supra* note 17, at 61.

20 ³¹ PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 30.

21 ³² Keith G. Wilson, et al., *Mental Disorders and the Desire for Death in Patients*
22 *Receiving Palliative Care for Cancer*, 6 *BMJ SUPPORTIVE & PALLIATIVE CARE*, 170
(2016), <https://spcare.bmj.com/content/bmjspcare/6/2/170.full.pdf>.

23 ³³ Surgeon General’s Call to Action, *supra* note 11, at 35.

24 ³⁴ PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 6.

25 ³⁵ Surgeon General’s Call to Action, *supra* note 11, at 43.

26 ³⁶ *Id.*

27 ³⁷ PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 7.

28 ³⁸ Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 *DUQ. L. REV.* 1,124

1 A meta-analysis of medical studies that followed people who had made suicide
2 attempts that resulted in medical care showed that over 90% of those who survived
3 did not go on to die by suicide at a later date.³⁹ Many people who have expressed
4 suicidality or even attempted suicide are now living and grateful for the additional
5 years of life.⁴⁰

6 **B. The Desire for Suicide Among Older Patients and Those with**
7 **Terminal Illness Is Common, Attributable to Depression, and**
8 **Treatable**

9 62. Older and terminally ill people who express a desire for suicide are
10 almost always experiencing a psychiatric illness, often characterized by major
11 depression and/or hopelessness, in addition to their terminal physical conditions.⁴¹
12 A 2021 meta-analysis of 24 studies examining the prevalence and predictors of
13 suicide among older adults, which included a total of 306,173 subjects, concluded
14 that “depression is a major reason for suicide in the elderly.”⁴² Unfortunately,
15 physiological changes associated with aging into one’s later years increases

17 (1985); PREVENTING SUICIDE: A GLOBAL IMPERATIVE, *supra* note 9, at 3, 11, 23-4;
18 Surgeon General’s Call to Action, *supra* note 11, at 11, 35; *Attempters’ Longterm*
19 *Survival*, HARV. T.H. CHAN SCH. PUB. HEALTH,
<https://www.hsph.harvard.edu/means-matter/means-matter/survival/> (last visited
20 Mar. 21, 2023).

21 ³⁹ David Owens, Judith Horrocks, & Allan House, *Fatal and Non-Fatal Repetition*
of Self-Harm: Systematic Review, 181 BRIT. J. PSYCH. 193 (2002).

22 ⁴⁰ See, e.g., Anonymous surgeon, *I Tried to Take My Life Five Years Ago. Now I’m*
Grateful to Be Alive, THE GUARDIAN (Oct. 8, 2020),
23 [https://www.theguardian.com/society/2020/oct/08/take-life-grateful-alive-surgeon-](https://www.theguardian.com/society/2020/oct/08/take-life-grateful-alive-surgeon-suicide-attempt)
[suicide-attempt](https://www.theguardian.com/society/2020/oct/08/take-life-grateful-alive-surgeon-suicide-attempt).

24 ⁴¹ David C. Clark, “Rational” Suicide and People with Terminal Conditions or
25 *Disabilities*, 8 ISSUES LAW MED. 147 (1992).

26 ⁴² Gloria Obuobi-Donkor, Nnamadi Nkire & Vincent Agyapong, *Prevalence of*
Major Depressive Disorder and Correlates of Thoughts of Death, Suicidal
Behaviour, and Death by Suicide in the Geriatric Population-A General Review of
Literature, 11 BEHAV. SCI. 142, (2021),
27 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8614881/>.

1 susceptibility to depression.⁴³

2 63. “Depression is clinically characterized by obvious changes in decision
3 making that cause distress and impairment ... and is associated with impaired
4 functioning in ventromedial prefrontal cortex and ventral striatum, two regions
5 known to play critical roles in value-based decision making.”⁴⁴ “Difficulty making
6 decisions is a core symptom of depressive illness,” and “those with more depressive
7 symptoms make decisions that are less likely to further their interests.”⁴⁵ “Studies
8 have shown that depressed, relative to non-depressed persons, make qualitatively
9 different decisions, leading many doctors and psychotherapists to suggest to their
10 patients that they should avoid making major life choices while in a depressed
11 state.”⁴⁶

12 64. Expressions of the desire for death are common among people with
13 cancer.⁴⁷ A landmark study of the desire for hastened death published in the Journal
14 of the American Medical Association (“JAMA”) concluded that “[d]epression and
15 hopelessness are the strongest predictors of desire for hastened death” among
16 terminally ill cancer patients and that those with a major depressive episode were
17

18 ⁴³ George S Alexopoulos, *Depression in the Elderly*, 365 THE LANCET 947, 1961-
19 [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)66665-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)66665-2/fulltext).

20 ⁴⁴ Dahlia Mukherjee, Sangil Lee, Rebecca Kazinka, Theodore D. Satterthwaite &
21 Joseph W. Kable, *Multiple Facets of Value-Based Decision Making in Major
Depressive Disorder*, 10 SCIENTIFIC REPORTS 3415 (2020),
<https://www.nature.com/articles/s41598-020-60230-z>.

22 ⁴⁵ Yan Leykin, Carolyn Sewell Roberts, & Robert J. DeRubeis, *Decision-Making
23 and Depressive Symptomatology*, 35 COGN THER RES 333-341 (2011),
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3132433/>.

24 ⁴⁶ Levkin et al., *supra* note 45

25 ⁴⁷ Wilson, et al., *supra* note 32; *see also* Guy Maytal, M.D. & Theodore A. Stern,
26 M.D., *The Desire for Death in the Setting of Terminal Illness: A Case Discussion*. 8
PRIM CARE COMPANION J. CLIN. PSYCHIATRY 299, 301 (2006),
27 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1764532/pdf/i1523-5998-8-5-299.pdf> (discussing studies finding that the rate of a desire for a hastened death
28 among terminally ill patients ranged from 17% to 45%).

1 four times more likely to endorse a desire for hastened death than those without
2 depression.⁴⁸ A recent study comparing people with advanced diseases who sought
3 physician-assisted suicide with comparable patients who did not found that those
4 who sought physician-assisted suicide had “significantly higher levels” of
5 depression.⁴⁹

6 65. Fortunately, there is a “general consensus that individuals with a major
7 depression can be effectively treated, even in the context of terminal illness.”⁵⁰
8 Researchers stress that “[i]mproved detection and early interventions are crucial in
9 preventing suicidal attempts and completed suicides. Depression which is a vital
10 predictor of suicide must be targeted and treated.”⁵¹ Doctors “should always suspect
11 that an unrecognized psychiatric illness has silently, invisibly influenced the
12 judgment of a [terminally ill] patient opting for suicide.”⁵² Recognizing that
13 “[m]ental disorders are a well-recognized comorbidity for many people with cancer,
14 with a disproportionately higher rate of suicide,” the editorial board of *The Lancet*
15 advised in 2021 that efforts to improve cancer care “must focus on ensuring mental
16 health services are an integral and accessible aspect of care for all.”⁵³

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18
19 _____
20 ⁴⁸ William Breitbart, Barry Rosenfeld, Hayley Pessin, et al., *Depression,*
21 *Hopelessness, and Desire for Hastened Death in Terminally Ill Patients With*
Cancer, 284 JAMA 2907, 2907 (2000),
<https://jamanetwork.com/journals/jama/fullarticle/193350>.

22 ⁴⁹ Kathryn A. Smith, Theresa A. Harvath, Elizabeth R. Goy, & Linda Ganzini,
23 *Predictors of pursuit of physician-assisted death*, 49 J PAIN SYMPTOM MANAGE. 555
(2015), <https://pubmed.ncbi.nlm.nih.gov/25116913/>.

24 ⁵⁰ Breitbart et al., *supra* note 48.

25 ⁵¹ Obuobi-Donkor et al., *supra* note 42.

26 ⁵² Clark, *supra* note 41.

27 ⁵³ Editorial, *Provision of mental health care for patients with cancer*, 22 THE
28 LANCET ONCOLOGY, 9, 1199 (2021),
<https://www.thelancet.com/action/showPdf?pii=S1470-2045%2821%2900480-0>.

1 **II. Requests for Physician Assisted Suicide Are Interrelated with Fears**
2 **About Living with Disability, and Are Best Addressed by Providing**
3 **Supportive Care and Treatment**

4 66. The physician-assisted suicide legalization movement thrives on
5 anecdotes of people who suffer greatly before death, and the avoidance of pain is
6 often raised as the primary reason for having such laws. Studies show, however,
7 that pain is not a leading concern of those who choose physician-assisted suicide.
8 Instead, the driving factor is the feeling of being helpless and in need, which is often
9 grounded within society's stigma, fear, disgust, and animus toward people with
10 disabilities. Addressing fears about dependence helps resolve these concerns.

11 67. California and all U.S. states permit the dispensing of sufficient pain
12 medication to maintain comfort at the end of life without intentionally hastening
13 death. "[A]ccording to experts in the field of pain control, almost all terminally ill
14 patients can experience adequate relief with currently available treatments."⁵⁴ More
15 than 90% of people with cancer respond to simple analgesic (painkiller drugs)
16 measures, and other effective treatments include additional pharmacologic
17 interventions, psychotherapy, cognitive and behavioral strategies, as well as
18 neurosurgical or anesthetic procedures.⁵⁵ For anyone who is dying in discomfort, it
19 is also legal in all U.S. states to receive palliative sedation, whereby the dying
20 person is sedated so discomfort is relieved during the dying process. Physician-
21 assisted suicide is not necessary to address end-of-life concerns about pain.

22 68. Publicly reported data about end-of-life concerns from over 4,000
23 people who died by physician-assisted suicide in Oregon and Washington show that
24 people overwhelmingly request assisted suicide out of fear, anxiousness, and/or
25 sadness about living as a disabled person without necessary supportive services

26 _____
27 ⁵⁴ Judith Ahronheim & Doron Weber, FINAL PASSAGES: POSITIVE CHOICES FOR THE
DYING AND THEIR LOVED ONES 102 (Simon & Schuster 1992).

28 ⁵⁵ Block & Billings, *supra* note 3, at 447.

1 and/or accommodations.⁵⁶ For Oregonians who died from physician-assisted
2 suicide, over 90% cited loss of autonomy and the loss of ability to engage in
3 activities that make life enjoyable, and over 70% cited loss of dignity. Just over a
4 quarter of people cited pain or concerns about future pain.⁵⁷ Washington’s data
5 show similar end-of-life concerns about losing autonomy (87%), losing ability to
6 engage in activities that make life enjoyable (86%), and loss of dignity (71%)
7 predominating. Fewer than four in ten people cited concerns about actual or
8 anticipated pain.⁵⁸ These data confirm that most people who request physician-
9 assisted suicide require are fearful of and require assistance in living with their
10 terminal disability—that is, for help in dealing with the depression, anxiety, grief,
11 dependence, lack of control, and fear about physical suffering that are attendant to
12 living with a terminal disability, especially when there are inadequate care options.⁵⁹

13 69. One well-worn expression among many who contemplate the need for
14 end-of-life care is: “I don’t want someone else wiping my ass.” But an even more
15 common and pressing concern is whether a person with a terminal disability has
16 reliable in-home care to assist with toileting in the first place, so that the person is
17 not forced to choose between laying for hours in a soiled bed or risking a fall to get
18 to the toilet. The everyday tasks associated with living, like meal preparation,
19 taking one’s meds, going to the bathroom, and bathing necessarily depend on the
20 assistance of others. Fears about control, personal privacy, and insecurity are
21 common among people who transition from full to partial independence. But the

22 _____
23 ⁵⁶ Oregon and Washington’s physician-assisted suicide laws require such reporting;
24 California’s EOLOA does not.

25 ⁵⁷ Or. Health Auth., OREGON DEATH WITH DIGNITY ACT: 2021 DATA SUMMARY 13
26 (<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf>).

27 ⁵⁸ *Id.*

28 ⁵⁹ Block & Billings, *supra* note 3.

1 uneasiness about *all* of the above reported end-of-life concerns are quite familiar to
2 people with disabilities, who are better able to cope with and manage such concerns
3 when provided access to adequate supportive services and accommodations, mental
4 health care, and counseling—even as they approach the end of their lives. When the
5 physical and psychological needs underlying requests for physician-assisted suicide
6 are addressed, the desire for death diminishes or goes away all together.⁶⁰

7 **III. EOLOA Targets People with Disabilities for Death and Stigmatization**

8 **A. The Individual Plaintiffs, Constituents of the Organizational** 9 **Plaintiffs, and People With “Terminal Diseases” Are All People** 10 **with Disabilities Who Are Entitled to Protection Under the ADA** 11 **and the Rehab Act**

11 70. Plaintiffs Lonnie VanHook and Ingrid Tischer are people with
12 disabilities. Plaintiffs United Spinal and CALIF are organizations whose members
13 and constituents include people with disabilities. United Spinal, CALIF, NDY and
14 IPR perform work on behalf of people with disabilities.

15 71. All people in California who qualify for EOLOA by having a “terminal
16 disease” have—by definition—conditions⁶¹ that qualify as disabilities under the
17 ADA and the Section 504. Under EOLOA, “terminal disease”⁶² means “an
18 incurable and irreversible disease that has been medically confirmed and will, within
19

20 ⁶⁰ Hendin, *supra* note 4.

21 ⁶¹ CDPH, CALIFORNIA END OF LIFE OPTION ACT 2021 DATA REPORT (2022) (“Cal.
22 2021 Data Report”), at 5-6,
23 [https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20Option_Act_Report_2021_FINAL.pdf)
24 [End_of_Life%20Option_Act_Report_2021_FINAL.pdf](https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20Option_Act_Report_2021_FINAL.pdf). (The major categories of
25 underlying diseases associated with those who died pursuant to the Act in 2021 were
26 documented as: cancer (66.0 percent), neurological diseases (13.2 percent),
27 cardiovascular diseases (8.4 percent), respiratory diseases (non-cancer; 6.6 percent),
28 and other diseases (5.8 percent). The “other diseases” were documented as: kidney
disease (2.1 percent); endocrine, nutritional, and metabolic disease (1.4 percent);
immune mediated disease (0.6 percent); cerebrovascular disease (0.4 percent); and
other (1.2 percent).).

⁶² Plaintiffs use “terminal disease” and “terminal illness” interchangeably
throughout this Complaint.

1 reasonable medical judgment, result in death within six months.”⁶³ All “terminal
2 diseases” under EOLOA are also disabilities under the ADA and Section 504
3 because they are physical impairments that substantially limit major life activities
4 including operation of major bodily functions, including but not limited to, functions
5 of the immune system, normal cell growth, digestive, bowel, bladder, neurological,
6 brain, respiratory, circulatory, endocrine, and reproductive functions.⁶⁴ These
7 conditions also substantially limit people in other major life activities including
8 caring for oneself, performing manual tasks, eating, sleeping, walking, and
9 breathing.⁶⁵ EOLOA is thus available only to people with disabilities.

10 **B. Physician-Assisted Suicide Laws Are Grounded in a Sordid Legal**
11 **Framework of Eugenic Discrimination Against People with**
12 **Disabilities**

12 72. EOLOA is situated within this country’s long history of using the
13 power of the State and its law-making powers to discriminate against people with
14 disabilities in the health care arena. The late 19th and first part of the 20th Century
15 saw the rise of the eugenics movement in the United States, which argued that
16 reproduction by people with disabilities would ruin the species and advocated for
17 their sterilization.⁶⁶ From 1909 through 1979, over 20,000 people were forcibly
18 sterilized under California’s eugenics laws—the majority of whom were Black,
19 Indigenous, other people of color, and/or with disabilities—most of whom lived in
20 state-run hospitals, homes, and institutions.⁶⁷ Even after California repealed its
21

22 ⁶³ Cal. Health & Safety Code § 443.1(r).

23 ⁶⁴ 42 U.S.C § 12102(2)(B).

24 ⁶⁵ 42 U.S.C § 12102(A).

25 ⁶⁶ See Robyn M. Powell & Michael Ashley Stein, *Persons with Disabilities and*
26 *Their Sexual, Reproductive, and Parenting Rights: An International and*
27 *Comparative Analysis*, 11 FRONT. L. CHINA 53, 60–68 (2016) (explaining the ways
in which restrictions on sexual, reproductive, and parenting rights for people with
disabilities have evolved over time and across jurisdictions).

28 ⁶⁷ Derek Hawkins, *California Once Forcibly Sterilized People by the Thousands*.

1 compulsory sterilization laws in 1979, nearly 1,400 sterilizations were performed
2 from 1997 to 2013 by State prison doctors.⁶⁸

3 73. The same rationale and arguments used to advocate for forced
4 sterilization were deployed in support of this country’s euthanasia movement, with
5 highly influential leaders publicly endorsing schemes to euthanize “diseased,”
6 “deformed and deficient” “unproductive members” of society.”⁶⁹ For example,
7 Stanford University’s founding president, David Starr Jordan, wrote that “a race of
8 men or a herd of cattle are governed by the same laws of selection. Those who
9 survive inherit the traits of their own actual ancestry. If we sell or destroy the rough,
10 lean or feeble calves, we shall have a herd descended from the best.”⁷⁰

11 74. The earliest American proposals to legalize euthanasia did not succeed.
12 In 1906, Ohio and Iowa lawmakers introduced legislation “based upon an individual
13 rights platform permitting those suffering from a terminal illness or extreme pain to
14 end life, provided that the decision was voluntary and competent.”⁷¹ Other
15

16 _____
17 *Now the Victims May Get Reparations*, WASH. POST (Jul. 9, 2021, 6:24 PM),
18 <https://www.washingtonpost.com/nation/2021/07/09/california-once-forcibly-sterilized-people-by-thousands-now-victims-may-get-reparations/>; *California*
19 *Launches Program to Compensate Survivors of State-Sponsored Sterilization*,
20 OFFICE OF GOVERNOR GAVIN NEWSOM (Dec. 31, 2021),
21 [https://www.gov.ca.gov/2021/12/31/california-launches-program-to-compensate-](https://www.gov.ca.gov/2021/12/31/california-launches-program-to-compensate-survivors-of-state-sponsored-sterilization/)
22 [survivors-of-state-sponsored-sterilization/](https://www.gov.ca.gov/2021/12/31/california-launches-program-to-compensate-survivors-of-state-sponsored-sterilization/).

23 ⁶⁸ Shilpa Jindia, *Belly of the Beast: California’s Dark History of Forced*
24 *Sterilizations*, GUARDIAN (Wash.) (Jun. 30, 2020, 6:00 AM),
25 [https://www.theguardian.com/us-news/2020/jun/30/california-prisons-forced-](https://www.theguardian.com/us-news/2020/jun/30/california-prisons-forced-sterilizations-belly-beast)
26 [sterilizations-belly-beast](https://www.theguardian.com/us-news/2020/jun/30/california-prisons-forced-sterilizations-belly-beast).

27 ⁶⁹ Neil M. Gorsuch, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 34-5
28 (Princeton U. Press 2006).

29 ⁷⁰ Claire Wang, *Stanford’s History With Eugenics*, THE STANFORD DAILY (Dec. 7,
30 2016, 2:52 PM), [https://stanforddaily.com/2016/12/07/stanfords-history-with-](https://stanforddaily.com/2016/12/07/stanfords-history-with-eugenics/)
31 [eugenics/](https://stanforddaily.com/2016/12/07/stanfords-history-with-eugenics/).

32 ⁷¹ Helen Y. Chang, *A Brief History of Anglo-Western Suicide: From Legal Wrong to*
33 *Civil Right*, 46 S.U. L. REV. 150, 181-2 (2018),
34 <https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1854&context=pubs>
35 [s](https://digitalcommons.law.ggu.edu/cgi/viewcontent.cgi?article=1854&context=pubs).

1 unsuccessful legislative attempts to legalize euthanasia took place throughout the
2 country, including in Nebraska and New York in the 1930s.⁷² In 1931, the Illinois
3 Homeopathic Medical Association argued in support of euthanasia for “imbeciles
4 and sufferers from incurable diseases.”⁷³

5 **C. The ADA and Section 504 Prohibit Public Entities from Excluding**
6 **Persons with Disabilities from Public Services**

7 75. Responding to the long history of discrimination against people with
8 disabilities, Congress enacted Section 504 in 1974 and the ADA in 1990 to provide
9 “a clear and national mandate for the elimination of discrimination” based on
10 disability. 42 U.S.C. § 12101(b)(1). The ADA prohibits public entities from
11 excluding persons with disabilities from the receipt of public services and benefits
12 from governmental agencies and medical providers (both public and private), and
13 requires that health care providers provide full and equal access to health care
14 services for people with disabilities. *See* 42 U.S.C. §§ 12132 and 12182; 28 C.F.R.
15 §§ 35.130(b) and 36.202(b) and (c).

16 76. Title II of the ADA represents Congress’ attempt to apply this “clear
17 and comprehensive national mandate” to the “services, programs, or activities,” 42
18 U.S.C. § 12132, of “any State or local government” and “any department,
19 agency, ... or other instrumentality of a State.” Title II of the ADA applies “to
20 anything a public entity does [and] is not limited to ‘Executive’ agencies, but
21 includes activities of the legislative and judicial branches of State and local
22 governments. All governmental activities of public entities are covered, even if they
23 are carried out by contractors.” 28 C.F.R. App’x B to Part 35 at § 35.102.

24
25 ⁷² Derrick A. Carter, *Knight in the Duel with Death: Physician Assisted Suicide and*
26 *the Medical Necessity Defense*, 41 VILL. L. REV. 663, 680 (1996),
[https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?referer=&httpsredir=1](https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=2963&context=vlr)
[&article=2963&context=vlr](https://digitalcommons.law.villanova.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=2963&context=vlr).

27 ⁷³ *Death for Insane and Incurable Urged by Illinois Homeopaths*, N.Y. TIMES,
28 May 9, 1931, at 4.

1 Section 504 applies to any program or activity that receives federal funds. EOLOA
2 conflicts with and is preempted by federal disability law.

3 **D. Medical Bias Against People with Disabilities Remains Pervasive**

4 77. Contemporary studies show that, even after the passage of the
5 Section 504 and ADA, many American physicians continue to have negative
6 perceptions of people with disabilities, and that this bias affects all sorts of health
7 care decisions that lead to broad disparities in treatment and outcomes. A 2021
8 Harvard Medical School survey of practicing physicians nationwide revealed that
9 82% reported that people with significant disability have a worse quality of life than
10 non-disabled people.⁷⁴ This is in stark contrast to the views of people with
11 disabilities themselves; over half of whom rate their quality of life as good or
12 excellent.⁷⁵ Only 41% of physicians surveyed in 2021 were very confident about
13 their ability to provide the same quality of care to people with disabilities, and
14 barely half of those surveyed strongly agreed that they welcomed people with
15 disability into their practices.⁷⁶ Another study published in 2022 found that
16 “physicians’ bias and general reluctance to care for people with disabilities play a
17 role in perpetuating the health care disparities they experience.”⁷⁷ People with
18 multiple disabilities face additional levels of bias from their providers.

19 78. Medico-legal bias against people with disabilities became widely
20 visible in 2020, when the implementation of health care rationing systems in
21

22 _____
23 ⁷⁴ See Lisa I. Iezzoni, et al., *Physicians’ Perceptions of People With Disability and
24 Their Health Care*, 40 HEALTH AFF. (Millwood) 297 (2021),
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8722582/pdf/nihms-1763873.pdf>.

25 ⁷⁵ *Id.*

26 ⁷⁶ *Id.*

27 ⁷⁷ Tara Lagu, Carol Haywood, Kimberly Reimold, Christene DeJong, Robin Walker
28 Sterling, & Lisa I. Iezzoni, “*I Am Not The Doctor For You*”: *Physicians’ Attitudes
About Caring For People With Disabilities*, 41 HEALTH AFF. (Millwood) 1387,
1387 (2022), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00475>.

1 response to the COVID-19 pandemic showed that doctors explicitly prioritized the
2 lives of people without disabilities for access to ventilators and other critical care.⁷⁸

3 79. Plaintiff Ingrid Tischer experienced firsthand medical bias based on her
4 disabilities and the related pressure to forgo life-sustaining medical care. In January
5 2021, Ms. Tischer went to the emergency room, where she was admitted to the
6 hospital for a six-day stay. She was diagnosed with pneumonia, put on antibiotics,
7 and placed on a breathing machine. When she was offered a consultation with a
8 psychiatrist, she accepted it and the consultation resulted in a diagnosis of
9 depression and anxiety, and a treatment plan that included psychiatric medication,
10 psychosocial therapy, and meeting with a social worker. Her mental health status
11 was documented. Concerned about her rapid muscular deterioration, Ms. Tischer
12 asked the neurologist about participating in an in-patient rehabilitation program, the
13 neurologist responded that the facility would not take patients with progressive
14 disabling conditions like hers because the admitting criteria required a likelihood
15 that the patient would regain their original baseline. When Ms. Tischer asked if this
16 was not exclusionary of people like her, the neurologist replied it was not
17 discriminatory, it was simply the program’s admission policy. She asked why the
18 criteria would not simply be an ability to work toward the best health possible. The
19 neurologist gestured toward her body and responded that Ms. Tischer must have
20 always known that death was just around the corner and “there’s nothing we can
21 really do about it.” Fortunately, Ms. Tischer proved the doctor wrong. While she
22 ultimately recovered, she takes medication for anxiety and fears that she will once
23 again find herself in the care of a doctor who refuses supportive services and instead
24

25 ⁷⁸ Liz Essley Whyte, *State Policies May Send People With Disabilities to the Back*
26 *of the Line for Ventilators*, CTR. PUB. INTEGRITY (Apr. 13, 2020),
27 [https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-
28 send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/](https://publicintegrity.org/health/coronavirus-and-inequality/state-policies-may-send-people-with-disabilities-to-the-back-of-the-line-for-ventilators/); see also HHS-
OCR Complaints Re COVID-19 Medical Discrimination, THE ARC (Mar. 23, 2020),
[https://thearc.org/resource/hhs-ocr-complaint-of-disability-rights-washington-self-
advocates-in-leadership-the-arc-of-the-united-states-and-ivanova-smith/](https://thearc.org/resource/hhs-ocr-complaint-of-disability-rights-washington-self-advocates-in-leadership-the-arc-of-the-united-states-and-ivanova-smith/).

1 steers her towards physician-assisted suicide as the solution to her medical needs.

2 **E. Medical Bias Against People with Disabilities Intersects with Pre-**
3 **Existing Bias in the Medical Profession Based on Race and Class**

4 80. Physicians’ bias against people with disabilities has long intersected
5 with medical bias based on race and ethnicity, and healthcare disparities by
6 race/ethnicity remain widespread.⁷⁹ It is well known that throughout U.S. history,
7 Black Americans have been disproportionately subject to unethical medical
8 experiments by government officials, including exposure to untested
9 pharmaceuticals, forced anatomical investigations, and radiation of unsuspecting
10 victims.⁸⁰ Contemporary research shows that racist health care policies and
11 practices continue to result in widespread disparities in access to care and health
12 outcomes. A March 15, 2023 study published by the Kaiser Family Foundation
13 “found that Black, Hispanic, and [American Indian and Alaska Native] people fared
14 worse than White people across the majority of examined measures of health and
15 health care and social determinants of health.”⁸¹

16 81. Current medical studies also show that medical providers are less likely
17 to discuss end-of-life treatment preferences with historically underrepresented
18

19 ⁷⁹ NAT’L COUNCIL ON DISABILITY, THE DANGER OF ASSISTED SUICIDE LAWS: PART
20 OF THE BIOETHICS AND DISABILITY SERIES (Oct. 9, 2019, Letter of Transmittal)
21 (“NCD Report”), at 48, https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf (citing
22 Lydia S. Dugdale, Opinion Contributor, *Will Black Lives Still Matter to Death with Dignity Act?*, THE HILL (Jan. 23, 2017, 5:20 p.m.), [https://thehill.com/blogs/pundits-
blog/healthcare/315731-will-black-lives-matter-to-death-with-dignity-act](https://thehill.com/blogs/pundits-blog/healthcare/315731-will-black-lives-matter-to-death-with-dignity-act)).

23 ⁸⁰ See generally Harriet Washington, MEDICAL APARTHEID: THE DARK HISTORY OF
24 MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE
25 PRESENT (Doubleday 2006); Jean Heller, *Syphilis Victims in U.S. Study Went
Untreated for 40 Years*, N.Y. TIMES, Jul. 26, 1972, at 1, 8,
[https://www.nytimes.com/1972/07/26/archives/syphilis-victims-in-us-study-went-
untreated-for-40-years-syphilis.html](https://www.nytimes.com/1972/07/26/archives/syphilis-victims-in-us-study-went-untreated-for-40-years-syphilis.html).

26 ⁸¹ Latoya Hill, Nambi Ndugga, & Samantha Artiga, *Key Data on Health and Health
27 Care by Race and Ethnicity*, KAISER FAMILY FOUNDATION, Mar. 15, 2023,
28 [https://www.kff.org/report-section/key-data-on-health-and-health-care-by-race-
ethnicity-report/](https://www.kff.org/report-section/key-data-on-health-and-health-care-by-race-ethnicity-report/).

1 groups.⁸² Research has documented the “barriers to palliative/hospice care
2 utilization” that Black, Asian, and Hispanic persons regularly experience as a result
3 of racist medical policies and practices.⁸³ A 2016 JAMA Internal Medicine study
4 found that hospice patients were less likely to be visited by staff in their last two
5 days of life if they were Black.⁸⁴ California nursing facilities with higher numbers
6 of Black and Latino residents have “had higher rates of death.”⁸⁵

7 82. The intersection of medical bias against people of color with
8 disabilities is seen in the death of Michael Hickson, a 46-year-old Black father who
9 lived with a brain injury, quadriplegia, and cortical blindness. After contracting
10 COVID-19 in a nursing facility, he was transferred to a hospital for treatment.⁸⁶
11 Mr. Hickson’s hospital medical team precipitated his death by discontinuing
12 medical treatment, hydration, and nutrition—over the objection of his wife. The
13 attending physician explained to his wife that the decision to end treatment was

14
15 ⁸² Donna P. Mayeda & Katherine T. Ward. Methods for Overcoming Barriers in
16 Palliative Care for Ethnic/Racial Minorities: A Systematic Review. 17 PALLIATIVE
17 AND SUPPORTIVE CARE 697 (2019),
[https://www.cambridge.org/core/journals/palliative-and-supportive-
18 care/article/abs/methods-for-overcoming-barriers-in-palliative-care-for-ethnicracial-
19 minorities-a-systematic-review/EF5A6154814F5472CE8A3F3DAFC4692F](https://www.cambridge.org/core/journals/palliative-and-supportive-care/article/abs/methods-for-overcoming-barriers-in-palliative-care-for-ethnicracial-minorities-a-systematic-review/EF5A6154814F5472CE8A3F3DAFC4692F).

20 ⁸³ Jyotsana Parajuli, Aluem Tark, Ying-Ling Jao, & Judith Hupcey, *Barriers to
21 Palliative and Hospice Care Utilization in Older Adults with Cancer: A Systematic
22 Review*, 11 J. GERIATRIC ONCOLOGY 8, 13 (2020),
[https://www.geriatriconcology.net/action/showPdf?pii=S1879-
23 4068%2819%2930238-3](https://www.geriatriconcology.net/action/showPdf?pii=S1879-4068%2819%2930238-3).

24 ⁸⁴ Joan M. Teno,, Mike Plotzke,, Thomas Christian, et al., *Examining Variation in
25 Hospice Visits by Professional Staff in the Last 2 Days of Life*. 176 JAMA INTERN
26 MED. 364 (2016),
<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2488922>.

27 ⁸⁵ Letter from Members of Congress to Cal. Dep’t Health Care Servs., Comment re:
28 California’s 2022 – 2026 Renewal of the Home & Community-Based Alternatives
Waiver, [https://barragan.house.gov/wp-content/uploads/2021/09/HCBA-Comments-
Letter-Final-09-16-21.pdf](https://barragan.house.gov/wp-content/uploads/2021/09/HCBA-Comments-Letter-Final-09-16-21.pdf).

⁸⁶ Bazelon Ctr. for Mental Health Law, EXAMINING HOW CRISIS STANDARDS OF
CARE MAY LEAD TO INTERSECTIONAL MEDICAL DISCRIMINATION AGAINST COVID-
19 PATIENTS 2 (2021), [http://www.bazelon.org/wp-content/uploads/2021/02/FINAL-
Intersectional-Guide-Crisis-Care-PDF.pdf](http://www.bazelon.org/wp-content/uploads/2021/02/FINAL-Intersectional-Guide-Crisis-Care-PDF.pdf).

1 based on the doctor’s evaluation that Mr. Hickson did not “have much of” a quality
2 of life due to his pre-existing paralysis and brain injury.⁸⁷

3 83. Plaintiff Lonnie VanHook, an African American male with multiple
4 disabilities including quadriplegia, has experienced discrimination by several of his
5 providers, who have opined that his quality of life is low and questioned whether he
6 would be better off dead than alive. People of color, especially those who are
7 financially challenged, are more likely to be steered towards physician-assisted
8 suicide by their providers, who may view their lives as less worthy of preservation
9 due to the combined forces of racism and ableism.

10 **F. EOLOA Advances the Idea that Disabled Lives Are Not Worth**
11 **Living**

12 84. Physician-assisted suicide laws are based on ableist stereotypes,
13 implicit biases, and long-held fears about living with disability as well as the false
14 idea that it is rational for disabled persons to want to end their own lives. These
15 misleading tropes are glorified in Hollywood movies like *Me Before You* and
16 *Million Dollar Baby*, where the protagonist is portrayed heroically for choosing to
17 be euthanized rather than live with their disability.

18 85. In contrast to fictionalized stories, actual surveys about public support
19 for physician-assisted suicide laws show that “support is weakest among groups
20 who express concerns about being pressured to die (i.e., older adults, people with
21 disabilities, people with less education, women, and racial and ethnic minorities).”⁸⁸
22 Every prominent national disability rights organization that has taken a position on
23 assisted suicide has opposed it. Additionally, the National Council on Disability
24

25 _____
26 ⁸⁷ Kim Roberts, *Austin Hospital Withheld Treatment from Disabled Man Who*
27 *Contracted Coronavirus*, THE TEXAN (Jun. 29, 2020), [https://thetexan.news/austin-](https://thetexan.news/austin-hospital-withheld-treatment-from-disabled-man-who-contracted-coronavirus/)
28 [hospital-withheld-treatment-from-disabled-man-who-contracted-coronavirus/](https://thetexan.news/austin-hospital-withheld-treatment-from-disabled-man-who-contracted-coronavirus/).

⁸⁸ *Resolution on Assisted Dying*, AM. PSYCH. ASS’N (Aug. 2017),
<https://www.apa.org/about/policy/assisted-dying-resolution>.

1 (“NCD”)—an independent, bi-partisan federal agency that makes recommendations
2 to the President and Congress in order to enhance the quality of life for all
3 Americans with disabilities and their families—“has long opposed assisted suicide
4 laws.”⁸⁹ NCD’s 2019 report “The Danger of Assisted Suicide Laws,” concluded
5 that assisted suicide laws “create a deadly mix that poses multifaceted risks and
6 dangers to people with disabilities as well as people in other vulnerable
7 constituencies.”⁹⁰ Over the strong opposition of those most likely to die under
8 physician-assisted suicide laws, EOLOA sends the stigmatizing message that society
9 should endorse and even elevate suicide when the person has a terminal disability.

10 86. As discussed further in Sections V and VI, EOLOA unlawfully
11 discriminates against and deprives people with terminal disabilities of protections
12 afforded to other persons under California law, in violation of the ADA and
13 Section 504.

14 **IV. EOLOA Draws an Irrational Distinction Between People with Terminal**
15 **Disabilities and Everyone Else, Including People with Other Disabilities**
16 **and People without Disabilities**

17 **A. There Is No Rational Basis for the Act’s “Terminally Disease”**
18 **Classification**

19 87. The “author’s statement” to EOLOA provides that “how each of us
20 spends the end of our lives is a deeply personal decision. That decision should
21 remain with the individual, as a matter of personal freedom and liberty, without
22 criminalizing those who help to honor our wishes and ease our suffering.”⁹¹ None
23 of these justifications for physician-assisted suicide are rationally related to a

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⁸⁹ NCD Report, *supra* note 79 (Letter of Transmittal).

25 ⁹⁰ *Id.* at 16.

26 ⁹¹ Sen. Rules Comm., Off. of Sen. Floor Analyses, 3d reading analysis of Assem.
27 Bill 15 (2015-2016 2d Ex. Sess.) as amended Sept. 10, 2015,
28 https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520162ABI5#.

1 governmental purpose, especially where the discriminatory distinction between who
2 may and may not be assisted to die implicates the fundamental right to live.

3 88. To be sure, all Californians will die. EOLOA does not grant all
4 Californians the freedom and liberty to die by physician-assisted suicide, and there
5 is no rational relationship in the Act between autonomy and certain physical
6 disabilities with unreliable prognoses. The only other justification proffered by the
7 law's author is to ease suffering. But the fit between suffering and those with
8 terminal disabilities is also attenuated and loose. Only a minority of people eligible
9 to participate in EOLOA cite suffering from pain or even have a concern about it.
10 Many non-terminal people suffer from pain but are ineligible for physician-assisted
11 suicide under the Act. Likewise, many non-terminal people experience existential
12 suffering from losing autonomy, feeling a loss of dignity, losing control of bodily
13 functions, becoming a burden on caregivers, and/or the financial costs associated
14 with continued living—but are nevertheless ineligible to participate in EOLOA.

15 89. The Act treats differently people with terminal disabilities as compared
16 to everyone else that expresses a wish to die to their medical doctor (including
17 people with psychiatric and other disabilities as well as people without disabilities).
18 This distinction is arbitrary and irrational because all groups include people who
19 want to, and do, take their own lives. The Act does not reasonably advance its
20 claimed purposes of enabling autonomous choices in dying and relieving suffering.

21 90. Some people with terminal disabilities have impaired judgment and yet
22 express a wish to die. Their status is incompatible with autonomy and personal
23 decision-making. When people with terminal disabilities are provided lethal drugs,
24 there is a potential for exposing individuals to life-threatening mistakes and abuses.
25 EOLOA fails to contain safeguards sufficient to justify treating people with terminal
26 disabilities differently than others. As discussed further below and in Sections V
27 and VI, EOLOA violates the rights of people with terminal disabilities to equal
28 protection under the law.

1 **B. EOLOA’s Definition of “Terminal Disease” Includes People with**
2 **Terminal Disabilities Who Can Live for Years with Adequate**
3 **Treatments and Supports**

4 91. EOLOA also contains an overly-broad definition of “terminal disease”
5 such that a person may be diagnosed with a terminal disease even if the person’s
6 disability can be adequately managed for years with appropriate care and/or
7 supports. In determining whether a person’s condition meets the definition of
8 “terminal disease,” EOLOA has no requirement that the attending or consulting
9 physician consider the effect of treatments, counseling, or other supports on survival
10 rates. People who would otherwise survive beyond six months if provided treatment
11 or other supportive services are still eligible for physician-assisted suicide regardless
12 of whether those treatments or supports are denied by their insurance company,
13 refused, or otherwise not available. The relevant inquiry under the Act is: should
14 the disease take its course, *absent further treatment or supportive services*, is the
15 person likely to die within six months?

16 92. California doctors prescribe physician-assisted suicide drugs to patients
17 who opt to forgo chemotherapy, even though *with* treatment they may live for years.
18 Similarly, conditions that would not otherwise be considered “terminal” with
19 treatment—such as spinal cord injuries, diabetes, complications from falls, hernias,
20 and kidney disorders requiring dialysis—can and do qualify for assisted suicide.
21 People with anorexia have already died by physician-assisted suicide in the United
22 States.⁹² It is contrary to reasoned medical judgment and the standard of care in
23 California to facilitate the suicide of a person who can live a normal life span with
24 medical treatment and supports.

24 **C. Terminal Prognoses Are Arbitrary, Uncertain, and Often Wrong**

25 93. The six-month survival estimate embodied in EOLOA’s definition of
26

27 ⁹² Jennifer L. Gaudiani, Alyssa Bogetz, & Joel Yager, *Terminal Anorexia Nervosa:*
28 *Three Cases and Proposed Clinical Characteristics*. 10 J. EAT. DISORD. 23 (2022).
<https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-022-00548-3>.

1 “terminal disease” is not rationally related to the Act’s stated purposes of reducing
2 suffering.⁹³ There is no connection between suffering and the six-month mark.
3 Palliative care and pain control do not stop working six months before death. In
4 addition, people without a terminal disease also can suffer from pain.

5 94. EOLOA’s six-month criteria was selected for the sole reason that it
6 mirrors the federal six-month standard for hospice care coverage under Medicare
7 and Medi-Cal, which is purely a cost-reduction measure intended to cap the time a
8 person can spend in hospice. The six-month hospice criteria is inherently uncertain
9 and subject to error.⁹⁴ One study published in JAMA found that 75% of
10 hospitalized persons with hospice-eligible prognoses survived longer than six
11 months after hospital discharge.⁹⁵ Californians regularly outlive six-month
12 prognoses, and either have their hospice stays re-certified or leave to resume
13 treatment.⁹⁶ EOLOA contains no criteria, guidance, or assurances to make the six-
14 month prognosis any more accurate than it is in the hospice context. Because
15 EOLOA is limited to physical disabilities that will result in death within six months,
16 it makes an irrational distinction between physical disabilities that will most
17 certainly cause death in any longer period, like eight months or a year.

18 95. Physicians are not trained, equipped, or otherwise capable of predicting
19

20 _____
21 ⁹³ EOLOA’s use of the term “suffering” is assumed to mean untreatable pain given
22 that the Act does not require evaluation or treatment of a patient’s psychological
23 suffering.

24 ⁹⁴ NCD Report, *supra* note 79, at 21-3 (citing Nina Shapiro, *Terminal Uncertainty*,
25 SEATTLE WEEKLY, Jan. 14, 2009, reprinted at [https://dredf.org/wp-](https://dredf.org/wp-content/uploads/2012/08/Terminal-Uncertainty.pdf)
26 [content/uploads/2012/08/Terminal-Uncertainty.pdf](https://dredf.org/wp-content/uploads/2012/08/Terminal-Uncertainty.pdf)).

27 ⁹⁵ Ellen Fox et al., *Evaluation of Prognostic Criteria for Determining Hospice*
28 *Eligibility in Patients With Advanced Lung, Heart, or Liver Disease*, 282 JAMA.
1638 (1999). <https://jamanetwork.com/journals/jama/fullarticle/192058>.

⁹⁶ Auditor of State of Cal., CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT (2022)
29 (“State Auditor Report 2022”), at 25 (finding 51% of hospice patients in Van Nuys
30 receive a live discharge and 46% of patients in North Hollywood),
<https://www.auditor.ca.gov/pdfs/reports/2021-123.pdf>.

1 with a high degree of reliability, that a particular person with a particular condition
2 will certainly die within six months. The overwhelming research and clinical
3 information demonstrates that the timing of death is inherently unpredictable, that
4 physicians are not particularly good prognosticators, and that any such prediction is
5 deeply tainted by impermissible stereotypes, discriminatory biases, and structural
6 racism. A mistakenly grim prognosis may drive people to physician-assisted suicide
7 when they could otherwise live long lives with (or without) treatment. Spinal cord
8 injury survivors are at times suicidal following their injury and qualify as “terminal”
9 because their injury will often result in death without surgery and/or supportive
10 services—but they can and do live long, happy lives. Inaccurate end-of-life
11 predictions are common. For example:

12 a. In 2012, Stephanie Packer, a Californian mother of four, was
13 diagnosed with scleroderma and pulmonary fibrosis. She qualified for and had been
14 enrolled in hospice a number of times. Ms. Packer’s insurance company told her it
15 would not cover her chemotherapy but would cover lethal physician-assisted suicide
16 drugs. Ms. Packer refused physician-assisted suicide and became an advocate
17 against such laws.⁹⁷ On information and belief, she is still alive.

18 b. Laurie Hoirup, a California woman with a life-long disability of
19 spinal muscular atrophy, “survived *by decades* several terminal prognoses given to
20 her by physicians over the course of her life, including one that she would never
21 reach adulthood Ms. Hoirup finally died at the age of 60 from accidental
22 causes.”⁹⁸

23 c. In 2000, Michael Freeland was living in Oregon and was
24 diagnosed with lung cancer. Mr. Freeland had a 43-year medical history of
25

26 ⁹⁷ Adam Wesselinoff, *Go Away and Die: Message Received by Stephanie Packer*
27 CATHOLIC WEEKLY (Nov. 18, 2021), <https://www.catholicweekly.com.au/go-away-and-die-message-received-by-stephanie-packer/>.

28 ⁹⁸ *Id.* at 22 (emphasis added).

1 significant depression and suicide attempts when he requested physician-assisted
2 suicide. He was prescribed lethal drugs without any psychological evaluation.
3 Ultimately, Mr. Freeland obtained supportive services through a non-profit
4 organization that arranged for medication to treat his depression and physical pain.
5 He subsequently reconciled with his estranged daughter and died of natural causes
6 two years after his initial terminal prognosis.⁹⁹

7 d. Plaintiff Ingrid Tischer and activist/author Alice Wong were both
8 told as children that they would not live beyond 40 and 30 years of age,
9 respectively. They are both living well over a decade past their childhood
10 prognoses.

11 **V. Defendants Deny People with Terminal Disabilities Equal Access to**
12 **State-Based Programs and Services, in Violation of the ADA, Section 504,**
and Equal Protection Clause

13 **A. Defendant State Agencies and Officials Administer Suicide**
14 **Prevention Programs and Services from Which They Exclude**
15 **People Who Seek Physician-Assisted Suicide on the Basis of Their**
16 **Terminal Disabilities**

17 **1. California Operates Suicide Prevention Programs and**
18 **Services**

19 96. Defendant MHSOAC developed California’s Strategic Plan for Suicide
20 Prevention 2020-2025 (“Strategic Plan”), which strives for the “elimination of
21 suicide in California,” and states that “[o]ne life lost to suicide is one too many.”¹⁰⁰
22 Consistent with literature concerning suicidal thoughts among terminally ill
23 individuals, the Strategic Plan recognizes that “crises involving suicidal behavior
24 tend to be transient, and characterized by extreme ambivalence about the wish to die

25 _____
26 ⁹⁹ NCD Report, *supra* note 79, at 23-24; *see also* Wesley J. Smith, Charlotte Lozier
27 Inst., ASSISTED SUICIDE IS NOT COMPASSION, at 11 (Apr. 2015),
<https://lozierinstitute.org/wp-content/uploads/2015/04/American-Reports-Series-Assisted-Suicide-Is-Not-Compassion-WSmith-April-20151.pdf>.

28 ¹⁰⁰ California’s Strategic Plan, *supra* note 17, at 13.

1 or stay alive.”¹⁰¹ The Strategic Plan advises that “suicide risk factors” include
2 “[u]nmet acute or persistent physical health and behavioral health needs, including
3 chronic pain [and] disability,” as well as “mood disorders, such as depression;
4 medical illness; and access to the methods to attempt suicide.”¹⁰² These risk factors
5 are common among people who qualify for EOLOA.

6 97. California recognizes that “access to effective medical and mental
7 health care” reduces the risk for suicide.¹⁰³ California’s Strategic Plan calls for
8 practices and services such as: (1) lethal means restriction, (2) depression screening
9 and treatment, (3) collaborative interventions with older adults experiencing
10 depression, (4) provider education on risk and protective factors, and (5) expansion
11 of data collection and recording.¹⁰⁴

12 98. Defendant CDPH receives federal funds to administer suicide
13 prevention initiatives in California.¹⁰⁵ Defendant CDHCS is responsible for
14 providing suicide prevention services, including by providing resources to counties
15 for suicide prevention trainings and programs as well as by connecting individuals
16 in crisis to immediate assistance.¹⁰⁶ CDPH’s Office of Suicide Prevention supports
17 and facilitates suicide prevention activities throughout California, including services
18 targeted to older adults dealing with suicidal ideation and depression.¹⁰⁷

20 ¹⁰¹ *Id.* at 48.

21 ¹⁰² *Id.* at 9, 58.

22 ¹⁰³ *Id.* at 9.

23 ¹⁰⁴ *Id.*

24 ¹⁰⁵ *See, e.g., Comprehensive Suicide Prevention, Funded Programs, CDC,*
<https://www.cdc.gov/suicide/programs/csp/index.html> (Jan. 4, 2023).

25 ¹⁰⁶ *See, e.g., CDHCS, Suicide Prevention (2020),*
26 https://www.dhcs.ca.gov/Documents/CSD_YV/Youth%20Services%20Section%20Suicide%20Prevention/DHCS-Suicide-Prevention-Fact-Sheet.pdf.

27 ¹⁰⁷ *Comprehensive Suicide Prevention (CSP) Program, Injury and Violence*
28 *Prevention (IVP) Branch, CDPH,*

1 99. California law mandates that people who are an imminent danger to
2 themselves are connected to mental health services. Under Welfare & Institutions
3 Code section 5150, law enforcement officers and mental health professionals can
4 place a suicidal person on an emergency 72-hour hold if, due to a mental illness, the
5 person is determined to pose a danger to themselves.¹⁰⁸ During this 72-hour period,
6 the person may be taken into custody “for assessment, evaluation, and crisis
7 intervention, or placement for evaluation and treatment” in a hospital or other health
8 care facility.¹⁰⁹ If mental health professionals determine that the person needs
9 additional treatment because the individual is unwilling or unable to accept
10 voluntary treatment, the hold may be extended for up to 14 days.¹¹⁰

11 100. All of the above are programs, services, and/or activities subject to the
12 ADA and Section 504.

13 **2. EOLOA Denies People with Terminal Disabilities the Equal**
14 **Benefit of Suicide Prevention Programs and Services**

15 101. When a person in California who does not have terminal disabilities
16 expresses suicidal intentions to a physician, the standard of care requires the above
17 suicide prevention programs, services, and/or activities to be made available to the
18 person. If that person does not pursue those resources and maintains an interest in
19

20 [https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Comprehensive](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Comprehensive-Suicide-Prevention-(CSP).aspx)
21 [-Suicide-Prevention-\(CSP\).aspx](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Comprehensive-Suicide-Prevention-(CSP).aspx) (Aug. 9, 2022); Deborah M. Stone, et al., Nat’l Ctr.
22 <https://stacks.cdc.gov/view/cdc/44275>; CDC, PREVENTING SUICIDE: A TECHNICAL PACKAGE OF
23 [https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/OlderAdultSuicideCADataBrief_2019.pdf)
24 [%20Library/Suicide%20Prevention%20Program/OlderAdultSuicideCADataBrief_2](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/OlderAdultSuicideCADataBrief_2019.pdf)
[019.pdf](https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/OlderAdultSuicideCADataBrief_2019.pdf).

25 ¹⁰⁸ 5150 holds are not voluntary, comprehensive, community-based, recovery-
26 oriented, and culturally and linguistically competent mental health treatment and
services which have a track record of helping people overcome suicidal behaviors.

27 ¹⁰⁹ Cal. Welf. & Inst. Code § 5150(a).

28 ¹¹⁰ Cal. Welf. & Inst. Code § 5250.

1 suicide, the person is neither offered assistance to complete the act nor left to their
2 own devices. Instead, an entire system of prevention measures is deployed around
3 the person including, if necessary, emergency behavioral health services and/or
4 inpatient programs.

5 102. Defendant State agencies and officials are aware of the heightened risk
6 factors associated when a person has a terminal disability and requests physician-
7 assisted suicide—including that the person likely has depression that impairs the
8 person’s ability to make informed decisions—yet fail to ensure that the suicide
9 prevention programs that they develop and administer are equally available to those
10 individuals. Under EOLOA, Defendants permit the withholding of suicide
11 prevention services and interventions when the person has a terminal disability.
12 MHSOAC explicitly carves out physician-assisted suicide from the protection of its
13 suicide prevention services. In a 2019 letter to the President of the United States,
14 the National Council on Disability described this situation as “a double standard in
15 suicide prevention efforts” given that people with terminal disabilities “are not
16 referred for mental health treatment when seeking assisted suicide, while people
17 without disabilities receive such referrals.”¹¹¹

18 103. By relegating people with terminal disabilities to a less effective,
19 unequal, and separate program for people expressing suicidal ideation, EOLOA:
20 (1) “den[ies] qualified individuals with disabilities the opportunity to participate in
21 or benefit from” behavioral health programs, including suicide prevention,
22 hospitalization, and medication services, in violation of 28 CFR 35.130(b)(1)(i);
23 (2) afford[s] qualified individuals with disabilities an opportunity “that is not equal
24 to that afforded others” or that is not as “effective in affording equal opportunity
25 to ... gain the same benefit ... as that provided to others,” in violation of 25 CFR
26 35.130(b)(1)(ii)-(iii); and (3) provide[s] “different or separate aids, benefits, or
27

28 ¹¹¹ NCD Report, *supra* note 79.

1 services” to people with disabilities in a manner that does not “provide qualified
2 individuals with disability with aids, benefits, or services that are as effective as
3 those provided to others” in violation of 28 CFR 35.130 (b)(1)(iv).

4 **B. The Medical Board of California and its President Deny People**
5 **With Terminal Disabilities the Medical Licensing and Regulatory**
6 **Protections Available to Everyone Else in California**

7 104. The U.S. Supreme Court recognizes that the State “has an interest in
8 protecting the integrity and ethics of the medical profession.”¹¹² Defendant MBC
9 and MBC President Lawson protect health care consumers through the proper
10 licensing and regulation of physicians and certain allied health care professionals
11 through the vigorous, objective enforcement of the Medical Practice Act, as well as
12 by ensuring quality medical care through licensing and regulatory functions. By
13 law, the “highest priority” of the MBC in its regulatory and disciplinary functions is
14 the “[p]rotection of the public.” Cal. Bus. & Prof. Code § 2001.1. EOLOA,
15 however, eliminates MBC’s patient protections for people with terminal disabilities.

16 105. The MBC is charged with enforcing the disciplinary and criminal
17 provisions of the Medical Practice Act. *See* Cal. Bus. & Prof. Code § 2004. Where
18 the MBC finds evidence of a violation of the Medical Practice Act warranting
19 disciplinary action, the MBC forwards the case to Defendant Bonta’s Office for
20 proceedings. A physician who is found guilty may face an array of consequences,
21 including revocation of the physician’s license by order of the MBC, temporary
22 suspension of the physician’s right to practice or placement on probation, a public
23 reprimand, or any other action that the MBC or the hearing judge deems proper.
24 Cal. Bus. & Prof. Code § 2227.

25 _____
26 ¹¹² *Glucksberg*, 521 U.S. at 731 (citing American Medical Association, Code of
27 Ethics § 2.211 (1994) (“[p]hysician-assisted suicide is fundamentally incompatible
28 with the physician’s role as healer.”); *see also* Council on Ethical and Judicial
Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2233 (1992) (“[T]he
societal risks of involving physicians in medical interventions to cause patients’
deaths is too great”).

1 106. The MBC is required to “take action against any licensee who is
2 charged with unprofessional conduct.” Cal. Bus. & Prof. Code § 2234. This
3 includes repeated acts of clearly excessive prescribing as well as prescribing or
4 dispensing dangerous drugs without a medical indication. *Id.* §§ 2242, 725(a).
5 Pursuant to these provisions, the MBC has historically disciplined doctors for
6 prescribing excessive medications to patients at risk of suicide. Certain acts,
7 including excessive prescribing of dangerous drugs, can also be the basis for
8 criminal liability. *Id.* § 725(b). The MBC normally revokes the medical license of
9 any physician who intentionally kills a patient, including where the physician
10 prescribes drugs for the purpose of ending the patient’s life.

11 107. Under EOLOA, Plaintiffs and other individuals with terminal
12 disabilities are denied the equal benefit of MBC’s protections. The Act prohibits the
13 MBC from imposing any discipline on doctors who prescribe lethal drugs under
14 EOLOA, even though the doctor knows that the patient is suicidal. *See* Cal.
15 Health & Safety Code § 443.14(c). Instead, EOLOA requires doctors to adhere to
16 the standard of care only in “[m]aking an initial determination ... that an individual
17 has a terminal disease and informing him or her of the medical prognosis.” *Id.*
18 § 443.16(a)(1). Once the person is identified as having a terminal disability, the
19 disciplinary safeguards provided by the Medical Practice Act are eliminated. After
20 that point, doctors who follow EOLOA’s minimal procedural requirements have
21 total immunity from discipline. *Id.* § 443.14(c).

22 108. Plaintiffs are informed and believe and on that basis allege that the
23 MBC has not undertaken any investigations of complaints or conducted any
24 disciplinary proceedings against a healthcare professional in California based on
25 their prescribing of lethal medications pursuant to EOLOA. On January 13, 2023,
26 the MBC stated that it was in possession of no documents relating to any
27 disciplinary proceedings regarding a healthcare professional’s participation in
28 activities under EOLOA.

1 109. Additionally, people can normally contact the MBC to learn whether a
2 doctor has been subject to charges or has had administrative-related action taken
3 against them. But this public benefit is not available to people looking for
4 investigations and complaints regarding EOLOA. The MBC will not provide such
5 information.

6 **C. Defendant Law Enforcement Agencies and Officers Deny People**
7 **with Terminal Disabilities the Protection of California’s Criminal**
8 **Laws as Well as Civil Protections for the Elderly and Vulnerable**

8 **1. Criminal Laws Relating to Assisting Suicide Are Meant to**
9 **Protect People**

10 110. Once illegal, suicide is now legal in all states. The decriminalization of
11 suicide occurred throughout the U.S. as society recognized the link between suicide
12 and mental illness.¹¹³ Decriminalization of suicide reduces social stigma, helps
13 remove barriers to obtaining adequate mental health care, increases access to
14 emergency medical services, fosters suicide prevention activities, improves the well-
15 being of people vulnerable to suicidal behaviors, and contributes to more accurate
16 monitoring of suicidal behaviors.¹¹⁴

17 111. Whereas taking one’s own life was decriminalized to prevent suicide,
18 the act of assisting suicide *is* criminalized in most states for the very same purpose
19 of protecting those susceptible to suicide from completing the act. Throughout the
20 history of this nation, “we have directed the force of the criminal law against aiding
21 or assisting suicide.”¹¹⁵

22
23 ¹¹³ Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?* 23
HASTINGS CTR. REP, 32, 32 (1993); Marzen, et al., *supra* note 38, at 99.

24 ¹¹⁴ Int’l Ass’n for Suicide Prevention (IASP), THE DECRIMINALISATION OF
25 ATTEMPTED SUICIDE: POLICY POSITION STATEMENT (2020),
26 <https://www.iasp.info/wp-content/uploads/IASP-Decriminalisation-Policy-Position-Statement-GA.pdf>.

27 ¹¹⁵ Kamisar, *supra* note 113, at 33; *see also Glucksberg*, 521 U.S. at 715 (“By the
28 time the Fourteenth Amendment was ratified, it was a crime in most States to assist
a suicide”).

1 112. Consent is no defense where the decedent may have requested the
2 perpetrator’s assistance.¹¹⁶ Commentary to the Model Penal Code explains that the
3 interests in preserving life “that are represented by the criminal homicide laws are
4 threatened by one who expresses a willingness to participate in taking the life of
5 another, even though the act may be accomplished with the consent, or at the
6 request, of the suicide victim.”¹¹⁷ And until the passage of recent state laws
7 permitting physician-assisted suicide, no law in this country pertaining to assisted
8 suicide took into account the physical health of the decedent.¹¹⁸ Even after the
9 enactment of state-based physician-assisted suicide statutes, the federal Assisted
10 Suicide Funding Restriction Act prohibits the use of federal funds to pay, directly or
11 indirectly, for “any health care item or service furnished for the purpose of causing,
12 or for the purpose of assisting in causing, the death of any individual, such as by
13 assisted suicide, euthanasia, or mercy killing.”¹¹⁹

14 **2. EOLOA Denies the Protection of Criminal Laws From**
15 **People with Terminal Disabilities**

16 113. Defendants Governor Newsom, Attorney General Bonta, the DA’s
17 Office, and DA Gascón are all responsible to ensure fair and equal enforcement of
18 the law. They fail to discharge this responsibility and deny this public benefit to
19 individuals with terminal disabilities when they permit physicians to assist in
20 suicides of people with impaired judgment without legal consequence. EOLOA
21 “utilize[s] criteria [and] methods of administration” in criminal law enforcement that
22

23 _____
¹¹⁶ Marzen, et al., *supra* note 38, at 78.

24 ¹¹⁷ *Glucksberg*, 521 U.S. at 716 (citing Model Penal Code § 210.5, Comment 5, p.
25 100 (Official Draft and Revised Comments 1980)).

26 ¹¹⁸ *Glucksberg*, 521 U.S. at 714-15; *see also, e.g., People v. Roberts*, 178 N.W. 690,
27 692 (Mich. 1920) (holding that providing means of suicide to one’s terminally ill
wife is murder at common law).

28 ¹¹⁹ 42 U.S.C. § 14402(a)(1)-(3).

1 discriminate against individuals with disabilities and “defeat” “accomplishment of
2 the objectives of” the criminal legal system with respect to such individuals. 28
3 C.F.R. § 35.130(b)(3)(i), (ii). Law enforcement falls within the ambit of the ADA.
4 *See* 28 C.F.R. § 42.540(j) (“benefit” includes “provision of services, financial aid, or
5 disposition (i.e., handling, decision, sentencing, confinement, or other prescription
6 of conduct”).

7 114. Providing lethal drugs to a person with a life-threatening disease *was* a
8 criminal offense for all California victims immediately prior to the enactment of
9 EOLOA. In 2015, after EOLOA was signed into law but before the law became
10 effective, the California Court of Appeal held that “prescribing a lethal dose of
11 drugs to a terminally ill patient with the knowledge the patient may use it to end
12 [their] life goes beyond the mere giving of advice and encouragement and falls
13 under the category of direct aiding and abetting.” *Donorovich-Odonnell v. Harris*,
14 241 Cal. App. 4th 1118, 1129 (2015).

15 115. EOLOA changed the law on June 9, 2016, adding subsection (b) to
16 Penal Code Section 401, which now provides that “[a] person whose actions are
17 compliant with the provisions of the End of Life Option Act [] shall not be
18 prosecuted under this section.” Under the Act, “a health care provider or a health
19 care entity shall not be subject” to any criminal sanction, penalty, other liability for
20 participating in EOLOA. Thus, Californian law still protects most people from
21 doctors willing to prescribe lethal drugs—but not people with terminal disabilities.

22 116. California criminal law contains many protections for older people,
23 dependent adults, and persons with disabilities, stating that these individuals
24 “deserve a special consideration and protection.” Cal. Pen. Code § 368(a). It is a
25 crime, for example, to willfully cause or permit such individuals to suffer
26 unjustifiable physical pain or mental suffering, or to be placed in a situation where
27 their health is in danger. *Id.* § 368(b). California’s Elder Abuse and Dependent
28 Adult Civil Protection Act (“The Elder Abuse Act”), Welf. & Inst. Code §§ 15600

1 *et seq.*, makes it unlawful for caregivers to fail to report known or suspected
2 incidents of abuse of older or dependent adults. But these laws, like the criminal
3 law against aiding and abetting suicide, are not enforced by the law enforcement
4 Defendants against doctors who prescribe physician-assisted suicide to people with
5 terminal disabilities—even if their doctor prescribes drugs that result in a
6 distressing or botched suicide attempt, or are ultimately administered by another
7 person. EOLOA’s broad exemption from criminal liability extends to all criminal
8 laws so long as the physician complies with the Act’s limited requirements.

9 117. Defendant Bonta’s Office has an Elder Abuse Division that includes a
10 Criminal Law Unit that investigates and prosecutes crimes against elders and
11 dependent adults committed by employees in care facilities, including physical
12 abuse and homicide. Defendant Bonta’s Office also has a Facilities Enforcement
13 Team that investigates and prosecutes owners and operators of nursing homes,
14 hospitals, and residential care facilities for the elderly, for policies and/or practices
15 that lead to poor quality of care. Upon information and belief, however, Defendant
16 Bonta has not investigated or prosecuted anyone in connection with a death by lethal
17 drugs made available pursuant to EOLOA, nor has his Office even considered
18 bringing criminal charges for a death pursuant to EOLOA.

19 118. Defendants DA’s Office and DA Gascón have a specialized division
20 focused on elder abuse, which handles cases of physical abuse, emotional abuse,
21 physical neglect, and financial abuse of victims 65 years and older. Upon
22 information and belief, however, Defendants DA’s Office and DA Gascón have not
23 investigated or prosecuted anyone in connection with a death by lethal drugs made
24 available pursuant to EOLOA, nor have they even considered bringing criminal
25 charges against an individual in this context.

26 119. EOLOA shields assisted suicide even from investigation as to its
27 possible misuse. By statute, information collected pursuant to the Act “shall not be
28 disclosed, discoverable, or compelled to be produced in any civil, criminal,

1 administrative, or other proceeding.”¹²⁰ This provision effectively handcuffs law
2 enforcement agencies, making it impossible to investigate and prosecute violations
3 of the Act. In this lax context, without any systematic investigation of accident or
4 abuse, or even a way to report it, the examples of abuse that have come to light are
5 likely only the tip of the iceberg. On information and belief, the law enforcement
6 Defendants have neither investigated nor prosecuted any medical professional for
7 assisting a suicide pursuant to EOLOA.

8 **D. EOLOA Denies People with Terminal Disabilities the Equal**
9 **Benefit of Civil Laws Protecting Older People, People with**
10 **Disabilities, and Suicidal People**

11 120. Physicians in California have a duty to provide health care that falls
12 within what is known as the “standard of care.” California’s civil jury instructions
13 define the standard of care as the “level of skill, knowledge and care in diagnosis
14 and treatment that other reasonably careful [physicians] would use in the same or
15 similar circumstances.”¹²¹ California’s interests in protecting suicidal people is also
16 reflected in part in its laws imposing duties of care on doctors who treat suicidal
17 patients. As explained in *Vistica v. Presbyterian Hospital and Medical Center*, 67
18 Cal. 2d 465 (1967) and *Meier v. Ross General Hospital*, 69 Cal. 2d 420 (1968),
19 doctors who do not take reasonable precautions to prevent a patient’s death by
20 suicide may be civilly liable in an action for negligence or wrongful death. *Meier*
21 and *Vistica* both involved hospitalized patients; courts have since extended this duty
22 to physician-patient relationships in outpatient settings as well. *See, e.g., Klein v.*
23 *BIA Hotel Corp.*, 41 Cal. App. 4th 1133 (1996). But under EOLOA, it is impossible
24 to bring a successful negligence or wrongful death claim against a physician who
25 failed to “provide appropriate treatment for potentially suicidal patients” where that

26 ¹²⁰ Cal. Health & Safety Code § 443.19(a).

27 ¹²¹ Judicial Council of California Civil Jury Instructions (2022) No. 501, Standard of
28 Care for Health Care Professionals, [https://www.justia.com/trials-
litigation/docs/caci/500/501/](https://www.justia.com/trials-litigation/docs/caci/500/501/).

1 physician complied with EOLOA’s minimal requirements.

2 121. The Elder Abuse Act also permits private civil enforcement of laws that
3 protect against abuse and neglect of older or dependent adults. EOLOA denies these
4 protections to patients solely on account of their terminal disability.¹²²

5 **VI. EOLOA Unlawfully Steers People with Terminal Disabilities Toward**
6 **Suicide**

7 122. In fair housing law, steering occurs where “real estate brokers and
8 agents preserve and encourage patterns of racial segregation in available housing by
9 steering members of racial and ethnic groups to buildings occupied primarily by
10 members of such racial and ethnic groups and away from buildings and
11 neighborhoods inhabited primarily by members of other races or groups.” *Havens*
12 *Realty Corp. v. Coleman*, 455 U.S. 363, 366, n.1 (1982). In a similar manner,
13 EOLOA unlawfully and irrationally discriminates by steering people with terminal
14 disabilities towards physician-assisted suicide and all others towards life-preserving
15 suicide treatment services. This sorting of people by perceived physical health is
16 especially harmful because people with terminal disabilities are, at baseline,
17 substantially more likely to be suicidal than all other people.¹²³

18 123. Steering has the further effect of subjecting people with terminal
19 disabilities to coercion and undue influence—depriving individuals of a truly
20 voluntary and informed waiver of their right to live. Likely under the influence of
21 depression and decreased decision-making capacity, a person evaluating physician-
22 assisted suicide may be highly influenced by others’ opinions about whether they
23 should go forward with the act. Insurers, hospitals, nursing homes, physicians, and
24 even family members all have their own perspectives and unique incentives that
25 inevitably help shape the person’s ultimate decision. People with terminal
26

27 ¹²² See Cal. Health & Safety Code § 443.14(d)(2).

28 ¹²³ Wilson, et al., *supra* note 32.

1 disabilities are particularly susceptible to undue influence from these stakeholders,
2 who may directly or indirectly pressure them to obtain physician-assisted suicide for
3 the stakeholder’s own convenience, financial gain, or other interest at odds with
4 keeping the person alive. In their administration and enforcement of EOLOA,
5 Defendants subject only people with terminal illnesses to these coercive situations.

6 124. In fair housing law, all steering is unlawful—even when it is well-
7 intentioned. The real estate agent who sincerely attempts to create a hospitable
8 community by directing a non-English speaking family to an apartment building
9 where they can communicate with neighbors in their native language is just as guilty
10 of steering as the agent who invidiously segregates all prospective renters into
11 different buildings in an effort to preserve racial purity. Since EOLOA was enacted,
12 the floodgates have opened for myriad influences to tip the balance in favor of using
13 physician-assisted suicide. Crucially, only people with terminal disabilities are
14 subject to having their choice about suicide influenced—and even implemented—
15 with the help of others. The mere presence of the option invites steering.

16 **A. Defendants’ Failure to Provide Supportive Services Steers People**
17 **with Terminal Disabilities Towards Physician-Assisted Suicide**

18 125. Most people in the elder community will experience a chronic
19 disability or disease at the end of their lives and require extra care to safely remain
20 in their home. But if that care is not made available and an individual’s only
21 alternatives to physician-assisted suicide are waiting for a nursing home placement,
22 burned-out or unavailable family care, or suffering in isolation, assisted suicide can
23 become a preferable option. That is what happened when Plaintiffs Ms. Tischer and
24 Mr. VanHook experienced medical crises, believing that physician-assisted suicide
25 may be the most desirable and only alternative to living without adequate medical
26 care and dignity.

27 126. EOLOA presents a false choice between obtaining end-of-life care or
28 assisted suicide. The Act purports to make physician-assisted suicide “one more

1 option” for end-of-life care. Expanding care options should decrease suicidality, not
2 elevate it.¹²⁴ But the system is rigged to make physician-assisted suicide the *only*
3 viable option. Assisted suicide is fully covered by Medi-Cal for California’s
4 majority non-White participants who live near or below the federal poverty
5 threshold. Yet life-sustaining treatment, long-term supportive services, in-home
6 nursing services, palliative care, and hospice may be unavailable (or denied) due to
7 a variety of reasons—including Defendants’ system of setting health care priorities.
8 The Act does nothing to require that sufficient long-term care actually be available
9 to the person, and exhausted or knowingly rejected, so that they can make an
10 informed choice between assisted suicide and continuing to live with some
11 semblance of independence. Physician-assisted suicide reduces pressure on
12 Defendant State agencies and actors to supply support services that enable people
13 with terminal disabilities to make a *meaningful* choice between options that actually
14 exist. True autonomy presupposes having access to real options and being
15 empowered to choose from among them.

16 127. Recent studies by the California Health Care Foundation have found
17 significant shortfalls and wide regional discrepancies in the availability of palliative
18 care in the State. Indeed, the studies show that many counties in California have *no*
19 community-palliative care options, and those that do have far too little to meet the
20 need.¹²⁵

21 128. Widespread safety problems and deficiencies in care among California
22 hospices suggest that people with terminal disabilities in hospice are likely not
23

24 ¹²⁴ See Xin Hu, et al., *Suicide Risk Among Individuals Diagnosed With Cancer in the*
25 *US, 2000-2016*. 6 JAMA NETW OPEN e2251863 (2023),
26 <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800688#:~:text=Findings%20In%20this%20population%2Dbased,contributing%20to%20the%20elevated%20risk> (finding that Medicare expansion was associated with decreased suicide rates among individuals diagnosed with cancer).

27 ¹²⁵ Cal. Health Care Found., *Palliative Care in California: Narrowing the Gap 2*
28 *tbl.1* (2018), <https://www.chcf.org/wp-content/uploads/2018/05/NarrowingGap.pdf>.

1 receiving adequate care, which could be a contributing factor to their decision to
2 seek physician-assisted suicide.¹²⁶ A December 2020 Los Angeles Times
3 investigation found massive neglect and under-enforcement of safety requirements
4 in California hospice care, including mismanaged medications, neglected wounds,
5 and missed appointments.¹²⁷ Documenting the explosive growth of for-profit
6 hospice agencies in Los Angeles County fueled by fraudulent providers, the State
7 Auditor issued a March 2022 report finding “the State’s weak controls have created
8 the opportunity for large-scale fraud and abuse.”¹²⁸ The State Auditor singled out
9 Defendant CDPH for its “inadequate performance” and noted that it did “not
10 adequately safeguard patient care or prevent fraud.”¹²⁹ A recent JAMA Internal
11 Medicine study of more than 600,000 patients found that over 12% received no
12 visits from hospice staff in the last two days of life.¹³⁰

13 129. The availability of in-home care services for people with terminal
14 disabilities is woefully inadequate in California, and steers people towards
15 physician-assisted suicide. Medi-Cal’s In-Home Supportive Services (“IHSS”)
16 program is meant to serve aged and/or disabled Californians at risk of nursing home
17 placement. In 2021, the State Auditor issued a report concluding that the IHSS
18 program “is not providing needed services to all Californians approved for the
19
20

21 ¹²⁶ See U.S. Dep’t Health Hum. Servs., OIG, HOSPICE DEFICIENCIES POSE RISKS TO
22 MEDICARE BENEFICIARIES 32 (2019), https://oig.hhs.gov/oei/reports/oei-02-17-00020.pdf?utm_source=summary-page&utm_medium=web&utm_campaign=OEI-02-17-00020-PDF.

23 ¹²⁷ Kim Christensen & Ben Poston, *Dying Californians Suffer Harm and Neglect*
24 *From an Industry Meant to Comfort Them*, L.A. TIMES (Dec. 9, 2020),
25 <https://www.latimes.com/california/story/2020-12-09/california-hospice-under-fire-mistreatment-patients>.

26 ¹²⁸ State Auditor Report 2022, *supra* note 96, at iii.

27 ¹²⁹ *Id.*

28 ¹³⁰ Teno, et al. *supra* note 84.

1 program, is unprepared for future challenges, and offers low pay to caregivers.”¹³¹
2 Among other things, the State Auditor found that each month more than 40,000
3 IHSS recipients do not receive the services for which they qualify, and that over a
4 five-year period between 2015 and 2019, there were “more than 130 million hours
5 of services IHSS recipients needed but did not receive.”¹³² Plaintiff Mr. VanHook
6 relies on in-home supportive services in order to live and although he is approved
7 for virtually 24/7 care he is unable to find, train, and retain sufficient help because
8 the IHSS wage rate is too low to attract suitable caregivers, leaving him without
9 adequate care.

10 130. Defendant CDHCS fails to provide sufficient supportive services to
11 allow people to avoid physician-assisted suicide. CDHCS administers the State’s
12 Home and Community-Based Alternatives (“HCBA”) waiver, which allows some
13 Medi-Cal beneficiaries with high-level care needs to obtain in-home personal care
14 services (“PCS”) that includes nursing care. These types of PCS are useful in
15 addressing the concerns that drive people to physician-assisted suicide, but CDHCS
16 enforces harsh rationing on HCBA in-home care, with long approval times,
17 waitlists, and a track record of serving only a tiny fraction of the need.¹³³

18 131. Medi-Cal also covers some assisted living and memory care centers,
19 but that placement program is plagued with long waitlists which can stretch two or
20 three years.¹³⁴ Many older people are forced to spend down their savings to become
21

22 ¹³¹ Auditor of State of Cal. IN-HOME SUPPORTIVE SERVICES PROGRAM (2021) (“State
23 Auditor Report 2021”), <https://www.auditor.ca.gov/pdfs/reports/2020-109.pdf>.

24 ¹³² *Id.* at 1.

25 ¹³³ CDHCS, *Home and Community-Based Alternatives Waiver Monthly Dashboard:*
26 *October 2022*, <https://www.dhcs.ca.gov/services/ltc/Documents/2022-1131-HCBA-Web-Totals-Oct2022.pdf>; CDHCS, *MEDI-CAL MONTHLY ELIGIBLE FAST FACTS,*
27 *AUGUST 2022 (Nov. 2022)*, <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-August2022.pdf>.

28 ¹³⁴ See Ana B. Ibarra, *‘Operating Under Water’: Families Trying to Place Loved*

1 eligible for assisted living care. Nursing facilities are often considered a placement
2 of last resort, made out of desperation, as older people are often terrified of being
3 placed in facilities where “abuse of older residents by other residents in long-term
4 care facilities is now recognized as a problem that is more common than physical
5 abuse by staff.”¹³⁵

6 132. EOLOA’s stated purpose includes aspirational language about
7 autonomy and freedom: “In the end, how each of us spends the end of our lives is a
8 deeply personal decision. That decision should remain with the individual, as a
9 matter of personal freedom and liberty.”¹³⁶ Despite such lofty ideals, EOLOA
10 extends this “freedom” only to the decision to die by physician-assisted suicide.
11 Defendants fail to ensure availability of *any* of the “feasible alternatives” the
12 attending physician is supposed to review with the patient. Under the Act, there is
13 no freedom to continue living in one’s own home with adequate supportive services,
14 and no requirement that such services be exhausted or knowingly rejected, as a less
15 restrictive alternative to death. Without access to adequate pain control or hospice
16 care, the liberty to choose how to spend one’s final days are illusory. A public
17 health system which fails to adequately care for the living should not be empowered
18 with the license to kill.

19 **B. Insurance Providers Steer People with Terminal Disabilities**
20 **Towards Physician-Assisted Suicide**

21 133. EOLOA purports to prohibit insurance steering by barring
22

23 _____
24 *Ones in Medi-Cal Assisted Living Program Wait Years*, CALMATTERS (Sept. 7,
2022), <https://calmatters.org/health/2022/09/medi-cal-assisted-living/>.

25 ¹³⁵ Mark S. Lachs & Karl A. Pillemer, *Elder Abuse*, 373 N. ENG. J. MED. 1947
26 (2015), <https://www.nejm.org/doi/full/10.1056/NEJMra1404688>.

27 ¹³⁶ Sen. Rules Comm., Off. of Sen. Floor Analyses, 3d reading analysis of Assem.
28 Bill 15 (2015-2016 2d Ex. Sess.,) as amended Sept. 10, 2015,
https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201520162ABI5#.

1 simultaneous written communication of treatment denials and physician-assisted
2 suicide coverage.¹³⁷ This bar is easily evaded. For example, California resident
3 Stephanie Packer, “a mother of four and a cancer patient, was denied her previously
4 approved chemotherapy treatment, but offered low-cost suicide pills by her insurer
5 by phone instead.”¹³⁸ Similarly, Dr. Brian Callister attempted to transfer his patient,
6 a California resident, to a California provider for a procedure not available at the
7 hospital he worked at across the border in Nevada. Although he had not requested
8 assisted suicide and the patient was not terminal if provided treatment, the
9 California insurer advised that they would not cover the transfer or treatment but
10 would cover assisted suicide.¹³⁹ Even if there was perfect compliance with
11 EOLOA’s prohibition on such communications, the Act does nothing to ensure that
12 insurers do not deny or delay approval of life saving medications while at the same
13 time covering the costs of physician-assisted suicide. Direct coercion is not
14 necessary where “patients are denied necessary life-sustaining health care treatment,
15 or even if the treatment they need is delayed[;] many will, in effect, be steered
16 toward assisted suicide.”¹⁴⁰

17 134. Defendant CDHCS administers Medi-Cal, the State’s Medicaid
18 program that serves low-income individuals, including families, seniors, and persons
19 with disabilities. Medi-Cal serves approximately one-third of California’s
20

21 _____
22 ¹³⁷ Cal. Health & Safety Code § 443.13(c) (the statute permits two separate letters,
sent separately).

23 ¹³⁸ NCD Report, *supra* note 79, at 21.

24 ¹³⁹ *Id.* (citing PRAF, *Physician Assisted Suicide—The Real Effects* (May 31, 2017),
25 https://www.youtube.com/watch?v=CWrpr_5e4RY [video about Dr. Brian
Callister’s patients]); *see also* *Fatally Flawed Experiments: California*, AUSTL
26 CARE ALLIANCE, <https://www.australiancarealliance.org.au/california> (last visited
Mar. 23, 2023).

27 ¹⁴⁰ DREDF, *Why Assisted Suicide Must Not Be Legalized*, section I(C)(1),
28 <https://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#marker13> (last visited Mar. 23, 2023).

1 population, and over half of people on Medi-Cal whose race/ethnicity is known are
2 Hispanic.¹⁴¹ Medi-Cal’s EOLOA policy and billing information indicates that
3 Medi-Cal covers physician-assisted suicide for all qualifying patients, but “routine
4 office visits involving general discussions between a recipient and their physician ...
5 regarding available medical options for addressing the terminal illness (for example,
6 hospice, palliative care or aid-in-dying services) are not a covered end of life
7 service.”¹⁴² California is incentivized to save millions of dollars by providing its
8 eligible low-income and majority-minority population with physician-assisted
9 suicide instead of health care services and supports.

10 **C. Medical Care Providers Steer People with Terminal Disabilities**
11 **Towards Physician-Assisted Suicide**

12 135. Having one’s own doctor encourage or even agree with the choice to
13 use physician-assisted suicide is a powerful factor in support of that decision.¹⁴³
14 Research has shown that doctors’ own discomfort with people with terminal
15 disabilities can influence the person’s request to hasten death.¹⁴⁴ Some physicians
16 have a “tendency to assume that the depressive illness of an older patient is less
17 likely to respond to treatment, that pain control is a less important issue for older
18 patients, [and] that an older patient’s suicidal wishes are more likely to be inherently
19 ‘rational’ than those of a younger patient.”¹⁴⁵

20 136. Doctors’ value judgments about their patient’s quality of life also lead
21

22 ¹⁴¹ CDHCS, MEDI-CAL MONTHLY ELIGIBLE FAST FACTS, SEPTEMBER 2022 10 (Dec.
23 2022), <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/FastFacts-September2022.pdf>.

24 ¹⁴² CDHCS, *End of Life Option Act Services*, at 2 (updated Aug. 2020),
25 <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/eloa.pdf>.

26 ¹⁴³ See, e.g., Steven H. Miles, *Physicians and Their Patients’ Suicides*. 271 JAMA
1786 (1994).

27 ¹⁴⁴ Maytal & Stern, *supra* note 47, at 302.

28 ¹⁴⁵ Clark, *supra* note 41.

1 to recommendations of physician-assisted suicide as a way to address perceived
2 low-quality of life. For example, the wife of one seriously ill person in Oregon
3 overheard her husband’s doctor giving a “sales pitch” for assisted suicide including
4 saying “[t]hink of what it will spare your wife, we need to think of her.”¹⁴⁶ Another
5 oncologist admitted to prescribing lethal drugs to a person who explained that he
6 sought physician-assisted suicide because “I don’t have any friends. I don’t have
7 any real quality of life—not because I’m ill, but for social-economic reasons.” The
8 doctor rationalized that the person’s self-determination outweighed the doctor’s
9 impulse for medical intervention: “I don’t really feel it’s my job to judge the quality
10 of their reason,” he explained.¹⁴⁷ Some physicians possess a “false empathy”
11 towards their patients, believing that a person with a terminal disability is better off
12 dead than alive without inquiring into the quality of life available with adequate
13 supportive services or even the barriers to accessing supportive services. Moreover,
14 physicians often receive little training in quality-of-life interventions that can make
15 continued life more desirable.¹⁴⁸

16 137. A study from Georgetown University’s Center for Clinical Bioethics
17 found a strong link between cost-cutting pressure on physicians and their willing-
18 ness to prescribe lethal drugs to patients.¹⁴⁹ For hospitals, it is much less expensive
19 to assist a person’s suicide than it is to provide for care. Last year, in a secret
20 recording obtained by the Associated Press, the director of ethics at a Canadian
21 hospital was heard telling a person with a degenerative brain disorder that it was
22

23 _____
¹⁴⁶ DREDF, *supra* note 140.

24 ¹⁴⁷ Anita Hannig, *Author[iz]ing Death: Medical Aid-in-Dying and the Morality of*
25 *Suicide*, 34 J. CULTURAL ANTHROPOLOGY 53, 69 (2019).

26 ¹⁴⁸ NCD Report, *supra* note 79, at 30.

27 ¹⁴⁹ DREDF, *supra* note 140 (citing Daniel P. Sulmasy, Benjamin P. Linas, Karen F.
28 Gold, & Kevin A. Schulman *Physician Resource Use and Willingness to Participate*
in Assisted Suicide, 158 ARCH. INTERN. MED. 974, 978 (1998).)

1 costing “north of \$1,500 a day” for the person to remain in the hospital. When the
2 person replied that he felt like he was being coerced and asked about the plan for his
3 long-term care, the hospital director replied that “[m]y piece of this was to talk to
4 you, to see if you had an interest in assisted dying”—even though the person never
5 brought the issue up himself.¹⁵⁰

6 138. By allowing physicians with moral, religious, or ethical objections to
7 opt out of EOLOA participation, the Act makes a bad situation even worse—the
8 only physicians available to speak to about obtaining a physician-assisted suicide
9 prescription are those who agree that it is appropriate to provide people with
10 terminal disabilities with the lethal means to commit suicide. Plaintiffs are informed
11 and believe, and on that basis allege, that people with illnesses or conditions
12 perceived as terminal are rarely, if ever, denied access to a lethal prescription. The
13 Act permits doctor shopping, such that if one physician finds the person ineligible,
14 the person can contact additional physicians until they get approval for physician-
15 assisted suicide.

16 **D. Family and Caregiver Pressures Steer People with Terminal**
17 **Disabilities Towards Physician-Assisted Suicide**

18 139. People who die by physician-assisted suicide often cite the burden on
19 family caregivers as a contributing factor. Family members and other caregivers
20 involved in decisions about physician-assisted suicide have tremendous influence
21 and can distort patient choice, based in part on their own anxiety, depression, and
22 burnout from caring for a person with a terminal disability. Family members who
23 find it difficult to accept functional impairments in a loved one and/or are motivated
24 by a desire to end perceived or actual suffering may—intentionally or unintention-
25
26

27 ¹⁵⁰ Maria Cheng, *‘Disturbing’: Experts Troubled by Canada’s Euthanasia Laws*, AP
28 (Aug. 11, 2022), <https://apnews.com/article/covid-science-health-toronto-7c631558a457188d2bd2b5cfd360a867>.

1 ally—convey the idea that the person would be “better off dead.”¹⁵¹

2 140. Some people who die by physician-assisted suicide identify the “finan-
3 cial implications of treatment” as a reason for requesting lethal drugs.¹⁵² The high
4 cost of continuing medical care for people with cancer and other terminal conditions
5 can drain a family’s savings, even with insurance.¹⁵³ In contrast, physician-assisted
6 suicide is fully covered under Medi-Cal. People with terminal disabilities may
7 experience overt pressure from family members concerned about mounting bills as
8 well as their own internalized guilt that they will be incapable of leaving sufficient
9 money or property to their next of kin—or worse, saddling them with unpaid
10 healthcare costs.¹⁵⁴

11 **VII. EOLOA Unconstitutionally Deprives People with Terminal Disabilities of**
12 **Due Process Protections**

13 141. EOLOA lacks sufficient safeguards and unconstitutionally deprives
14 people with terminal disabilities of protections for their right to live. The Act fails
15 to ensure adequate due process for people who waive this constitutional right and
16 that they are free from undue influence and coercion—including the types identified
17 in the preceding Section. EOLOA fails to require the consideration, exhaustion,
18 and/or knowing rejection of less restrictive, alternatives to physician-assisted
19 suicide. The Act affirmatively places people with terminally disabilities in danger
20 by acting with deliberate indifference to the known, obvious, and foreseeable
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23 ¹⁵¹ NCD Report, *supra* note 79, at 28-9 (citing Gill, *supra* note 88).

24 ¹⁵² See, e.g., Oregon 2021 Data Summary, *supra* note 57.

25 ¹⁵³ John G. Cagle et al., *Financial Burden Among US Households Affected by*
26 *Cancer at the End of Life*, 25 PSYCHOONCOLOGY 919 (2016),
<https://onlinelibrary.wiley.com/doi/abs/10.1002/pon.3933>.

27 ¹⁵⁴ Ezekiel J. Emanuel et al., *Understanding Economic and Other Burdens of*
28 *Terminal Illness: The Experience of Patients and Their Caregivers*, 21 ANNALS
INTERN. MED. 451, (2000), <https://www.acpjournals.org/doi/10.7326/0003-4819-132-6-200003210-00005>.

1 dangers of making physician-assisted suicide available to those with the highest risk
2 factors for suicide. Through their acts and omissions, Defendants fail to ensure that
3 people who die by physician-assisted suicide are provided their constitutional due
4 process rights and had a *real* end-of-life option.

5 142. EOLOA’s authors attempted to downplay concerns about systemic
6 abuse and other due process violations by including a statement that “[t]his bill
7 includes strong provisions to safeguard patients from coercion” and that “[t]here is
8 substantial evidence from [the five states that had already legalized physician-
9 assisted suicide] that prove this law can be used safely and effectively.”¹⁵⁵ Promi-
10 nent national medical professional organizations disagree. The American Medical
11 Association’s Code of Ethics observes that “permitting physicians to engage in
12 assisted suicide would ultimately cause more harm than good.”¹⁵⁶ The American
13 College of Physicians, the American Medical Directors Association, and the
14 National Hospice and Palliative Care Organization all oppose physician-assisted
15 suicide.¹⁵⁷ EOLOA’s safeguards are illusory, frequently disregarded, and/or
16 circumvented in ways that harm people with terminal disabilities.¹⁵⁸

17 **A. EOLOA’s Vague Definition of “Terminal Disease” Fails to Ensure**
18 **an Adequate Process to Determine Physician-Assisted Suicide**
19 **Eligibility**

20 143. As explained in Section IV.B, the statutory definition of “terminal

21 ¹⁵⁵ *Id.*

22 ¹⁵⁶ AMA CODE MED. ETHICS, Opinion 5.7, *Physician-Assisted Suicide*, [https://code-](https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide)
23 [medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide](https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide); *see also*
AMA CODE MED. ETHICS, Opinion 5.8, opposing euthanasia.

24 ¹⁵⁷ *See* Lois Snyder Sulmasy & Paul S. Mueller, *Ethics and the Legalization of*
25 *Physician-Assisted Suicide: An American College of Physicians Position Paper*, 167
ANNALS INTERN. MED. 576 (2017),
26 <https://www.acpjournals.org/doi/full/10.7326/M17-0938>; *Position Statement on*
27 *Care at the End of Life*, AMDA - SOCIETY FOR POST-ACUTE AND LONG-TERM CARE
MEDICINE (Mar. 1, 1997), [https://paltc.org/amda-white-papers-and-resolution-](https://paltc.org/amda-white-papers-and-resolution-position-statements/position-statement-care-end-life)
[position-statements/position-statement-care-end-life](https://paltc.org/amda-white-papers-and-resolution-position-statements/position-statement-care-end-life).

28 ¹⁵⁸ *See generally*, NCD Report, *supra* note 79, at 20-34.

1 disease” is overbroad and encompasses the class of persons who have medical
2 conditions that would result in death within six months *without* medical care but
3 who can live for more than six months *with* medical care. By leaving this key term
4 vague and unclear, EOLOA fails to define the class of persons eligible for
5 physician-assisted suicide with precision, and fails to provide adequate guidance to
6 the State’s physicians as to how to determine whether a patient’s condition meets
7 the principle eligibility criteria. UCSF Medical Center, for example, does not even
8 include the term “terminal” or “terminal disease” in its guidance as to who is
9 eligible for physician-assisted suicide, and instead advises that people qualify if they
10 “[h]ave a diagnosis of a serious, life-limiting illness with a prognosis of six months
11 or less (as estimated by two doctors).”¹⁵⁹ The category of people with “terminal
12 disease” is inherently unstable.

13 144. As explained in Section IV.C, physicians are notoriously poor
14 prognosticators regarding the timing of their patients’ deaths. By failing to rely on
15 any criteria or methodology to determine length of remaining life with any level of
16 precision, and by failing to provide any guidance to the State’s physicians as to how
17 to determine whether a particular person’s condition will or will not “result in death
18 within six months” (with or without medical care), EOLOA sweeps in untold
19 numbers of individuals whose conditions will (and do) not result in death within six
20 months.

21 145. The lack of clarity surrounding the process for determining who is
22 eligible for State-sanctioned assisted suicide places individuals’ lives at the
23 unaccountable discretion and potential biases of individual doctors, and deprives
24 those at risk of obtaining physician-assisted suicide prescriptions without decision-
25 making capacity or voluntariness the due process required by the U.S. Constitution.

26
27 ¹⁵⁹ *FAQs: End of Life Option Act at UCSF*, Patient Education, UCSF HEALTH,
28 <https://www.ucsfhealth.org/education/faq-end-of-life-option-act-at-ucsf> (last visited April 6, 2023).

1 **B. No Meaningful Mental Health Assessment or Treatment Is**
2 **Required Under the Act**

3 146. People who seek physician-assisted suicide have the highest risk factors
4 for suicide (old age, illness, disability), along with extraordinarily high levels of
5 depression and accompanied impaired decision making capacity. EOLOA’s lack of
6 safeguards with respect to this population deprives people of life without due
7 process of law.

8 147. Depression plays an enormous role in California’s physician-assisted
9 suicide deaths. Data from medical studies about the desire for death among
10 terminally ill people show “a strong correlative relationship between the clinical
11 manifestations of major depressive disorder and patients with life-threatening illness
12 expressing a desire for a hastened death.”¹⁶⁰ “Eighty per cent of patients with
13 cancer who complete suicide have a mood disorder, and, in primary care
14 populations, treatment of depression reduces suicidal ideation.”¹⁶¹ EOLOA neither
15 offers nor ensures provision of treatment for depression. The co-director of Harvard
16 Medical School’s Center for Palliative Care, after studying physician-assisted
17 suicide practices, has written that all people who request hastened death should be
18 assessed by a psychiatrist for treatable depression.¹⁶² Most people diagnosed as
19 terminal who express a desire to die are indirectly asking for help in dealing with the
20 depression and accompanying concerns common to all people nearing the end of
21

22 _____
23 ¹⁶⁰ Maytal & Stern, *supra* note 47, at 301; *see also* Linda Ganzini, Elizabeth R.
24 Goy, & Steven K. Dobscha, *Prevalence of Depression and Anxiety in Patients*
25 *Requesting Physicians’ Aid in Dying: Cross Sectional Survey* 337 *BMJ* 973 (2008),
<https://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf> (“For people at the end of
life, depression, hopelessness, and psychosocial distress are among the strongest
correlates of desire for hastened death.”).

26 ¹⁶¹ Ganzini et al., *supra* note 160 at 973.

27 ¹⁶² Block & Billings, *supra* note 3, at 448; *see also* Wilson, et al., *supra* note 32, at
28 173 (“the expression of a desire for death by a terminally ill patient should raise a
suspicion about mental health problems”).

1 life.¹⁶³ When these needs are addressed “the desire for death diminishes.”¹⁶⁴

2 148. Reduced decision-making capacity also plays an enormous role in
3 deaths pursuant to EOLOA. While the Act contains a requirement that the attending
4 physician determine that the person has the “capacity to make medical decisions,”¹⁶⁵
5 “[m]any physicians receive no formal training in capacity assessment and may hold
6 erroneous beliefs about decisional capacity.”¹⁶⁶ A study published in the American
7 Journal of Geriatric Psychiatry in 2018 “revealed high rates of decisional impair-
8 ment in terminally ill participants,” and found that although “[m]ost terminally ill
9 participants were able to express a treatment choice (85.7%),” “impairment was
10 common on the Understanding (44.2%), Appreciation (49.0%) and Reasoning
11 (85.4%) subscales.”¹⁶⁷

12 149. Defendant State agencies and officials fail to ensure that the standard of
13 care—including a mental health evaluation—is implemented for people who seek
14 physician-assisted suicide from their doctors. Psychiatrists and psychologists are
15 *almost never* involved in decisions surrounding physician-assisted suicide. Instead,
16 the attending physician is required to refer the patient to a mental health specialist
17 assessment only “if there are indications of a mental disorder”¹⁶⁸—but the Act does
18
19

20 ¹⁶³ Block & Billings, *supra* note 3.

21 ¹⁶⁴ Hendin, *supra* note 4, at 46.

22 ¹⁶⁵ Defined as “the ability to understand the nature and consequences of a health
23 care decision, the ability to understand its significant benefits, risks, and
24 alternatives, and the ability to make and communicate an informed decision to
25 health care providers.” Cal. Health & Safety Code § 443.1(e).

26 ¹⁶⁶ Elissa Kolva, Ph.D., Barry Rosenfeld, Ph.D., & Rebecca Saracino, Ph.D.,
27 *Assessing the decision making capacity of terminally ill patients with cancer* 26 AM
28 J GERIATR PSYCHIATRY 5, 523-531, (2018)
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6345171/>.

27 ¹⁶⁷ *Id.*

28 ¹⁶⁸ Cal. Health & Safety Code § 443.5(a)(1)(A)(ii).

1 not define what constitutes a mental disorder, nor require training in detection.¹⁶⁹
2 Significantly, EOLOA assumes that a request for physician-assisted suicide is *not* an
3 indication of a mental disorder, when other California laws make precisely the
4 opposite assumption for virtually everyone else, and those laws require interventions
5 up to and including involuntary hospitalization to test the assumption and diagnose
6 the condition. Plaintiffs are informed and believe, and on that basis allege, that few,
7 if any, people who are provided physician-assisted suicide under California’s
8 EOLOA are referred for psychological assessments before receiving lethal
9 prescriptions. Oregon and Washington’s data show that over 95% of people who
10 qualify for and seek physician-assisted suicide are *not* referred to psychological
11 assessments but instead prescribed lethal drugs—California collects but does not
12 publish this information.

13 150. Even when a person *is* referred to a mental health assessment under
14 EOLOA, the provider’s inquiry is limited to “determining that the individual has the
15 capacity to make medical decisions and is not suffering from impaired judgment due
16 to a mental disorder.”¹⁷⁰ In a study of Oregon’s physician-assisted suicide law,
17 more than half of psychiatrists surveyed reported that they were “not at all confident
18 that they could, in the context of a single consultation, determine if a mental
19 disorder or depression impaired the judgment of a person requesting assisted
20 suicide.”¹⁷¹

21 151. EOLOA’s procedures are insufficient for differentiating between
22 people who have adequate decision-making capacity and those who do not.

24 ¹⁶⁹ See Clark, *supra* note 41, at 150 (noting that primary care physicians “are clearly
25 ill-equipped to assess the presence and effect of depressive illness in older
patients”).

26 ¹⁷⁰ Cal. Health & Safety Code § 443.1(l).

27 ¹⁷¹ Linda Ganzini, et al., *Evaluation of Competence to Consent to Assisted Suicide:*
28 *Views of Forensic Psychiatrists*, 157 AM. J. PSYCH. 595, 595 (2000),
<https://ajp.psychiatryonline.org/doi/epdf/10.1176/appi.ajp.157.4.595>.

1 **C. EOLOA Fails to Include Any Safeguards To Ensure that People**
2 **Are Not Judgment-Impaired or Unduly Influenced at the Time of**
3 **Death**

4 152. Once a prescription for physician-assisted suicide drugs is provided to
5 the patient, there are no requirements whatsoever in EOLOA to ensure that the
6 necessary predicates for the physician prescribing the lethal medication remain true
7 at a later time when the person may actually decide to ingest the medication: is the
8 person under duress, capable of making medical decisions, suffering from a mental
9 disorder that impairs judgment, still deemed to have a “terminal disease,” and
10 capable of understanding feasible alternatives? Importantly, the time that the person
11 ingests the lethal drugs may be days, weeks, months, or even years after the request
12 for physician-assisted suicide was approved.

13 153. There are no witness requirements at time of ingestion, no requirement
14 that the attending physician be present or informed of the person’s death, and no
15 obligation to inform authorities of the true manner or cause of death—despite
16 California law requiring the coroner to inquire into and determine the
17 “circumstances, manner, and cause of all ... known or suspected ... suicide[s].”¹⁷²
18 There are no requirements that the drugs be used within days, weeks, months, or
19 years, and neither EOLOA nor Defendants do anything to ensure that the drugs are
20 safely stored prior to consumption or properly disposed of should the person not
21 take the medication. This places the requestor and other people in the home—
22 including children—at risk of suicide, misuse, or accidental ingestion of the drugs.

23 154. The Act does not require any evidence that the person ingested the
24 lethal drugs themselves, that is whether the person self-administered the lethal drugs
25 as required by the Act or whether anyone else (family member, nurse, physician, or
26

27 ¹⁷² Cal. Gov’t Code § 27491. In fact, EOLOA requires that coroners misrepresent
28 the cause of death and omit suicide. Cal. Health & Safety Code § 443.18 (“Actions
taken in accordance with this part shall not, for any purposes, constitute suicide,
homicide, or elder abuse under the law”).

1 friend) administered the medication or physically assisted the person. Anything
2 other than self-administration is a violation of the Act, but Defendants do nothing to
3 determine whether this critical line between suicide and active euthanasia is ever
4 crossed and in implementing and enforcing EOLOA, Defendants make clear that
5 they do not care or want to know.

6 **D. EOLOA Fails to Provide Viable Alternatives to Suicide, Fails to**
7 **Require Consideration or Exhaustion of Less Restrictive**
8 **Alternatives to Suicide, and Lacks Independent Oversight**

9 155. EOLOA requires the attending physician to inform the patient of the
10 “feasible alternatives or additional treatment opportunities, including, but not
11 limited to, comfort care, hospice care, palliative care, and pain control” in order to
12 ensure that the patient makes an “informed decision.”¹⁷³ But the Act includes no
13 requirements or guidance regarding how in-depth or comprehensive this discussion
14 must be, and Defendants fail to provide any. Upon information and belief,
15 alternatives to assisted suicide are routinely under-emphasized or not discussed in
16 any meaningful way. And as discussed in Section VI.A, EOLOA fails to ensure that
17 any of these alternatives are actually available. Defendants are aware that in many
18 instances meaningful alternatives are unavailable to the person seeking physician-
19 assisted suicide—rendering the advisement requirement deficient and/or useless.

20 156. EOLOA fails to require that people meaningfully consider, exhaust,
21 and/or knowingly reject less restrictive, truly viable alternatives to assisted suicide,
22 including suicide prevention services, palliative and/or hospice care, medical and
23 nursing support services, and other personal support services that are ostensibly
24 included among the “feasible alternatives” that California providers are supposed to
25 discuss with persons who seek physician-assisted suicide. The Act fails to require
26 the provision or exhaustion of the State’s suicide prevention program, which is
27 expressly designed to address the underlying concerns that drive people to suicidal

28 ¹⁷³ Section 443.5(a)(2)(E).

1 thoughts and deter people from taking unnecessary, uninformed, untreated, or
2 otherwise preventable suicidal actions. By providing lethal medication to
3 individuals Defendants know to be at high risk for suicide, the State has an
4 obligation to ensure that the person has exhausted or knowingly rejected less
5 restrictive alternatives than death.

6 157. By endorsing physician-assisted suicide, the State also has an
7 obligation to ensure proper oversight and accountability by appropriately trained
8 professionals (including training in recognizing depression and decision-making
9 impairments). Yet EOLOA lacks any independent oversight for the decision to
10 grant a physician-assisted suicide request (i.e., review by a probate court, as with
11 civil commitments). None of the Defendants provide adequate oversight of the
12 process, and the Act itself specifically precludes their participation in ensuring the
13 practice is truly free of bias, coercion, and malfeasance.

14 **E. Prescribing Physicians Often Lack a Patient-Provider Relationship**
15 **with the People for Whom They Prescribe Lethal Drugs**

16 158. EOLOA contains no safeguards to ensure that the physician who
17 prescribes lethal drugs have any preexisting relationship with the patient or
18 knowledge of their illness and treatment history. There is no requirement for the
19 attending physician to request the patient’s medical records before assisting their
20 suicide. The attending and consulting physicians need not even ever see the suicidal
21 patient in person, as the Act allows doctors to meet, evaluate, and prescribe lethal
22 drugs to patients over the phone.¹⁷⁴ People who qualify can obtain lethal drugs from
23 a doctor the patient has “known” for only two days.

24 159. EOLOA operates on the fiction that on the basis of a two-day
25 telephonic relationship, a prescribing doctor can: (1) make the terminal prognosis,
26

27 ¹⁷⁴ See, e.g., *FAQs: End of Life Option Act at UCSF*, Patient Education, UCSF
28 HEALTH, <https://www.ucsfhealth.org/education/faq-end-of-life-option-act-at-ucsf>
(noting the availability of telehealth “visits”).

1 (2) ensure the patient is not acting under impaired judgment or duress, (3) decide
2 whether to refer the patient for a mental health assessment, and (4) counsel the
3 patient on their options and alternatives. The two-day doctor-patient relationship
4 facilitates doctor-shopping, by which the patient seeks out a second physician, and
5 in some cases, a third and a fourth “opinion,” until one of them eventually agrees to
6 write the prescription. California makes no effort to track or restrict this practice,
7 allowing easy evasion of the “safeguards” against duress, neglect, and abuse. In
8 contrast, California and federal law track all sorts of efforts by individuals to obtain
9 other types of drugs. For example, just to obtain pseudoephedrine, an over-the-
10 counter cold medicine, an individual must present to drug-store cashiers a
11 government-issued identification and sign a logbook, usually electronic, which can
12 be accessible by law enforcement at any time.

13 **F. Physician-Assisted Suicide Drug Cocktails Are Unregulated Under**
14 **EOLOA, and Place People at Risk of Distressing Deaths**

15 160. EOLOA provides no guidance as to what drugs should be prescribed
16 for physician-assisted suicide, yet it promotes the idea of “a peaceful death.”¹⁷⁵
17 Such statements further the public misconception that lethal drugs provide an easy
18 transition from life to death. The evidence, however, demonstrates that such drugs
19 as administered under EOLOA can cause agonizing and painful deaths.¹⁷⁶

20 161. As drug companies have reduced supply and increased costs of the
21 first-generation of physician-assisted suicide drugs (which are also used in death
22 penalty executions), advocates have sought other, cheaper drugs, including new, and
23 often untested, combinations. Diazepam, a benzodiazepine, has now supplanted
24

25 ¹⁷⁵ Senate Floor Analyses, *supra* note 91.

26 ¹⁷⁶ Ana Worthington, Ilora Finlay, & Claud Regnard. *Efficacy and Safety of Drugs*
27 *Used for ‘Assisted Dying’*, 142 BRIT. MED. BULL. 15 (2022),
28 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9270985/pdf/ldac009.pdf>; Sean
Riley, *Navigating the New Era of Assisted Suicide and Execution Drugs*, 4 J. LAW
BIOSCIENCES 424 (2017), <https://academic.oup.com/jlb/article/4/2/424/4265564>.

1 barbiturates as the primary drug in effectuating physician-assisted suicide deaths in
2 states that permit the use of DDMA (diazepam, digoxin, morphine sulfate and
3 amitriptyline) and DDMP (diazepam, digoxin, morphine sulfate and propranolol).¹⁷⁷
4 DDMA and DDMP are now responsible for over 99% of physician-assisted suicide
5 deaths in Oregon, where annual complication rates have reached 14.8% and people
6 are reported to have experienced difficulty ingesting, drug regurgitation, seizures,
7 and have even regained consciousness after ingesting the drug cocktails.¹⁷⁸

8 162. DDMP, the predominant drug used to end life in California physician-
9 assisted suicide deaths, was the cause of one distressing assisted suicide in which the
10 person was observed coughing, choking, and vomiting, and took over four hours to
11 die.¹⁷⁹ The amount of time between drug ingestion and death varies dramatically.
12 Twenty years of data from Oregon show that the time from ingestion to death has
13 ranged up to 104 hours.¹⁸⁰ The median time between ingestion and death has
14 doubled since the introduction of the experimental drug cocktails DDMA and
15 DDMP.¹⁸¹ Unlike Oregon, California does not require physicians to keep records of
16 the amount of time between ingestion and death.

17 **G. What Safeguards Exist Are Being Methodically Stripped From**
18 **EOLOA and Safeguards In Place Now May Not Be Present For**
19 **Long**

20 163. EOLOA lacks safeguards to protect people from dying by suicide
21 impulsively. Risk for depression and suicidality is often present immediately after a
22 traumatic injury or grave diagnosis, including a spinal injury. A 2023 study of over

23 ¹⁷⁷ Worthington, et al., *supra* note 176, at 17-18.

24 ¹⁷⁸ *Id.* at 18.

25 ¹⁷⁹ Kevin Simpson, *Voting for Aid in Dying Was Easy, But One Couple Found*
26 *Themselves Struggling Toward a Graceful Death*. DENVER POST (Dec. 14, 2017,
2:08 PM), <https://www.denverpost.com/2017/12/14/colorado-aid-in-dying-law/>.

27 ¹⁸⁰ Oregon 2021 Data Summary, *supra* note 57, at 17.

28 ¹⁸¹ *Id.*

1 16 million people with cancer in the U.S. found that the “highest suicide risk
2 occurred in the first 6 months after diagnosis, during which individuals diagnosed
3 with cancer bore more than 7 times the suicide risk of the general population.”¹⁸²

4 164. In 2021, Defendant Governor Newsom signed into law a bill amending
5 EOLOA by shortening the waiting period from fifteen days to only 48 hours.¹⁸³ The
6 likelihood that depression or another disorder that impairs judgment will resolve
7 itself within two days is unlikely. Californians can now make an oral request to the
8 attending physician; have their diagnosis, prognosis, and capacity confirmed by a
9 second consulting doctor (who does not have to meet with the patient in person);
10 and 48 hours after the first request, ingest lethal drugs prescribed by the attending
11 physician. The mandatory waiting period for purchasing a gun in California is ten
12 days—a far longer period to let impulses simmer down.

13 165. California amendments to EOLOA also eliminated the requirement that
14 the person make a final attestation affirming their choice before self-administering
15 the lethal drugs. The minimal safeguards which were used to allay the fears of
16 legislators and the public about the safety of physician-assisted suicide are being
17 eliminated to ensure that people with terminal disabilities are promptly provided the
18 means to die rather than the standard of care for suicide prevention when they
19 express a desire to kill themselves. EOLOA’s provisions are discriminatory,
20 unconstitutional, and fail to protect Californians.

21 CLAIMS FOR RELIEF

22 FIRST CLAIM FOR RELIEF 23 (Americans with Disabilities Act, 42 U.S.C. §§ 12132, 12203) 24 (Against All Defendants)

25 166. Plaintiffs reallege and hereby incorporate by reference the allegations

26 ¹⁸² Xin Hu, et al., *supra* note 124, at 9.

27 ¹⁸³ Cal. Health & Safety Code § 443.3(a) (effective June 9, 2016, Amended by Stats.
28 2021, Ch. 542, Sec. 2. (SB 380) Effective January 1, 2022.)

1 contained in the preceding paragraphs of this Complaint.

2 167. Title II of the ADA provides that “no qualified individual with a
3 disability shall, by reason of such disability, be excluded from participation in or be
4 denied the benefits of services, programs, or activities of a public entity, or be
5 subjected to discrimination.” 42 U.S.C. § 12132. A “public entity” includes State
6 and local governments, their agencies, and their instrumentalities. 42 U.S.C.
7 § 12131(1). Defendants qualify as public entities and/or officers of public entities
8 within the meaning of 42 U.S.C. § 12131 and 28 C.F.R. § 35.104.

9 168. The ADA defines “a qualified individual with a disability” as a person
10 who has a “physical or mental impairment that substantially limits one or more
11 major life activities,” including, but not limited to, “caring for oneself, performing
12 manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending,
13 speaking, breathing, learning, reading, concentrating, thinking, communicating, and
14 working.” 42 U.S.C. § 12102(1)(A), (2)(A). The ADA Amendments Act of 2008
15 expanded the definition of “major life activities” to also include: “the operation of a
16 major bodily function, including but not limited to, functions of the immune system,
17 normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory,
18 circulatory, endocrine, and reproductive functions.” 28 C.F.R. § 35.108(c)(ii). “The
19 definition of ‘disability’ shall be construed broadly in favor of expansive coverage,
20 to the maximum extent permitted by the terms of the ADA.” 28 C.F.R.
21 § 35.108(a)(2)(i).

22 169. Plaintiffs’ constituents and/or members include, and Plaintiffs are,
23 qualified individuals with disabilities as defined in the ADA and ADA Amendments
24 Act of 2008.

25 170. Defendants the State of California and Governor Newsom are
26 responsible for enacting, executing, and overseeing the enforcement and
27 implementation of the laws of the State, including EOLOA, and in so doing, violate
28 the ADA and its implementing regulations by: (1) denying people with terminal

1 disabilities the opportunity to benefit from the State’s laws and public services;
2 (2) providing an opportunity to people with terminal disabilities to benefit from
3 State’s laws and public services that is not equal to that afforded to others;
4 (3) providing the benefit of the State’s laws and public services to people with
5 terminal disabilities that is not as effective in affording equal opportunity to obtain
6 the same result or benefit as that provided to other people; (4) unnecessarily
7 providing a different or separate benefit of the State’s laws and public services to
8 individuals with terminal disabilities; (5) limiting people with terminal disabilities in
9 the enjoyment of rights, privileges, advantage, or opportunities enjoyed by others;
10 and (6) using criteria or methods of administration that have the effect of
11 discriminating against people with terminal disabilities and substantially impairing
12 accomplishment of the objectives of these public entities with respect to individuals
13 with terminal disabilities. *See* 28 CFR §§ 35.130(b)(1)(i)-(iv), (1)(vii), (3)(i), (3)(ii).

14 171. Defendants MBC, Lawson, Attorney General Bonta, the DA’s Office,
15 and District Attorney Gascón are responsible for enforcing the laws of the State,
16 including criminal laws and certain civil laws protecting older people and those with
17 disabilities, and suicidal people, but fail to discharge their duties to enforce these
18 laws pursuant to EOLOA. In so doing, Defendants MBC, Lawson, Attorney
19 General Bonta, the DA’s Office, and District Attorney Gascón violate the ADA and
20 its implementing regulations by: (1) denying people with terminal disabilities the
21 opportunity to benefit from enforcement of criminal and certain civil laws;
22 (2) providing an opportunity to people with terminal disabilities to benefit from
23 enforcement of criminal and certain civil laws that is not equal to that afforded to
24 others; (3) providing a benefit of enforcement of criminal and certain civil laws to
25 people with terminal disabilities that is not as effective in affording equal
26 opportunity to obtain the same result or benefit as that provided to others;
27 (4) unnecessarily providing a different or separate benefit of enforcement of
28 criminal and certain civil laws to individuals with terminal disabilities; (5) limiting

1 people with terminal disabilities in the enjoyment of rights, privileges, advantage, or
2 opportunities enjoyed by others, including the benefit of enforcement of criminal
3 and certain civil laws; and (6) using criteria or methods of administration that have
4 the effect of discriminating against people with terminal disabilities and
5 substantially impairing accomplishment of the objectives of these public entities
6 with respect to individuals with terminal disabilities. *See* 28
7 CFR §§ 35.130(b)(1)(i)-(iv), (1)(vii), (3)(i), (3)(ii).

8 172. Defendants CDPH, CDHCS, MHSOAC, Aragón, Baass, and Madrigal-
9 Weiss are responsible for implementing and administering suicide prevention
10 programs and EOLOA. In so doing, they violate the ADA and its implementing
11 regulations by: (1) denying people with terminal disabilities the opportunity to
12 participate in or benefit from public and behavioral health services; (2) providing an
13 opportunity to people with terminal disabilities to participate in or benefit from
14 public and behavioral health services that is not equal to that afforded to others;
15 (3) providing public and behavioral health services to people with terminal
16 disabilities that are not as effective in affording equal opportunity to obtain the same
17 result or benefit as that provided to others; (4) unnecessarily providing different or
18 separate public and behavioral health services to individuals with terminal
19 disabilities; (5) limiting people with terminal disabilities in the enjoyment of rights,
20 privileges, advantage, or opportunities enjoyed by others, including the benefits of
21 public and behavioral health services; and (6) using criteria or methods of
22 administration that have the effect of discriminating against people with terminal
23 disabilities and substantially impairing accomplishment of the objectives of these
24 public entities with respect to individuals with terminal disabilities. *See* 28
25 CFR §§ 35.130(b)(1)(i)-(iv), (1)(vii), (3)(i), (3)(ii).

26 173. The ADA aims “to provide a clear and comprehensive national
27 mandate for the elimination of discrimination against individuals with disabilities.”
28 42 U.S.C. § 12101(b)(1). Title II of the ADA represents Congress’ attempt to apply

1 this “clear and comprehensive national mandate” to the “services, programs, or
2 activities,” 42 U.S.C. § 12132, of “any State or local government’ and ‘any
3 department, agency, ... or other instrumentality of a State,” *United States v.*
4 *Georgia*, 546 U.S. 151, 154 (omission in original) (quoting 42 U.S.C. § 12131(1)).
5 Congress also included in Title II a provision expressly abrogating the sovereign
6 immunity of the states. *See* 42 U.S.C. § 12202. “In the ADA, Congress provided
7 [a] broad mandate” to “effectuate its sweeping purpose [to] ... forbid[]
8 discrimination against disabled individuals in major areas of public life,
9 [including] ... public services” *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 675.

10 174. EOLOA is preempted because it conflicts with federal anti-
11 discrimination law, and supplants it with a State policy permitting physician-assisted
12 suicide, in violation of the ADA. *See, e.g., Bay Area Addiction Rsch. & Treatment,*
13 *Inc. v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999); *Dare v. California*, 191 F.3d
14 1167 (9th Cir. 1999).

15 175. Plaintiffs have no adequate remedy at law, and unless the relief herein
16 is granted, Plaintiffs and their members will suffer irreparable harm in that they will
17 continue to be discriminated against and denied equal access to the program or
18 activity operated and overseen by Defendants. Consequently, Plaintiffs are entitled
19 to injunctive relief and attorneys’ fees pursuant to 42 U.S.C. §§ 12101 and 12205.

20 **SECOND CLAIM FOR RELIEF**
21 **(Rehabilitation Act, 29 U.S.C. § 794)**
22 **(Against All Defendants)**

23 176. Plaintiffs reallege and hereby incorporate by reference the allegations
24 contained in the preceding paragraphs of this Complaint.

25 177. Section 504 of the Rehabilitation Act (“Section 504”) provides that “no
26 otherwise qualified individual with a disability in the United States ... shall, solely
27 by reason of his or her disability, be excluded from the participation in, be denied
28 the benefits of, or be subjected to discrimination under any program or activity
receiving federal financial assistance.” 29 U.S.C. § 794(a). Section 504 is

1 interpreted similarly to the ADA, *see Vinson v. Thomas*, 288 F.3d 1145, 1152 n. 7
2 (9th Cir. 2002), and applies to any entity that receives federal funds.

3 178. At all times relevant to this action, Defendants are and have been
4 recipients of federal financial assistance within the meaning of the Rehabilitation
5 Act.

6 179. An “individual with a disability” is defined under the statute, in
7 pertinent part, as “an individual who has a physical or mental impairment that
8 substantially limits one or more major life activities of such individual.” 29 U.S.C.
9 § 705(20)(B) (referencing 42 U.S.C. § 12102). “Qualified” means, with respect to
10 services, a person who meets the essential eligibility requirements for the receipt of
11 such services. 28 C.F.R. § 41.32. Plaintiffs’ members include, and Plaintiffs are,
12 qualified individuals with disabilities as they have disabilities that substantially limit
13 one or more major life activities and meet the essential eligibility requirements of
14 the Act.

15 180. Plaintiffs’ constituents and/or members include, and Plaintiffs are,
16 qualified individuals with disabilities as defined in Section 504, which tracks the
17 definition in the ADA.

18 181. The United States DOJ is charged under Executive Order 12250 with
19 coordinating the implementation of Section 504. 28 C.F.R. § 41.1. Pursuant to this
20 mandate, the DOJ has issued regulations defining the forms of discrimination
21 prohibited by Section 504 which require:

22 a. In providing any aid, benefit, or service, a recipient of federal
23 financial assistance “may not ... [d]eny a qualified handicapped person the
24 opportunity to participate in or benefit from the aid, benefit or service,” “[a]fford a
25 qualified handicapped person an opportunity to participate in or benefit from the aid,
26 benefit, or service that is not equal to that afforded others,” “[p]rovide a qualified
27 handicapped person with an aid, benefit, or service that is not as effective in
28 affording equal opportunity ... as that provided to others,” “[o]therwise limit a

1 qualified handicapped person in the enjoyment of any right, privilege, advantage, or
2 opportunity enjoyed by others,” or “provide different or separate aids, benefits, or
3 services to individuals with disabilities or to any class of individuals with disabilities
4 than is provided to others unless such action is necessary to provide qualified
5 individuals with disabilities with aids, benefits, or services that are as effective as
6 those provided to others.” 45 C.F.R. § 84.4(b)(i)(iv), (vii).

7 182. Defendants the State of California and Governor Newsom are
8 responsible for enacting, executing, and overseeing the enforcement and
9 implementation of the laws of the State, including EOLOA, and in so doing, violate
10 Section 504 by: (1) denying people with terminal disabilities the opportunity to
11 benefit from the State’s laws and public services; (2) providing an opportunity to
12 people with terminal disabilities to benefit from State’s laws and public services that
13 is not equal to that afforded to others; (3) providing the benefit of the State’s laws
14 and public services to people with terminal disabilities that is not as effective in
15 affording equal opportunity to obtain the same result or benefit as that provided to
16 other people; (4) unnecessarily providing a different or separate benefit of the
17 State’s laws and public services to individuals with terminal disabilities; (5) limiting
18 people with terminal disabilities in the enjoyment of rights, privileges, advantage, or
19 opportunities enjoyed by others; and (6) using criteria or methods of administration
20 that have the effect of discriminating against people with terminal disabilities and
21 substantially impairing accomplishment of the objectives of these public entities
22 with respect to individuals with terminal disabilities. *See* 45 C.F.R. § 84.4(b)(1)(i)-
23 (iv), (b)(1)(vii), (b)(4).

24 183. Defendants MBC, Lawson, Attorney General Bonta, the DA’s Office,
25 and District Attorney Gascón are responsible for enforcing the laws of the State,
26 including criminal laws and certain civil laws protecting older people and those with
27 disabilities, and suicidal people, but fail to discharge their duties to enforce these
28 laws pursuant to EOLOA. In so doing, they violate Section 504 by: (1) denying

1 people with terminal disabilities the opportunity to benefit from enforcement of
2 criminal and certain civil laws; (2) providing an opportunity to people with terminal
3 disabilities to benefit from enforcement of criminal and certain civil laws that is not
4 equal to that afforded to others; (3) providing a benefit of enforcement of criminal
5 and certain civil laws to people with terminal disabilities that is not as effective in
6 affording equal opportunity to obtain the same result or benefit as that provided to
7 others; (4) unnecessarily providing a different or separate benefit of enforcement of
8 criminal and certain civil laws to individuals with terminal disabilities; (5) limiting
9 people with terminal disabilities in the enjoyment of rights, privileges, advantage, or
10 opportunities enjoyed by others, including the benefit of enforcement of criminal
11 and certain civil laws; and (6) using criteria or methods of administration that have
12 the effect of discriminating against people with terminal disabilities and
13 substantially impairing accomplishment of the objectives of these public entities
14 with respect to individuals with terminal disabilities. *See* 45 C.F.R. § 84.4(b)(1)(i)-
15 (iv), (b)(1)(vii), (b)(4).

16 184. Defendants CDPH, CDHCS, MHSOAC, Aragón, Baass, and Madrigal-
17 Weiss are responsible for implementing and administering suicide prevention
18 programs and EOLOA. In so doing, they violate Section 504 by: (1) denying
19 people with terminal disabilities the opportunity to participate in or benefit from
20 public and behavioral health services; (2) providing an opportunity to people with
21 terminal disabilities to participate in or benefit from public and behavioral health
22 services that is not equal to that afforded to others; (3) providing public and
23 behavioral health services to people with terminal disabilities that are not as
24 effective in affording equal opportunity to obtain the same result or benefit as that
25 provided to others; (4) unnecessarily providing different or separate public and
26 behavioral health services to individuals with terminal disabilities; (5) limiting
27 people with terminal disabilities in the enjoyment of rights, privileges, advantage, or
28 opportunities enjoyed by others, including the benefits of public and behavioral

1 health services; and (6) using criteria or methods of administration that have the
2 effect of discriminating against people with terminal disabilities and substantially
3 impairing accomplishment of the objectives of these public entities with respect to
4 individuals with terminal disabilities. *See* 45 C.F.R. § 84.4(b)(1)(i)-(iv), (b)(1)(vii),
5 (b)(4).

6 185. EOLOA is preempted because it conflicts with federal anti-
7 discrimination law, and supplants it with a State policy permitting physician-assisted
8 suicide, in violation of Section 504. *Cf. Barber ex rel. Barber v. Colorado Dep't of*
9 *Revenue*, 562 F.3d 1222, 1234 (10th Cir. 2009) (“the demands of the federal
10 Rehabilitation Act do not yield to state laws that discriminate against the disabled; it
11 works the other way around”) (Gorsuch, J., concurring).

12 186. Plaintiffs have no adequate remedy at law, and unless the relief herein
13 is granted, Plaintiffs and their members will suffer irreparable harm in that they will
14 continue to be discriminated against and denied equal access to the program or
15 activity operated and overseen by Defendants. Consequently, Plaintiffs are entitled
16 to injunctive relief and attorneys’ fees pursuant to 29 U.S.C. § 794(a).

17 **THIRD CLAIM FOR RELIEF**
18 **(14th Amendment Equal Protection, 42 U.S.C. § 1983)**
19 **(Against Defendants Governor Newsom, Attorney General Bonta, Aragón,**
20 **Baass, Lawson, Madrigal-Weiss, and District Attorney Gascón, in their**
21 **Official Capacities)**

22 187. Plaintiffs reallege and hereby incorporate by reference the allegations
23 contained in the preceding paragraphs of this Complaint.

24 188. The Equal Protection Clause of the Fourteenth Amendment provides
25 that no State may deny any person within its jurisdiction the equal protection of the
26 laws.

27 189. It is a fundamental, long-standing principle that the government has
28 important, legitimate, fundamental, and compelling interests in preventing suicide.
In addition the “unqualified interest in the preservation of life,” the U.S. Supreme
Court has identified four additional and related State interests in the context of

1 assisted suicide.¹⁸⁴ First, “the State has an interest in preventing suicide and in
2 studying, identifying, and treating its causes.”¹⁸⁵ Second, the State “has an interest in
3 protecting the integrity and ethics of the medical profession.”¹⁸⁶ Third, the State
4 “has an interest in protecting vulnerable groups—including the poor, the elderly,
5 and disabled persons—from abuse, neglect, and mistakes,” recognizing “the real
6 risk of subtle coercion and undue influence in end-of-life situations.”¹⁸⁷ This
7 interest “goes beyond protecting the vulnerable from coercion; it extends to
8 protecting disabled and terminally ill people from prejudice, negative and inaccurate
9 stereotypes, and “societal indifference.”¹⁸⁸ Finally, the State has an interest in
10 avoiding opening the door to “voluntary and perhaps even involuntary
11 euthanasia.”¹⁸⁹

12 190. Plaintiffs’ constituents and/or members include, and Plaintiffs are,
13 individuals with disabilities who are likely to die at some future time if they cease or
14 fail to receive treatment or care necessary to the operation of major bodily functions,
15 and therefore, are likely to be diagnosed by physicians as having a “terminal
16 disease” under EOLOA.

17 191. EOLOA facially and intentionally discriminates on the basis of
18 physical health, denying protections and safeguards to those diagnosed with a
19 “terminally disease,” all of whom are persons with disabilities, without any rational
20

21 ¹⁸⁴ *Glucksberg*, 521 U.S. at 728 (finding no constitutional right to assisted suicide).

22 ¹⁸⁵ *Id.* at 730.

23 ¹⁸⁶ *Id.* at 731 (citing American Medical Association, Code of Ethics § 2.211 (1994)
24 (“[p]hysician-assisted suicide is fundamentally incompatible with the physician’s
25 role as healer.”); Council on Ethical and Judicial Affairs, Decisions Near the End of
Life, 267 JAMA 2229, 2233 (1992) (“[T]he societal risks of involving physicians in
medical interventions to cause patients’ deaths is too great”).

26 ¹⁸⁷ *Glucksberg*, 521 U.S. at 731-32.

27 ¹⁸⁸ *Id.* at 732.

28 ¹⁸⁹ *Id.*

1 basis. The Act undermines and interferes with the State’s interest in suicide
2 prevention by sanctioning the act of helping someone else kill themselves based on
3 the perceived nature and duration of their physical health and disability. By singling
4 out only people with terminal disabilities for State-sanctioned assisted suicide, the
5 Act sends a powerful message that their decision to die is the right choice and not
6 worthy of the resources devoted to preserve all other lives. In doing so, the Act
7 draws an irrational distinction based on physical health and certain terminal
8 disabilities, is both over and under-inclusive by allowing certain individuals to
9 choose assisted suicide while denying that choice to others, and does not advance or
10 otherwise further legitimate governmental interests. There is no compelling or even
11 rational basis to treat the lives of people with terminal diseases any different from
12 other groups of people ineligible to participate in EOLOA who nevertheless share
13 similar concerns about losing autonomy, the loss of dignity, losing control of bodily
14 functions, becoming a burden on caregivers, pain, and/or the financial costs
15 associated with continued living.

16 192. Because EOLOA implicates a fundamental right—the right to live—the
17 discrimination perpetuated by the Act warrants a heightened level of review.

18 193. Defendant Governor Newsom is responsible for enacting, executing,
19 and overseeing the enforcement and implementation of the laws of the State,
20 including EOLOA. Defendants Lawson, Attorney General Bonta, District Attorney
21 Gascón are responsible for enforcing the laws and regulations of the State, but fail to
22 discharge their duties to enforce these laws, pursuant to EOLOA. Defendants
23 Aragón, Baass, and Madrigal-Weiss are responsible for implementing and
24 administering the State’s suicide prevention programs and EOLOA. Through their
25 actions and omissions related to EOLOA, Defendants Governor Newsom, Attorney
26 General Bonta, Aragón, Baass, Lawson, Madrigal-Weiss, and District Attorney
27 Gascón violate the Equal Protection Clause by offering protection and public
28 services to people without terminal disabilities who become suicidal, while

1 simultaneously justifying, validating, steering, and assisting the suicide of those
2 with terminal disabilities when they become suicidal. This disparate treatment,
3 which implicates the fundamental right to protection and security for the right to
4 live, perpetuates harmful bias and stereotypes about the quality of life for people
5 with terminal disabilities and the idea that their lives are less worthy of protection
6 and preservation. These constitutional violations inflict ongoing harm upon
7 Plaintiffs.

8 194. The actions and omissions of Defendants Governor Newsom, Attorney
9 General Bonta, Aragón, Baass, Lawson, Madrigal-Weiss, and District Attorney
10 Gascón violate Plaintiffs’ rights to equal protection guaranteed by the Fourteenth
11 Amendment to the United States Constitution, and these violations inflict ongoing
12 harm upon Plaintiffs.

13 **FOURTH CLAIM FOR RELIEF**
14 **(14th Amendment Due Process, 42 U.S.C. § 1983)**
15 **(Against Defendants Governor Newsom, Attorney General Bonta, Aragón,**
16 **Baass, Lawson, Madrigal-Weiss, and District Attorney Gascón, in their**
17 **Official Capacities)**

18 195. Plaintiffs reallege and hereby incorporate by reference the allegations
19 contained in the preceding paragraphs of this Complaint.

20 196. The Due Process Clause of the Fourteenth Amendment provides that no
21 State shall deprive any person of life, liberty, or property without due process of
22 law.

23 197. Plaintiffs’ constituents and/or members, and Plaintiffs themselves, have
24 a fundamental right under the Due Process Clause to protections and security for
25 their right to live, and this fundamental right cannot be waived without due process.
26 This fundamental right is grounded in the nation’s history and legal traditions,
27 which have punished or otherwise disapproved of assisting suicide and generally
28 rendered such assistance a crime. The U.S. Supreme Court recognized in
Washington v. Glucksberg, 521 U.S. 702, 732 (1997) that physician-assisted suicide
laws pose a “risk of harm [that] is greatest for the many individuals in our society

1 whose autonomy and well-being are already compromised by poverty, lack of
2 access to good medical care, advanced age, or membership in a stigmatized social
3 group.” EOLOA violates the Due Process Clause by denying the fundamental
4 interest in the preservation of life to individuals whose doctors diagnose them with
5 terminal diseases and prescribe lethal drugs on that basis. The Act depends on
6 predictions of imminency that are inherently unknowable, highly unreliable, and
7 plainly discriminatory. EOLOA deprives due process and protection from State
8 actors employing their power to steer individuals to prematurely end their lives,
9 including people with disabilities. The Act implicates the state-created danger
10 doctrine, *id.*, under which “the state may be constitutionally required to protect a
11 plaintiff that it affirmatively places in danger by acting with deliberate indifference
12 to a known or obvious danger.” *Martinez v. City of Clovis*, 943 F.3d 1260, 1271
13 (9th Cir. 2019) (internal quotations omitted). Here, Defendants Governor Newsom,
14 Attorney General Bonta, Aragón, Baass, Lawson, Madrigal-Weiss, and District
15 Attorney Gascón have been deliberately indifferent in creating and/or exposing
16 individuals with terminal disabilities to the foreseeable dangers of physician-assisted
17 suicide that otherwise would have not existed but for their enforcement,
18 implementation, and administration of EOLOA.

19 198. The Act also violates the Due Process Clause, as elucidated by U.S.
20 Supreme Court in *Glucksberg*, by lacking sufficient safeguards to ensure that an
21 individual’s waiver of their fundamental right to live is made with adequate due
22 process. EOLOA’s failure to require that people meaningfully consider, exhaust,
23 and/or knowingly reject less restrictive alternatives to assisted suicide, including
24 suicide prevention services, medical and nursing support services, hospice care, and
25 other personal support services currently provided by California violates the Due
26 Process Clause of the Fourteen Amendment.

27 199. Defendant Governor Newsom is responsible for enacting, executing,
28 and overseeing the enforcement and implementation of the laws of the State,

1 including EOLOA. Defendants Lawson, Attorney General Bonta, and District
2 Attorney Gascón are responsible for enforcing the laws and regulations of the State,
3 but fail to discharge their duties to enforce these laws pursuant to EOLOA.
4 Defendants Aragón, Baass, and Madrigal-Weiss are responsible for implementing
5 and administering EOLOA. By participating in these activities related to EOLOA,
6 Defendants Governor Newsom, Attorney General Bonta, Aragón, Baass, Lawson,
7 Madrigal-Weiss, and District Attorney Gascón violate the Due Process Clause.

8 200. The actions of Defendants Governor Newsom, Attorney General Bonta,
9 Aragón, Baass, Lawson, Madrigal-Weiss, and District Attorney Gascón violate
10 Plaintiffs’ rights to due process guaranteed by the Fourteenth Amendment to the
11 United States Constitution, and these violations inflict ongoing harm upon Plaintiffs.

12 **PRAYER FOR RELIEF**

13 WHEREFORE Plaintiffs pray for relief and judgment against Defendants,
14 and each of them, as follows:

- 15 1. Declaring that EOLOA violates Title II of the Americans with
- 16 Disabilities Act;
- 17 2. Declaring that EOLOA violates Section 504 of the Rehabilitation Act;
- 18 3. Declaring EOLOA unconstitutional under the Fourteenth Amendment’s
- 19 Equal Protection Clause;
- 20 4. Declaring EOLOA unconstitutional under the Fourteenth Amendment’s
- 21 Due Process Clause;
- 22 5. Preliminarily and permanently enjoining Defendants from enforcing
- 23 EOLOA; and

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1 6. Granting such other and further relief as this Court may deem just and
2 proper, including an award to Plaintiffs of the costs of this suit and reasonable
3 attorneys' fees and litigation expenses.

4
5 DATED: April 25, 2023

Respectfully submitted,

6 ROSEN BIEN GALVAN & GRUNFELD LLP

7 By: /s/ Michael W. Bien

8 Michael W. Bien

9 Attorneys for Plaintiffs
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