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Compassion & Choices

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF RIVERSIDE

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

Plaintiffs,

v.

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

Defendant,

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

Defendants/Intervenors.

Case No. RIC 1607135

Hon. Daniel A. Ottolia

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

Complaint filed: June 8, 2016

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

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I. INTEREST OF THE AMICUS CURIAE

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

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

II. ARGUMENT

A. Preliminary Injunction Standard

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

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

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

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

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

Jennifer was an advocate for medical aid in dying. In her words, "I'm doing everything I can to extend my life, but no one has the right to prolong my death." Jennifer Glass, *At Last: I Want The Last Word As To How My Story Ends*, The Huffington Post, April 27, 2017[1]; *see also* George F. Will, *Affirming A Right To Die With Dignity*, Wasington Post, August 28, 2015.[2] Mavis recalls that Jennifer wanted to die at home, surrounded by those who loved her, but that Jennifer did not want her family to watch her suffer because it would cause her family additional

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

[2] *Available at* https://www.washingtonpost.com/opinions/distinctions-in-end-of-life-decisions/2015/08/28/b34b8f6a-4ce7-11e5-902f-39e9219e574b_story.html, attached as Exhibit_2.

pain.

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

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

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

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

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

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

In addition to avoidance of prolonged and agonizing pain, terminally ill patients seek medical aid in dying because they wish to die at home, they seek to avoid loss of autonomy, loss of freedom, and the inability to enjoy the activities that made life enjoyable, and they fear future poor quality of life and inability to care for themselves. *See* Ganzini et al., *Why Oregon Patients Request Assisted Death: Family Members' Views* (2007) 23 J. Gen. Intern. Med. 154, 155[6] (reporting that "the most important reasons" for requesting physician assisted death were "wanting control of the circumstances of death; loss of dignity; wanting to die at home and concerns about loss of independence, quality of life, ability to care for self in the future."); Loggers et al., *Implementing a*

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[5] *Available at* https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf (2016), at 7 (reporting median time between ingestion and death as 25 minutes), attached as Exhibit 5.

[6] Attached as Exhibit 6.

Death with Dignity Program at a Comprehensive Cancer Center (2013) 368 New Eng. J. Med. 1417[7] ("the most common reasons for participation were loss of autonomy (97.2%), inability to engage in enjoyable activities (88.9%), and loss of dignity (75.0%).").

Still other terminally ill persons seek medical aid in dying because treatments such as palliative sedation or withdrawal of life support are not available to them. For example, some patients, such as Christie O'Donnell, are morphine-intolerant and thus cannot receive palliative sedation to avoid their suffering. *See Donorovich-Odonnell v. Harris* (2015) 241 Cal.App.4th 1118, 1125. Christie was diagnosed with stage IV adenocarcinoma—the most advanced stage—and was given a terminal diagnosis of less than six months. *Id.* The invasive tumors in her lungs had spread to other tissues and organs, metastasizing to her brain, liver, spine, and rib. *See id.* Because she could not alleviate her pain and suffering through palliative sedation due to her morphine intolerance, and because the End of Life Option Act was not available at the time, Christie took the extraordinary measure of bringing a lawsuit to win the right to receive medical aid in dying. *Donorovich-O'Donnell v. Harris*, Case No. 37-2015-00016404-CU-CR-CTL (San Diego Super. Ct. filed May 15, 2015). In *Donorovich-O'Donnell*, the Hon. Gregory Pollack recognized the need for legislative intervention, stating that "the legislature ought to be fixing the law so that the legitimate needs of terminally-ill patients and their physicians are recognized, respected and protected." *Donorovich-O'Donnell v. Harris*, July 24, 2015 Order at p. 19[8]

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

[7] Attached as Exhibit 7.
[8] Attached as Exhibit 8.

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

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

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

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

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[9] *Available at* http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/, attached as Exhibit 9.

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

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

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

The End of Life Option Act facilitates open discussion of end-of-life options between patients and physicians insofar as it exempts medical aid in dying from criminal liability under Penal Code § 401. Numerous studies in Oregon and Washington, along with a host of national surveys, link the availability of medical aid in dying as a palliative care option to more positive outcomes for end-of-life care. Patients' questions about medical aid in dying can also prompt in-depth conversations between doctors and patients about the full range of end-of-life care, including hospice, pain management, and emotional support, in addition to medical aid in dying. One study of end-of-life care concluded that "it is possible that the Oregon Death with Dignity Act has resulted in or at least reflects more open conversation and careful evaluation of end-of-life options, more appropriate palliative care training of physicians, and more effort to reduce barriers to access to hospice care and has thus increased hospice referrals and reduced potentially concerning patterns of hospice use in the state." Wang et al., *Geographic Variation of Hospice Use Patterns at the End of Life* (2015) 18 J. of Palliative Med. 771, 778[11] ; *see also* Smith et al., *Quality of Death and Dying in Patients Who Request Physician-Assisted Death* (2011) 14 J. Palliative Med. 445[12] (patients requesting life-ending prescriptions were more satisfied with their symptom control, control over surroundings, and preparedness for death than those who did not pursue prescription).

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

[11] Attached as Exhibit 11.
[12] Attached as Exhibit 12.

communications between terminally ill patients and their physicians regarding end-of-life care options and the Act's ability to facilitate such communications. In an op-ed article published in the Los Angeles Times on July 1, 2016, Dr. Nguyen stated: "Regardless of one's personal beliefs on [the End of Life Option Act], I am hopeful that it will ultimately serve an important role in beginning a critical conversation about death, dying and what it means to retain autonomy over the final days of our lives." Dr. Vincent Nguyen, *Commentary: End of Life Option Act requires rigorous physician review*, L.A. Times, July 1, 2016.[13] The End of Life Option Act allows terminally ill patients just that—the opportunity for open discussions with their physicians regarding available options for their end-of-life care. Granting a preliminary injunction will chill open discussion between terminally ill Californians and their physicians of available end-of-life options.

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

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

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

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

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

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

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

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

Plaintiffs' application rests on a foundation of speculation. They surmise that some terminally ill people might suffer from depression, that some people might not follow the law, and that the Act provides insufficient deterrents for some physicians who might be negligent or malicious. But a recent analysis of nearly two decades' worth of reported physician data in Oregon shows that the availability of medical aid in dying under that state's Death with Dignity Act has not had a negative impact on end of life care, including the availability and use of hospice and palliative care. Ganzini, *Legalised Physician-Assisted Death in Oregon* (2016) 16 QUT L. Rev. 76, 79.[14] Medical aid in dying has been "rarely chosen by terminally ill patients" in Oregon, in part because the requirements under the Oregon statute "require planning and foresight" on the part of patients.[15] *Id.* In short, none of the Oregon opponents' public policy fears came true.

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

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[14] Attached as Exhibit 14.

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

dependence on others, and to die at home. *See* Ganzini et al., *supra*, at 155[16]; Ganzini, *supra*, at 80[17]; Loggers et al., *supra*, at 1417[18]. The rate of depression in those who request medical aid in dying is not significantly higher than in terminally ill patients who do not request medical aid in dying. Ex. 14 at 83. It is simply untrue that the availability of medical aid in dying permits patients suffering from depression to hastily end their lives. *See* Pearlman et al., *Motivations for Physician-assisted Suicide* (2004) 20 J. Gen. Intern. Med. 234, 238[19] ("[P]atients considered a hastened death over prolonged periods of time and repeatedly assessed the benefits and burdens of living versus dying. None of the participants cited responding to bad news, such as the diagnosis of cancer, or a depressed mood as motivations for interest in hastened death.").

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

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

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[16] Attached as Exhibit 6.
[17] Attached as Exhibit 14.
[18] Attached as Exhibit 7.
[19] Attached as Exhibit 15.

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

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

III. CONCLUSION

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

Dated: July 18, 2016

JOHN KAPPOS
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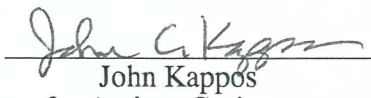
By: 
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