UNITED STATES DISTRICT COURT
DISTRICT OF NEW MEXICO

MARK LACY M.D., and **CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS**,

Plaintiffs,

v.

RAÚL TORREZ, in his official capacity as Attorney General of the State of New Mexico; **PATRICK M. ALLEN**, in his official capacity as Acting Secretary of the New Mexico Department of Health; and **KAREN CARSON, M.D., ERIC ANDERSON, M.D., STEVEN M. JENKUSKY, M.D., PETER T. BEAUDETTE, M.D., EILEEN BARRETT, M.D., MARK EDWARD UNVERSAGT, M.D., BRADLEY SCOGGINS, D.O., KRISTIN REIDY, D.O., KATHY JOHNSON, P.A.,** and **BUFFIE SAAVEDRA**, in their official capacities as members of the New Mexico Medical Board.

Defendants.

Case No. 1:22-cv-00953-MIS-KK

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

ORAL ARGUMENT REQUESTED

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INTRODUCTION[1]

This case is about an unconstitutional New Mexico law that forces health care professionals to speak with their patients about physician-assisted suicide and refer them to individuals who will bring about their demise. The law also forbids professional associations from ensuring that their members affirm medical ethics, which categorically condemns assisted suicide. This Court should protect objecting health care professionals by enjoining these provisions and declaring them unconstitutional both facially and as applied to Plaintiffs. Indeed, a court recently enjoined California's assisted-suicide law, which also compelled speech and participation by objecting health care professionals. *See Christian Med. & Dental Ass'n. v. Bonta*, Order Granting in Part Plaintiffs' Mot. for Prelim. Inj., Case No. 5:22-cv-00335-FLA-GJS, ECF No. 108 (C.D. Cal. Sept. 2, 2022) (attached as Exhibit A).

For thousands of years, medical ethics have uniformly condemned physician-assisted suicide. This commitment is embodied in the Hippocratic Oath, which requires physicians to swear: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[2] Still today, the American Medical Association (AMA) code of ethics provides that "[p]hysician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." AM. MED. ASS'N, CODE OF MED. ETHICS § 5.7, available at https://bit.ly/35gicR9. Simply put, assisted suicide is unethical.

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[1] Plaintiffs made good-faith efforts to confer with counsel for defendants by phone and e-mail. Counsel for the Attorney General indicated that they oppose this motion. Plaintiffs were not able to attain a position from counsel for the Secretary of the Department of Health or from the Medical Board Defendants.

[2] Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation*, ANCIENT MEDICINE, SELECTED PAPERS 3, 6 (Johns Hopkins Univ. Press 1967).

Consistent with millennia of medical ethics, "for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide." *Washington v. Glucksberg*, 521 U.S. 702, 711 (1997). "By the time the Fourteenth Amendment was ratified [in 1868], it was a crime in most States to assist a suicide." *Id.* at 715. And for 60 years, the State of New Mexico made it a crime for physicians to assist patients in committing suicide. N.M. STAT. ANN. § 30-2-4 (West 1963); *see Morris v. Brandenburg*, 2016-NMSC-027, ¶ 1, 376 P.3d 836 (N.M. 2016).

Despite the universal and historic condemnations of assisted suicide, in 2021, New Mexico enacted the Elizabeth Whitefield End-of-Life Options Act ("the Act"), to legalize and promote assisted suicide. *See* N.M. STAT. ANN. § 24-7C-1, *et seq.* (West 2021). The Act purports to protect physicians who object to assisted suicide for reasons of conscience, saying they will not be required to "participate." But that promise rings hollow. Strings and conditions are attached to the provisions for ethical protections, requiring objecting physicians to nonetheless facilitate suicide.

The Act compels objecting physicians to speak with terminally ill patients about the availability of assisted suicide as a "reasonable option" to consider. N.M. STAT. ANN. § 24-7C-6. It forces objecting physicians to refer their patients to physicians or organizations who are "able and willing to carry out" the patient's suicide. N.M. STAT. ANN. § 24-7C-7(C). And it prohibits professional associations from suspending, denying, or revoking membership to physicians who participate in assisted suicide, even though the practice violates their fundamental beliefs, mission, and message. *Id.* at § 24-7C-7(B). The State of New Mexico thus compels objecting health care professionals to speak a certain message about assisted suicide and forces them to provide proximate and material cooperation in an unethical and immoral act.

The Christian Medical & Dental Associations ("CMDA") is a national association of Christian health care professionals whose religious convictions and professional ethics forbid any act to facilitate or participate in assisted suicide. Plaintiff Mark Lacy, M.D. is a New Mexico physician and CMDA member who regularly treats terminally ill patients and who has been asked to assist in bringing about a patient's death, but he has not—and will not—inform patients about assisted suicide or refer his patients to others willing to facilitate it. Thus, Plaintiffs have repeatedly violated—and will continue to violate—the Act's requirements due to their religious convictions and ethical commitments. Plaintiffs respectfully ask this Court to enjoin these provisions of the Act and declare them unconstitutional, facially and as applied to Plaintiffs.

STATEMENT OF FACTS[3]

Plaintiffs' Religious and Ethical Beliefs

Christian Medical & Dental Associations ("CMDA") is a national nonprofit professional organization with over 13,000 Christian physicians and health care professional members. Verified Complaint ¶ 18, ECF No. 1 ("VC"). Dr. Mark Lacy, M.D. is a CMDA member and full-time licensed medical doctor who specializes in internal medicine, infectious diseases, and pediatrics at Christus St. Vincent's Regional Medical Center in Sante Fe, New Mexico. *Id.* ¶¶ 33-34.

For all CMDA members, including Dr. Lacy, their practice of health care is founded on, compelled by, and central to, their Christian religious beliefs. *Id.* ¶¶ 21, 36-37. CMDA members have chosen careers as health care providers, in part, because their Christian beliefs instruct that they care for and help others. *Id.* CMDA members also believe that human life is a gift from God and is sacred because it bears God's

[3] Facts in this brief are in the Verified Complaint unless otherwise indicated.

image; that it has worth because Jesus Christ redeemed it; and that it has meaning because God has an eternal purpose for it. *Id.* ¶ 22. Because of these beliefs, CMDA members oppose facilitating physician-assisted suicide in any way, and oppose any intervention with the intent to produce death whether for the relief of pain and suffering, economic considerations, or for the convenience of the patient, family, or society. *Id.* ¶¶ 24-25.

CMDA members like Dr. Lacy live out their Christian beliefs—including their belief about the sanctity of life—through their professions as health care providers. *Id.* ¶¶ 23, 37. CMDA, as a professional organization, also expresses this message about the sanctity of life and opposition to physician-assisted suicide to the public through its members, its position statements, and other forms of communication and advocacy. *Id.* ¶ 26. CMDA and its members have refused to inform patients about assisted suicide, and they intend to either engage in speech that discourages assisted suicide, or at a minimum to remain silent on the subject. *Id.* ¶ 91.

CMDA members believe informing patients about the availability of physician-assisted suicide and referring them to providers who will perform it constitutes complicity and material cooperation in physician-assisted suicide, facilitates the unjustified taking of life, is sinful, and therefore violates their religious beliefs. *Id.* ¶ 24. CMDA also has not expressed—and will not express—any message that facilitates or appears to condone assisted suicide. *Id.* ¶¶ 27-32. Based on their religious and ethical beliefs, CMDA members have not, cannot, and will not facilitate or participate in physician-assisted suicide in any way, including by (a) referring patients to health care providers who perform assisted suicide, (b) referring patients to a person or organization who would help find a physician willing to perform assisted suicide, or (c) providing information about assisted suicide or notice that it is legally available in New Mexico. *Id.* ¶¶ 23, 32.

New Mexico's "End of Life Options Act"

The Act took effect in 2021. It not only legalized physician-assisted suicide in the state, but also forced every licensed physician, nurse practitioner, and physician assistant to facilitate assisted suicide in material ways. *See* N.M. STAT. ANN. § 24-7C-1, *et seq*. The Act authorizes health care providers to prescribe suicide drugs to patients with a "terminal illness," defined as "a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgment, will result in death within six months." *Id.* § 24-7C-2. Patients may then take the drugs to end their life. *See id.* It has been reported that over 100 people have died by "legalized" assisted suicide since the Act was passed last year. VC ¶ 93.

Three provisions of the Act require even objecting health care providers to facilitate assisted suicide in material and proximate ways that violate Plaintiffs' religious beliefs. *First*, a health care provider "shall inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-of-life care." N.M. STAT. ANN. § 24-7C-6 (**"Informing Requirement"**). Because the Act renders assisted suicide "legally available" in New Mexico, health care providers must speak with terminally ill patients about the option of assisted suicide—regardless of whether the patient requests it and regardless of health care professionals' objections to the practice. *Id.*

Second, if a qualifying patient requests drugs to kill themselves, an objecting health care provider must not only inform the patient of their objection but must also "refer the individual to a health care provider who is able and willing to carry out the individual's request or to another individual or entity to assist the requesting individual in seeking medical aid in dying." N.M. STAT. ANN. § 24-7C-7(C). (**"Referral Requirement"**).

Third, the Act prohibits a "professional organization or association"—like CMDA—from subjecting a person to "to censure, discipline, suspension, loss or denial of license, credential, privileges or membership or other penalty . . . for participating" in assisted suicide. *Id.* § 24-7C-7(B) (**"Membership Requirement"**).

Two provisions of the Act purport to protect the conscience rights of objecting health care professionals, but both contain conditions and limitations that nonetheless require objecting professionals to facilitate the practice. One provision purports to immunize health care providers from "criminal liability, licensing sanctions or other professional disciplinary action for . . . participating, or refusing to participate, *in medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act*." *Id.* § 24-7C-7(A) (emphasis added). But that immunity narrowly applies to a refusal to participate "in medical aid in dying," *id.*, which the Act narrowly defines as the "practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to bring about . . . death." *Id.* § 24-7C-2(E). And even that immunity is limited to individuals whose refusal to participate nonetheless remains "in good faith compliance" with other the provisions of the Act, including its Informing, Referral, and Membership Requirements. *Id.* § 24-7C-7(A).

Another provision of the Act states that "[n]o health care provider who objects for reasons of conscience to participating *in the provision of medical aid in dying* shall be required to participate *in the provisi*on *of medical aid in dying* under any circumstance." *Id.* § 2-7C-7(C) (emphasis added). But again, this protection is limited to those who refuse to directly "provi[de]" and prescribe suicide drugs, *id.* § 2-7C-2(E) (defining "medical aid in dying") and does not protect health care professionals who cannot instruct their patients to consider assisted suicide, much less refer them to others willing to cooperate in ending the patient's life. *Id.* § 2-7C-7(C).

Notably, the Act also states that "[p]articipating in medical aid in dying shall not be the basis for a report of unprofessional conduct," without providing a similar assurance for those who refuse to participate. *Id.* § 24-7C-7(H). As such, the Act requires advertisement and referral for assisted suicide.

The Act's Effects on Plaintiffs

CMDA members, including Dr. Lacy, routinely treat terminally ill patients. VC ¶¶ 39-44, 97. The Referral and Informing Requirements thus compel them to speak with their terminally ill patients about the availability and possibility of assisted suicide as a "reasonable option" to consider, *and* to refer patients who request it to a physician who is "able and willing to carry out" the practice, even though doing so makes Plaintiffs complicit in the death and violates their sincerely held religious beliefs, professional oath, ethics, and duties. *Id.* ¶¶ 78–79. And because the Informing Requirement forces physicians to discuss assisted suicide in the first place, such conversations make it all the more likely that a patient will request that a CMDA member facilitate assisted suicide. Moreover, the Membership Requirement prevents CMDA from suspending, denying, or revoking membership to physicians who participate in assisted suicide, even though the practice violates its fundamental beliefs, and undermines its mission and message.

CMDA members like Dr. Lacy have treated and advised many terminally ill patients since the Act took effect, but they have not—and will not—speak with them about the possibility and availability of assisted suicide. *Id.* ¶ 40. They also have not referred—and will not refer—patients to others who are able and willing to provide assisted suicide. *Id.* ¶¶ 27, 38, 109. Thus, Plaintiffs have repeatedly violated the Act and concretely plan to continue violating with these Requirements in their regular interactions with terminally ill patients. Because Plaintiffs have not and cannot comply with the Act, Plaintiffs are not in "good faith compliance" with the law, and

therefore, the Act does not immunize Plaintiffs from liability and discipline under § 24-7C-7(A). And because Plaintiffs refuse to facilitate assisted suicide in any way—not merely refusing to prescribe suicide drugs—their refusal is not protected under either § 24-7C-7(A) or (C). As such, CMDA members face civil, administrative, and professional liability, including revocation or suspension of their medical licenses, fine, censure, and reprimands and other enforcement action for violating the Act. *See, e.g.*, N.M. STAT. ANN § 61-6-15, § 9-7-6 (West 2022).

Plaintiffs would rather stop practicing medicine than violate their consciences and facilitate assisted suicide. VC ¶¶ 30, 47. The Act puts them precisely to that impossible choice: (a) violate their religious convictions to speak the State's message on, and facilitate, assisted suicide; or (b) violate the Act and either cease the practice of medicine or face discipline and penalty. The Act's compelled speech, burden on religion, and unequal treatment is unconstitutional and should be enjoined.

LEGAL STANDARD

A preliminary injunction is appropriate when the movant shows: (1) a likelihood of success on the merits; (2) a likely threat of irreparable harm in the absence of injunctive relief; (3) the movant's alleged harm outweighs any harm to the non-moving party; and (4) the injunction will be in the public interest. *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1128 (10th Cir. 2013), *aff'd sub nom. Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014). In constitutional cases, "the likelihood of success on the merits will often be the determinative factor." *Id.* at 1145 (citing *ACLU of Ill. v. Alvarez*, 679 F.3d 583, 589 (7th Cir. 2012)). "That is because: [1] the loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury . . . ; [2] when a law . . . is likely unconstitutional, the interests of those the government represents, such as voters, do not outweigh a plaintiff's interest in having its constitutional rights protected; and

[3] it is always in the public interest to prevent the violation of a party's constitutional rights." *Id.* (cleaned up).

ARGUMENT

The law has long recognized that health care professionals must be protected from forced participation in acts that violate their religious and ethical principles. Respect for medical professionals' conscientious objections to taking human life has been specifically recognized by the U.S. Supreme Court, including in *Roe v. Wade*. There the Supreme Court quoted the AMA House of Delegates resolution that, "no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles." 410 U.S. 113, 143 n. 38 (1973), *overruled on other grounds*, *Dobbs v. Jackson Women's Health Org.*, 213 L. Ed. 2d 545, 142 S. Ct. 2228 (2022).

When the U.S. Supreme Court considered whether there is a "fundamental right" to physician-assisted suicide in *Washington v. Glucksberg*, it agreed with the AMA that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." 521 U.S. 702, 731 (1997) (quoting AM. MED. ASS'N, CODE OF MED. ETHICS § 2.211 (1994)). Consistent with these principles, the "Church Amendments" (42 U.S.C. §§ 300a-7(b)–(e)), the Weldon Amendment (Sec. 507(d) of Title V of Division H of the Consolidated Appropriations Act, 2016 Pub. L. No. 114-113), and the Affordable Care Act (42 U.S.C. §§ 18023(b)(4), 18113(a)), have all included provisions protecting medical rights of conscience.

The Act pays lip service to medical professionals' rights of conscience while simultaneously forcing them to advertise, discuss and facilitate assisted suicide. The law's conscience protections narrowly apply to refusals to directly prescribe and

provide suicide drugs; and even then, the protections only apply if doctors otherwise counsel and refer in favor of assisted suicide. This overreach is unconstitutional, and a preliminary injunction is necessary to protect health care professionals like Plaintiffs, whose religious beliefs require them to regularly violate the Act.

I. Plaintiffs are likely to succeed on the merits of their claims.

The Act is unconstitutional for at least five distinct reasons. First, the Act's Referral and Informing Requirements violate the Free Speech Clause by compelling physicians to speak the government's message on assisted suicide regardless of religious and ethical objections. Second, the Referral and Informing Requirements violate the Free Exercise Clause by forcing objecting physicians to choose between violating the law or providing material and proximate support for a practice that violates their religious beliefs. Third, the Act violates the Due Process Clause because it contains multiple ambiguous terms and phrases that fail to adequately inform physicians what conduct is proscribed. Fourth, the Act violates the Equal Protection Clause by treating physicians who are willing to facilitate assisted suicide more favorably than physicians who cannot. And fifth, the Act violates the First Amendment expressive association rights of CMDA by prohibiting professional associations from making membership decisions necessary to ensure that their mission and message is not undermined.

A. The Act violates the Free Speech Clause.

1. The Act triggers strict scrutiny because it compels health care providers to speak the State's message on assisted suicide in violation of the Free Speech Clause.

"Since all speech inherently involves choices of what to say and what to leave unsaid . . . one important manifestation of the principle of free speech is that one who chooses to speak may also decide what *not to say*." *Hurley v. Irish-Am. Gay, Lesbian*

& Bisexual Grp. of Bos., 515 U.S. 557, 573 (1995) (emphasis added) (cleaned up); *see Riley v. Nat'l Fed'n of the Blind of N.C., Inc.*, 487 U.S. 781, 797 (1988). Indeed, a law that compels individuals to speak a particular message "alters the content of [their] speech." *Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2371 (2018) ("*NIFLA*") (quoting *Riley*, 487 U.S. at 795). As such, laws compelling speech on particular topics constitute content-based regulations, which "are presumptively unconstitutional and may be justified only if the government proves that they are narrowly tailored to serve compelling state interests." *Id.* (quoting *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015)). This stringent standard reflects the fundamental principle that governments have "no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Id.* (cleaned up).

For these reasons, it is axiomatic that the government cannot compel an individual to speak a message that he otherwise would not. *NIFLA*, 138 S. Ct. at 2371 (state could not compel pro-life pregnancy centers to tell clients about the availability of abortion and where to obtain it); *Wooley v. Maynard*, 430 U.S. 705, 714 (1977) (state could not compel residents to display state motto on license plates); *Miami Herald Publ'g Co. v. Tornillo*, 418 U.S. 241, 256 (1974) (state could not compel newspaper to print an editorial reply); *Riley*, 487 U.S. at 796–801 (state could not compel fundraisers to disclose to potential donors financial statistics). Laws that compel speech trigger and almost always fail strict scrutiny.

Both the Referral and Informing Requirements trigger strict scrutiny because they compel Plaintiffs' speech and thus modify and restrict the content of the messages they wish to convey. *See CMDA v. Bonta*, Ex. A at 18–22. To begin, the Informing Requirement expressly compels a physician speak to "inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-

of-life care." N.M. STAT. ANN. § 24-7C-6 (emphasis added). Because the Act made assisted suicide "legally available to terminally ill patients" in New Mexico, health care providers must speak with terminal patients about the possibility and availability of assisted suicide. The law requires health care providers to convey a message that presents assisted suicide as a "reasonable option" that patients should consider. *Id.* The law also compels them to advance a message that assisted suicide "meet[s] the medical standards of care for end-of-life care." *Id.* And the title of this statute ("Medical aid in dying; right to know") reveals that the law is not focused on generalized discussions of medical options, but places special emphasis on ensuring that physicians' conversations specifically include a message that assisted suicide is possible, available, meets medical standards of care, and is among the patient's "reasonable options." *See id.*

Similarly, the Referral Requirement provides that "[i]f a health care provider is unable or unwilling to carry out an individual's request pursuant to the End-of-Life Options Act, that health care provider shall so inform the individual and refer the individual to a health care provider who is able and willing to carry out the individual's request or to another individual or entity to assist the requesting individual in seeking medical aid in dying." N.M. STAT. ANN. § 24-7C-7. Thus, the Referral Requirement forces objecting health care providers to speak in order to refer patients to another provider or organization who is "able and willing to carry out" the assisted-suicide request. *Id.* § 24-7C-7(C). Put bluntly, when a person asks how and where they can obtain an instrument to intentionally kill a human person (in this case, themselves), the Referral Requirement requires Plaintiffs to engage in affirmative speech to make the fatal connection.

By compelling Plaintiffs to speak in these ways, the Informing and Referral Requirements modify and restrict the message that they wish to convey. Plaintiffs

believe that notifying their terminal patients about the option of assisted suicide and referring those patients to physicians who will perform assisted suicide to be complicity in an act that is unethical and gravely sinful. VC ¶¶ 13, 28. Plaintiffs strenuously disagree that assisted suicide meets the relevant standards of care or that it is an appropriate—much less "reasonable"—option in response to illness or injury. VC ¶ 91. As such, Plaintiffs wish to engage in speech that discourages assisted suicide or to remain silent on the subject. *Id.* So their intended message is to *not* to inform their patients about assisted suicide and *not* to refer their patients to other physicians or organizations who will bring about the patient's death. *Id.* ¶¶ 94–95. The Act triggers strict scrutiny because it requires Plaintiffs to express the State's opposite message. And as explained in Section I.F. below, the Act fails strict scrutiny.

2. Plaintiffs' speech is entitled to full protection.

The First Amendment's speech protections apply with full force to health care professionals like Plaintiffs. *See CMDA v. Bonta*, Ex. A at 19–20. The Supreme Court has rejected the view that "professional speech" is a distinct category of speech and has clarified that "[s]peech is not unprotected merely because it is uttered by 'professionals.'" *NIFLA*, 138 S. Ct. at 2371–72. In fact, the Supreme Court has specifically expressed concern over "the danger of content-based regulations 'in the fields of medicine and public health, where information can save lives.'" *Id.* at 2374. "Doctors help patients make deeply personal decisions, and their candor is crucial." *Id.* Particularly relevant here, the Supreme Court recognized that "[p]rofessionals might have a host of good-faith disagreements, both with each other and with the government," including disagreements "about the ethics of assisted suicide." *Id.*

Courts may afford less protection for professional speech in only two narrow circumstances that do not apply here. *Id.* at 2372. First, "more deferential review" may apply to "laws that require professionals to disclose factual, *noncontroversial*

information in their '*commercial speech*.'" *Id.* (emphasis added). But information regarding the availability, reasonability, and referral sources for assisted suicide is anything but noncontroversial. *Id.* at 2375; *Glucksberg*, 521 U.S. at 711. And Plaintiffs' *refusal* to participate in assisted suicide does not constitute commercial speech discussing "the terms under which [the physicians'] services will be available." *Zauderer v. Off. of Disciplinary Couns. of Sup. Ct. of Ohio*, 471 U.S. 626, 651 (1985); *see NIFLA*, 138 S. Ct. 2366 (holding that compelled notice of abortion availability by pro-life pregnancy center was not noncontroversial commercial speech). Thus, the first circumstance does not apply.

Second, "States may regulate professional conduct, even though that conduct incidentally involves speech." *NIFLA*, 138 S. Ct. at 2372. But the Informing and Referral Requirements do not regulate mere conduct like the provision of informed consent. Indeed, the Requirements "do[ ] not facilitate informed consent to a medical procedure." *Id.* at 2373. This is because these the Act forces health care providers to inform every terminally ill patient about assisted suicide regardless of whether such an option is sought by the patient or offered by the provider. *Id.*; *see CMDA v. Bonta*, Ex. A at 19–20 (explaining that speech about assisted suicide under California's "End of Life Options" law was not mere professional speech regarding informed consent).

As the United States District Court for the Central District of California rightly recognized, the State cannot justify compelling physicians' speech about assisted suicide by urging diminished protections for professional speech. *CMDA v. Bonta*, Ex. A at 19–20 (citing *NIFLA*). Accordingly, Plaintiffs' speech rights—including their right *not* to speak—are entitled to full protection.

B. The Act violates the Free Exercise Clause.

"The Free Exercise Clause of the First Amendment, applicable to the States under the Fourteenth Amendment, provides that 'Congress shall make no law . . .

prohibiting the free exercise of religion.'" *Fulton v. City of Phila., Penn.*, 141 S. Ct. 1868, 1876 (2021). The Free Exercise Clause does not merely protect an individual's right to private, mental belief. Indeed, the Supreme Court has recognized that "the 'exercise of religion' often involves not only belief and profession but the performance of (or abstention from) physical acts." *Emp. Div. Dep't of Hum. Res. of Or. v. Smith*, 494 U.S. 872, 877 (1990).

1. The Act triggers strict scrutiny because it burdens religious exercise while infringing hybrid speech rights.

Generally speaking, laws that burden religious exercise should be subjected to strict scrutiny. *Swanson v. Guthrie Indep. Sch. Dist. No. I-L*, 135 F.3d 694, 697 (10th Cir. 1998) (citing *Sherbert v. Verner*, 374 U.S. 398, 402–03 (1963)). In *Smith*, the Supreme Court held that laws incidentally burdening religion need not satisfy strict scrutiny if they are neutral and generally applicable. *Id.*; *Smith*, 494 U.S. 877–78. However, "the Supreme Court noted the difference between cases solely involving the Free Exercise Clause and those implicating other constitutional protections . . . ." *Swanson*, 135 F.3d at 699. The Court recognized that reduced scrutiny does not apply when a plaintiff asserts a "hybrid situation" involving "the Free Exercise Clause in conjunction with other constitutional protections, such as freedom of speech . . . ." *Smith*, 494 U.S. at 881.

This Circuit has recognized the hybrid-rights exception discussed in *Smith*. *Axson-Flynn v. Johnson*, 356 F.3d 1277, 1295 (10th Cir. 2004) (citing *Swanson*, 135 F.3d at 699). The hybrid-rights exception applies when a plaintiff asserts a free-exercise claim along with a companion constitutional claim and makes "a colorable showing of infringement of recognized and specific constitutional rights." *Swanson*, 135 F.3d at 700. The companion constitutional claim is "colorable" if the plaintiff shows "a fair probability or likelihood, but not a certitude, of success on the merits." *Axson-Flynn*, 356 F.3d at 1297.

The hybrid-rights exception applies and triggers strict scrutiny. Plaintiffs have alleged that religious exercise is integral to their practice of health care and that it would violate their religious convictions to inform patients about assisted suicide or to refer them to individuals who will bring about their death. VC ¶¶ 21–28, 36–38, 85–86. The Informing and Referral Requirements plainly burden Plaintiffs' religious exercise by forcing them to choose between violating the law or engaging in speech that is directly opposed to their religious convictions. *See Fulton*, 141 S. Ct. at 1875. And as explained in Section I.A., Plaintiffs have shown at least a fair probability or likelihood that they will succeed on the merits of their free-speech claim. Indeed, Plaintiff CMDA asserted a similar free-speech claim and succeeded in obtaining a preliminary injunction on California's End of Life Option Act, which imposes even fewer obligations on objecting physicians. *See CMDA v. Bonta*, Ex. A at 18–22.

2. The Act is not neutral and generally applicable.

The hybrid-rights exception to *Smith* applies, but in any event, the Act triggers strict scrutiny because it is neither neutral nor generally applicable. "A law is not generally applicable if it invites the government to consider the particular reasons for a person's conduct by providing a mechanism for individualized exemptions." *Fulton*, 141 S. Ct. at 1877 (cleaned up); *see also Axson-Flynn,* 356 F.3d at 1297–99 (explaining that a law is not generally applicable when the government allows individualized exemptions through "subjective" "ad hoc discretionary decisions") (cleaned up).

The Act purports to immunize physicians from "criminal liability, licensing sanctions or other professional disciplinary action" for either "participating, or refusing to participate, in medical aid in dying . . . ." N.M. STAT. ANN. § 24-7C-7. But because the Act narrowly defines "medical aid in dying" to mean the act of prescribing suicide drugs, § 24-7C-2(E), this provision does nothing to protect those who cannot

advertise or refer for assisted suicide. Indeed, health care professionals can only invoke this protection if they are "in good faith compliance with the provisions of the" Act. N.M. STAT. ANN. § 24-7C-7. But the Act fails to explain what "good faith compliance" requires. This provision thus creates a mechanism for individualized exemptions: to determine whether the immunity in § 24-7C-7(A) applies, Defendants must exercise unbridled discretion and decide whether a physician's actions under the Act are "in good faith compliance" with the other provisions of the Act. And apart from deciding good faith compliance, Defendants have broad discretion to penalize for violating the Act on a case-by-case basis. *See e.g.*, N.M. STAT. ANN. § 61-6-15 (giving the Medical Board broad discretion to impose disciplinary action, including the ability to reduce punishment to only probation "for good cause shown"). Because the immunity provision "invites the government to decide which reasons for not complying with the [Act] are worthy of solicitude," the Act is not generally applicable. *Fulton*, 141 S. Ct. at 1879.

The Act is also not neutral or generally applicable because it immunizes physicians who are willing to be complicit in physician-assisted suicide in *some* way—whether informing patients about assisted suicide or referring patients to a provider who will prescribe suicide drugs—but it does not exempt from penalty physicians who refuse to be complicit in assisted suicide in *any* way. For example, the Act ensures that "[p]articipating in medical aid in dying shall not be the basis for a report of unprofessional conduct," without providing a similar assurance for those who refuse to participate. N.M. STAT. ANN. § 24-7C-7(H). And because the Act's protections only apply to refusals to actually prescribe suicide drugs, *id.* §§ 24-7C-7(A) & (C), 24-7C-2(E), and only when physicians otherwise comply with the Informing and Referral Requirements, *id.* § 24-7C-7(A), the Act provides material protection for physicians

who are willing to counsel and refer for suicide while denying the same protection to religious objectors like Plaintiffs.

The Act thus treats those who refuse to comply worse than those who only refuse to prescribe suicide drugs. *See Tandon v. Newsom,* 141 S. Ct. 1294, 1296 (2021) (holding that "government regulations are not neutral and generally applicable, and therefore trigger strict scrutiny under the Free Exercise Clause, whenever they treat *any* comparable secular activity more favorably than religious exercise"). Refusing to comply with *some* provisions and refusing to comply with *all* provisions are comparable activities because any claimed government interest—such as in removing obstructions to assisted suicide—would be hindered by both types of refusal, yet only the former (refusing to comply with *some* provisions) is immune from liability and professional discipline. *See id.* Such a "subtle departure[ ] from neutrality" triggers strict scrutiny. *Church of the Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 534 (1993).

C. The Act violates the Due Process Clause.

The Due Process Clause's "void-for-vagueness doctrine . . . guarantees that ordinary people have fair notice of the conduct a statute proscribes." *Sessions v. Dimaya*, 138 S. Ct. 1204, 1212 (2018). "A statute is unconstitutionally vague for one of two reasons: it either fails to provide people of ordinary intelligence a reasonable opportunity to understand what conduct it prohibits; or it authorizes or even encourages arbitrary and discriminatory enforcement." *Dr. John's, Inc. v. City of Roy,* 465 F.3d 1150, 1158 (10th Cir. 2006) (cleaned up). Vague and ambiguous terms are especially harmful in the "First Amendment context," because they will cause "citizens [to] steer far wider of the unlawful zone than if the boundaries of the forbidden areas were clearly marked." *Id.* (citations omitted).

The Act contains multiple terms that are unconstitutionally vague. To begin, "terminal illness" is defined as "a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgment, will result in death within six months." N.M. STAT. ANN. § 24-7C-2(J). But no reasonable health care professional in Plaintiffs' shoes can know whether a disease or condition is in fact "incurable and irreversible" or whether death will result in six months. VC ¶¶ 142–144. Nor can a reasonable physician know whether this definition means *with* treatment or *without* treatment. *Id.* ¶ 143. For instance, a national study of live discharges from hospices in 2010 found that about 1 in 5 hospice patients were discharged alive. Joan M. Teno, et al., *A National Study of Live Discharges from Hospice*, J. OF PALLIATIVE MED. (October 2014), https://bit.ly/3LP57z1. Physicians have differing beliefs about end-of-life care, and whether it is *reasonable* to conclude death will likely result would greatly depend on the physician's own medical judgment. *NIFLA*, 138 S. Ct. at 2371–72. Because the Act leaves physicians making a "best-guess" as to who has a terminal illness, it is unconstitutionally vague.

Another critical term, "participating," is repeatedly used in the Act but is not defined. A reasonable health care professional could not understand how one must "participate" in physician-assisted suicide and how far refusing to "participate" is lawful under the Act. For example, physicians are not required to "participate in the provision of medical aid in dying," but are still required to inform patients and refer them to willing physicians. N.M. STAT. ANN. § 24-7C-7. Whether the latter crosses the line from "participation" to "refusing to participate"—or something in between—is unclear, potentially subjecting physicians to liability and penalty for not complying "in good faith" with the Act.

Similarly, "in good faith compliance with the provisions" of the Act is undefined. A reasonable physician thus has no way to understand what is required

to invoke the immunity afforded by § 24-7C-7(A). The "good faith provision" also "authorizes . . . arbitrary and discriminatory enforcement," *Dr. John's*, 465 F.3d at 1158, as discussed above, *supra* § I.B.2.

Finally, no reasonable health care professional in Plaintiffs' position could understand the meaning of the Informing Requirement: to "inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-of-life care." § 24-7C-6. What is a "reasonable option"? What is "related to the patient's care"? What is "the medical standard[ ] of care for end-of-life care"? The answers depend on the medical expertise of the treating physician, and these undefined terms grant unbridled discretion to the government. The Act violates the Due Process Clause.

D. The Act violates the Equal Protection Clause.

The Act also violates the Equal Protection Clause because it offers greater protection to, and distinguishes among, similarly situated groups based on fundamental rights. *See Clark v. Jeter,* 486 U.S. 456, 461 (1988). The Act creates two classes of physicians with respect to their religious beliefs: (1) physicians who hold conscientious objections to *performing* assisted suicide but not to informing patients about, and referring them to obtain, assisted suicide; and (2) physicians who object to participating in assisted suicide in *any* way (*e.g.*, Plaintiffs and similar physicians). Yet only the former is immune under § 24-7C-7(A) & (C), while the latter remains subject to liability and penalty. Because the Act creates these two classes based on physicians' fundamental rights—*i.e.,* their conscientious objections based on *beliefs* (religious freedom) and *viewpoint* (free speech)—but treats them dissimilarly, the law triggers strict scrutiny. *See Ashaheed v. Currington*, 7 F.4th 1236, 1251 (10th Cir. 2021) (religious classifications trigger strict scrutiny).

E. The Act violates CMDA's right to expressive association.

The Act's Membership Requirement violates CMDA's First Amendment right "to associate with others in pursuit of . . . political, social, economic, educational, religious, and cultural ends." *Boy Scouts of Am. v. Dale*, 530 U.S. 640, 647 (2000). This right to expressive association includes "freedom not to associate" with people who "may impair [the group's] ability" to express its views. *Id.* at 647–48. A plaintiff's expressive association rights are violated when (1) "the group engages in 'expressive association,'" and (2) "the forced inclusion" of a person "affects in a significant way the group's ability to advocate public or private viewpoints." *Id.* CMDA satisfies both.

First, CMDA "engage[s] in some form of expression." *Id.* at 648. CMDA's existence is dedicated to the collective expression and propagation of shared ethical, moral, and religious ideals, including the sanctity of human life and opposition to assisted suicide. VC ¶ 166. CMDA expresses a message that it opposes "intervention with the intent to produce death for the relief of pain, suffering, or economic considerations, or for the convenience of patient, family, or society" and "physician-assisted suicide in any form." VC ¶¶ 24-27. It is "sufficient" that CMDA "takes an official position with respect to" physician-assisted suicide. *Dale*, 530 U.S. at 655.

Second, the Membership Requirement forces inclusion and retention of members who participate in assisted suicide, which undermines and "affects in a significant way the group's ability to advocate public or private viewpoints." *Dale*, 530 U.S. at 648. The Act prohibits CMDA from suspending, denying, or revoking membership for participation in assisted suicide. § 24-7C-7(B) It thus forces CMDA to allow and retain pro-assisted-suicide members who would undermine CMDA's ability to convey its anti-assisted-suicide message. *Dale*, 530 U.S. at 650. The mere presence of members who support assisted suicide would undermine and dilute CMDA's ability to share its beliefs about the sanctity of life. *See id.* at 653 (explaining that the presence of an unwanted person would "force the organization to send a

message, both to [fellow-members] and the world" that the person's point of view is "legitimate"). This infringement also triggers strict scrutiny.

F. The Act fails strict scrutiny.

Because the Act violates Plaintiffs' constitutional rights as set forth above, it must survive strict scrutiny, the "most demanding test known to constitutional law." *City of Boerne v. Flores*, 521 U.S. 507, 534 (1997). This means the State must prove that the Act is "narrowly tailored to serve compelling state interests." *NIFLA*, 138 S. Ct. at 2371; *Fulton*, 141 S. Ct. at 1881; *Dale*, 530 U.S. at 648. "Content-based laws—those that target speech based on its communicative content—are presumptively unconstitutional." *Reed*, 576 U.S. at 163. The Act fails strict scrutiny.

A compelling interest cannot be "broadly formulated" or based on speculation. *Fulton*, 141 S. Ct. at 1881. Rather, the State must demonstrate a specific interest in forcing Plaintiffs—in particular—to deliver the State's preferred message about, and to facilitate, assisted suicide and in commandeering the membership of groups like CMDA. *See id.* The State lacks any legitimate interest—much less a compelling one—in promoting a practice that violates medical ethics, "is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." AM. MED. ASS'N, CODE OF MED. ETHICS § 5.7. And no matter how the State characterizes its interest, it cannot justify forcing physicians who "might have a host of good-faith disagreements . . . about the ethics of assisted suicide" to affirmatively promote and facilitate it. *NIFLA*, 138 S. Ct. at 2374–75.

The Act also fails strict scrutiny because it is not narrowly tailored. If the State desires to inform terminally ill patients about the availability of assisted suicide, the government can inform the public itself, perhaps through a "public-information campaign" or by posting notices on public property. *Id.* at 2376. Just like California in *NIFLA*, New Mexico here tries to "co-opt" the medical providers "to deliver its

message for it." *Id.* But "the First Amendment does not permit the State to sacrifice speech for efficiency." *Id.* (quoting *Riley*, 487 U.S. at 795); *see also Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 730 (2014) (to satisfy strict scrutiny, "in some circumstances" the government may need to "expend additional funds to accommodate citizens' religious beliefs").

And if the State has an interest "in ensuring individuals are able to take part in the Act," *CMDA v. Bonta*, Ex. A at 21, then it similarly can provide resources to patients to help them locate "able and willing" physicians. For instance, it could set up a telephone hotline service or a website directory to direct people to assisted suicide. But rather than pursuing those options, the Act forces all physicians to be a mouthpiece for the State and act as a referral service. There are various less burdensome options that would not compel speech or burden religious exercise.

Because the Act triggers and fails strict scrutiny, Plaintiffs are likely to succeed on the merits of their claims.

II. The remaining preliminary injunction factors weigh heavily in favor of granting injunctive relief.

When a plaintiff shows a likelihood of success on the merits of a constitutional claim, "no further showing of irreparable injury is necessary." *Kikumura v. Hurley*, 242 F.3d 950, 963 (10th Cir. 2001) (citation and quotation marks omitted). This is so because "the loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." *Sebelius*, 723 F.3d at 1145 (citation omitted). The Act inflicts a current and ongoing constitutional injury because Plaintiffs regularly treat terminally-ill patients but have not—and will not—speak in compliance with the Informing, Referral, or Membership Requirements. VC ¶¶ 25, 27–28, 31–32, 38, 40. Indeed, Plaintiffs have already repeatedly violated the Act and will continue to do so. *Id.* ¶ 44. Further, the Act inflicts a current and ongoing

constitutional injury by putting Plaintiffs to the choice of violating the Act or violating their religious beliefs. *Fulton*, 141 S. Ct. at 1876.

The balance of equities heavily favor Plaintiffs. "[W]hen [government action] is likely unconstitutional, the interests of those the government represents, such as voters do not outweigh a plaintiff's interest in having its constitutional rights protected." *Sebelius*, 723 F.3d at 1145 (cleaned up). Without an injunction, CMDA members face a choice of: (a) practicing medicine according to their conscience and religious beliefs but in violation of the Act, or (b) ceasing their practice of medicine in New Mexico. This subjects them to "the Hobson's choice" of either "catastrophic fines" or conscience. *Id.* at 1146–47.

Finally, "[t]he balance of equities and the public interest . . . tip sharply in favor of enjoining" a law that infringes on the free speech rights. *Klein v. City of San Clemente,* 584 F.3d 1196, 1208 (9th Cir. 2009). As explained above, the Act facially regulates the content of physicians' speech. *See supra* § I.A. And "it is always in the public interest to prevent the violation of a party's constitutional rights." *Sebelius*, 723 F.3d at 1147 (citation and quotation marks omitted).

CONCLUSION

For the reasons explained above, Plaintiffs respectfully request that the Court grant a preliminary injunction to prohibit Defendants from enforcing the Act's Informing, Referral, and Membership Requirements.

Respectfully submitted this 30th day of January, 2023.

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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of January, 2023, I electronically filed Plaintiffs' Memorandum of Law in support of their Motion for Preliminary Injunction with the Clerk of the Court using the CM/ECF system, which will send notifications of such filing to and serve all parties.

s/Mark A. Lippelmann
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