End-of-Life Care: “Death with Dignity”: The Role of Medical Professionals

February 9, 2016
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SPEAKER BIOGRAPHIES

DAVID C. LEVEN, ESQ. has been the Executive Director of End of Life Choices New York since 2002. The organization seeks to ensure that patients have their healthcare wishes honored at the end of life and that they receive quality care. As an advocate for patients and an expert on advance care planning, patient rights, palliative care and end-of-life issues, including aid in dying, Mr. Leven has played a leadership role in policy changes in New York to improve pain, palliative and end-of-life care. He initiated the Palliative Care Education and Training Act, the Palliative Care Information Act and several laws pertaining to health care proxies. Mr. Leven lectures frequently to diverse professional groups, students and citizens and has been a regular guest lecturer at the College of New Rochelle School of Nursing and Fordham Graduate School of Social Service. He has spoken at numerous medical centers and conferences focusing on palliative and end-of-life care. Mr. Leven has lectured at every area law school as well as at Rutgers and Yale law schools, at the Sheen Center for Thought and Culture and Mt. Sinai Medical School. A graduate of the University of Rochester and Syracuse University College of Law, Mr. Leven is a recipient of numerous awards including the Westchester Civil Liberties Union, Civil Liberties Award and the Public Interest Law Award, Public Law Committee of the New York State Bar Association. He is a past Distinguished Lawyer in Residence at Touro Law School.

DEAN ALICIA OUELLETTE ’94 serves as Albany Law School’s President and Dean. Dean Ouellette is also a Professor of Law at Albany Law School and a Professor of Bioethics in the Union Graduate College/Mt. Sinai School of Medicine Program in Bioethics. Prior to her appointment as President and Dean, she served as Associate Dean for Academic Affairs and Intellectual Life. Dean Ouellette’s research focuses on health law, disability rights, family law, children’s rights and human reproduction. Her book, Bioethics and Disability: Toward a Disability Conscious Bioethics, was published in 2011 by Cambridge University Press. She has authored numerous articles published in academic journals such as the American Journal of Law and Medicine, the Hastings Center Report, the American Journal of Bioethics, the Hastings Law Journal, the Indiana Law Journal and Oregon Law Review. Before joining the law faculty, Dean Ouellette served as an Assistant Solicitor General (“ASG”) in the Office of the New York State Attorney General. As ASG, Prof. Ouellette briefed and argued more than 100 appeals on issues ranging from termination of treatment for the terminally ill to the responsibility of gun manufacturers for injuries caused by handguns. Before that, Dean
Ouellette worked in private practice and served as a confidential law clerk to Judge Howard A. Levine on the New York State Court of Appeals. She has continued her advocacy work in select cases and was lead counsel on the law professors’ brief submitted in support of same-sex couples who sought the right to marry in New York State. She received an A.B. from Hamilton College and a J.D. from Albany Law School, where she was Editor-in-Chief of the *Albany Law Review*.

**TIMOTHY E. QUILL, MD** is the Thomas and Georgia Gosnell Distinguished Professor in Palliative Care at the University of Rochester Medical Center (“URMC”), where he is also Professor of Medicine, Psychiatry, Medical Humanities and Nursing. He was the Founding Director of the URMC Palliative Care Division and a Past President of the American Academy of Hospice and Palliative Medicine. Dr. Quill has published and lectured widely about various aspects of the doctor-patient relationship, with special focus on end-of-life decision making, including how to deliver bad news, non-abandonment, discussing palliative care earlier, and exploring last-resort options. He is the author of several books on end of life, including *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice* (Johns Hopkins University Press, 2004), *Caring for Patients at the End of Life: Facing an Uncertain Future Together* (Oxford University Press, 2001), *A Midwife Through the Dying Process: Stories of Healing and Hard Choices at the End of Life* (Johns Hopkins University Press, 1996) and *Palliative Care and Ethics* (Oxford University Press, 2014). He is also an author of over 150 articles published in major medical journals including “Death and Dignity: A Case of Individualized Decision Making” published in 1991 in the *New England Journal of Medicine*. Dr. Quill was the lead physician plaintiff in the New York State legal case challenging the law prohibiting physician-assisted death that was heard in 1997 by the U.S. Supreme Court (*Quill v. Vacco*). Dr. Quill received his undergraduate degree from Amherst College (1971) and his M.D. from the University of Rochester (1976). He completed his residency in internal medicine in 1979 and a fellowship in medicine/psychiatry liaison in 1981, both from the University of Rochester School of Medicine and Dentistry. Dr. Quill is a Fellow in the American Academy of Hospice and Palliative Medicine, a Fellow in the American College of Physicians, an ABMS certified palliative care consultant, and a past board member of the American Academy of Hospice and Palliative Medicine.
AN ACT to amend the public health law, in relation to establishing the "New York end of life options act"

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act shall be known and may be cited as the "New York end of life options act".

§ 2. The public health law is amended by adding a new article 29-CC to read as follows:

ARTICLE 29-CCCC
NEW YORK END OF LIFE OPTIONS ACT

Section 2994-aaa. Definitions.
  2994-ccc. Request process.
  2994-ddd. Right to rescind request; requirement to offer opportunity to rescind.
  2994-eee. Attending physician responsibilities.
  2994-fff. Death certificate.
  2994-ggg. Consulting physician confirmation.
  2994-hhh. Counseling referral.
  2994-iii. Informed decision required.
  2994-jjj. Form of request.
  2994-lli. Effect on construction of wills, contracts and statutes.
  2994-mmm. Insurance or annuity policies.

EXPLANATION.--Matter in italics (underscored) is new; matter in brackets [ ] is old law to be omitted.
§ 2994-aaa. Definitions. As used in this article, the following words and phrases shall have the following meanings:
1. "Adult" means an individual who is eighteen years of age or older.
2. "Aid-in-dying medication" means medication prescribed by a physician to a qualified individual, which the patient may choose to self-administer to bring about a peaceful death if they find their suffering due to a terminal illness to be unbearable.
3. "Attending physician" means the physician who has primary responsibility for the care of an individual and treatment of the individual's terminal illness.
4. "Capacity" means that in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist the individual has the ability to make and communicate an informed decision to healthcare providers, including communication through a person familiar with the individual's manner of communicating if that person is available.
5. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's illness.
6. "Counseling" means one or more consultations as necessary between an individual and a psychiatrist or psychologist licensed in this state for the purpose of determining that the individual is competent and is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
7. "Healthcare provider" or "provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer healthcare or dispense medication in the ordinary course of business or practice of a profession, nurse practitioners and physician assistants notwithstanding, and includes a healthcare facility.
8. "Informed decision" means a decision by a terminally ill individual to request and obtain a prescription for medication that the individual may self-administer to end the individual's life that is based on an understanding and acknowledgment of the relevant facts and that is made after being fully informed by the attending physician of:
   (a) the individual's medical diagnosis and prognosis;
   (b) the potential risks associated with taking the medication to be prescribed;
   (c) the probable result of taking the medication to be prescribed;
   (d) the possibility that they may not choose to obtain the medication, or may obtain the medication but may decide not to take it; and
   (e) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care and pain management.
9. "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.
10. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this state.
11. "Qualified individual" means a terminally ill adult possessing capacity who has satisfied the requirements of this article.
12. "Self-administer" means a qualified individual's affirmative, conscious act of using the medication to bring about their own peaceful and humane death.

13. "Terminal illness" means an incurable and irreversible illness that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

§ 2994-bbb. Right to request aid-in-dying medication. 1. A qualified individual possessing capacity may make a documented request to receive a prescription for aid-in-dying medication if:

(a) the qualified individual's attending physician and a consulting physician have determined the qualified individual to be suffering from a terminal illness; and

(b) the qualified individual has voluntarily expressed the wish to receive a prescription for aid-in-dying medication.

2. A person may not qualify under the provisions of this article solely because of age or disability.

§ 2994-ccc. Request process. 1. A qualified individual wishing to receive a prescription for aid-in-dying medication pursuant to this article shall submit a written request and make an oral request to their attending physician.

2. A valid written request for aid-in-dying medication under this article must be:

(a) in substantially the form described in section twenty-nine hundred ninety-four-jjj of this article;

(b) signed and dated by the qualified individual seeking the medication; and

(c) witnessed by at least two other individuals who, in the presence of the qualified individual, attest that to the best of their knowledge and belief the qualified individual:

(i) possesses capacity;

(ii) is acting voluntarily; and

(iii) is not being coerced to sign the request.

3. One of the witnesses must be an individual who is not:

(a) related to the qualified individual by blood, marriage or adoption;

(b) at the time the request is signed, entitled to any portion of the qualified individual's estate upon death of the qualified individual under a will or any operation of law; or

(c) an owner, operator, or employee of a healthcare facility where the qualified individual is receiving medical treatment or where the qualified individual resides.

4. Neither the qualified individual's attending physician nor any consulting physician may be a witness to the signing of a written request.

§ 2994-ddd. Right to rescind request; requirement to offer opportunity to rescind. 1. A qualified individual may at any time rescind their request for aid-in-dying medication without regard to the qualified individual's mental state.

2. A prescription for aid-in-dying medication under this article may not be written without the attending physician offering the qualified individual an opportunity to rescind the request.

§ 2994-eee. Attending physician responsibilities. The attending physician shall:

1. make the initial determination of whether an adult making a request under this article:

(a) has capacity;
§ 2994-ggg. Consulting physician confirmation. Before a patient is suffering from a terminal disease, and verify that the attending physician may sign the qualified individual's death certificate.

§ 2994-fff. Death certificate. 1. Unless otherwise prohibited by law, the attending physician may sign the qualified individual's death certificate.

§ 2994-hhh. Counseling referral. If in the opinion of the attending physician or the consulting physician an individual may be suffering from a terminal disease, and verify that the attending physician may sign the qualified individual's death certificate.
from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No aid-in-dying medication shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
§ 2994-iii. Informed decision required. An individual may not receive a prescription for aid-in-dying medication pursuant to this article unless they have made an informed decision as defined in this article.
§ 2994-ijj. Form of request. 1. A request for aid-in-dying medication as authorized by this article must be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE
IN A HUMANE AND DIGNIFIED MANNER

I, _________________________________, am an adult of sound mind.
I am suffering from ______________________________, which my attending physician has determined is in its terminal phase and which has been medically confirmed.
I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment opportunities including comfort care, hospice care and pain management.
I request that my attending physician prescribe medication that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.
INITIAL ONE:
I have informed my family of my decision and taken their opinions into consideration.
I have decided not to inform my family of my decision.
I have no family to inform of my decision.
I understand that I have the right to rescind this request at any time.
I understand the full import of this request, and I expect to die if I take the aid-in-dying medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.
I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.
Signed: __________________________
Dated: __________________________

2. Pursuant to paragraph (a) of subdivision two of section twenty-nine hundred ninety-four-ccc of this article, each witness must complete documentation in substantially the following form:

DECLARATION OF WITNESSES

We declare that the person signing this request:
(a) is personally known to us or has provided proof of identity;
(b) signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
A. 2129--A

(d) is not an individual for whom either of us is the attending physician.

Witness 1, Date:

Witness 2, Date:

NOTE: One witness may not be a relative (by blood, marriage or adoption) of the person signing this request, may not be entitled to any portion of the person's estate upon death, and may not own, operate, or be employed at a healthcare facility where the person is a patient or where the person resides.

§ 2994-kkk. Standard of care. Physicians and medical personnel shall provide medical services under this article that meet the standard of care for end of life medical care.

§ 2994-lll. Effect on construction of wills, contracts and statutes.

1. A provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for aid-in-dying medication, is not valid.

2. An obligation owing under any currently existing contract may not be conditioned or affected by an individual making or rescinding a request for aid-in-dying medication.

§ 2994-mmm. Insurance or annuity policies. 1. The sale, procurement or issuance of a life, health or accident insurance or annuity policy, or the rate charged for a policy may not be conditioned upon or affected by a person making or rescinding a request for aid-in-dying medication.

2. A qualified individual's act of self-administering aid-in-dying medication may not have an effect upon a life, health, or accident insurance or annuity policy other than that of a natural death from the underlying illness.

§ 2994-nnn. Immunities; prohibitions on certain healthcare providers; notification; permissible sanctions. 1. A person is not subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this article, including an individual who is present when a qualified individual self-administers the prescribed aid-in-dying medication.

2. A healthcare provider or professional organization or association may not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this article.

3. A request by an individual for or provision by an attending physician of medication in good faith compliance with the provisions of this article does not constitute neglect or elder abuse for any purpose of law, or provide the sole basis for the appointment of a guardian or conservator.

4. A healthcare provider may choose whether to participate in providing aid-in-dying medication to a qualified individual pursuant to this article. If a healthcare provider is unable or unwilling to carry out an individual's request under this article and the individual transfers care to a new healthcare provider, the prior healthcare provider shall transfer, upon request, a copy of the individual's relevant medical records to the new healthcare provider.

5. Nothing in this section shall prevent a healthcare provider from providing an individual with healthcare services that do not constitute participation in this article.

§ 2994-ooo. Non-sanctionable activities. A healthcare provider may not be sanctioned for:
making an initial determination that an individual has a terminal illness and informing them of the medical prognosis;

2. providing information about the New York End of Life Options Act to a patient upon the request of the individual;

3. providing an individual, upon request, with a referral to another physician; or

4. contracting with an individual to act outside the course and scope of the provider's capacity as an employee or independent contractor of a healthcare provider that prohibits activities under this article.

§ 2994-ppp. Penalties. 1. A person who without authorization of the qualified individual willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the qualified individual's death is guilty of a class A felony.

2. A person who coerces or exerts undue influence on a qualified individual to request medication to end the qualified individual's life, or to destroy a rescission of a request, is guilty of a class A felony.

3. Except as provided in subdivisions one and two of this section, it shall be a class A misdemeanor for a person without authorization of the individual to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the individual's desires and interests with the intent or effect of affecting a healthcare decision.

4. This article does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

5. The penalties in this article do not preclude criminal penalties applicable under other provisions of law for conduct that is inconsistent with this article.

§ 2994-qqq. Severability. If any clause, sentence, paragraph, section or part of this article shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof, directly involved in the controversy in which such judgment shall have been rendered.

§ 3. This act shall take effect on the ninetieth day next succeeding the date upon which it shall have become a law.
Hospice care isn’t enough for all the dying

Even with the best care, terminal patients suffer intolerably

CEO of Oregon hospice group says she changed mind about right-to-die law

BY ANN JACKSON
Special to The Bee

People who opposed laws in California, Oregon, Washington, Montana and Vermont authorizing medical aid in dying for terminally ill adults often claim there are better alternatives to relieve suffering.

I was one of them. In fact, I served as chief executive officer and chief spokesperson of the Oregon Hospice Association before and after the implementation in 1998 of the nation’s first medical aid-in-dying law. I voted against the referendum because I believed it was unnecessary if terminally ill Oregonians had access to high-quality hospice and palliative care.

However, I came to realize that it was arrogant of me to believe that hospice and palliative care professionals could meet all the needs of the dying.

Oregon is consistently rated among the best states for providing hospice and palliative care. Yet, even with the best care, some patients still suffer intolerably and want the option to take prescription medication to die painlessly, peacefully and quickly in their sleep.

Other medical professionals also are realizing that terminally ill adults should have access to a full range of end-of-life options. In May, the California Medical Association dropped its 28-year-long opposition to medical aid in dying,
acknowledging that “despite the remarkable medical breakthroughs we’ve made and the world-class hospice or palliative care we can provide, it isn’t always enough.”

Many opponents claim that palliative sedation (sedating the patient into coma and withholding nutrition and fluids until death occurs in days or weeks) effectively eases the suffering of patients when other means fail to do so. However, it is an unacceptable option for most terminally ill adults whose primary concerns are losing autonomy, quality of life and their dignity.

Today, I am convinced that medical aid in dying can be, and is, practiced responsibly in Oregon. That explains why Oregon’s law is the model for subsequent laws or legislation in 30 states and the District of Columbia, including California’s law that takes effect next year.

Until I retired from the Oregon Hospice Association in 2008, I met with front-line hospice workers regularly to discuss their experiences. Whether they supported or opposed medical aid in dying, they unanimously agreed that conversations about death and dying improved significantly after the law’s implementation. It literally put the topic on the table.

Evidence shows that these conversations are far more likely to reassure a dying person rather than to direct them toward making a request for medical aid in dying. The vast majority of people who raise the possibility of medical aid in dying with their doctor will not go on to make a formal request. When a physician can respond openly, the likelihood of successfully addressing fears or reasons behind the request is much greater than when patients are deterred by the law from expressing their concerns and wishes.

While some health care professionals expressed fierce opposition to medical aid in dying prior to the law changing in Oregon, since then, those voices have softened, in the face of indisputable evidence, and no representative medical organization has called for the law to be repealed.

Ann Jackson is former CEO of the Oregon Hospice Association and co-wrote the chapter about hospice and palliative care in “The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals.” She can be contacted at Jackson@ann-jackson.com.
AID IN DYING:
AN INFORMATIONAL SUMMARY

COMPILED BY
END OF LIFE CHOICES NEW YORK

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EXECUTIVE SUMMARY

- **Aid in dying** is the process by which a mentally competent, terminally ill adult patient obtains a prescription of medicines which the patient may ingest to end suffering and achieve a peaceful death.

- **Aid in dying laws** exist in California, Vermont, Washington, Montana and Oregon. A court decision is pending in New Mexico.

- **Physicians support aid in dying** by 54% to 31% according to a 2014 Medscape survey.

- **A 2015 poll in New York State** by Eagle Point Strategies showed:
  - 77% overall support for aid in dying.
  - 72% of Republicans support aid in dying.
  - 67% of self-identified conservatives support aid in dying.
  - 78% of Upstate New Yorkers support aid in dying.

- **75% of Catholics in NYS support aid in dying** (Eagle Point Strategies, 2015).

- **68% of Americans support aid in dying** according to a Gallup national poll, which has found that a majority of Americans support aid in dying since 1973.

- **Americans of every political affiliation support aid in dying**, including 61% of Republicans, 80% of Independents, and 72% of Democrats (Gallup 2014).

- **The U.S. Supreme Court** ruled that patients have the right to refuse unwanted medical treatment, as well as to refuse food and water. All of these actions are legally sanctioned methods for ending your life.

- **Aid in dying already happens**. National physician surveys indicate that 20% of doctors have received at least one request to assist a terminally-ill patient with dying, and that 3%-18% of physicians consent to these requests.

- **Palliative sedation** is another legal strategy to bring a peaceful end to one’s life. It is done to commence the dying process when all hope is lost – just like aid in dying.

- **But palliative sedation has none of the protections that aid in dying does**: no written patient consent, no required statutory determination that a patient has capacity, no physician obligation to assess depression, no mandatory reporting of related actions in the patient’s medical record, and no reporting to the Department of Health when it occurs. It’s therefore ironic that some opponents of aid in dying, including the Catholic Church, consider palliative sedation a better alternative.

- **Claimed abuses have not been found**. As a 2007 Journal of Medical Ethics study (Battin et al) of aid in dying in Oregon and The Netherlands concluded, “…we found no evidence to justify the grave and important concern expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.” To the contrary, that study found that “people who died with a physician’s assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges.”

- **Oregon’s experience proves aid in dying works**. From 1997-2013, there were 527,695 deaths in Oregon. Only 859 of those deaths were due to aid in dying, or only .16% of all Oregon deaths from 1997-2013.

- **90% of Oregon aid in dying patients** had cancer, ALS, AIDS, or heart disease.

- **Patients in Oregon** were primarily motivated by a fear of losing autonomy (93%), no longer being unable to lead the life they desire (over 89%), a loss of dignity (73%), and losing control of their bodily functions (50%).

- **Researchers in Oregon**, looking at 1,327 families, found zero incidences of coercion.

- **New York’s proposed law has strict safeguards** to ensure patient safety, including: limited to 21 years of age or older; must have legal capacity; must not be suffering from depression; must have a prognosis of 6 months or less to live; must make a written request for aid in dying witnessed by 2 people who attest that the patient: 1) has capacity; 2) is acting voluntarily; and 3) is not being coerced; must be informed of all other available options. Only a patient can administer the medication, and they can rescind their decision at any time.

- **Editorial support** for aid in dying has emerged statewide, including from the New York Times, the Buffalo News, the Albany Times-Union, and the Middletown Times Herald-Record.
FICTION & FACT

FICTION #1: Aid in dying is suicide.

FACT:
- Suicide is the act of ending your life, unrelated to a terminal illness, usually in isolation, and often impulsively and violently, by a clinically depressed person who wants to die.
- Aid in dying is sought by patients with 6 months or less to live. It is the process by which a very small number of mentally competent dying patients obtain prescribed medicines to end their suffering and achieve a peaceful death. They don’t want to die, but understand that due to their illness, death is imminent or will occur soon. These terminally ill patients simply want to gain control of their dying process.
- The American Public Health Association, the American Academy of Hospice & Palliative Medicine, the American Women’s Medical Association and the American College of Legal Medicine have all concluded that aid in dying is not suicide, as has every state which has a law permitting aid in dying.

FICTION #2: Doctors oppose aid in dying.

FACT:
- While the AMA opposes aid in dying, other medical organizations do not.
- Supporters include the American Medical Student Association, the American Medical Woman’s Association, the American College of Legal Medicine, and the American Public Health Association.
- Prior to aid in dying legislation passing in California, the California Medical Association removed its opposition (in place since 1987) to aid in dying. In doing so, the CMA said, “We believe it is up to the individual physician and their patient to decide voluntarily whether the End of Life Option Act is something in which they want to engage. Protecting that physician-patient relationship is essential.”
- According to a 2014 Medscape survey of over 21,000 physicians, doctors support aid in dying by a very wide margin: 54% to 31%.
**FICTION #3: The public doesn’t support aid in dying.**

**FACT:**
- A 2015 poll in New York State by Eagle Point Strategies showed:
  - 77% overall support for aid in dying.
  - 75% of Catholics support aid in dying.
  - 72% of Republicans support aid in dying.
  - 67% of self-identified conservatives support aid in dying.
  - 78% of Upstate New Yorkers support aid in dying.

- Recent polls in neighboring states show widespread support for aid in dying from voters, with almost identical support from people with disabilities in those states: MA, 74% and 71%; CT, 66% and 65%; and NJ, 63% and 62%.

- Nationally, Gallup has polled support for aid in dying since 1947. Since 1973, a majority of Americans have supported it. In their most recent poll, 68% of Americans supported aid in dying.

- Gallup’s national polling shows aid in dying is supported across the political spectrum: Republicans 61%, Independents 80%, Democrats, 72%.

**FICTION #4: No state allows aid in dying, and New York shouldn’t either.**

**FACT:**
- Aid in dying is legal in California (2015, legislature), Montana (2008, court decision), Vermont (2013, legislature), Washington (2008, initiative), and Oregon (1998, initiative). In New Mexico (2014, court decision), the court ruled in favor of aid in dying; this decision was then overturned on appeal. That decision is now under appeal in the New Mexico Supreme Court; arguments were heard in late October.
FICTION #5: The proposed New York law has no safeguards to protect against abuse.

FACT:
- The proposed law has numerous safeguards to protect patients, including:
  - Doctor must confirm the patient has capacity, is 21 or older, is acting voluntarily, and has 6 months or less to live.
  - Patient must sign a written request for aid in dying, witnessed by 2 individuals who confirm the patient has capacity, is acting voluntarily, and is not being coerced.
  - If depression is present, the patient must secure a psychiatric or psychological evaluation, and may not proceed unless they are proven NOT to be suffering from depression.
  - Age and being disabled are explicitly NOT factors that may determine patient eligibility.
  - Medical records must account for every legally-mandated step in the aid in dying process being recorded.
  - Written and oral contracts, wills, and insurance policies are prohibited from being contingent on/limited due to a patient’s desire to use/not use aid in dying.
  - Patient must administer aid in dying medications themselves.

FICTION #6: Rather than enact an aid in dying law, we should expand access to hospice care.

FACT:
- Hospice is a complement to, not a replacement for, aid in dying.
- In Oregon’s 17-year experience, 90% of aid in dying patients were enrolled in hospice at the time of their death.

FICTION #7: The medical system doesn’t allow people to end their lives, so we shouldn’t make aid in dying legal.

FACT:
- The U.S. Supreme Court ruled that patients have the right to refuse unwanted medical treatment, as well as to refuse food and water. All of these actions are legally sanctioned methods for ending your life.
- The practice of “palliative sedation” (originally known as “terminal sedation”), is also legal throughout the U.S, and is practiced in virtually all medical settings, including those managed by the Catholic Church, which supports its use. Palliative sedation is sedating a terminally ill patient, for whom no treatment has been effective at managing their pain, into unconsciousness. Once the patient loses consciousness, food and hydration are withdrawn. Just as with aid in dying, palliative sedation is a proactive action by a physician to commence a process which will lead to the patient’s death. A more extensive discussion of palliative sedation can be found on page 8 of this packet.
FICTION #8: Catholics are opposed to aid in dying, so it should not become law.

FACT:
- 75% of Catholics in NYS support aid in dying (Eagle Point Strategies, 2015).
- 65% of Catholics nationally support aid in dying (Gallup, 2014).
- Self-determination is at the core of aid in dying. Catholics and other religious individuals and institutions have a right to decline aid in dying, but not to impose their beliefs on others.

FICTION #9: Some terminally-ill people want every effort made to treat them. If there was an aid in dying law, there would be a strong motivation to deny them that care.

FACT:
- There is no evidence that aid in dying laws have been used to deny anyone the care they desire. Indeed, a nationally-prominent medical ethicist, Arthur Caplan, Director of the Division of Medical Ethics at NYU Medical Center, stated, “I worried about people being pressured to do this. But...the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy.”

FICTION #10: Aid in dying laws lead to poor and disabled people being encouraged to kill themselves.

FACT:
- No study has ever found a link between aid in dying and the disabled or poor being coerced into using it. In fact, studies have proven the opposite to be true.
- In practice, poor and disadvantaged people exhibit the same lack of access to aid in dying as they do to everything else in health care. Studies in Oregon have shown that those who utilized aid in dying are overwhelmingly white (98%), middle class (98% have health insurance), highly-educated (70% have college degrees) individuals capable of maneuvering through the somewhat complex aid in dying process. If anything, Oregon’s experience shows that the poor suffer from a lack of access to aid in dying.
- As a 2007 Journal of Medical Ethics study (Battin et al) of aid in dying in Oregon and The Netherlands concluded, “…we found no evidence to justify the grave and important concern expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups.” To the contrary, that study found that “people who died with a physician’s assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges.”
- The Journal of Medical Ethics concluded there was no link between aid and dying and coercion targeted at the disabled after studying patients in Oregon.
**FICTION #11:** If aid in dying becomes law in New York, depressed or mentally incompetent people will be able to legally obtain drugs to kill themselves.

**FACT:**
- The only people who could legally obtain drugs under the law are those with capacity and a diagnosis of 6 months or less to live. If you don’t have a terminal diagnosis, you are legally prohibited from utilizing aid in dying.
- The proposed NY law explicitly prohibits disability and age as an eligibility criteria for aid in dying.

**FICTION #12:** If aid in dying were legal, people with any kind of disease could kill themselves.

**FACT:**
- People with any disease could use aid in dying, **BUT** only if their physician has determined that they have 6 months or less to live.
- In Oregon’s 17 years of experience, over 90% of patients who used aid in dying had cancer, ALS, AIDS, or heart disease.

**FICTION #13:** If aid in dying becomes law, its use will become widespread.

**FACT:**
- In Oregon, where aid in dying has been the law for 17 years, it is still rarely used. For example, in 2013 (the latest year with complete data), of 33,931 total deaths, only 71 involved aid in dying, or just .22% of all deaths in Oregon that year.
- From 1997-2013, there were 527,695 deaths in Oregon. Only 859 of those deaths were due to aid in dying, or only .16% of all Oregon deaths during those 17 years.

**FICTION #14:** Hospitals, many of whom are Catholic institutions, will be routinely confronted with aid in dying requests if aid in dying were legal.

**FACT:**
- In Oregon, 95% of aid in dying deaths occurred at home, reflecting the primary motivation of patients who use it: to control how and where they die.
FICTION #15: Aid in dying will lead people facing financial difficulties, or concerned about pain, to kill themselves.

FACT:
- In Oregon, concerns about pain (about 24%) or financial difficulties (less than 3%) were the reasons least cited by patients as a rationale for seeking aid in dying.
- Patients were primarily motivated by a fear of losing autonomy (93%), no longer being unable to lead the life they desire (over 89%), a loss of dignity (73%), and losing control of their bodily functions (50%). Patients who seek aid in dying are motivated by a desire to maintain control of the conditions under which they die, not a fear of uncontrolled pain or a heavy financial burden.
- A New England Journal of Medicine study of hospice nurses and hospice social workers that cared for aid in dying patients in Oregon concluded that financial problems, depression and fears of pain were not what motivated their patients to seek aid in dying. Rather, they said that the primary motivations of their patients were: 1) a desire to control the circumstances of their death; 2) a desire to die at home; and 3) being ready to die.

FICTION #16: The families of aid in dying patients will be devastated by this process.

FACT:
- In Oregon, two studies of family members of aid in dying patients show that they were better prepared for and accepting of the patient’s death, had diminished states of denial, had more resolved grief, were more likely to believe the patient’s choices were honored, and were less likely to have regrets about the death. Family members of aid in dying patients also rated the quality of the moment of death as better than did the families of patients who didn’t use aid in dying.

FICTION #17: Family members will coerce sick relatives to end their life if aid in dying is legal.

FACT:
- To our knowledge there have been no studies that have found any coercion, despite the fact that thousands of patients have considered aid in dying where it is legal.
- The New York legislation has provisions to guard against patient coercion (see Fiction #5 above).

FICTION #18: Aid in dying will irrevocably damage the doctor-patient relationship.

FACT:
- A 2007 US GAO study, comparing Oregon to 3 other states without aid in dying, concluded that Oregon physicians are more comfortable discussing end of life issues since aid in dying was enacted, and that it helped foster a doctor-patient relationship in which end of life options were discussed more openly.
FICTION #19:  Because it is illegal, no physicians currently assist their patients with aid in dying.

FACT:
- Researchers estimate that 1 in 250 deaths nationally involve aid in dying.
- National physician surveys indicate that 20% of doctors have received at least one request to assist a terminally-ill patient with dying, and that 3%-18% of physicians consent to these requests.

FICTION #20:  The use of “palliative sedation” makes aid in dying unnecessary.

FACT:
- Palliative sedation is used to help terminally ill patients die, as is refusing food and hydration, and refusing treatment, all of which are legal in the U.S. Because it is only used for the small number of patients who have uncontrollable pain, it is not an option for patients with other conditions but still seek aid in dying. In addition, palliative sedation does not address the needs of patients who want to use aid in dying nearly as well: a desire to maintain control of their body and the dying process until the very end of their lives; a desire to maintain their dignity as they die; and a desire to avoid a radical decline in their quality of life. Aid in dying is also a potentially better option for some patients because it doesn’t force them to linger for days or weeks.
SUMMARY OF A.5261-C (PAULIN)/S.5841-A (BONACIC)

- Patient must: be 21 years of age and older, have legal capacity, be a NYS resident, and have a prognosis of 6 months or less to live.
- Patient must make a written request for aid in dying, witnessed by 2 people who attest that the patient: 1) has capacity; 2) is acting voluntarily; and 3) is not being coerced.
- One witness shall NOT be: 1) a relative; 2) a person entitled to a portion of the patient's estate; 3) an owner, operator or employee of a health care facility where the patient resides; or 4) the patient's physician.
- If a patient exhibits any signs of depression, their physician must refer them for a psychiatric evaluation. Only patients found to not be suffering from depression may proceed.
- Patient may rescind his or her decision at any time.
- Patient must be informed of all risks associated with the aid in dying medication.
- Patients must administer the medication by themselves.
- Physician must have a bona fide relationship with a patient requesting aid in dying.
- Physicians must: 1) diagnose that the patient has 6 months or less to live; 2) confirm that the patient is a NY resident; 3) refer the patient for psychiatric or psychological counseling if they deem them to be depressed; 4) document all aid in dying actions; and 5) prescribe the aid in dying medications.
- Physicians must document: 1) all oral patient requests for aid in dying; 2) the patient's prognosis; 3) the outcome of the patient's psychiatric counseling, if any; and 4) state in the patient's medical record that all requirements of the law have been met.
- Protects physicians and health care facilities acting within the law from civil, criminal, and professional liability.
- Physicians, nurses, pharmacists and other persons are under no obligation to participate in aid in dying.
- Facilities can prohibit aid in dying based on religious or moral beliefs.
- Family and friends are not subject to civil or criminal liability for being present when medication is taken, or for failing to prevent the medication from being taken.
- Health care providers are liable for negligent conduct and intentional misconduct if they fail to comply with the law.
- Health care providers and institutions may refuse to participate in aid in dying if they find it morally objectionable or if it is against their religion.
- Patient insurance benefits cannot be denied or conditioned on a patient’s decision to use or refuse aid in dying.
- Physician malpractice insurance cannot be restricted, and rates cannot be adjusted, based on a physician's willingness to participate in aid in dying, or to not participate.
- No contract, will, or other written or oral agreement may be contingent on the use of, or refusal to use, aid in dying.
- DOH must issue regulations to ensure the safe disposal of unused aid in dying medications.
- Physicians are prohibited from killing a patient by lethal injection, mercy killing, or active euthanasia.
- The patient’s death certificate shall specify the underlying illness as the cause of death.
- Takes effect immediately.
“Palliative sedation” is a legitimate end of life option—but not the only option. Unlike aid in dying, it requires that patients suffer intractable pain, and it lacks the safeguards required in aid in dying.

Palliative sedation was originally called “terminal sedation,” as the intent is to bring about the patient’s death.

Palliative sedation is the continuous administration of medication, to the point of coma, to relieve severe, intractable pain that cannot be controlled while the patient is conscious.

Palliative sedation is an option used when nothing else works to control a patient’s suffering, usually from pain. As such, its use requires that the patient suffer before it is utilized.

Once the patient is in unconscious, all life support is sometimes withdrawn or withheld.

Palliative sedation takes days to weeks to produce death. As such, it is a less humane way than aid in dying to help a dying patient manage their dying process.

Palliative sedation is not a “natural” death, as some would suggest. It involves the administration of powerful sedatives, and often the withholding or withdrawal of food and hydration.

Even though palliative sedation leads to death, it is practiced in Catholic health care institutions across the state. Indeed, the Catholic Church advocates palliative sedation as an alternative to aid in dying—even though both are proactive procedures designed to manage a patient’s death.

Palliative sedation is done to commence the dying process when all hope is lost—just like aid in dying—but without any of the safeguards. Palliative sedation has none of the protections that aid in dying does. There is no written patient consent, no required statutory determination that a patient has capacity, no physician obligation to assess depression, no mandatory reporting of related actions in the patient’s medical record, and no reporting to the Department of Health when it occurs. It can also be requested by a health care agent or surrogate for those who lack capacity. It’s therefore ironic that some opponents of aid in dying consider palliative sedation a better alternative.
OREGON’S DEATH WITH DIGNITY ACT (ODDA):
MAJOR FINDINGS

- Enacted in 1994, the ODDA was delayed by court challenges and an unsuccessful repeal initiative. It finally took effect in 1998. It is quite similar to the bill in NY.
- From 1998-2014, 1,327 people have had prescriptions written, and 859 have died using aid in dying medications.
- Over the past 17 years, only 0.16% of all deaths in Oregon are a result of aid in dying.
- Annually, the proportion of patients who ingested the medication they received ranged from 47.7% to 82%, with a median of 62%. The remainder of patients died from their disease progression, having never used the drugs.
- 90% of aid in dying patients were enrolled in hospice at the time of their death.
- Over 98% of aid in dying patients had health insurance.
- Cancer patients made up almost 80% of all aid in dying patients, with ALS patients second at approximately 8%.
- The median duration, from first request to death, was 47 days.
- The most frequently cited motivation for aid in dying was a loss of autonomy (93%), a decreased ability to participate in activities that make life enjoyable (89%), a loss of dignity (73%), and the loss of bodily function (50%). Inadequate pain control (24%) and financial concerns (3%) were the least frequently cited reasons.
- Approximately 5% of Oregon physicians have received formal requests for aid in dying.
- A survey of hospice participation in aid in dying revealed that 16% participated fully, 32% moderately, 27% in a limited fashion, and 25% not at all.
- 95% of aid in dying patients died at home. Only one died in a hospital.
- Unconsciousness and death occur rapidly: unconsciousness occurred in a median of 5 minutes, and death in a median of 25 minutes.
- Studies indicate that the families of aid in dying patients are, on average, more prepared for the death, and more accepting of it.
- The very small number of aid in dying cases, and the stability in the number of cases each year, has alleviated concerns that the law would lead to coercion and other pressures on patients to use aid in dying.
- Researchers found no evidence of heightened risk resulting from aid in dying for the elderly, women, the uninsured, people with little education, the poor, the physically disabled or chronically ill, minors, people with psychiatric disorders, or racial or ethnic minorities.
EDITORIAL SUPPORT FOR AID IN DYING LEGISLATION ACROSS NEW YORK STATE
Offering a Choice to the Terminally Ill

BY THE EDITORIAL BOARD
MARCH 14, 2015

Last year, the radio host Diane Rehm watched in agony as her husband, John, starved to death over the course of 10 days.

Severely crippled by Parkinson’s disease, his only option for ending the suffering was to stop eating and drinking. Physicians in most states, including Maryland, where he lived, are barred from helping terminally ill patients who want to die in a dignified way.

“He was a brilliant man, just brilliant,” Ms. Rehm said in an interview. “For him to go out that way, not being able to do anything for himself, was an insufferable indignity.”

Ms. Rehm, whose current affairs talk show at WAMU is distributed by NPR, the public radio network, has brought a strong and poignant voice to a debate gaining attention in state legislatures around the country.

Currently, only Oregon, Washington, Vermont, New Mexico and Montana allow health care providers, under strict guidelines, to hasten the death of terminally ill patients who wish to spare themselves and their loved ones from the final, crippling stages of deteriorating health. Lawmakers in 15 other states and the District of Columbia have introduced so-called aid in dying bills in recent months to make such a humane option available to millions of Americans at a time when the nation’s population of older adults is growing.

The impetus for many of the bills was the widely publicized story of Brittany Maynard, a 29-year-old woman from California who moved to Oregon, after learning in the spring of 2014 that she had incurable brain cancer, so she could die on her own terms. The nonprofit organization Compass & Choices, which has worked closely with Ms. Maynard’s relatives and with Ms. Rehm, has played a leading role in getting state lawmakers to introduce bills.

The right-to-die movement has strong opponents, including the Catholic Church, which opposes any form of suicide. Meanwhile, some medical professionals argue that the practice is at odds with their mission as healers and worry that it could be abused. Unfortunately, many Americans associate the issue with Dr. Jack Kevorkian, a notorious advocate of assisted suicide who was convicted in 1999 of murder and who aided dozens of patients, many of whom were not terminally ill, in ending their lives.

As local lawmakers around the country debate the bills, they should consider how successfully and responsibly the law has been carried out in Oregon. The state’s Death With Dignity Act, which went into effect in 1997, gives doctors the right to prescribe a lethal dose of medication to patients who are terminally ill and who have been advised of their alternatives, such as hospice care. The law provides layers of safeguards to ensure proper diagnosis of the disease, determine a patient’s competency to make the decision, and protect against coercion. Last year, 105 patients in Oregon, a record high, died after receiving a lethal dose of medication.

Health care providers in states where assisted suicide is illegal face wrenching choices when dying patients ask them for help. In one case, prosecutors in Pennsylvania perversely charged Barbara Mancini, a nurse, with assisting a suicide for handing a bottle of morphine in February 2013 to her 93-year-old father, who was in hospice care. A judge dismissed the case the following year.

Some doctors caught in these painful situations end up handing patients lethal doses of painkillers with a wink and a nod, right-to-die activists say. But these unregulated practices put patients and doctors on dangerous terrain. “Making a secret process transparent makes it safer,” Barbara Coombs Lee, the president of Compassion & Choices, said in an interview. Ms. Rehm said she and her husband had long agreed they would help each other die if either was in growing distress from a terminal illness. Her inability to help him die humanely is a situation no spouse should have to face.

“There was no question but that I would support him and honor whatever choice he would make,” she said. “As painful as it was, it was his wish.”
Editorial: New York should consider joining states that allow doctors to help terminally ill patients die

It is time to have a serious conversation about death and dying. We need to discuss allowing the terminally ill and mentally fit to be able to fulfill their final wish to leave the good Earth with dignity.

The group End of Life Choices New York is pushing for that conversation and has, along with the national nonprofit disability rights advocacy group, Disability Rights Legal Center, recently filed a lawsuit in State Supreme Court to clarify the ability of mentally competent, terminally ill New York patients “to obtain aid in dying from their physician if they find their dying process unbearable.”

There has been plenty of pushback. Religious groups and others incorrectly perceive hastening of death in these specific situations to be “assisted suicide.” It is not.

End of Life Choices New York describes “aid in dying” as “the practice of a physician prescribing medication to a terminally ill, mentally competent patient who may choose to ingest it to end suffering they find unbearable, and achieve a peaceful death.”

The idea is that patients, who have met a series of requirements ensuring they are not being coerced and are mentally capable of such a decision and are within a few months of dying, must themselves ingest the medication. Some correctly wonder how this is worse than a decision to discontinue life-sustaining treatment such as a ventilator or feeding tube.

Aid in dying is permitted by statute in Oregon, Washington and Vermont. Montana and New Mexico permit the practice by court decision. Montana has a lower court decision on appeal. All these states or courts recognize “aid in dying,” and not “assisted suicide.”

The distinction is critical. The language goes directly to the heart of the discussion for someone who is of sound mind but whose body has failed him and there is no hope for an extended life. To fully understand the calculation that goes into such a decision, listen to the stories of people like Sara Myers, who with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig’s disease, merely wants the right to choose, with the medicine on hand. So do many others in similarly hopeless situations.

Findings have shown that about one-third of people who get the medicine in states where the right is given never take it. Denying a terminally ill, mentally competent patient this choice can cause undue emotional suffering for the patient. Dr. Marcia Angell wrote an article for the Washington Post that was published in The News last November about her dying husband, a distinguished physician in his own right, and his request to choose the process of his demise. Diagnosed with metastatic cancer, he had a good idea of what the end would look like. He died at home in Massachusetts, with hospice care, his wife wrote, “but not in the way he wanted.”

Brittany Maynard brought a national spotlight to the subject when the 29-year-old who had incurable brain cancer moved from California to Oregon, the jurisdiction with the longest history of allowing aid in dying, so that she could have her wishes legally met.

The end is inevitable, but for some it comes as the result of an excruciating and cruel illness. Why not allow those capable of making a sound decision a choice? It won’t be an easy discussion, but it is an important one that is well worth having.
Suffering’s silent treatment

BY TU EDITORIAL BOARD ON JULY 5, 2015

We’re all going to die, some of us peacefully in our sleep, some of us not so gently. For some of us, death will be the climax of prolonged suffering.

Many people, and some states, have decided it does not have to be that way – that competent, terminally ill individuals in pain should have the choice to end their life on their own terms, with the aid of lethal drugs prescribed by a physician.

Legislation was introduced this past session to make that a right in New York.

But the bills died in committee.

This issue demands a public debate, not legislative silence.

We realize this is not an easy discussion. It conjures frightening prospects – of greedy heirs pressuring patients to stop running down their inheritance on medical bills; of a devaluation of the lives of the elderly, sick, or disabled; of a societal message that suicide is an easy answer to any suffering; or a slippery slope toward involuntary euthanasia.

Yet as some states – Oregon, Vermont and Washington – have shown, it’s possible to write well-crafted laws that take into account these serious concerns. They can require that the person be terminally ill, with six months or less to live; suffering, in the judgement of one or more physicians; competent and able to make an informed decision; and able to administer the medication – typically, a lethal dose of barbiturates – by themselves. A second physician can be required to review the case, and the request could also require disinterested witnesses – not the physician, family members, or staff of the health care facility the person is in. Among the physicians’ responsibilities would be to insure that, in their best judgement, the patient is not being coerced.

Oregon’s law has been in place since 1997, and to date, studies have found no evidence of abuse or coercion.

Though New York lawmakers may prefer to dodge this issue by burying bills in committee, it isn’t going away.

Besides the states that have already passed thoughtful aid-in-dying laws, 20 other states are looking at the issue legislatively. And in two states so far – Montana and New Mexico – advocates have successfully pressed the issue in court (although the latter has appealed the ruling).

The fact is, we already allow people to make the choice to end their lives, and in far less pleasant ways. People can refuse life-prolonging treatment. They can stop eating and taking fluids. They can write an advance directive not to be resuscitated or to have extraordinary measures taken to keep them alive should they fall into a coma, become brain dead, or otherwise become unable to voice that wish.

Many opponents of aid-in-dying legislation support those clearly life-ending acts.

We recognize that some people and religions view suicide as a sin, and suffering as a path to an affirmation of faith.

They’re entitled to that view. But such spiritual beliefs are far from universal. They should not be used to hinder intelligent, compassionate laws that respect the right of suffering people, should they choose, to choose to die peacefully, with dignity, on their own terms.
Editorial: End-of-life needs calm consideration

JUNE 10. 2015

A controversial topic is likely to get the consideration it deserves in Albany now that state Sen. John Bonacic, R-Mount Hope, has agreed to sponsor legislation legalizing the practice of assisted suicide in New York.

As he explained in introducing a Senate bill, a companion to one already being considered in the Assembly: "I introduced this legislation to start a statewide discussion about the aid-in-dying issue ... I recognize that not everyone agrees with the decision to end one’s own suffering, but I believe it is right to give people the opportunity to make their own personal decisions, particularly when it comes to their health and end-of-life care.”

Under the bill as it now is written, a physician would be able to prescribe a lethal dose of drugs after receiving a written request from a patient suffering from a terminal illness. The physician would not be able to administer the drug and the illness is defined as one reasonably expected to cause death within six months.

Two statements by witnesses, at least one of whom could not be a relative or entitled to any of the patient’s estate, would have to accompany the request and attest that the patient was of sound mind.

Advocates for the bill note that some patients already can end their suffering when death is near. David Leven, executive director at the advocacy group End of Life Choices New York, pointed out that patients already may choose to end their life by not eating or drinking or by asking for a ventilator to be removed.

“This is a bill that extends the choices people already have,” he said. “It's extraordinarily important for people to have a wide range of choices at the end of their lives.”

The Assembly sponsor, Amy Paulin, a Westchester Democrat, has attracted bipartisan support with, among other points, the argument that those who are not on medicine or machines that are prolonging their life are doomed to suffer because they do not have other options.

The issues has been in the news in recent months because of the decision by Brittany Maynard, a 29-year-old woman with brain cancer, to move to Oregon where physician-assisted suicide is legal and to end her life. Vermont and Washington state have similar laws to the one now being considered in New York.

Opponents, including disability groups and the Catholic Church, do not believe that the practice should be legalized no matter what safeguards are included in the law. In addition to religious objections, some opponents believe that this is the first step on a slippery slope to euthanasia, killing those who would not be able to defend themselves.

Legislations and legislative debate will not be able to convince those who are opposed for religious reasons or consider the practice immoral by definition. But if opponents will forego some of the heated rhetoric that greeted Bonacic’s announcement, a debate in Albany should allow those who are troubled by the unnecessary suffering of the terminally ill to see that this practice is a humane approach that can be regulated by legislation with appropriate safeguards.
NY needs end of life option

SUNDAY, 8 NOVEMBER 2015
STACEY GIBSON

My husband Sid was a smart, successful man who relished life. A loving father and grandfather, he was also my best friend and worked his entire life so that he and I could spend our golden years together.

But it was not meant to be. In May of 2014, a rare progressive degenerative motor neuron disease called spino cerebella ataxia took his life at the age of 68, after an eight-year battle. The disease caused Sid’s body to slowly weaken and atrophy; yet his extraordinary mind remained sharp until the end. As body parts stop working, including the lungs, the cause of death for those with the disease is typically an inability to breathe.

Sid didn’t want to die but his failing body had become too much for him. After entering hospice, he wanted the option of aid in dying, which would have allowed him the choice to self-administer life-ending medication to bring about a more peaceful and humane death. But unlike four other states and most recently, California, aid in dying is not an option in New York. That needs to change.

Sid’s symptoms first appeared when he collapsed in a parking lot after his legs just gave out on him. Over the years, he lost his ability to walk, his bowel and bladder control, and even to smoke his cigars, one of his great pleasures.

Despite all of this, he clung to life and managed to find joy in his family around him. But his atrophying body just wore him down. He developed dysphasia, which caused his food and liquid intake to divert from his esophagus into his lungs – he would gag, but his diaphragm was so weak that he could barely cough up the food and liquid that he was choking on. His body would continue to deteriorate, until he eventually lost the ability to breathe. It was a prospect that terrified him more than death itself.

At a recent forum in Cortlandt on aid in dying sponsored by Assemblywoman Sandy Galef, an opponent of aid in dying and patient autonomy made the claim that VSED may be peaceful for some, but it was anything but for Sid. Six weeks after being admitted to hospice and well into his dying process, Sid chose VSED to avoid the worst of his disease. It took him 12 days to die – can you imagine not eating or drinking for 12 days just waiting to die? While the good people at hospice did all they could to keep him comfortable during that time, Sid developed terminal agitation, which resulted in extreme verbal and physical outbursts, making his final days horrific and frightening. It was not peaceful. It was not the death Sid wanted.

He wanted the option of aid in dying so that he could die in peace surrounded by his loved ones. Isn’t that the good death we all want? We are not talking about suicide here, as some opponents charge. Sid wanted to live but his body was dying. His disease was killing him and his death was imminent – he deserved the patient autonomy and ability to make his own end-of-life health care decisions.

That is why New York must pass the End of Life Options Act (S3685/A2129A), sponsored by Senator Diane Savino and Assemblymember Linda Rosenthal, which would authorize aid in dying in our state. New Yorkers deserve the peace of mind and comfort that comes with knowing that if death is imminent there is another option to die without suffering.

This is probably one of the most difficult issues I have ever faced in my 64 years of life. There are those who might choose aid in dying and those that wouldn’t. The issue is that it should be up to the individual, based on their own beliefs, values and end-of-life wishes.

When my time comes, if I do face a terminal prognosis like Sid and so many others, I’m not sure what I would do. But I am sure that I would want aid in dying to be available as a last resort. Sid didn’t have access to the option he wanted, so I am advocating for aid in dying in the State of New York in his memory, so that others might have the option to die according to their wishes.

*The writer lives in Garrison.*
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Words matter. Aid in dying is the term now widely accepted in law and medicine to describe the practice of a physician prescribing medication to a terminally ill, mentally competent patient who may choose to ingest it to end suffering they find unbearable, and achieve a peaceful death. The American Public Health Association and the American Medical Women’s Association have accepted this term.

It is inappropriate and inaccurate to use the value laden, pejorative terms “assisted suicide” or “physician assisted suicide” to describe aid in dying. Opponents of the practice use this biased terminology to equate aid in dying with criminal acts, and imply a social stigma.

Those who choose aid in dying do not want to die, and they are not suicidal. They want to live, but will soon be dead from terminal illnesses. What is causing their deaths is their disease. Dying patients reject the terms “assisted suicide” and “suicide” as insulting and derogatory. In states where aid in dying is permitted by statute, Oregon, Washington and Vermont, these terms are specifically rejected, and it is explicitly recognized that actions comporting with the laws do not constitute “suicide” or “assisted suicide.” Similarly, in Montana and New Mexico, which permit the practice by court decision, the courts have recognized a right to “aid in dying,” not “assisted suicide”.

Medical, health policy and mental health professionals recognize that the terms "suicide" and "assisted suicide" are inaccurate, biased and pejorative in this context. Thus, mainstream relevant and respected organizations have rejected the term “assisted suicide.” These include the American Public Health Association, American Medical Women’s Association, American Academy of Hospice and Palliative Medicine, the American College of Legal Medicine and the American Medical Students Association. They have variously stated that “suicide” terminology is “emotionally charged,” “inaccurate and inappropriate,” and “unfairly colors the issue.”

Aid in dying is the accepted accurate and value neutral term. It should be used in all communications by the media and others, in media stories and in headlines, on the issue to avoid what might appear to be media bias.

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New York Supreme Court
APPELLATE DIVISION—FIRST DEPARTMENT

SARA MYERS, STEVE GOLDBERG, ERIC A. SEIFF, HOWARD GROSSMAN, M.D., SAMUEL C. KLAGSBRUN, M.D., TIMOTHY E. Quill, M.D., JUDITH K. SCHWARZ, Ph.D., CHARLES A. THORNTON, M.D., and END OF LIFE CHOICES NEW YORK,

Plaintiffs-Appellants,

—against—

ERIC SCHNEIDERMANN, in his official capacity as ATTORNEY GENERAL OF THE STATE OF NEW YORK,

Defendant-Respondent,

JANET DiFIORE, in her official capacity as DISTRICT ATTORNEY OF WESTCHESTER COUNTY, SANDRA Doorley, in her official capacity as DISTRICT ATTORNEY OF MONROE COUNTY, KAREN Heggen, in her official capacity as DISTRICT ATTORNEY OF SARATOGA COUNTY, ROBERT JOHNSON, in his official capacity as DISTRICT ATTORNEY OF BRONX COUNTY and CYRUS R. VANCE, JR., in his official capacity as DISTRICT ATTORNEY OF NEW YORK COUNTY,

Defendants.

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PRELIMINARY STATEMENT

This action was brought by terminally-ill, mentally-competent patients and by medical professionals who regularly care for or counsel such patients. The patients seek to exercise control, avoid a loss of dignity and reduce unbearable suffering as they approach death by obtaining a prescription from their physicians for medication they could ingest to achieve a peaceful death – a practice known as aid-in-dying. The Complaint sought (i) a declaration that a physician who provides aid-in-dying does not violate New York’s Assisted Suicide Statute; (ii) a declaration that, if the Assisted Suicide Statute applies to aid-in-dying, the Statute would violate the Due Process Clause of New York’s Constitution; and (iii) a declaration that, if the Assisted Suicide Statute applies to aid-in-dying, the Statute would violate the Equal Protection Clause of New York’s Constitution.

The trial court erroneously granted Defendant’s motion to dismiss the Complaint for failure to state a cause of action. In dismissing Plaintiffs’ statutory claim, the trial court failed to credit or even to address the Complaint’s factual allegations that aid-in-dying is not assisted suicide and that aid-in-dying is indistinguishable from other lawful medical practices. For example, the Complaint

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1 New York Penal Law §§ 120.30 and 125.15 (the “Assisted Suicide Statute” or the “Statute”) provide that “promoting a suicide attempt” by “intentionally caus[ing] or aid[ing] another person to attempt suicide” or “to commit suicide” constitute felonies.
as well as supporting affidavits explained that aid-in-dying is a medically and ethically appropriate course of treatment for patients facing unbearable suffering in the final stages of the dying process; that medical and public health professionals reject the use of the term “suicide” to refer to aid-in-dying; and that aid-in-dying is indistinguishable from other lawful practices like terminal sedation — the administration of drugs to keep the patient continuously in deep sedation, with food and fluid withheld until death results.

The trial court further erred by dismissing Plaintiffs’ causes of action alleging violations of the Due Process Clause and the Equal Protection Clause of the New York Constitution. New York has long recognized a common law fundamental right to self-determination with respect to one’s body and to control the course of one’s medical treatment. The Complaint pleads facts to establish that application of the Assisted Suicide Statute to aid-in-dying would infringe this right in violation of the Due Process and Equal Protection Clauses of the New York Constitution.

In assessing Plaintiffs’ constitutional claims, questions regarding Plaintiffs’ privacy and liberty interests and any State interest that may exist in prohibiting aid-in-dying necessarily require development of an evidentiary record, not dismissal of the Complaint at the pleading stage. Moreover, the trial court did not discuss Plaintiffs’ due process claim and dismissed Plaintiffs’ equal protection claim based
upon inapposite authority that did not involve application of the New York Constitution to aid-in-dying.

The facts alleged in the Complaint, and the affidavits submitted in opposition to Defendant’s motion to dismiss, more than suffice to state justiciable statutory and constitutional claims. Plaintiffs’ claims should proceed so that Plaintiffs have their day in court to present the profoundly important issues raised by this lawsuit.

**Questions Presented**

1. Did the trial court err in dismissing Plaintiffs’ claim that the Assisted Suicide Statute does not apply to aid-in-dying when it failed to credit the Complaint’s factual allegations that aid-in-dying is not suicide and that aid-in-dying is indistinguishable from other lawful conduct?

2. Did the trial court err in dismissing Plaintiffs’ claims that the Assisted Suicide Statute, if applied to aid-in-dying, violates the Due Process Clause and the Equal Protection Clause of the New York Constitution when it (i) failed to consider New York’s broad fundamental right to self-determination, (ii) failed to acknowledge the need for a developed record concerning Plaintiffs’ privacy and liberty interests and any State interest in prohibiting aid-in-dying, and (iii) relied on inapposite legal authority?
STATEMENT OF THE NATURE OF THE CASE AND THE FACTS

Plaintiffs are mentally-competent patients with terminal illnesses and medical professionals who regularly care for or counsel such patients. On February 4, 2015, Plaintiffs filed in New York Supreme Court, New York County a three-count Complaint seeking a declaration that “the Assisted Suicide Statute does not encompass the conduct of a New York licensed physician who provides aid-in-dying to a mentally-competent, terminally-ill individual who has requested such aid.” Compl. ¶ 3 (R. 23). The Complaint also seeks a declaration that the application of the Assisted Suicide Statute to aid-in-dying would violate the Due Process and Equal Protection provisions of New York’s Constitution. Id. 2

The Complaint includes numerous factual allegations that aid-in-dying is not assisted suicide and that aid-in-dying is indistinguishable from other lawful practices, such as terminal sedation. See, e.g., Compl. ¶ 38 (R. 36) (Aid-in-dying is “a recognized term of art for the medical practice of providing a mentally-competent, terminally-ill patient with a prescription for medication that the patient

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2 The Complaint named as defendants the New York State Attorney General and the District Attorneys for each district in which a Plaintiff resides. Rather than burdening the Court with additional filings, Plaintiffs and the District Attorneys entered into a stipulation that they would be bound by any result reached in the litigation between Plaintiffs and the Attorney General. As part of the stipulation, this action was discontinued without prejudice as to the District Attorney defendants.
may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable....It is recognized that what is causing the death of a patient choosing aid-in-dying is the underlying terminal illness.”); id. ¶ 44 (R. 38) (“Public health, medical, and mental health professionals... recognize that the choice of a dying patient for a peaceful death through aid-in-dying is not suicide, just as withholding or withdrawal of treatment or the choice of terminal or palliative sedation is not suicide.”).

On April 13, 2015, Defendant Eric T. Schneiderman filed a motion to dismiss the Complaint pursuant to CPLR § 3211 (a)(7) on the ground that the Complaint failed to state a cause of action, and pursuant to CPLR § 3211(a)(2) on the ground that the Complaint does not present a justiciable controversy. (R. 47). Plaintiffs opposed Defendant’s motion and requested oral argument. Plaintiffs also submitted affidavits from three medical professionals who regularly treat patients with terminal illnesses that explain why aid-in-dying is not suicide and why aid-in-dying is indistinguishable from other lawful conduct.

On October 23, 2015, without oral argument, the trial court issued a decision and order granting Defendant’s motion to dismiss pursuant to CPLR § 3211 (a)(7). Although the trial court held that Plaintiffs “successfully pled that they are entitled to judicial review of the statutes in question,” (Order at 6) (R. 11) the court concluded that the Complaint failed to state a cause of action. The trial court’s
decision neither addressed nor credited the factual allegations of the Complaint. The trial court also failed to address Plaintiffs’ cause of action alleging a violation of Plaintiffs’ due process rights.

Plaintiffs timely filed a notice of appeal and now seek reversal of the trial court’s dismissal of the Complaint.

ARGUMENT

I. THE TRIAL COURT IGNORED THE COMPLAINT’S FACTUAL ALLEGATIONS AND ERRONEOUSLY DISMISSED PLAINTIFFS’ CLAIM FOR DECLARATORY RELIEF CONCERNING THE MEANING OF THE ASSISTED SUICIDE STATUTE.

The trial court made a passing reference to – but failed to follow – the standard of review on a motion to dismiss under CPLR § 3211 (a)(7). A complaint should “be construed liberally,” and the court must “accept as true not only the complaint’s material allegations but also whatever can be reasonably inferred therefrom in favor of the pleader.” P.T. Bank Cent. Asia v. ABN Amro Bank N.V., 301 A.D.2d 373, 375-76 (1st Dep’t 2003) (citation and quotation marks omitted). A plaintiff is entitled to “the benefit of every possible favorable inference,” and the Court’s analysis is limited to determining “only whether the facts alleged fit within any cognizable legal theory.” Leon v. Martinez, 84 N.Y.2d 83, 87-88 (1994) (citation and quotation marks omitted).

Moreover, on a motion to dismiss a declaratory judgment action, “[t]he sole consideration . . . is whether a cause of action for declaratory relief is set forth, not
the question of whether the plaintiff is entitled to a favorable declaration.” *M.H. Mandelbaum Orthotic & Prosthetic Svcs., Inc. v. Werner*, 126 A.D.3d 857, at 858 (2d Dep’t 2015) (citation and quotation marks omitted). A motion to dismiss a declaratory judgment action should be denied “where a cause of action is sufficient to invoke the court’s power to render a declaratory judgment . . . as to the rights and other legal relations of the parties to a justiciable controversy . . .” *DiGiorgio v. 1109-1113 Manhattan Ave. Partners, LLC*, 102 A.D.3d 725, 728 (2d Dep’t 2013) (citation and quotation marks omitted) (alteration in original).

The trial court entirely failed to address, much less credit, the Complaint’s factual allegations concerning aid-in-dying. The trial court’s decision includes no discussion of Plaintiffs’ factual allegations. Instead, the trial court engaged in an abstract discussion of statutory interpretation and prosecutorial discretion unrelated to the Assisted Suicide Statute or to aid-in-dying. Order at 7-9 (R. 12-14).

The only question at this stage of the proceedings is whether Plaintiffs have stated a claim. In dismissing the Complaint, the trial court ignored this Court’s mandate that “[i]n a declaratory judgment action, the material facts and circumstances should be fully developed before the rights of the parties are adjudicated.” *Wolff v. 969 Park Corp.*, 86 A.D.2d 519, 520 (1st Dep’t 1982).
A. The Complaint Alleges That Aid-In-Dying Is Not Assisted Suicide.

Whether the Assisted Suicide Statute applies to aid-in-dying implicates factual issues that the trial court ignored and that cannot be resolved on a motion to dismiss. The Complaint alleges that “[i]n some cases, providing aid-in-dying is, in the professional judgment of a physician, a medically and ethically appropriate course of treatment.” Compl. ¶ 45 (R. 38). Moreover, the Complaint expressly alleges that “[p]ublic health, medical, and mental health professionals, including the physician Plaintiffs, recognize that the choice of a dying patient for a peaceful death through aid-in-dying is not suicide.” Compl. ¶ 44 (R. 38).

On Defendant’s motion to dismiss, Plaintiffs provided the trial court with affidavits and additional evidence concerning aid-in-dying – none of which the trial court mentioned – to support the Complaint’s allegations that aid-in-dying is not assisted suicide. See Leon v. Martinez, 84 N.Y.2d at 88 (on a motion to dismiss, a court “may freely consider affidavits submitted by the plaintiffs” (citation and quotation marks omitted)). For example, Plaintiffs provided evidence that professional organizations such as the American Public Health Association (“APHA”) “[r]eject[ ] the use of inaccurate terms such as ‘suicide’ or ‘assisted suicide’ to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death.” Schallert Aff. Ex. 1 (APHA Policy No. 20086) (R. 145). Other professional organizations – such as
the American Medical Women's Association, the American Medical Student
Association and the American College of Legal Medicine – have reached a similar
conclusion and determined that aid-in-dying is an appropriate medical option for
mentally-competent patients with terminal illnesses who are facing unbearable
suffering in the final stages of the dying process. *Id.* Exs. 2, 3, 4 (R. 144-155). In
states such as Oregon and Washington where aid-in-dying has been deemed
lawful, the death certificates of patients who choose it as an option identify the
cause of death as the patient’s underlying disease, rather than “suicide” or the
medication that is ingested. See, e.g., Wash. Rev. Code Ann. § 70.245.040 (“the
patient’s death certificate . . . shall list the underlying terminal disease as the cause
of death”); Schallert Aff. Ex. 8 at 48-49 (The Oregon Death with Dignity Act: A
Guidebook for Health Care Professionals) (R. 326-327) (“the attending physician
[should] complete the death certificate with the underlying terminal condition(s) as
the cause of death, and the manner of death as ‘natural’).

The conclusion that aid-in-dying is not assisted suicide was reinforced by the
expert affidavits of Dr. Eric Kress and Dr. Katherine Morris provided to the trial
court. Based on his experience in Montana, where the Montana Supreme Court
held that physicians providing aid-in-dying are not subject to criminal prosecution
(*Baxter v. State*, 224 P.3d 1211 (Mont. 2009)), Dr. Kress opined that aid-in-dying
is “one compassionate medical treatment option for dying patients” that should not
be considered suicide (Kress Aff. ¶ 9) (R. 438-439), that patients choosing aid-in-dying are “not suicidal” (Id. ¶ 10) (R. 439), that survivors of patients who choose aid-in-dying do not experience the adverse impact known to afflict survivors of someone who commits suicide (Id. ¶ 13) (R. 440), and that the practice is governed by professional standards. Id. ¶¶ 5, 12 (R. 437, 439). Based on her experience in other states where the practice is also lawful, Dr. Morris opined that she does not consider the deaths of her patients who choose aid-in-dying to be “any sort of ‘suicide’” (Morris Aff. ¶ 12) (R. 444), that she attributes the cause of death of such patients to their underlying illnesses (Id.), and that aid-in-dying is governed – as is all of medical practice – by professional practice standards, also referred to as “best practices” and “standard of care.” Id. ¶ 17 (R. 446).  

As other courts have recognized, the opinions of medical professionals are entitled to great weight in matters such as this.

The judicial process has classically deferred to the medical profession to provide guidelines in determining questions involving medical standards; court decisions are ultimately shaped by medical opinions and properly so. No one can seriously doubt that medical questions of life and death, particularly the proprietary of medical

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3 Since briefing was completed on Defendant’s motion, the Journal of Palliative Medicine released an article ahead of print in November 2015 that provides additional evidence that aid-in-dying is governed by clinical criteria and medical standards of care. See David Orentlicher, MD, et al., Clinical Criteria for Physician Aid in Dying, J. of Palliative Med., available at http://online.liebertpub.com/doi/abs/10.1089/jpm.2015.0092
treatment for the terminally ill, are matters calling for the consideration of professional medical opinion. 


B. The Complaint Alleges That Aid-In-Dying Is Indistinguishable From Other Lawful Practices.

The Complaint and the affidavits of Dr. Kress, Dr. Morris and Dr. Timothy Quill also explain why as a factual matter aid-in-dying is indistinguishable from other medical practices that are not considered suicide. Compl. ¶¶ 40-44 (R. 36-38); Kress Aff. ¶ 9 (R. 438); Morris Aff. ¶ 17 (R. 446); Quill Aff. ¶ 24 (R. 433). One such lawful option is terminal sedation – the administration of drugs to keep the patient continuously in deep sedation, with food and fluid withheld until death results. If the trial court had credited these factual allegations, Plaintiffs clearly plead that aid-in-dying is not unlawful. Indeed, the Supreme Court of Canada recently upheld the findings of a trial judge, after considering “the evidence of physicians and ethicists,” that “there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death.” *Carter v. Canada (Attorney General),* 2015 SCC 5, ¶ 23 (2015) (attached as Exhibit 6 to the Schallert Affirmation) (R. 162).
Justice Stevens' concurrence in *Washington v. Glucksberg*, 521 U.S. 702, 750-51 (1997) (Stevens, J., concurring), a case that analyzed aid-in-dying under the federal constitution, similarly undermines any such distinctions:

There may be little distinction between the intent of a terminally ill patient who decides to remove her life support and one who seeks the assistance of a doctor in ending her life; in both situations, the patient is seeking to hasten a certain, impending death. The doctor's intent might also be the same in prescribing lethal medication as it is in terminating life support. A doctor who fails to administer medical treatment to one who is dying from a disease could be doing so with an intent to harm or kill that patient. Conversely, a doctor who prescribes lethal medication does not necessarily intend the patient's death – rather that doctor may seek simply to ease the patient's suffering and to comply with her wishes. The illusory character of any differences in intent or causation is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation – the administration of sufficient dosages of pain-killing medication to terminally ill patients to protect them from excruciating pain even when it is clear that the time of death will be advanced. The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes, and the actual cause of death is the administration of heavy doses of lethal sedatives. This same intent and causation may exist when a doctor complies with a patient's request for lethal medication to hasten her death.
C. The Trial Court’s Discussion Of The Law Was Flawed.

Instead of addressing the well-pleaded factual allegations of the Complaint, the trial court made several legal observations that were wrong or irrelevant.

First, the trial court asserted that the Complaint sought to rewrite “a portion of the language” of the Assisted Suicide Statute. Order at 7 (R.12). This is simply inaccurate. The Complaint asked the court to decide whether the Assisted Suicide Statute applies to the underlying facts; no rewriting of the law is needed to declare Plaintiffs’ rights under the Statute.

Second, the trial court stated that the penal law as written was “clear and concise” (Order at 8) (R. 13) without any discussion of whether it applied to aid-in-dying. The Assisted Suicide Statute, on its face, does not purport to address aid-in-dying, nor has it been applied by any New York court to a physician providing aid-in-dying since its first codification nearly two hundred years ago. See Act of Dec. 10, 1828, ch. 20, § 4 1828 N.Y. Laws 19 (codified at N.Y. Rev. Stat. pt. 4, ch.1, tit. 2, art. 1, § 7, p. 661 (1829)). Indeed, aid-in-dying was not even a recognized concept in 1965 when the Assisted Suicide Statute obtained its current wording with the enactment of the present New York Penal Code. Whether the Assisted Suicide Statute is “clear and concise” is hardly determinative of Plaintiffs’ rights at the pleading stage.
Third, the trial court observed that “courts lack the authority to compel the prosecution of criminal actions” and that a court acts “beyond its jurisdiction” when it “assumes the role of the district attorney by compelling prosecution.” Order at 9 (R. 14). These propositions may be correct, but they are entirely irrelevant to this case because the Complaint did not seek an order compelling prosecution of criminal actions.

Fourth, the trial court asserted that “to prohibit a district attorney from prosecuting an alleged violation of law” would “exceed” the Court’s jurisdiction. Order at 9 (R.14). The trial court, however, manifestly has jurisdiction to determine whether the Assisted Suicide Statute applies to aid-in-dying and to determine whether any such application is constitutional. See Matter of Eichner (Fox), 73 A.D.2d at 452-53 (“[W]hen appropriate litigants present the court with a vital problem involving private rights as well as public policy, we would be remiss if we declined to act. . . . [T]his power of interpretation must be lodged somewhere, and the custom of the constitution has lodged in the judges.”). The trial court acknowledged as much when it held that “Plaintiffs have successfully pled that they are entitled to judicial review of the statutes in question.” Order at 6 (R.11).

The Complaint alleges that application of the Assisted Suicide Statute to aid-in-dying would violate Plaintiffs' rights to privacy and other fundamental liberties without due process of law in violation of the Due Process Clause of the New York Constitution, article I, § 6. See Compl. ¶¶ 66-73 (R. 43-44). The Complaint also alleges that applying the Assisted Suicide Statute to physicians providing aid-in-dying would violate the Equal Protection Clause of the New York Constitution, article I, § 11, because the Assisted Suicide Statute would not treat equally all similarly situated patients who are in the final stages of a fatal illness. See Compl. ¶¶ 58-65 (R. 41-43).

When a statute burdens a fundamental right protected under the Due Process Clause, or when it treats differently similarly situated classes of individuals in a manner that burdens a fundamental right, it is subjected to strict scrutiny, “meaning that it will be sustained only if it is narrowly tailored to serve a compelling state interest.” Hernandez v. Robles, 7 N.Y.3d 338, 375 (2006) (citation and quotation marks omitted). The trial court ignored New York’s longstanding fundamental right to self-determination with respect to one’s body and to control the course of his medical treatment, which is sufficiently broad to encompass aid-in-dying. Plaintiffs have pled facts to establish an infringement of this right to self-
determination in violation of both the Due Process Clause and Equal Protection Clause of the New York Constitution, if the Assisted Suicide Statute is applied to aid-in-dying.

Even if aid-in-dying is found not to implicate a fundamental right, Plaintiffs may succeed on their constitutional claims if they can demonstrate that a prohibition on aid-in-dying or that the distinctions drawn by the Assisted Suicide Statute are not rationally related to a legitimate government interest. *Hernandez*, 374 N.Y.3d at 375. This inquiry inherently requires development of a factual record, the resolution of which is wholly improper on a pre-answer motion to dismiss. The trial court failed to address these factual issues. The trial court also did not even mention Plaintiffs’ Due Process claim and relied upon – and misconstrued – inapposite authority in disposing of Plaintiffs’ Equal Protection claim.

A. The Trial Court Failed To Consider New York’s Broad Fundamental Right To Self-Determination, Which Encompasses Aid-In Dying.

New York has long recognized a fundamental common law right to self-determination with respect to one’s body and to control the course of his medical treatment. *See Rivers v. Katz*, 67 N.Y.2d 485, 492 (1986) (“It is a firmly established principle of the common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his
own body and to control the course of his medical treatment.” (citations and quotation marks omitted)); Matter of Delio v. Westchester Cnty. Med. Ctr., 129 A.D.2d 1, 13 (2d Dep’t 1987) (“The right to self-determination with respect to one’s body has a firmly established foundation in the common law.”).

The Court of Appeals has broadly described the right to self-determination:

In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Rivers, 67 N.Y.2d at 493 (citations and quotation marks omitted). This fundamental right to self-determination is described more broadly than the privacy rights recognized under the Federal Constitution. Although New York courts have not yet addressed the specific question of whether aid-in-dying is a fundamental right, the fundamental right to self-determination is certainly broad enough to encompass aid-in-dying. See Delio, 129 A.D.2d at 16 (“The primary focus evident in the Court of Appeals analysis is upon the patient’s desires and his right to direct the course of his medical treatment rather than upon the specific treatment involved.”).

Indeed, patients who seek aid-in-dying have the same stake as others in the autonomy, privacy, bodily integrity, and self-determination protected by the
fundamental liberties recognized in New York. See Eichner, 73 A.D.2d at 459
(“Individuals have an inherent right to prevent pointless, even cruel, prolongation
of the act of dying. . . . [A] competent adult who is incurably and terminally ill has
the right, if he so chooses, not to resist death and to die with dignity.”) (citations
and quotation marks omitted).

Prohibiting patients from choosing aid-in-dying would severely infringe
these rights. See Rivers, 67 N.Y.2d at 493 (recognizing the “fundamental
common-law right [to self-determination] is coextensive with the patient’s liberty
interest protected by the due process clause of our State Constitution” in context of
refusing medical treatment (citation omitted)). Without having access to this
medically and ethically appropriate end-of-life care, patients for whom aid-in-
dying would be an appropriate option likely face further severe and needless
suffering. See, e.g., Compl. ¶¶ 43 (R. 37); Quill Aff. ¶ 6, 24 (R. 428, 433). They
face the real possibility that their death will be drawn out, unbearable, and lacking
in dignity and peace. See, e.g., Compl. ¶ 33 (R. 32-33).

The Complaint alleges that patients who seek aid-in-dying are exercising a
fundamental right to privacy and that any law prohibiting them from exercising
that right is a violation of the due process guarantees of the New York
Constitution. Compl. ¶ 67 (R. 43). The Complaint also alleges that, if the Assisted
Suicide Statute is interpreted to encompass aid-in-dying, it deprives Plaintiffs of
equal protection of the law in violation of the New York Constitution. *Id.* ¶ 63 (R. 42). The Complaint further alleges that such prohibitions are not the least restrictive means of advancing a compelling state interest. *Id.* ¶¶ 64, 71 (R. 42-43). Plaintiffs’ claims under the New York Constitution are properly pled.

**B. Plaintiffs’ Constitutional Claims Require Development Of An Evidentiary Record, Not Dismissal At The Pleading Stage.**

Even if aid-in-dying is found not to involve a fundamental right, Plaintiffs may still succeed on their constitutional claims if they can show that a prohibition on aid-in-dying is not rationally related to a legitimate government interest. *Hernandez*, 374 N.Y.3d at 375. The Complaint alleges that a State prohibition on aid-in-dying has no rational basis (Compl. ¶¶ 64, 71) (R. 42-43); questions regarding whether any legitimate interest exists requires development of an evidentiary record.

Defendant argued to the trial court that it has an interest in preserving life, protecting the integrity and ethics of the medical profession, protecting vulnerable patients, and maintaining clear rules regarding assisted suicide. Although Plaintiffs are not required to present evidence at the pleading stage to survive a motion to dismiss, Plaintiffs provided the trial court with evidence that would rebut these asserted interests. For example, there is abundant evidence from Oregon that, since aid-in-dying became available, end-of-life care has improved in measurable ways: referrals to hospice care occur more often and earlier, and
palliative care and communication between patient and physician have improved. All of these developments improve quality of life of patients with terminal illnesses. See, e.g., Quill Aff. ¶ 19 (R. 431); Morris Aff. ¶ 15 (R. 445); Schallert Aff. Ex. 9, at 4 (R. 409).

Extensive experience has also shown that where aid-in-dying is openly practiced, life may be extended, not shortened. In such states, “there is evidence that some patients may even survive longer because they have the option of dying on their own terms. Freed of the anxiety over loss of control and unbearable suffering, patients’ remaining days are of higher quality.” Quill Aff. ¶ 19 (R. 431). The Supreme Court of Canada recently upheld a trial court’s factual finding, based on hearing extensive testimony from witnesses and experts, that “the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.” Carter, 2015 SCC 5, at ¶ 57 (R. 206). The development of an evidentiary record was crucial, as the Canadian Supreme Court’s decision cited over fifty times to the factual conclusions of the trial court that were based on the evidence presented. Plaintiffs are entitled to present similar evidence on a full record here.

Plaintiffs are also entitled to present evidence concerning how access to aid-in-dying affects their privacy and liberty interests that are at stake. For example,
the trial court should have the benefit of Plaintiffs’ testimony concerning how access to aid-in-dying would provide the patient Plaintiffs with individual autonomy, free choice, privacy, and dignity as they approach the final stages of the dying process. The trial court should also have the benefit of testimony concerning how the uncertainty surrounding the legality of aid-in-dying has deprived the patient Plaintiffs of their fundamental right to self-determination and their right to life, liberty and happiness.

Only upon a developed evidentiary record can the State’s interests in prohibiting aid-in-dying be weighed against Plaintiffs’ privacy and liberty interests. Plaintiffs have asserted that the violation of their rights is not rationally related to any legitimate state interest, does not further an important state interest, nor is it the least restrictive means of advancing any compelling state interest.

Compl. ¶¶ 64, 71 (R. 42-43). The trial court was required to credit these allegations on Defendant’s motion to dismiss.

C. The Trial Court Ignored Plaintiffs’ Due Process Claim And Relied Upon Inapposite Authority In Dismissing Plaintiffs’ Equal Protection Claim.

The trial court entirely failed to address Plaintiffs’ Due Process claim and articulated no basis for dismissing it. This was error. Plaintiffs have pled a claim for the violation of their due process rights for the reasons explained above. In dismissing Plaintiffs’ Equal Protection claim, the trial court relied on Bezio v.

The trial court erroneously stated that “Plaintiffs’ equal protection contentions were recently analyzed in *Bezio v. Dorsey.*” Order at 10-11 (R. 14-15). *Bezio*, however, did not address aid-in-dying but instead addressed whether the rights of an inmate who undertook a hunger strike were violated by a judicial order permitting the State to feed him by nasogastric tube after his health devolved to the point that his condition became life threatening. *Bezio*, 21 N.Y.3d at 96. Although the court in *Bezio* rejected the prisoner’s constitutional claims, it specifically distinguished his situation from that of “terminally-ill patients or those in an irreversible incapacitated condition as a result of illnesses or injuries beyond their control.” *Id.* at 102-03. The court observed that “[i]n those circumstances, unlike this one, the patients were suffering from dire medical conditions that were not of their own making . . . .” *Id.* at 103. The Complaint in this case clearly alleges that Plaintiffs are afflicted with terminal illnesses; *Bezio* thus has no bearing on Plaintiffs’ Equal Protection claim.

The trial court also erred when it stated that this case is “factually and legally indistinguishable from *Vacco.*” The claims in *Vacco* were brought under the United States Constitution, not the New York State Constitution. In any event, although the U.S. Supreme Court declined at the time to find a federal
constitutional right to choose aid-in-dying in *Vacco* (and in the companion case *Washington v. Glucksberg*), it left the matter open for states to determine the legality for themselves. *See Washington v. Glucksberg*, 521 U.S. 702, 735 (1997) ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."); *Vacco*, 521 U.S. at 737 ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. . . . In such circumstances, the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . .") (O'Connor, J., concurring) (second and third omissions in original) (citation and internal quotation marks omitted)).

The Supreme Court also carefully reserved the possibility that it might in the future, based upon particular circumstances, find that a prohibition on aid-in-dying violated the Equal Protection Clause of the Federal Constitution. *See Vacco*, 521 U.S. at 809 n.13 ("Justice Stevens observes that our holding today 'does not foreclose the possibility that some application of the New York statute may impose an intolerable intrusion on the patient's freedom.' This is true . . . .") (citations and quotation marks omitted). Accordingly, *Vacco* clearly does not foreclose a New
York court from finding that Plaintiffs’ rights will be violated under the New York
Constitution if the Assisted Suicide Statute is applied to aid-in-dying.

To the extent the United States Supreme Court’s jurisprudence informs the
interpretation of the New York State Constitution, its analysis of fundamental
liberties has evolved since it decided Vacco eighteen years ago. More recent cases
such as Lawrence v. Texas, 539 U.S. 558 (2003) and Obergefell v. Hodges, 135 S.
Ct. 2584 (2015) recognize that the inquiry into the existence of fundamental rights
properly calls for consideration of evolving social views. See Obergefell, 135 S.
Ct. at 2602 (“[Fundamental rights] rise, too, from a better informed understanding
of how constitutional imperatives define a liberty that remains urgent in our own
era.”); Lawrence, 539 U.S. at 571-72 (“In all events we think that our laws and
traditions in the past half century are of most relevance here.”).

If the U.S. Supreme Court were today faced with the issues that were
presented in Vacco, it would have the benefit of evidence of evolving societal
views over the past eighteen years, including the adoption of policies by various
medical associations that support aid-in-dying (Schallert Aff. Exs. 1, 2, 3, 4. ) (R.
144-155), polls reflecting public acceptance of aid-in-dying (see, e.g., Compl. ¶ 50)
(R. 39), and developments in other countries that have recognized the right of a
patient to physician assistance in achieving a peaceful death. See, e.g., Carter v.
Canada (Attorney General), 2015 SCC 5 (2015) (R. 162) (striking down Canada’s assisted suicide statute). The trial court’s reliance on Vacco was thus misplaced.
CONCLUSION

For the foregoing reasons, this Court should reverse the trial court’s order dismissing Plaintiffs’ Complaint.

Dated: November 23, 2015
New York, New York

Respectfully submitted,

DEBEVOISE & PLIMPTON LLP

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STATEMENT PURSUANT TO CPLR 5531

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION—FIRST DEPARTMENT

Sara Myers, Steve Goldenberg, Eric A. Seiff, Howard
Grossman, M.D., Samuel C. Klagsbrun, M.D., Timothy E.
Quill, M.D., Judith K. Schwarz, Ph.D., Charles A.
Thornton, M.D., and End of Life Choices New York,

Plaintiffs-Appellants,

—against—

Eric Schneiderman, in his official capacity as Attorney
General of The State of New York,

Defendant-Respondent,

Janet DiFiore, in her official capacity as District Attorney
of Westchester County, Sandra Doorley, in her official
capacity as District Attorney of Monroe County, Karen
Heggen, in her official capacity as District Attorney of
Saratoga County, Robert Johnson, in his official capacity as
District Attorney of Bronx County and Cyrus R. Vance, Jr.,
in his official capacity as District Attorney of New York
County,

Defendants.

1. The Index Number in the trial court was 151162/15.

2. The full names of the parties are as stated in caption above. The Attorney General’s Office
and Plaintiffs-Appellants voluntarily discontinued the action without prejudice against the
following District Attorney Defendants: Janet DiFiore (Westchester County), Sandra
Doorley (Monroe County), Karen Heggen (Saratoga County), Robert Johnson (Bronx
County), and Cyrus Vance, Jr. (New York County).

3. The action was commenced in the Supreme Court, New York County.

4. The summons and complaint were served on all Defendants-Respondents on February 4,
2015. No answer has been served.

5. Plaintiffs-Appellants seek a declaration that a physician who provides aid-in-dying to a
patient who has requested such aid does not violate New York Penal Law §§ 120.30 and
125.15 (the “Assisted Suicide Statute”). Plaintiffs-Appellants seek, in the alternative, a
declaration that the application of the Assisted Suicide Statute to aid-in-dying violates the
Due Process and Equal Protection provisions of the New York State Constitution. Plaintiffs-Appellants seek an order permanently enjoining the Defendants, their agents, and all those acting in concert with them, from prosecuting Plaintiffs-Appellants under the Assisted Suicide Statute for providing aid-in-dying to mentally-competent, terminally-ill individuals.

6. The appeal is from an order of the Supreme Court of the County of New York, Joan M. Kenney, J., dated October 16, 2015, entered in the New York County Clerk’s Office on October 19, 2015.

7. The appeal is being perfected on the full record method.
No. 151162/15
To be argued by:
ANISHA S. DASGUPTA

Supreme Court, New York County

Supreme Court of the State of New York
Appellate Division – First Department

SARA MYERS, STEVE GOLDENBERG, ERIC A. SEIFF, HOWARD GROSSMAN, M.D.,
SAMUEL C. KLAGSBRUN, M.D., TIMOTHY E. QUILL, M.D., JUDITH K. SCHWARZ, PH.D.,
CHARLES A. THORNTON, M.D., and END OF LIFE CHOICES NEW YORK,

Plaintiffs-Appellants,

-against-

ERIC SCHNEIDERMAN, in his official capacity as
ATTORNEY GENERAL OF THE STATE OF NEW YORK,

Defendant-Respondent,

JANET DI FIORE, in her official capacity as DISTRICT ATTORNEY OF WESTCHESTER
COUNTY, SANDRA DOORLEY, in her official capacity as DISTRICT ATTORNEY OF
MONROE COUNTY, KAREN HEGGEN, in her official capacity as DISTRICT ATTORNEY OF
SARATOGA COUNTY, ROBERT JOHNSON, in his official capacity as DISTRICT ATTORNEY
OF BRONX COUNTY, and CYRUS R. VANCE, JR., in his official capacity as DISTRICT
ATTORNEY OF NEW YORK COUNTY,

Defendants.

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Dated: January 6, 2016

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PRELIMINARY STATEMENT

New York State has a long-standing and legitimate concern for the lives of all of its citizens, whatever their mental or physical condition. To that end, the State has taken various measures to prevent suicides and to protect individuals in the vulnerable position of making end-of-life decisions. These measures include the enactment of Penal Law 120.30 and 125.15, which prohibit aiding another person’s efforts to commit suicide.

Plaintiffs seek declaratory and injunctive relief that would except, from the Penal Law’s prohibition, the conduct of a medical provider who prescribes lethal medications for use by a patient to take his or her own life. Plaintiffs contend that Penal Law §§ 120.30 and 125.15 do not by their terms apply to such conduct, and that any such application would be inconsistent with the New York Constitution’s guarantees of equal protection and due process.

Supreme Court properly dismissed plaintiffs’ suit and this Court should affirm. The Penal Law’s prohibition on intentionally aiding another person to attempt suicide plainly encompasses the act of providing an individual with medication to use in ending his or her life.
And in any event, plaintiffs are incorrect that this question presents a factual issue, rather than a legal issue that could be resolved on a motion to dismiss. See Br. at 8-11.

Plaintiffs’ equal protection and due process claims also fail. The Court of Appeals has repeatedly recognized that “a right to refuse medical treatment is not the equivalent of a right to commit suicide.” See Matter of Bezio v. Dorsey, 21 N.Y.3d 93, 101-02 (2013); Fosmire v. Nicoleau, 75 N.Y.2d 218 (1990). And New York law plainly does not confer any fundamental right to receive assistance in taking one’s own life. Since colonial times, New York has consistently criminalized aiding another person to take his or her life, including when such actions are motivated by sympathetic concerns. Powerful state interests underlie those prohibitions, such as the State’s commitment to safeguarding the lives of all of its citizens and protecting individuals in the vulnerable position of making end-of-life decisions.

New York has reasonably determined that creating the exception plaintiffs seek at this time would, among other things, risk harm to persons whose decision to seek the medication is motivated by external pressures—for example, those who are elderly, poor, without access to
good medical care, or suffering from uncontrolled pain or untreated depression. The State has also reasonably determined that allowing such an exception could pose grave risks to terminally ill patients who do not wish to terminate their lives, or who are not mentally competent to make health decisions for themselves. The State is entitled to draw clear rules in this context to avoid opening the door to involuntary euthanasia, or requests for lethal medication from those who are not facing imminent death but wish to end their lives for other reasons.

**QUESTIONS PRESENTED**

1. Does New York’s prohibition on assisting in another person’s suicide prohibit a physician from prescribing a lethal dose of medication to a mentally competent, terminally ill patient who requests the medication for the purpose of ending his or her life?

2. Is this application of New York’s prohibition on assisting in another person’s suicide consistent with constitutional guarantees of equal protection and due process?

   Supreme Court answered both questions in the affirmative.
STATEMENT OF THE CASE

A. New York’s Long-standing Prohibitions on Assisting Suicide

“[F]or 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) (discussing historical statutes and commentaries). As early as the thirteenth century, the English common law treated the act of taking one’s own life as a felony offense and also prohibited the practice of assisting with such an act. Id. at 711; id. at 774 n.13 (Souter, J., concurring). The family of an individual who took his own life could be punished by forfeiture of the individual’s movable goods, and, in some cases, by forfeiture of their real property as well. See id. at 711.

During colonial times, New York applied these common law prohibitions and penalties. See N.Y. Const. of 1777, art. XXXV.¹ After

¹ This provision states in relevant part:

[S]uch parts of the common law of England, and of the statute law of England and Great Britain, and of the acts of the legislature of the colony of New York, as together did form the law of the said colony on the 19th day of April, in the year of our Lord one thousand seven hundred and

(continued on the next page)
the Revolutionary War, New York State passed statutes recognizing the existence of common-law crimes and setting forth procedures and penalties for their punishment. Act of Feb. 21, 1788, ch. 37, § 2, 1788 N.Y. Laws 664, 665; see also Law Revision Commission, Report, No. 65, at 830 (1937) (observing that New York’s prohibition on assisting suicide is “traceable into the ancient common law”).

In 1828, New York passed the first American statute explicitly criminalizing the act of helping another person to end his or her life, providing for treatment of that offense as manslaughter in the first degree. Rev. Stat. pt. IV, ch. 1, tit. 2, art. 1, § 7 (1829). In 1881, the State explicitly prohibited attempts to take one’s own life, setting a penalty of up to two years in prison, a fine, or both. Penal Law tit. IX, ch. 1, §§ 175, 176, 178 (1881), codified at 4 N.Y. Consolidated Laws, Penal Law §§ 2300 to 2306 (1909). The 1881 law also deemed the act of

*seventy-five*, shall be and continue the law of this State, subject to such alterations and provisions as the legislature of this State shall, from time to time, make concerning the same.

N. Y. Const. of 1777, Art. XXXV (emphasis added).
taking one’s own life “a grave public wrong” but noted that because of the “impossibility of reaching the successful perpetrator, no forfeiture is imposed.” Id. §§ 172-173. The State continued to penalize assisting that act as first-degree manslaughter, however. See id. § 175.

In 1919, New York decriminalized the act of attempting to take one’s own life, yet declined to decriminalize the conduct of helping with such an act. See Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193, 1193; see also 4 N.Y. Consolidated Laws, Penal Law § 2305 (1909). Similarly, in its 1965 revision of the Penal Law, the State omitted the declaration that taking one’s own life is a “grave public wrong,” but retained the criminal prohibition on assisting with that act. See ch. 1030, 1965 N.Y. Laws 2343, 2385, 2387, codified at Penal Law §§ 120.30, 125.15(3).

At present, section 120.30 of the Penal Law provides that “[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.” Section 125.15(3) provides that “[a] person is guilty of manslaughter in the second degree when,” among other things, “[h]e intentionally causes or aids another
person to commit suicide.” Violation of either section of the law constitutes a felony.

These prohibitions apply “even where the defendant is motivated by ‘sympathetic’ concerns, such as the desire to relieve a terminally ill person from the agony of a painful disease.” People v. Duffy, 79 N.Y.2d 611, 615 (1992) (quoting Staff Notes of Comm’n on Revision of Penal Law and Crim. Code to Proposed N.Y. Penal Law, McKinney’s Cons. Laws of N.Y., Spec. Pamphlet, at 339 (West 1964) (“Staff Notes”)). See Richard G. Denzer and Peter McQuillan, Practice Commentary to § 125.15, 39 McKinney’s Cons. Laws of N.Y. at 226-27 (West 1967) (“1967 Practice Commentary”).

Since 1965, New York has continued to reflect upon end-of-life issues, and to clarify the outlines of individuals’ rights to autonomy in the medical context. In 1985, the State established the New York State Task Force on Life and the Law (“Task Force”), to assist the State in developing public policy on issues arising at the intersections of medicine, law, and ethics. The next year, the Task Force issued a report and recommendations on “do not resuscitate” orders, including a proposal for legislation. See Task Force, Do Not Resuscitate Orders: The

In 1987 the Task Force issued a report discussing the withdrawal of life-sustaining treatment and the appointment of health care proxies. See Task Force, Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent (July 1987). In that report, the Task Force examined the ethics of foregoing medical treatment and the difference between killing a patient and letting that patient die. Id. at
While endorsing the view that competent adults have a right to make “decisions about the withholding and withdrawal of artificial nutrition and hydration,” the Task Force concluded that “the taking of human life” through euthanasia “must not be granted legal sanction.” Id. at 40-41. “If one human being is legally permitted to take the life of another,” the Task Force reasoned, “society will have changed its understanding of human life.” Id. at 42. The legislature subsequently codified the distinction between withdrawal of medical treatment and killing. In 1990, it authorized health-care proxies to direct the withholding of life-sustaining treatment, but declared at the same time that this measure “is not intended to permit or promote suicide, assisted suicide, or euthanasia.” See Public Health Law § 2989(3) (enacted 1990).

Summary and Introduction. The Task Force based its view on (i) the risks that could be presented to the elderly, poor, socially disadvantaged, and those without access to good medical care; and (ii) the role of treatable symptoms such as pain and depression in creating a desire for lethal medications. \textit{Id}. The Task Force also considered consequences that would result from blurring the State’s bright-line prohibitions on assisting another person to take his or her life, especially given that most doctors lack a sufficiently close relationship to their patients to appropriately evaluate a request for help in committing suicide. \textit{Id}. Finally, the report expressed concern about the possibility that permitting physician-assisted suicide could open the door to euthanasia of those incapable of consent. \textit{Id}.

Since 1994, various legislative amendments to the Penal Law have been proposed that would permit physicians to aid patients in ending their lives without criminal penalty.\footnote{\textit{See, e.g.}, A. 5261, 238th Sess. (2015) (proposal to amend the public health law to authorize physicians to prescribe medications that assist a patient in ending his or her life), A. 2129, 238th Sess. (2015)} Each of these efforts, however, has failed.
B. The Petition in This Case

Plaintiffs seek an exception from New York’s prohibition on assisting suicide for medical professionals who provide lethal narcotics to mentally competent, terminally ill patients. They contend that the prohibition does not by its terms apply to such an act (R. 7) or, in the alternative, that such an application is inconsistent with the equal protection and due process clauses of the New York Constitution. (R. 9, 41-44).

Plaintiffs Sara Myers and Steve Goldenberg are terminally ill adults. (See R. 7, 26-27.) Plaintiff Eric Seiff has an illness that he is concerned may progress to a terminal stage. (See R. 7, 30.) The other plaintiffs are five medical professionals who regularly treat terminally ill patients, and End of Life Choices New York, an advocacy group.
Each of the patient-plaintiffs has alleged that he or she is mentally competent and seeks to obtain—or wishes to have available the option of obtaining—prescription narcotics to aid in achieving death when the pain from his or her condition becomes too much to bear. (See R. 7, 26-30.) Plaintiffs term this option “aid-in-dying” (R. 2, 36), and assert that the death they seek is distinct from suicide, which plaintiffs define as “precipitat[ing] a premature death of a life of otherwise indefinite duration, often motivated by treatable depression” (R. 38).

C. Supreme Court’s Dismissal of the Complaint

Supreme Court, New York County (Kenney, J.) granted the State’s motion to dismiss the complaint for failure to allege facts showing a cause of action. (R. 5-17.) See C.P.L.R. 3211(a)(7).

Noting the “clear” language of Penal Law §§ 120.30 and 125.15, the court first held that the State’s prohibition on assisting suicide undoubtedly extends to the practice of providing lethal medications to mentally competent, terminally ill patients. (R. 12-13.) The court then

3 Plaintiffs discontinued their suit against the District Attorney defendants during the trial proceedings, leaving the State as the sole defendant in this suit. (See R. 6.)
rejected plaintiffs’ claim that such an application was inconsistent with the New York Constitution’s guarantees of equal protection and due process, relying on the New York Court of Appeals’ recognition that “the State has long made a constitutionally-permissible distinction between a right to refuse medical treatment and a right to commit suicide (or receive assistance in doing so).” R. 15 (quoting Matter of Bezio v. Dorsey, 21 N.Y.3d 93, 101 (2013)). The court also observed that plaintiffs’ constitutional arguments were essentially identical to the arguments rejected by the United States Supreme Court in Vacco v. Quill, 521 U.S. 793 (1997).

ARGUMENT

On a motion to dismiss under C.P.L.R. 3211, the court “determines only whether the facts as alleged fit within any cognizable legal theory.” VisionChina Media Inc. v. Shareholder Representative Servs., LLC, 109 A.D.3d 49, 55 (1st Dep’t 2013). Because the facts presented here do not meet that bar, Supreme Court’s decision should be affirmed.
POINT I

NEW YORK'S PENAL LAW PROHIBITS
THE ACT OF ASSISTING ANOTHER
PERSON TO TAKE HIS OR HER LIFE

From colonial times, New York has consistently prohibited the act of helping another person to end his or her life. See supra pp. 4-10 & 10-11 n.2. The current version of that prohibition is codified in the State’s Penal Law, which authorizes the imposition of criminal penalties on an individual who “aids another person to commit suicide,” Penal Law § 125.15(3), or “aids another person to attempt suicide,” id. § 120.30.


Here, as this Court has observed, “[t]here is nothing confusing or unclear about the words ‘aiding . . . another person to commit suicide.’” Id. at 204-05 (ellipsis in original quotation). Suicide is commonly
defined as “the act of taking one’s own life.” *Black’s Law Dictionary* 1662 (10th ed. 2014); *see also* Merriam-Webster’s *Collegiate Dictionary, Eleventh Edition* (Merriam-Webster, Inc., 11th ed. 2003) (defining suicide as “the act or an instance of taking one’s own life voluntarily and intentionally”). “The ordinary meaning of the term ‘aid’ is to help or assist” through active or passive means. *Minor*, 111 A.D.3d at 205.

The Penal Law’s prohibition on aiding “suicide” thus plainly encompasses the act of providing an individual with medication to use in ending his or her life: the same conduct that plaintiffs term “aid-in-dying” (*See* Br. at 1; *see* R. 36). Contrary to plaintiffs’ claims (Br. at 8), no factual inquiry is necessary to resolve that question. As the Court of Appeals has observed, it is clear that the drafters of §§ 120.30 and 125.15(3) intended those provisions to apply “even where the defendant is motivated by ‘sympathetic’ concerns, such as the desire to relieve a terminally ill person from the agony of a painful disease.”* Duffy*, 79 N.Y.2d at 615 (quoting Staff Notes, *supra*, at 339).

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*4 For example, as explained in a practice commentary for § 125.15 that was published contemporaneously with the statute’s enactment and cited by the Court of Appeals in *Duffy*, New York’s prohibition on* (continued on the next page)
In any event, plaintiffs have not identified any factual disputes that Supreme Court failed to resolve in their favor.\textsuperscript{5} Rather, the “affidavits and additional evidence” plaintiffs reference in their brief concern the policy views of various individuals, organizations, and the States of Oregon and Washington. See Br. at 8-9 (explaining that these entities have taken the position that “aid-in-dying is an appropriate medical option”). But the existence of differing opinions on whether physician-assisted suicide should be permitted does not change the legal reality that New York has chosen to prohibit the act of providing another individual with active or passive assistance in taking their own life.

assisting suicide would cover the actions of a “man who, upon the plea of his incurably ill wife, brings her a lethal drug in order to aid her in ending a tortured existence.” 1967 Practice Commentary, \textit{supra}, at 226-27; see also Duffy, 79 N.Y.2d at 615.

\textsuperscript{5} Plaintiffs are mistaken in asserting that Supreme Court was required to credit their “allegations that aid-in-dying is not assisted suicide.” Br. at 1. On a motion to dismiss, a court “need not accept legal conclusions or factual allegations that are inherently incredible or flatly contradicted by documentary evidence or well-established law.” \textit{Bumbury v. City of N.Y.}, 62 A.D.3d 621, 624 (1st Dep’t 2009).
The same is true of plaintiffs’ assertions that certain medical practitioners and the Supreme Court of Canada have concluded “there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death,” such as administering palliative drugs to a patient who has declined to receive life-sustaining artificial hydration and nutrition (Br. at 11 (quotation marks omitted)). Whether or not others might differentiate between those practices, New York law unquestionably does. Indeed, as the Court of Appeals has recognized, “the State has long made a constitutionally-permissible distinction between a right to refuse medical treatment and a right to commit suicide (or receive assistance in doing so).” Matter of Bezio, 21 N.Y.3d at 103. And the Court has confirmed that this distinction holds even where the refusal to receive medical treatment is “arguably life-threatening.” Id. at 102.

Various proposals have been made to the Legislature to “decriminalize a patient’s act of requesting medication to end life and the prescribing of such medication by a physician licensed in New York
state.” S. 677, 224th Sess. (2001); see S. 7396, 223rd Sess. (2000) (same). These efforts, however, have been unsuccessful.

Thus, contrary to plaintiffs’ assertions (Br. at 13), Supreme Court did not err in describing plaintiffs’ arguments as being aimed at “rewriting” the Penal Law to achieve an outcome they have been unable to obtain through the legislative process. What plaintiffs seek is the resolution to a policy question—namely, whether the Penal Law should treat physician-assisted death as an appropriate medical option. But a court of law is not the appropriate venue for obtaining this answer. When courts review legislation, they “do so to protect rights, not to make policy.” See Campaign for Fiscal Equity, Inc. v. State, 8 N.Y.3d 14, 28 (2006).

See also Sponsor’s Mem. for A. 5261, 238th Sess. (2015) (proposed legislation would provide “that a physician shall not be subject to civil or criminal liability or professional disciplinary action if the physician prescribes to a terminally ill patient medication to be self-administered for the purpose of hastening the patient’s death . . .”); Sponsor’s Mem. for A. 2129, 238th Sess. (2015) (“This bill . . . will protect physicians from civil or criminal liability and from professional disciplinary action if they fulfill a qualified patient’s request” for medication to end the patient’s life).
POINT II
GOVERNING PRECEDENT FORECLOSES PLAINTIFFS’ EQUAL PROTECTION AND DUE PROCESS CLAIMS

A. Plaintiffs’ Allegations Do Not State an Equal Protection Claim.

New York’s equal protection clause “does not mandate absolute equality of treatment but merely prescribes that, absent a fundamental interest or suspect classification, a legislative classification be rationally related to a legitimate State purpose.” People v. Meckwood, 20 N.Y.3d 69, 73 (2012) (citation omitted). Because plaintiffs do not allege that they constitute a suspect class, and because the Penal Law does not implicate a fundamental right (see infra Point II.B.1), the statutory provisions at issue here “need only be supported by some rational basis to survive constitutional scrutiny.” Id. (quotation marks and citation omitted).

The court below properly applied these standards to dismiss plaintiffs’ claim that prohibiting physicians from providing lethal drugs to patients, while allowing terminally ill patients to refuse life-sustaining treatment, creates unconstitutional distinctions between “similarly situated patients who are in the final stages of a fatal
illness.” Br. at 15. (See R. 41-42; see also R. 15.) Under New York law, all mentally competent, terminally ill patients may “refuse unwanted lifesaving medical treatment” and “no one is permitted to assist a suicide” or receive such assistance. Vacco, 521 U.S. at 800 (emphasis original).

Regarding the rationality of that approach, the Court of Appeals has recognized on more than one occasion that “a right to refuse medical treatment is not the equivalent of a right to commit suicide.” Matter of Bezio, 21 N.Y.3d at 101 (discussing Fosmire v. Nicoleau, 75 N.Y.2d 218 (1990)). As the Court has explained, the right to avoid medical intervention is “based on the common law and statutory right of informed consent,” but there is no equivalent common-law or statutory right to commit self-harm or to take one’s own life. Id. at 101-02; see also Fosmire, 75 N.Y.2d at 226-27; Matter of Storar, 52 N.Y.2d at 377.

The United States Supreme Court relied on similar observations when rejecting a federal equal-protection challenge to New York’s prohibition on physician-assisted suicide. See Vacco, 521 U.S. at 797. The Court determined that “the distinction between assisting suicide
and withdrawing life-sustaining treatment” is “widely recognized and endorsed in the medical profession and in our legal traditions.” 521 U.S. at 800. And the Court concluded that this distinction was “certainly rational” in light of settled principles of causation. Id. at 801. For example, when a patient dies after refusing life-sustaining medical treatment, he dies because of the underlying disease or pathology that created the need for that treatment. Id.; see also Matter of Bezio, 21 N.Y.3d at 103. But when a patient dies after ingesting lethal medication, it is that medication and not the underlying condition that has ended the patient’s life. Vacco, 521 U.S. at 801 (citing People v. Kevorkian, 447 Mich. 436, 470-72 (1994), cert. denied sub nom. Hobbins v. Kelley, 514 U.S. 1083 (1995)).

Put another way, “whereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention.” Kevorkian, 447 Mich. at 472-73. The distinction between these acts accordingly reflects the “distinction between ‘misfeasance’ and ‘nonfeasance’” or “between active misconduct and passive inaction,” which “is deeply rooted in the law of negligence.” Id. at 471.
The United States Supreme Court, in *Vacco*, thus held that “refusing lifesaving medical treatment and assisted suicide” are readily distinguishable, and that “New York may therefore, consistent with the [United States] Constitution, treat them differently.” 521 U.S. at 807-08. The Equal Protection Clause of the New York Constitution “is no more broad in coverage than its Federal prototype.” *Dorsey v. Stuyvesant Town Corp.*, 299 N.Y. 512, 530 (1949); accord *Esler v. Walters*, 56 N.Y.2d 306, 313-14 (1982). And in “New York cases arising under the equal protection clauses of the Federal and State Constitutions it has not been suggested that the reach of the latter differed from that of the former.” *Stuyvesant Town Corp.*, 299 N.Y. at 530-531. Accordingly, the Court of Appeals, relying on *Vacco*, has recognized that the State’s long-established distinction between “a right to refuse medical treatment and a right to commit suicide (or receive assistance in doing so)” is a “constitutionally-permissible” policy judgment under New York law. *Matter of Bezio*, 21 N.Y.3d at 103.

These governing precedents foreclose plaintiffs’ equal protection claims as a matter of law, making “development of a factual record” (Br. at 16) unnecessary. Supreme Court thus correctly dismissed
plaintiffs’ equal protection claims for failure to allege facts showing a cause of action.

**B. Plaintiffs’ Allegations Do Not State a Due Process Claim.**

Legislation is consistent with the New York Constitution’s due process clause “where no fundamental right is infringed” and the legislation “is rationally related to legitimate government interests.” *People v. Knox*, 12 N.Y.3d 60, 67 (2009). Here, as the court below correctly observed, settled law establishes that New York’s prohibition on helping another to end his or her life does not “infringe fundamental rights” (R. 16 (quoting *Vacco*, 521 U.S. at 799)) and “is not arbitrary under the due process standard” (R. 15). The court therefore acted properly in dismissing plaintiffs’ due process challenge (R. 17).

1. **New York law does not recognize a fundamental right to assistance with taking one’s own life.**

In evaluating claims that legislation implicates a fundamental right, New York courts look to whether the asserted right is “deeply rooted” in “history and tradition.” *Knox*, 12 N.Y.3d at 67 (quoting *Glucksberg*, 521 U.S. at 721). And New York’s history and
traditions—like those of almost every other State—have never recognized a right to take one’s own life, or to assistance with taking one’s own life. See, e.g., Glucksberg, 521 U.S. at 710-16.

From colonial times through the early nineteenth century, New York applied the Anglo-American common law’s prohibitions on taking one’s own life and assisting in such an act. See supra pp. 4-5 (discussing history of New York’s assisted suicide prohibition). The common law’s prohibitions “never contained exceptions for those who were near death.” Glucksberg, 521 U.S. at 714. Rather, “those who were hopelessly diseased or fatally wounded” were protected by the law to the same extent as persons “who were in the full tide of life’s enjoyment, and anxious to continue to live.” Id. at 714-15 (internal quotation marks and brackets omitted).

In 1828, New York passed the first American statute explicitly outlawing the act of helping another to end his or her life. See Rev. Stat. pt. IV, ch. 1, tit. 2, art. 1, § 7 (1829); Glucksberg, 521 U.S. at 715. In 1881, the State adopted penal laws deeming taking one’s own life “a grave public wrong,” providing for penalties of up to two years in prison for the crime of attempting that act, and providing for the crime of
assisting in that act to be treated as first degree manslaughter. Penal Law tit. IX, ch. 1, §§ 172-173, 175-176 (1881), codified at 4 N. Y. Consolidated Laws, Penal Law §§ 2300-2301, 2304-2305 (1909). Those prohibitions covered the act of “furnishing another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life.” Glucksberg, 521 U.S. at 715 (quotation marks omitted).

Since then, New York has repeatedly declined to lift its criminal prohibition on the act of helping another person to take his or her life. See 4 N. Y. Consolidated Laws, Penal Law § 2305 (1909) (continuing to prohibit assisting in suicide); ch. 1030, 1965 N.Y. Laws 2343, 2385, 2387, codified at Penal Law §§ 120.30, 125.15(3) (same); see also supra pp. 10, 10-11 n.2, 17-18, 18 n.6 (summarizing failed legislative proposals to amend the penal law). Furthermore, although the State has decriminalized the act of attempted suicide (see supra p. 6), it continues to “intervene to prevent suicide,” Matter of Bezio, 21 N.Y.3d at 101 (quotation marks omitted). For example, state law authorizes the involuntary commitment of a person who has a mental illness likely to result in serious harm to himself, Mental Hygiene Law §§ 9.37, 9.39,
9.41; the transfer to a psychiatric hospital of a prison inmate who appears likely to cause serious harm to himself, Correction Law §§ 402(9), 508(2)); and the use of reasonable physical force to thwart a person who is about to commit suicide, Penal Law § 35.10(4).7

In sum, New York’s history, traditions, and existing law demonstrate the nonexistence of any state due process right to take one’s own life or to receive assistance with taking one’s own life. Contrary to plaintiffs’ assertions, considering New York’s “longstanding fundamental right to self-determination” does not lead to a different conclusion. Br. at 15.

First, plaintiffs are incorrect in suggesting that New York grants its citizens an absolute right “to control the course of [their] medical treatment” Br. at 16-17 (quoting Rivers v. Katz, 67 N.Y.2d 485, 492 (1986). As the Court of Appeals has explained, the common-law right to determine the course of one’s medical treatment “is not absolute and in

7 The authorization for use of reasonable physical force applies to private and public actors. It states in full: “A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result.” Penal Law § 35.10.
some circumstances may have to yield to superior interests of the State.” Fosmire, 75 N.Y.2d at 226. Thus, for example, the State may “prohibit medical procedures that pose a substantial risk to the patient alone,” id., in light of its “well-recognized interest in protecting and preserving the lives of its citizens,” id. at 227.

Second, in any event, “the State has long made a constitutionally-permissible distinction” between the right to exercise self-determination with respect to one’s body by refusing medical treatment and the “right to commit suicide (or receive assistance in doing so)” Matter of Bezio, 21 N.Y.3d at 103. See supra Point II.A. For instance, the state law authorizing health care proxies to request the withholding of life-sustaining treatment also provides that “[t]his article is not intended to permit or promote suicide, assisted suicide, or euthanasia.” Public Health Law § 2989(3).

Plaintiffs identify no authority supporting their claim (Br. at 17, 20-21) that New York’s prohibition on physician-assisted suicide is inconsistent with their state constitutional right to privacy. And no such inconsistency exists because “only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty, are
included in this guarantee of personal privacy.” *Matter of Von Holden v. Chapman*, 87 A.D.2d 66, 68 (4th Dep’t 1982) (quotation marks and citations omitted). Indeed, the only New York appellate court to consider the question has held that “the right to privacy does not include the right to commit suicide.” *Id.*

New York is not an outlier in declining to recognize a due-process right to physician-assisted suicide. The United States Supreme Court has held that the due process clause of the federal constitution does not include “a right to commit suicide which itself includes a right to assistance in doing so.” *Glucksberg*, 521 U.S. at 723; *see also id.* at 728 (“[T]he asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.”). Moreover, no state court of final resort has overturned a statute prohibiting physician-assisted suicide on constitutional grounds, and several have expressly affirmed the constitutionality of such statutes. *See, e.g.*, *Sampson v. Alaska*, 31 P.3d 88 (Alaska 2001) (upholding constitutionality of state law prohibiting physician-assisted suicide); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997) (same); *Kevorkian*,


447 Mich. 436 (same). Only four states—Oregon, Washington, Vermont, and California—have passed legislation allowing physicians to prescribe lethal medications to terminally ill patients. Accordingly, this is not a case where “evolving social views” (Br. at 24; see also R. 39) require the recognition of a new right that lacks any basis in New York’s history and traditions.

2. **New York’s prohibition on assisting in a suicide serves legitimate state interests.**

In light of plaintiffs’ failure to allege facts showing the infringement of a fundamental right (see supra Point II.B.1), New York’s prohibition on physician-assisted suicide must be sustained as

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8 Montana’s highest court has found it unnecessary to reach the constitutional question, having concluded that a physician who assists in a patient’s suicide may be shielded from criminal liability by a Montana statute that creates a limited consent defense to the crime of homicide. *See Baxter v. Montana*, 224 P.3d 1211, 1215 (2009).

long as it “is rationally related to legitimate government interests,” *Knox*, 12 N.Y.3d at 67; *see also Hope v. Perales*, 83 N.Y.2d 563, 577 (1994). And regarding that issue, the United States Supreme Court has already concluded that the prohibition serves the legitimate state interests of “prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians’ role as their patients’ healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia.” *Vacco*, 521 U.S. at 808-09. Plaintiffs are therefore mistaken in asserting that “questions regarding whether any legitimate interest exists requires [sic] development of an evidentiary record” 10 (Br. at 19).

As the New York Court of Appeals has already recognized, “the State has a significant interest in preserving life and preventing suicidal acts.” *Matter of Bezio*, 21 N.Y.3d at 104; *see also Matter of Von*

10 Plaintiffs are also mistaken in asserting that the trial court was required to credit their allegations that New York’s prohibition on assisted suicide “is not rationally related to any legitimate state interest, does not further an important state interest, nor is it the least restrictive means of advancing any compelling state interest.” Br. at 21. (*See also* R. 42, 44.) *See Bumbury*, 62 A.D.3d at 624.
Holden, 87 A.D.2d at 68 (“[T]he State has a legitimate and compelling interest in preventing suicide”). Moreover, the State’s “legitimate interest in protecting the lives of its citizens,” Matter of Stora, 52 N.Y.2d at 377, is not limited to the lives of persons in good health. For example, the Court of Appeals has held that this interest was implicated even in the case of a patient with “an incurable disease.” Id. at 382. Other New York statutes reflect a similar determination. The Public Health Law, for instance, clearly announces that it is not the State’s policy “to permit or promote suicide, assisted suicide, or euthanasia” whatever the underlying state of the patient’s physical health.11 Public Health Law § 2989(3). “The State’s prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest.” Glucksberg, 521 U.S. at 728.

There is nothing irrational about the State’s policy judgment that “all persons’ lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law,” Id. at 729.

11 See, also, e.g., Mental Hygiene Law §§ 9.37, 9.39, 9.41 (focusing on risk of self-harm rather than the individual’s physical health), Penal Law § 35.10(4) (same); and Correction Law §§ 402(9), 508(2) (same).
This is especially true in light of the risk that illnesses can be misdiagnosed as terminal. “A surprising number of people have had the experience of being misinformed that they had a terminal illness.” Richard A. Posner, *Aging and Old Age* at 245 (U. Chi. 1995). And physician-assisted suicide “leave[s] no opportunity to recognize or correct a diagnosis that is negligently provided, or provided competently, but proves incorrect over time.” 1994 Task Force Report at 131. As noted by the New York State Task Force on Life and the Law—an entity charged with assisting the state in developing public policy on issues arising at the intersections of medicine, law, and ethics—“[o]ne study of adults over 50 years of age showed that more individuals committed suicide in the mistaken belief that they were dying of cancer than those who actually had a terminal illness and committed suicide.” *Id.* at 12-13.

New York’s prohibition on assisted suicide also serves important public health goals of the State, including its interest in ensuring that all patients—including the terminally ill—receive appropriate medical treatment for pain and other debilitating conditions. A report by the State’s Task Force on Life and the Law discusses research showing that
“[u]ncontrolled or poorly controlled pain can increase a patient’s feelings of hopelessness and helplessness,” 1994 Task Force Report at 26, and that “[d]epression, accompanied by symptoms of hopelessness and helplessness, is the most prevalent condition among individuals who commit suicide,” id. at 11; see also Glucksberg, 521 U.S. at 730 (discussing these findings). The report notes that treatment for these conditions has been shown to reduce or eliminate a patient’s wish to die, even where the patient is suffering from a serious condition such as advanced cancer. 1994 Task Force Report at 26; see also id. at 120-21; Glucksberg, 521 U.S. at 730. Nonetheless, as the report observes, depression is difficult to diagnose, 1994 Task Force Report at 26, and multi-symptom illnesses “pose[] special challenges for pain and symptom management,” id. at 27. The State could thus rationally conclude that legalizing physician-assisted suicide would make it more difficult for the State to ensure adequate medical treatment for those who are suffering from untreated pain and depression.

A further state interest advanced by the prohibition is New York’s determination to protect vulnerable patients from external influences that may cause them to abandon an otherwise strong desire to remain
alive. See id. at 731-32. These influences include indifference or prejudicial assumptions regarding the value of the lives lived by such persons, as well as psychological and financial pressures. Id. Upon studying the issue, the State’s Task Force on Life and the Law concluded that the danger of harmful influences was particularly pronounced for the poor, the elderly, those lacking access to good medical care, and members of stigmatized groups. Id. at 732 (citing 1994 Task Force Report at 120). The Task Force determined that “[t]he risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.” 1994 Task Force Report at 120.

The State could rationally conclude that “[i]f physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.” Glucksberg, 521 U.S. at 732. Moreover, it could reasonably embrace an absolute prohibition on assisted suicide as a means to communicate “its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a
seriously disabled person’s suicidal impulses should be interpreted and
treated the same way as anyone else’s.” Id.

New York is also a regulator and monitor of the practice of medicine in the State. See Matter of Koch v. Sheehan, 21 N.Y.3d 697, 701-02 (2013); Matter of Doe v. Axelrod, 71 N.Y.2d 484, 488 (1988). And in this capacity it has an interest in protecting “the integrity and ethics of the medical profession” by safeguarding the physician’s role as a healer. Glucksberg, 521 U.S. at 731.

Relatedly, the State has an interest in maintaining clear rules regarding assisted suicide to prevent a potentially dangerous expansion of the right that plaintiffs here seek to establish. Id. at 732-33. Courts may have difficulty differentiating the right to be prescribed medication from the right to have that medication administered, or the right to physician-assisted suicide from the right to assistance with suicide from family members or friends. Courts also may have trouble resolving questions such as what differentiates a patient with a condition expected to result in death within six months—a necessary requirement for physician-assisted suicide in Oregon, Washington, Vermont, and
California—from a patient with a longer life expectancy but a greater amount of discomfort, debilitation, or pain.

Indeed, one of the plaintiffs here, Dr. Timothy Quill, has asserted that limiting the right of assisted suicide to the terminally ill would, in his view, “arbitrarily exclude persons with incurable, but not imminently terminal, progressive illness.” Timothy Quill, *Death and Dignity* 162 (1993) (quoted in Yale Kamisar, *Against Assisted Suicide – Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 740 (1995)). Dr. Quill has also observed that the same reasons justifying physician-assisted suicide also warrant legalizing voluntary euthanasia, stating that “[t]o confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so.” Franklin G. Miller *et al.*, *Sounding Board: Regulating Physician-Assisted Death*, 331 New Eng. J. Med 119, 120 (1994) (quoted in Kamisar, 72 U. Det. Mercy L. Rev. at 748).

It is not irrational for the State to be concerned that recognizing a right for mentally competent individuals to end their lives could open the door to voluntary and involuntary euthanasia. 1994 Task Force
Report at 145. For example, a study relied upon by the United States Supreme Court in *Glucksberg* found that in the Netherlands, cases where physicians administered lethal morphine overdoses “without an explicit request” or without “the patients’ explicit consent” far outnumbered instances of assisted suicide and voluntary euthanasia. See 521 U.S. at 734.

As New York’s Task Force on Life and the Law has observed, “assisted suicide and euthanasia are closely linked.” 1994 Task Force Report at 145. “Permitting physicians to assist the suicide of patients physically capable of committing suicide, and characterizing this action as a ‘treatment,’” could easily “lead to acceptance of voluntary euthanasia for patients physically unable to perform the final act.” *Id.* Moreover, requiring physician participation might exacerbate rather than mitigate the pressures on the patient, because “patients who are ambivalent or hesitant may find it harder to delay or change the decision to die” in the presence of a physician. *Id.* Accordingly, New York has not acted unreasonably in adopting an absolute prohibition on assisting in a suicide in order to prevent “what is couched as a limited right to ‘physician-assisted suicide’” from becoming “in effect, a much
broader license, which could prove extremely difficult to police and contain.”12 Glucksberg, 521 U.S. at 733; see also id. at 734 (discussing the Netherland’s experience with euthanasia).

* * * * *

The State does not deny that the issue of physician-assisted suicide, or aid-in-dying, is a complex one. Nor does it condemn the actions of States that have chosen to make this option available to those facing the rigors of terminal illness. But the question whether physicians should be permitted to provide individuals with the means to take their own lives is a quintessential policy judgment that should be made by a legislature. It cannot be answered by ignoring the plain text of Penal Law §§ 120.30 and 125.15 and controlling precedents interpreting those statutes. This Court should therefore affirm.

12 Contrary to plaintiffs’ argument (Br. at 14), Supreme Court was thus correct to note that it would exceed a court’s authority to prohibit the criminal prosecution of any physician who prescribed lethal medication for use by a patient to end his or her life (see R. 14).
CONCLUSION

For the reasons stated above, this court should affirm Supreme
Court’s judgment.

Dated: New York, NY
January 6, 2016

Respectfully submitted,

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New York Supreme Court
APPELLATE DIVISION—FIRST DEPARTMENT

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Plaintiffs-Appellants,

—against—

ERIC SCHNEIDERMAN, in his official capacity as ATTORNEY GENERAL OF THE STATE OF NEW YORK,

Defendant-Respondent,

JANET DIPIORE, in her official capacity as DISTRICT ATTORNEY OF WESTCHESTER COUNTY, SANDRA DOORLEY, in her official capacity as DISTRICT ATTORNEY OF MONROE COUNTY, KAREN HEGGEN, in her official capacity as DISTRICT ATTORNEY OF SARATOGA COUNTY, ROBERT JOHNSON, in his official capacity as DISTRICT ATTORNEY OF BRONX COUNTY and CYRUS R. VANCE, JR., in his official capacity as DISTRICT ATTORNEY OF NEW YORK COUNTY,

Defendants.

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Plaintiffs submit this brief in further support of their appeal and in reply to the Brief of Defendant-Respondent (‘Def. Br.’).

**Preliminary Statement**

Defendant’s brief demonstrates a fundamental misunderstanding of the relevant pleading standard. At this preliminary stage, the Court should not declare Plaintiffs’ rights by resolving whether aid-in-dying constitutes assisted suicide within the meaning of the Assisted Suicide Statue, and it should not determine whether the due process or equal protection guarantees of the New York Constitution protect this choice. Nor should the Court decide whether a prohibition on aid-in-dying is narrowly tailored to achieve a compelling State interest or is rationally related to a legitimate State interest. Those questions should be addressed after the development of an evidentiary record. The only question on this appeal is whether, based upon the facts alleged in the Complaint, Plaintiffs have stated claims for declaratory relief.

Defendant makes the astonishing assertion that “plaintiffs have not identified any factual disputes that Supreme Court failed to resolve in their favor” (Def. Br. 16), even though the lower court never addressed any of the material factual allegations of the Complaint. Like the lower court, Defendant fails to credit these allegations: aid-in-dying is a recognized medical practice that is distinct from suicide and can be a medically and ethically appropriate course of treatment for
patients facing unbearable suffering in the final stages of the dying process; the
death of a person who chooses aid-in-dying is caused by the patient’s underlying
terminal illness; medical and public health professionals do not consider aid-in-
dying to be suicide; and aid-in-dying is indistinguishable from other lawful
medical practices that result in a patient’s death, such as terminal sedation.

The Complaint also alleges facts to establish that the application of the
Assisted Suicide Statute to aid-in-dying would violate the Due Process and Equal
Protection Clauses of the New York Constitution by infringing New York’s
longstanding fundamental right to self-determination with respect to one’s body
and to control the course of one’s medical treatment. Defendant concedes that
such a fundamental right exists but argues that the right is not absolute and must
yield to superior interests of the State in some circumstances. Whether the State’s
interest is sufficient to overcome Plaintiffs’ fundamental right to self-determination
under the factual circumstances alleged in the Complaint is precisely the type of
issue that is not appropriate for resolution on a motion to dismiss.

Moreover, the U.S. Supreme Court in *Glucksberg* and *Vacco* addressed
federal constitutional claims on a summary judgment record and explicitly
reserved the possibility that a prohibition on aid-in-dying may violate the Equal
Protection and Due Process Clauses of the Federal Constitution. Accordingly, a
claim based on New York’s Constitution should certainly proceed beyond a motion
to dismiss. Defendant (and its amici) cannot establish as a matter of law that the State’s purported interests in prohibiting aid-in-dying are advanced by relying on factual assumptions from different cases decided eighteen years ago that have been undermined by subsequent experience and data and evolving societal views. Indeed, Plaintiffs have already provided evidence that, where aid-in-dying is available, desirable public health outcomes are enhanced: referrals to hospice happen earlier and more frequently, pain management improves, and communication between patient and doctor improves.

ARGUMENT

I. DEFENDANT MISCONSTRUES THE RELEVANT PLEADING STANDARD.

Defendant misconstrues the standard to be applied on a pre-answer motion to dismiss Plaintiffs’ claims for declaratory judgment. The only issue presented for consideration at this stage of the proceedings is “whether a cause of action for declaratory relief is set forth, not the question of whether the plaintiff is entitled to a favorable declaration.” DiGiorgio v. 1109-1113 Manhattan Ave. Partners, LLC, 102 A.D.3d 725, 728 (2d Dep’t 2013) (citation and quotation marks omitted).
Thus, where a cause of action is sufficient to invoke the court’s power to render a declaratory judgment . . . as to the rights and other legal relations of the parties to a justiciable controversy, a motion to dismiss that cause of action should be denied. . . . [I]f the material allegations of the complaint, taken as true, implicate factual issues such that the rights of the parties cannot be determined as a matter of law, a declaration upon a motion to dismiss is not permissible.”

*Id.* (citation and quotation marks omitted) (first alteration in original) (emphasis added); accord *Wolff v. 969 Park Corp.*, 86 A.D.2d 519, 520 (1st Dep’t 1982) (“In a declaratory judgment action, the material facts and circumstances should be fully developed before the rights of the parties are adjudicated.”).

Moreover, the Court must “accept as true not only the complaint’s material allegations but also whatever can reasonably be inferred therefrom in favor of the pleader.” *P.T. Bank Cent. Asia, N.Y. Branch v. ABN Amro Bank N.V.*, 301 A.D.2d 373, 375-76 (1st Dep’t 2003) (citation and quotation marks omitted). To affirm the lower court’s dismissal of Plaintiffs’ claims would impermissibly ignore myriad factual allegations in the Complaint – along with the affidavits and additional evidence provided by Plaintiffs – carefully detailing the factual reasons why aid-in-dying is not assisted suicide. An affirmance would also require a premature determination that a patient’s choice for a more peaceful death through aid-in-dying is not protected by due process or equal protection guarantees of the New York Constitution, that a prohibition on aid-in-dying is narrowly tailored to further
a compelling State interest, and that a prohibition is rationally related to a legitimate State interest.

II. THE LOWER COURT ERRED IN DISMISSING PLAINTIFFS’ CLAIM FOR DECLARATORY RELIEF CONCERNING THE MEANING OF THE ASSISTED SUICIDE STATUTE.

A. Like The Lower Court, Defendant Fails To Credit Plaintiffs’ Factual Allegations.

The Complaint and the supporting affidavits make clear that a mentally-competent, terminally-ill patient who requests aid-in-dying is not committing suicide and that aid-in-dying is indistinguishable from other lawful end-of-life medical treatments. For example:

- “In some cases, providing aid-in-dying is, in the professional judgment of a physician, a medically and ethically appropriate course of treatment.” Compl. ¶ 45 (R. 38).

- “It is recognized that what is causing the death of a patient choosing aid-in-dying is the underlying terminal illness.” Id. ¶ 38 (R. 36).

- “Public health, medical, and mental health professionals, including the physician Plaintiffs, recognize that the choice of a dying patient for a peaceful death through aid-in-dying is not suicide, just as withholding or withdrawal of treatment or the choice of terminal or palliative sedation is not suicide.” Id. ¶ 44 (R. 38).

- The American Public Health Association (“APHA”) and other professional organizations reject as inaccurate the use of the term “assisted suicide” as applied to aid-in-dying. APHA Policy No. 20086 (R. 145) (citation and quotation marks omitted).

- “Aid-in-dying is one compassionate medical treatment option for dying patients, among a number of others that physicians providing care to a dying patient can offer, which allows patients to have control over the timing of their death.” Kress Aff. ¶ 9 (R. 438).
Defendant attempts to reframe Plaintiffs’ well-pled factual assertions as “legal conclusions,” “policy views” and “opinions on whether physician-assisted suicide should be permitted.” Def. Br. 16 & n.5 (emphasis in original). These mischaracterizations assume the conclusion that the underlying conduct of patients opting for aid-in-dying is suicide. However, whether a patient’s choice of aid-in-dying is encompassed by the statutory term “suicide” cannot be determined without consideration of facts such as medically and ethically appropriate end-of-life treatments, relevant standards of medical care, the medical conditions of patients, the opinions of treating physicians, the intent of physicians and patients, and the qualified judgments of medical, mental health and public health professionals. *See Matter of Eichner (Fox)*, 73 A.D.2d 431, 462 (2d Dep’t 1980) (“No one can seriously doubt that medical questions of life and death, particularly the propriety of medical treatment for the terminally ill, are matters calling for the consideration of professional medical opinion.”), order modified by, *Matter of Storar*, 52 N.Y.2d 363 (1981).

Defendant’s own formulation of the statutory question presented reinforces the existence of obvious factual issues. Defendant frames the statutory issue as whether a physician providing aid-in-dying is prescribing medication to a patient “for the purpose of ending his or her life.” Def. Br. 3 (emphasis added). The Complaint alleges – and the supporting affidavits confirm – that aid-in-dying
serves entirely different purposes, such as preserving personal integrity and dignity, avoiding unbearable suffering and prolonged and unrelieved anguish, and providing peace of mind that improves the quality of life, and that aid-in-dying prolongs life and avoids the premature loss of life, including by violent means. See, e.g., Compl. ¶ 44 (R. 38); Carter v. Canada (Attorney General), 2015 SCC 5, ¶¶ 1, 57 (R. 180, 206); Kress Aff. ¶ 7 (R. 437); Quill Aff. ¶ 19 (R. 431). Thus, even if the legality of aid-in-dying turned on its purpose, Defendant’s formulation further highlights the need for a developed evidentiary record.

Defendant’s simplistic characterization that the Assisted Suicide Statute prohibits “the act of helping another person to end his or her life” similarly misstates the issue. Def. Br. 14. Under Defendant’s formulation, many lawful end-of-life treatments – such as removing ventilators or withholding hydration and nutrition – would violate the Assisted Suicide Statute, as they clearly help patients to end their lives. See Compl. ¶¶ 40-42 (R. 36-37). Defendant states that New York courts have recognized that such conduct does not violate the Statute. Def. Br. 17 (citing Matter of Bezio v. Dorsey, 21 N.Y.3d 93 (2013)). That is precisely Plaintiffs’ point: New York courts have determined that certain conduct that “helps another person to end his or her life” is not assisted suicide. Plaintiffs seek a similar declaration as to aid-in-dying.
Defendant’s attempt to distinguish these lawful treatments from aid-in-dying by arguing that they are merely a “refusal to receive medical treatment” (Def. Br. at 17) again ignores the allegations of the Complaint. The Complaint alleges that other lawful medical practices include affirmative steps such as sedating patients to unconsciousness, while food and fluid are withheld. See Compl. ¶ 41 (R. 37). These treatments often have the effect of hastening death and even resulting in nearly immediate death as result of the sedatives used. See Kress Aff. ¶ 9 (R. 438-39). Lawful end-of-life treatments obviously go well beyond a mere refusal to receive treatment. See Compl. ¶¶ 1, 41 (R. 22, 37); Quill Aff. ¶ 24 (R. 433); Kress Aff. ¶ 9 (R. 438-39) (“None of these options are considered to be suicide, even when the patient clearly chooses the option in order to cause death.”).

B. Defendant’s Legal Analysis Has Numerous Flaws.

In addition to failing to credit Plaintiffs’ allegations, Defendant’s brief contains numerous misstatements and mischaracterizations of the law. Defendant relies on a definition of suicide that the Legislature repealed, invokes ancient legislative history that is irrelevant, points to legislative inaction that is at best ambiguous, cites completely inapplicable caselaw, and relies on secondary authorities that are inapposite or deserve no weight.

To begin with, Defendant relies on an inapplicable dictionary definition of “suicide.” Def. Br. 14-15 (quoting Black’s Law Dictionary and Merriam
Webster’s Collegiate Dictionary). The New York Legislature repealed a virtually identical definition nearly a century ago. See Act of July 26, 1881, ch. 676, § 172, 1881 N.Y. Laws (defining “suicide” as “the intentional taking of one’s life”), repealed by Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193. Because “a statutory term should be defined by the context of the statute rather than by the dictionary,” Matter of Spota v. Jackson, 10 N.Y.3d 46, 52 (2008), the dictionary definition that the Legislature discarded is hardly instructive.1

Defendant’s reliance on the history of the Assisted Suicide Statute dating back to “colonial times” (Def. Br. 4-7, 14) is similarly misplaced. Whether the Assisted Suicide Statute extends to aid-in-dying has never been addressed by legislation in the nearly two hundred years since the Assisted Suicide Statute’s first codification. In all of the revisions of the Statute, there is nothing to suggest that the Legislature intended to reach aid-in-dying. See Def. Br. 4-8. Indeed, the

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1 Even if the dictionary definition carried any weight, it would raise a factual issue whether a physician who prescribes the medication for aid-in-dying is assisting “the intentional taking one’s life.” First, the patient plaintiffs’ lives are being “taken” by terminal diseases. For example, Sara Myers – who suffers from ALS (also known as Lou Gehrig’s disease) – has “lost the ability to do nearly all activities that have given her joy in life” and faces “the further progressive loss of bodily function and integrity and increasing pain and suffering.” She is “trapped in a torture chamber of her own deteriorating body.” Compl. ¶ 24 (R. 26-27). Moreover, where aid-in-dying is lawful, the patient often does not actually ingest the prescribed medication. See Schallert Aff. Ex. 9, at 3 (R. 408) (multi-year study of Oregon patients shows a median of 62% ingest the medication).
current version of the Statute was enacted in 1965, more than twenty-five years before aid-in-dying became a recognized concept and was first discussed in medical literature. In short, as Judge Calabresi observed, the Statute “w[as] born in another age.” *Quill v. Vacco*, 80 F.3d 716, 732 (2d Cir. 1996) (Calebresi, J., concurring).  

New York’s *inaction* in failing to pass a law authorizing aid-in-dying (*see* Def. Br. 17-18) similarly does not resolve the issue of whether the Assisted Suicide Statute applies to aid-in-dying. *See, e.g.*, *Cricchio v. Pennisi*, 90 N.Y.2d 296, 308 n.5 (1997) (“We decline to attribute any definitive meaning to the Legislature’s failure to enact any of the proposed amendments . . . .”). Indeed, legislative inaction could suggest that the New York Legislature did not intend to prohibit aid-in-dying since other states that wanted to do so *have* done so recently through statutory enactments that specifically encompass the acts of physicians and health care professionals.  

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2 *See also* A. Gawande, *The New Yorker* (R. 252) (“For all but our most recent history, dying was typically a brief process. . . . These days, swift catastrophic illness is the exception; for most people, death comes only after long medical struggle with an incurable condition.”).

3 *See* Ark. Code Ann. § 5-10-106(b) (2007) (making illegal the act of a “physician or health care provider to commit the offense of physician-assisted suicide by (1) [p]rescribing any drug, compound, or substance to a patient with the express purpose of assisting a patient to intentionally end the patient’s life”); *see also* S.C. Code Ann. § 16-3-1090(G) (1998) (explicitly applying the assisted suicide criminal statute to “a licensed health care professional who
Nor have New York courts ever addressed the application of the Assisted Suicide Statute to aid-in-dying. The case law Defendant cites does not show that the Statute “plainly” (Def. Br. 15) applies to aid-in-dying. *People v. Duffy*, 79 N.Y.2d 611 (1992), upon which Defendant relies heavily (Def. Br. 7, 15, 16), addressed legal and factual issues entirely distinct from those presented here. *Duffy* involved a severely depressed, suicidal, inebriated, physically healthy teenager distraught over a breakup with his girlfriend. 79 N.Y.2d at 613. The defendant gave the teenager alcohol, challenged him several times “to jump headfirst off the porch of his second-story apartment,” and finally handed the teenager a gun and ammunition, urging him to “put the gun in his mouth and blow his head off.” *Id.* *Duffy* illustrates that the Statute has some entirely appropriate applications, but it sheds no light whatsoever on aid-in-dying. Although none of the cases Defendant cites address aid-in-dying, they do appear to recognize that end-of-life treatments of a patient with a terminal illness do not amount to suicide. *See, e.g., Matter of Bezio*, 21 N.Y.3d at 102-03 (distinguishing between a prisoner on a hunger strike and “terminally-ill patients or those in an irreversible incapacitated condition as a result of illnesses or injuries beyond their control” (emphasis added)).
For similar reasons, the secondary sources that Defendant cites are hardly dispositive on the issue of whether aid-in-dying is prohibited by the Statute. The Staff Notes cited in *Duffy* and in a 1967 Practice Commentary (*see* Def. Br. 7, 15-16 n.4) make no reference to a terminally-ill, mentally-competent patient under the care of a physician. Rather, they refer to a hypothetical involving a husband who brings a lethal drug to his terminally-ill wife. The hypothetical addresses an entirely different situation involving a lay person with no medical training. By contrast, physicians who prescribe medication for aid-in-dying are markedly different. They are empowered by the State to take a variety of actions that may result in death – such as terminally sedating a patient – and they are bound by professional and ethical standards, which also apply to aid-in-dying. *See* Kress Aff. ¶ 12 (R. 439-40); Morris Aff. ¶ 16 (R. 445-46).

The New York Task Force Report that Defendant repeatedly cites (*see* Def. Br. 8-10, 32-37), now more than twenty years old, should carry no weight. It was written simply “to assist the State in developing public policy on issues arising at the intersections of medicine, law and ethics,” (Def. Br. at 7), and does not resolve whether the Assisted Suicide Statue proscribes aid-in-dying. Moreover, the Complaint cites evidence and data that demonstrate that the concerns about aid-in-dying that the Task Force expressed have since been proven to be utterly without

Ultimately, the question of whether the Assisted Suicide Statute applies to aid-in-dying can be resolved only upon an evidentiary record that will enable the finder of fact to fully understand the medical practice of aid-in-dying and to determine whether the particular factual circumstances alleged in the Complaint constitute the “promoti[on] of a suicide attempt” by “intentionally caus[ing] or aid[ing] another person to attempt suicide” or “to commit suicide.” N.Y. Penal Law §§ 120.30, 125.15 (emphasis added).


A. Aid-In-Dying Is Encompassed Within New York’s Broad Fundamental Right To Self-Determination.

Defendant’s argument concerning Plaintiffs’ common law fundamental right to self-determination demonstrates precisely why Plaintiffs’ Due Process and Equal Protection claims should be allowed to proceed.

Defendant does not dispute that when a statute burdens a fundamental right protected under the Due Process Clause, or when it treats differently similarly situated classes of individuals in a manner that burdens a fundamental right, “it is subjected to strict scrutiny meaning that it will be sustained only if it is narrowly tailored to serve a compelling state interest.” Hernandez v. Robles, 7 N.Y.3d 338,
375 (2006) (citation and quotation marks omitted). Defendant also concedes that New York has recognized a common law fundamental right to self-determination with respect to one’s body and to control the course of one’s medical treatment. See Def. Br. 26-27. Defendant argues, however, that this right is “not absolute and in some circumstances may have to yield to superior interests of the State.” Id. (quoting Fosmire v. Nicoleau, 75 N.Y.2d 218, 226 (1990)). However, in order to determine whether Plaintiffs’ fundamental right to self-determination must yield to the interests of the State under the circumstances alleged in the Complaint, the lower court must first consider and weigh the competing interests based upon a fully developed evidentiary record.

Defendant again ignores the factual allegations of the Complaint and attempts to reframe the constitutional issues as whether a “right to commit suicide (or receive assistance in doing so)” exists under New York law. Def. Br. at 27 (quoting Matter of Bezio, 21 N.Y.3d at 103). The Complaint alleges, however, that patients choosing aid-in-dying are not committing suicide and that aid-in-dying is not assisted suicide, but rather that it is a medically and ethically appropriate course of treatment for patients facing unbearable suffering in the final stages of the dying process. Compl. ¶¶ 44-45 (R. 38). These allegations, if proven, would place aid-in-dying squarely within the protections of New York’s fundamental right to self-determination with respect to one’s body and to control the course of
one’s medical treatment. Because Defendant has incorrectly identified the right that Plaintiffs seek to protect, his discussion of New York’s “history, traditions, and existing law” (Def. Br. 26) concerning “a fundamental right to assistance with taking one’s life” (id. at 23) is irrelevant.4

B. The U.S. Supreme Court’s Decisions In Gluckberg and Vacco Permit Claims For Due Process and Equal Protection Violations Based On A Prohibition Of Aid-In-Dying.

Although the U.S. Supreme Court declined eighteen years ago to recognize a federal constitutional right to choose aid-in-dying, it carefully reserved the possibility that it might in the future, based upon particularized circumstances, find that a prohibition on aid-in-dying violates the Equal Protection Clause and Due Process Clause of the Federal Constitution. Vacco v. Quill, 521 U.S. 793, 809 n.13 (1997) (“Justice Stevens observes that our holding today ‘does not foreclose the possibility that some applications of the New York statute may impose an

4 To the extent that the lower court finds that aid-in-dying is not encompassed within New York’s fundamental right to self-determination, Plaintiffs are still entitled to present evidence concerning evolving societal views over the last eighteen years, including the adoption of policies by various medical associations that support aid-in-dying, polls reflecting public acceptance of aid-in-dying, and developments in other countries that have recognized the right, in order to support an independent fundamental right to aid-in-dying. Pl. Br. at 24-25 (citing Obergefell v. Hodges, 135 S. Ct. 2584, 2602 (2015) (“[Fundamental rights] rise, too, from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era.”)); Lawrence v. Texas, 539 U.S. 558, 571-72 (2003) (“In all events we think that our laws and traditions in the past half century are of most relevance here.”)).
intolerable intrusion on the patient’s freedom.’ This is true . . . .”); *Washington v. Glucksberg*, 521 U.S. 702, 735 n.24 (1997) (“Our opinion does not absolutely foreclose such a claim [for a Due Process violation].”). The fact that the Supreme Court reserved this possibility under the federal constitution, and did so only after evidence was developed upon a summary judgment record and not on a motion to dismiss, requires Plaintiffs’ claims to proceed. *See Glucksberg*, 521 U.S. at 753 (“The case reaches us on an order granting summary judgment . . . .”) (Souter, J., concurring).

Defendant’s brief discusses at length the possible legitimate State interests to which a prohibition on aid-in-dying is rationally related. *See* Def. Br. at 29-38. Notwithstanding both that this is not the time procedurally to consider these interests, and that this lower level of rational basis scrutiny applies only if the lower court does not find that aid-in-dying is encompassed within New York’s fundamental right to self-determination, Defendant’s stated interests are all based upon scant and stale evidence that persuaded the Supreme Court in *Glucksberg* and *Vacco* over eighteen years ago not to find a protected right to aid-in-dying.

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5 The Supreme Court reached the constitutional issues in *Glucksberg* and *Vacco* even though the Assisted Suicide Statute “had not been interpreted by the state courts” and “despite the concession of the parties that, under certain interpretations, the statutes would avoid constitutional challenge.” *Tunick v. Safir*, 209 F.3d 67, 74 (2d Cir. 2000) (Calabresi, C.J.).
Defendant cannot avoid defending the State’s purported interests upon a fresh evidentiary record, particularly in the face of a large and growing body of evidence that a prohibition on aid-in-dying is not rationally related to the various interests that Defendant articulates. See Pl. Br. at 19-20. When the Supreme Court considered Glucksberg and Vacco in 1997, it did so in a vacuum without information about how the practice of aid-in-dying would affect patients and end-of-life care because, at that time, there was no open practice in the United States. Experience and evidence gathered since then demonstrates that the concerns about aid-in-dying that gave the Supreme Court pause, and to which Defendant (and amici) refer here, have not materialized.

The lower court stands in a strikingly different position than the Supreme Court did when it confronted the issue eighteen years ago: it stands in a landscape rich with data showing that the speculated concerns were not well-founded. Today, overwhelming evidence establishes, for example, that there is no harm to vulnerable patients when an open practice of aid-in-dying is available, and that Defendant’s concern that allowing aid-in-dying would “risk harm to persons whose decision to seek the medication is motivated by external pressures” (Def. Br. 2) is contradicted by studies showing “no evidence of abuse or coercion” in states where aid-in-dying is legal, and “no evidence of heightened risk for the elderly, women, the uninsured, people with little education, the poor, the physically disabled or
chronically ill, minors, people with psychiatric illnesses, or racial or ethnic minorities.” Schallert Aff. Ex. 9, at 6 (R. 411).

The relationship between a prohibition on aid-in-dying and the purported State interests of preventing anticipated suicides resulting from the misdiagnosis of a terminal disease and of providing proper pain management and end-of-life care to patients (see Def. Br. at 32) is also contradicted by evidence. Experience has demonstrated that the legalization and availability of aid-in-dying has prompted patients with terminal illnesses to live longer lives. See Quill Aff. ¶ 19 (R. 431) (“[T]here is evidence that some patients may even survive longer because they have the option of dying on their own terms. Freed of the anxiety over loss of control and unbearable suffering, patients’ remaining days are of higher quality.”). Moreover, where aid-in-dying is practiced, end-of-life care has improved in measurable ways: referrals to hospice care occur more often and earlier, and palliative care and communication between patient and physician have improved. See Pl. Br. at 19-20 (citing Quill Aff. ¶ 19 (R. 431); Morris Aff. ¶ 15 (R. 445); Schallert Aff. Ex. 9, at 4 (R. 409).

The arguments advanced by amici in support of Defendant are also based on dated, inapplicable factual assumptions that demonstrate a clear misunderstanding of aid-in-dying. For example, the Disability Rights Amici urge that “[m]any people identified as candidates for assisted suicide could benefit from supportive
care or treatment, such as counseling, pain medication, or in-home consumer-directed personal assistance.” Disability Rights Amici Br. at 20-21. The amici, like Defendant, improperly frame the issue as whether a right to “assisted suicide” exists, and they fail to consider the evidence demonstrating that, when aid-in-dying is an available option, end-of-life care improves considerably. See Pl. Br. at 19-20 (citing Quill Aff. ¶ 19 (R. 431); Morris Aff. ¶ 15 (R. 445); Schallert Aff. Ex. 9, at 4 (R. 409). One common conclusion that is reinforced by both Defendant’s and the amici’s arguments is that the issues at the core of this case require a fully developed evidentiary record.
CONCLUSION

For the foregoing reasons, and for those stated in Plaintiffs’ opening brief, this Court should reverse the lower court’s order dismissing Plaintiffs’ Complaint.

Dated: January 15, 2016
New York, New York

Respectfully submitted,

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APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

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v. Index No. 151162/15

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STATEMENT OF ISSUES PRESENTED

Plaintiffs-appellants ("appellants") seek a court order prohibiting prosecution of physician assisted suicide under New York penal laws, as well as a court declaration that New York penal laws against physician assisted suicide are unconstitutional violations of due process and equal protection provisions. The Supreme Court of the State of New York, County of New York, dismissed appellants’ case against the State of New York on October 16, 2015, finding that appellants’ request “to prohibit a district attorney from prosecuting an alleged violation of the penal law, would . . . exceed this Court’s jurisdiction” (Myers v. Schneiderman, Memorandum of Decision ("Decision"), page 9) and that “the case at bar is factually and legally indistinguishable from Vacco” v. Quill (Decision, page 10), in which the U.S. Supreme Court ruled against precisely the same constitutional claims. Not Dead Yet, ADAPT, Association of Programs for Rural Independent Living, Autistic Self Advocacy Network, Center for Disability Rights, Disability Rights Center, Disability Rights Education and Defense Fund, National Council on Independent Living, New York Association on Independent Living, Regional Center for Independent Living and United Spinal Association (collectively the “Disability Rights Amici”), organizations with members in New York, support

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the New York Supreme Court’s ruling and Attorney General’s position that Sections 125.15(3) and 120.30 do not violate any New York constitutional provisions.

As noted by Judge Joan Kenney, this case does not concern the settled issue of the individual’s right to refuse treatment, even if it might result in death. *Decision*, pages 7, 10-11. Certainly, people have a "right to die" by removing their life supports, refusing life supports, and letting nature take its course. This case concerns only whether there is a New York constitutional right to receive active physician assisted suicide or, as appellants rename it, "physician aid in dying".

Were this Court to reverse the Supreme Court’s decision, it would soon face a number of related issues in future cases, including the following:

- Why should a constitutional right be limited to people who have a disabling condition that is labeled "terminal"? Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?
- Why should the constitutional right be limited to providing only lethal medications? Why not lethal injections?
- If such a constitutional right exists, why should a person's right be limited to "aid" only from doctors? What about family members, friends, or advocates?

**BACKGROUND**

Plaintiff/appellants claim that prohibiting "mentally competent, terminally ill"
people from obtaining a lethal dose of drugs from a third party violates their equal protection and due process rights under the New York Constitution.

The Supreme Court dismissed the case, finding that the Court of Appeals has previously stated that “the right to refuse medical treatment is not the equivalent of a right to commit suicide.” *(Decision at 11).* They referred to the U.S. Supreme Court’s ruling in *Vacco v. Quill* where the Court said that there has been a long time “distinction between a right to refuse medical treatment and a right to commit suicide (or receive assistance in doing so).” *521 US 793,* (1997). The State Supreme Court found this case indistinguishable from *Vacco* in which they unanimously held the New York State Penal law prohibiting assistance of a suicide was not arbitrary under the due process standard and did not violate the equal protection clause. *Id.*

Whether there is a constitutional right in New York to physician-assisted suicide must be addressed and understood from the perspective of the class of people who will be most adversely affected and impacted were such a right to be found: people with disabilities, whether their conditions are terminal or not. The Disability Rights Amici represent a very broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people whose disabilities existed from birth or were acquired during their lifetimes. Many are now, or at some point have been, erroneously labeled "terminal" by a physician. Many have had doctors threaten to remove life sustaining treatment on an involuntary basis
and have had to fight to receive continued care.

In fact, although pain (or the fear of pain) is often cited as the primary reason for enacting assisted suicide laws, doctors actually report that the top five reasons they issue lethal prescriptions are because of patients’ “loss of autonomy,” “less able to engage in activities,” “loss of dignity,” “loss of control of bodily functions,” and “feelings of being burden,” and that “[p]atients’ interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors.”

Major issues include the inadequacy of symptom control, difficulties in the person's relationships with family, and psychological disturbances – especially grief, depression, and anxiety.

The desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self […] Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: ‘I'm inconveniencing, I'm still inconveniencing other people who look after me and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't. I wouldn't. No. I'd rather die.’

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3 William Breitbart, MD et al, Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients, Am. J. Psychiatry 153, 238-242 (1996). See also Robert Pear, A Hard Charging Doctor on Obama’s Team, N.Y. Times, April 18, 2009, at A14 (noting that pain is "a common stereotype of patients expressing interest in euthanasia. In most cases… the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones”).
4 Block SD & Billings JA, Patient Requests to Hasten Death. Evaluation and Management in Terminal
These are quintessential disability issues. The Disability Rights Amici’s members know that these feelings are not inevitable, that their causes are and have been successfully addressed and that, most importantly, these emotions do not justify a lethal response.

Assisted suicide laws authorize doctors to decide who is eligible – i.e., whose condition is "terminal" and whose desire to commit suicide is "rational." In the context of our current healthcare system, with profit motives of insurance and managed care companies, and financial and other pressures on family members and individuals, the risks of subtle and even blatant coercion are great. These are precisely the issues and concerns described in the seminal report issued by the New York State Task Force on Life and the Law in 1994\(^5\) and discussed by the U.S. Supreme Court in *Vacco*.

No one is immune from the pervasive societal assumptions surrounding the disability label. Fear, bias, and prejudice against disability are inextricably intertwined in these assumptions and play a significant role in assisted suicide. Our

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*Care*, Archives of Internal Medicine, 154(18):2039-47 (Sept. 26, 1994).

society values and desires “healthy” bodies and minds. The idea that any person with a disability could be a happy, contributing member of society is outside the experience or thinking of most non-disabled persons. Severe disability is viewed as worse than death, thus justifying the deadly exception to laws for suicide prevention and laws against homicide. These views and assumptions are strongly opposed by people with disabilities.

The appellants use the term “dignified death” to justify assisted suicide, but when asked what "indignities" concern them, nondisabled (and some newly disabled) people invariably describe the need for assistance in daily activities like bathing, toileting, and other disability realities. These should never be the basis for a societal double standard for providing suicide assistance only to people with disabilities, including those labeled “terminal,” but suicide prevention to the rest of society.

SUMMARY OF ARGUMENT

The Supreme Court is correct - there is no fundamental right, under the New York or United States Constitutions, to assistance from a doctor or any other third party in committing suicide. Moreover, there are compelling State interests in prohibiting assisted suicide for all, including people with disabilities, terminal and nonterminal. State-sanctioned assisted suicide degrades the value and worth of
people with disabilities and violates the antidiscrimination rights, protections and mandates of the Americans with Disabilities Act, 42 U.S.C. § 12101, et seq.

ARGUMENT

STANDARD OF REVIEW

An appeal is properly before the Court of Appeals when it concerns the constitutionality of a statute “from a judgment of a court of record of original instance which finally determines an action where the only question involved on the appeal is the validity of a statutory provision of the state or of the United States under the constitution of the state or of the United States.” NY CPLR § 5601(b)(2) (2012).


In the lower court ruling it is stated that the decision whether to bring charges against an individual is properly that of a district attorney, and a court either
prohibiting or compelling prosecution of an individual would be beyond its jurisdiction in violation of separation of powers. *(Decision at 10).* Because ruling this statute unconstitutional would impinge on the separation of powers and because it would deny equal protection (e.g. equal suicide prevention) to people with disabilities, this statute’s constitutionality must be upheld. The appropriate basis of review for this statute is a rational basis one because this statute does not apply a suspect classification or burden a fundamental right.

The U.S. Supreme Court held in *Vacco* that assisted suicide was not a fundamental right. *Id. at 799.* While an individual may have a right to choose whether to live or die there is no right to engage a physician in this process. Even if this statute were subject to strict scrutiny it must be upheld because of the compelling governmental interest in not having physicians violate the Hippocratic oath and assist the suicides of any class of persons.

II. ASSISTED SUICIDE DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES

A. Assisted Suicide Is Part of the Long and Tragic History of Discrimination Against People with Disabilities

Assisted suicide must be viewed against the backdrop of the United States' long and tragic history of state-sanctioned discrimination against the disabled. The U.S. Supreme Court has acknowledged that at least one of the forms of such
discrimination – the practice of withholding lifesaving medical assistance by medical professionals from children with severe disabilities – demonstrates a "history of unfair and often grotesque mistreatment" arising from a legacy in this country of "prejudice and ignorance," and continuing well into the 20th century. 


Such attitudes, unfortunately, are not completely in the past. Prominent Ethicists, such as Peter Singer of Princeton University,\(^6\) have advocated the killing of infants with severe disabilities based on a belief that they will not lead a "good" life and will burden their parents and society.

**B. Appellants Advocate a Public Policy That Denies People with Disabilities the Benefit of the State’s Suicide Prevention Protections**

Assisted suicide singles out some people with disabilities, those labeled "terminal" or very severely impaired, for different treatment than other suicidal people receive. This lethal discrimination is viewed as justified based on the mistaken belief that a severe disability – which may cause, for example, use of a wheelchair or incontinence, or may require assistance bathing, eating, toileting, or

other activities of daily living – is worse than death.

The appellants’ quest to immunize physicians for assisting the suicides of persons with "terminal" disabilities or conditions, turns on its head the general assumption that suicide is irrational and is a "cry for help." Appellants seek to invalidate long standing protections of old, ill and disabled people and permit doctors to affirmatively facilitate suicide, an act that would be a crime but for the person's disability and a label of “terminal.” Persons with severe health impairments would be denied the benefit of New York's suicide prevention laws and programs. Indeed, the appellants’ proposal would guarantee that these suicide attempts would result in death – unlike those of the majority of other persons with suicidal ideation who attempt suicide and are not disabled. A practice that the State would otherwise expend public health resources to prevent is instead actively facilitated based on a "terminal" label, however unreliable and slippery such predictions may be, however effectively the person’s concerns can be addressed short of active measures to cause death, and however great the risk of non-consensual death through mistake, coercion and abuse.

The United States Supreme Court has recognized that suicide is a practice that States throughout the country actively discourage through laws and prevention programs. See Washington v. Glucksberg, 521 U.S. 702, 711 (1997). By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a
disabled person to do so, appellants argue that the non-disabled person's life is intrinsically more valuable and worthwhile than a disabled person's life.

Perhaps no attitude strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, stereotypes, barriers preventing assistance with activities of daily living, and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living. As the U.S. Supreme Court has recognized:

The State's interest here [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference ... " The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same as everyone else's.

*Glucksberg*, 521 U.S. at 732.

Appellants attempt to justify a double standard regarding suicide prevention based on the notion that people with disabilities who have a terminal prognosis are going to die soon anyway. There are several reasons why this argument fails.

First, terminal predictions by doctors are uncertain and unreliable.\(^7\) The

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Disability Rights Amici include many people with disabilities who have been given a terminal prognosis by mistake and then pulled through. This medical uncertainty and potential for an unduly grim prognosis is a particularly serious concern on behalf of people with severe new injuries or unexpected severe medical declines such as a stroke or major heart attack. These are times when knowledgeable and genuine suicide prevention is essential.

Second, it is clear from the Oregon State Health Division’s assisted suicide data that non-terminal people with disabilities are receiving lethal prescriptions in Oregon, presumably based on mistaken prognoses. The state reports reveal that some people outlived the six-month prognosis every year, based on the time lapse between the person’s request for assisted suicide and their death, with a reported time lapse of up to 1009 days.8

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Third, the Oregon state reports reveal that the overwhelming majority of the people who receive lethal prescriptions have disabilities, based on the reported reasons for requesting assisted suicide. Ninety-one percent reportedly made their request due to “loss of autonomy,” which indicates physical dependence on others for activities previously undertaken without assistance. In fact, the top five reasons are disability related. The Disability Rights Amici have direct knowledge and experience in addressing these issues, which would be the crux of meaningful suicide prevention.

Professionals in the field of suicide prevention also view these issues as treatable. The most extensive literature addresses elder suicide prevention. The U.S. Administration on Aging and Substance Abuse and Mental Health Services Administration state in an issue brief entitled “Preventing Suicide in Older Adults”:

There are several important risk factors for suicide in older adults. These include, among others: • Depression, • Prior suicide attempts, • Marked feelings of hopelessness, • Co-morbid general medical conditions that significantly limit functioning or life expectancy, • Pain and declining role function (e.g., loss of independence or sense of purpose), • Social isolation, • Family discord or losses (e.g., recent death of a loved one), • Inflexible personality or marked difficulty adapting to change . . .

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9 Id., Page 5.
10 See Older Adult Suicide Prevention Resources (http://www.sprc.org/sites/sprc.org/files/OlderAdultSuicidePreventionResources.pdf);
11 OLDER AMERICANS BEHAVIORAL HEALTH Issue Brief 4: Preventing Suicide in Older Adults (http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Issue%20Brief%204%20Preventing%20Suicide.pdf)
The State of Connecticut has included suicide prevention for people with chronic conditions and disabilities in its Suicide Prevention Plan 2020, discussing risk factors as follows at page 44:

Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system, traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.

In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality. Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.

In a letter to the New York legislature concerning assisted suicide bills pending in New York State, Dr. Herbert Hendin, CEO and Medical Director of Suicide Prevention Initiatives based in New York City, specifically discussed “the inadequacy of safeguards ostensibly designed to ensure a patient’s psychiatric health and the voluntariness of the decision” in assisted suicide as implemented in Oregon.

Finally, lobby groups that support a public policy of assisted suicide,

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including some appellants, have openly advocated expanding eligibility for assisted suicide beyond those with a six-month terminal prognosis. From the Harvard Model Act\textsuperscript{14} nearly twenty years ago, to repeated introductions of bills in New Hampshire with expansive definitions of “terminal”,\textsuperscript{15} to writings by appellant Quill\textsuperscript{16} it is clear that broad assisted suicide eligibility for people with non-terminal disabilities is a goal. Their incremental strategy is “Politics 101,” despite any claims or implications to the contrary in the context of this case.

C. Denying People with Disabilities the Benefit of Both State Suicide Prevention Laws and the Enforcement of Homicide Laws Violates the ADA

Responding to the long and tragic history of discrimination against people with disabilities, in 1990 Congress enacted the Americans With Disabilities Act ("ADA"), 42 U.S.C. § 12101 \textit{et seq}., the basic civil rights statute for people with


\textsuperscript{15} New Hampshire Death With Dignity Act, HB 1325, Section 137 L2 XIII, providing that “Terminal condition” means an incurable and irreversible condition, for the end stage for which there is no known treatment which will alter its course to death, and which, in the opinion of the attending physician and consulting physician competent in that disease category, will result in premature death.” http://www.gencourt.state.nh.us/legislation/2014/HB1325.pdf

disabilities. To address and remedy the “serious and pervasive social problem” of discrimination against individuals with disabilities, 42 U.S.C. § 12101(a)(2), Congress substantively required that "no qualified individual with a disability shall . . . be excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity ...." 42 U.S.C. § 12132; See 28 C.F.R. § 35.130(b) (discrimination includes denying or not affording an opportunity for people with disabilities to benefit from services either equal to or as effective as those afforded nondisabled persons).

Sanctioning assisted suicide only for people with disabilities, and denying them suicide prevention services based on a doctor's prediction of terminal status or other justification violates the ADA because the presence or absence of disability determines whether New York:

• Enforces its laws requiring health professionals to protect individuals who pose a danger to themselves;

• Responds to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities; and

• Investigates and enforces its abuse and neglect and homicide statutes in cases reported as assisted suicides.

A doctor's determination of someone's eligibility for assisted suicide confers
absolute legal immunity on the doctor and other participants in the death, and all State suicide-related procedures are set aside. The existence of a disability should never be the basis for these distinctions.

II. Assisted Suicide Poses Serious, Unavoidable Threats to People with Disabilities That New York Has a Significant State Interest in Preventing

As the U.S. Supreme Court has recognized, assisted suicide is contrary to well-established medical ethics. See Glucksberg, 521 U.S. at 731 (quoting American Medical Association, Code of Ethics section 2.211 (1994)); see also Vacco v. Quill, 521 U.S. 793, 801 n.6 (1997) (discussing medical profession's distinction between withholding treatment and assisted suicide). This rejection is firmly grounded in the potential harm that appellants’ proposed public policy poses to the lives of people with disabilities.

A. The Difficulty in Ensuring Decisions to Die Are Not Coerced or Made by Others Is a Critical State Interest

Some persons killed under assisted suicide laws may "choose" suicide under pressure from others, and New York has a significant State interest to ensure that does not happen. There is no way to ensure that persons are not unduly pressured by family members, because of financial, emotional, or other reasons.
Similarly, given the extraordinarily high cost of health care, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not unduly pressuring a person to request "aid in dying" for financial reasons. Doctors must not be immunized for active measures to cause death.

B. The Assumption that Suicide is "Rational" When Committed by a Person with a Disability Is Not Valid

As the Glucksberg decision recognized, "those who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." 521 U.S. at 730. The Court continued, "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." Id. A study of cancer patients showed that those with depression were four times more likely to want to die.17 Pain is rarely the reason people consider assisted suicide. Many people do so because they fear they will be a burden on their families. The Oregon Reports indicate that 40% of assisted suicide requests involved this factor.18

17 See William Breitbart et al., Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907, 2909 (Dec. 13, 2000).

In the most recent reporting year, 2014, physicians referred only 2.9% of persons who requested assisted suicide for a consultation to determine whether their judgment was impaired, and only 5.5% were referred over all the reported years.\textsuperscript{19} In a survey of psychiatrists, over half were "not at all confident" they could assess in a single consultation whether a psychiatric condition impaired a person's judgment; only six percent were "very confident."\textsuperscript{20} This is because such assessments are inherently subjective and unreliable. As one research analysis concluded:

There is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting [physician-assisted suicide]... There are no clinical criteria to guide such an assessment - just as there are no criteria to assess the rationality of any person's decision to commit suicide.\textsuperscript{21}

\textbf{C. The Uncertainty of Diagnosing a "Terminal Illness"}

As noted above, the diagnosis and prognosis of a "terminal condition" is inherently uncertain. Because terminal conditions are so often misdiagnosed, the policy that appellants advocate opens the door to assisted suicide for many

\textsuperscript{19} Id at page 5.
\textsuperscript{21} Brendan D. Kelly et al., \textit{Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box}, 181 British J. Psychiatry 278, 279 (2002).
people with disabilities who are not “terminally ill” within any predictable time frame. The risks to newly disabled people, such as those with significant spinal cord injuries and strokes, are particularly great. As the National Council on Disability has reported, "people with disabilities are aware of enough instances of dramatic mistakes that many of them have a healthy skepticism of medical predictions, particularly as it relates to future life quality."  

22 Evan Kemp, Director of the Equal Employment Opportunity Commission under President George H.W. Bush, wrote:

As a disabled person, I am especially sensitive to the "quality of life" rationale that is frequently introduced in the debate [over assisted suicide]. For the past 47 years I have lived with a progressive neuromuscular disease that first began to manifest itself when I was 12. My disease, Kugelberg Weyland Syndrome, has no known cure, and I have no hope for "recovery." Upon diagnosis, my parents were informed by the physicians treating me that I would die within two years. Later, another group of physicians was certain that I would live only to the age of 18. Yet here I am at 59, continuing to have an extraordinarily high quality of life.  

23 Many people identified as candidates for assisted suicide could benefit

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from supportive care or treatment, such as counseling, pain medication, or in-home consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, or lack of independence and choice. The National Council on Disability has found that "improving laws, policies, programs, and services for people with disabilities . . . would go a long way toward assuring that any self-assessment or decision about the quality of life of an individual with a disability would be made in an optimal context of independence, equality of opportunity, full participation, and empowerment." 24

Research demonstrates the lack of this type of assistance and support, rather than any intrinsic aspect of a person's disability, is the primary motivation for suicide. Assisted suicide, however, assumes that a medical condition inherently makes life unworthy of continuation. As a doctor at New York's Memorial Sloan-Kettering Cancer Center has observed, assisted suicide "runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care." 25

The question how to address the psychological and social needs that underlie the desire to die, however, is typically lost in a simplistic mental

24 National Counsel on Disability, supra note 9, at 13.

"competency" determination. One study noted that "the focus on competence may distract from adequate attention and resources on the person and their circumstances ...."26 Another study concluded that competency determinations "do not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide."27

III. THE CREATION OF A NEW YORK CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE FOR A CLASS OF PEOPLE BASED ON THEIR HEALTH AND DISABILITY STATUS IS A LETHAL FORM OF DISCRIMINATION

A. People with Disabilities Are the Class of People Who Will Be Affected If a Right to Assisted Suicide Is Found

The issue before the Court goes far beyond the 1980's cases in which courts dismissed the state interest in protecting the lives of these disabled individuals and found a "right to die" through the withdrawal of routine life-sustaining treatment. See e.g., Bouvia v. Superior Court, 179 Ca. App. 3d 1127, 255 Cal. Rptr. 297 (1986), review denied (June 5, 1986); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990); State v. McAfee, 385 S.E.2d 651 (Ga. 1989). With appropriate

26 Ganzini et al., supra note 7, at 600.

treatment and services, many of them would be alive today, as was later admitted in an apology by one of the leading bioethicists who addressed these cases.²⁸

However, even in those cases, the courts specifically distinguished any right involving active physician-assisted suicide. Before this Court is the request to obliterate this distinction. It is against the backdrop of these and other cases that your amici request protection from the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

B. Adequate State Safeguards Cannot Be Adopted to Protect People with Disabilities from Assisted Suicide Threat

1. Any Purported Limitation of the Right to Assisted Suicide to Terminally Ill Persons Will Not Protect People with Disabilities

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected, 42 U.S.C. § 12101 (a)(7), assisted-suicide "safeguards" cannot prevent abuse against people with disabilities. History demonstrates that assisted suicide has not and will not be limited to terminally ill persons.²⁹


terminally ill persons who request assisted suicide are or fear they will become disabled, and are a demographic subset of people with disabilities.

At issue is nondisabled peoples' intense fear of becoming disabled. The wish to die is based on the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids. Medical professionals, jurists and the public consistently ignore underlying treatable depression, lack of health care, in-home long term care services or other supports, and exhaustion from confronting interpersonal, societal and systemic discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless," "suffering needlessly," and "quality versus quantity of life," purportedly in a humanistic and compassionate way, they are really expressing fear of severe disability and a very misguided condemnation, "I could never live like that." Society translates these emotions into a supposedly rational social policy of assisted suicide. The wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from the same emotional disturbance or illogical despair that nondisabled persons face.

The medical profession is not immune to these erroneous assumptions. Research shows that doctors frequently project the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-

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prolonging treatment." It is particularly important to note that research on suicidal feelings among people with terminal illnesses demonstrates that such feelings are remediable through other means, including pain management, hospice services and counseling. As long as physicians believe that a person with a severe disability has a "life unworthy of living," lethal errors and abuses will occur.

Safeguards cannot protect one from family pressures due to financial burdens which may accompany a disability, especially when the health care system may not pay for assistance in daily living activities. Nor can safeguards stop families from doctor-shopping when one doctor says the person is not "terminal" or acting "voluntarily," to find another doctor who will say otherwise. Doctor shopping for assisted suicide “friendly” doctors is common in Oregon. The majority of Oregon assisted suicides involve doctors referred to patients by Compassion and Choices, the leading lobby group for assisted suicide bills. 

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2. Any Purported Limitation of a Right to Assisted Suicide Only in Cases of "Voluntary" Requests Will Not Protect People with Disabilities from Abuse

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary. The Disability Rights Amici are profoundly disturbed by the appellants’ advocacy of a constitutional right for assisted suicide in a society which refuses to find a concomitant right to adequate health care to stay alive. Now managed health care, with its emphasis on cost containment, further abridges the choices and endangers the lives of people with disabilities. Until society is committed to providing life supports, including in-home personal assistance services and technology supports, there is not voluntary choice.

Without health care and consumer-directed personal care services, people with disabilities do not receive what they need to live as independently and with as much autonomy as possible. Appropriate health care includes competent palliative care. Without the professional commitment to help make living worthwhile for people with disabilities, which is the core of suicide prevention, people with disabilities, including those whose conditions are terminal, will not receive the support necessary for informed and voluntary decisions. There are no safeguards that can protect against these prejudices and realities.

Finally, no system of safeguards can control conduct which results in the
death of the primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all persons equally.

C. **People With Disabilities, Whether Terminal or Nonterminal, Should Receive Equal Protection of Laws Pertaining to Suicide Prevention and Homicide**

Appellants urge this Court to minimize and ignore the risks of abuse impacting vulnerable people. There is already ample evidence of non-voluntary and involuntary withholding and withdrawal of treatment. For example, in a study published in 2011 in the Journal of Emergency Medicine, University of Pittsburgh researchers found that over 50% of physician respondents misinterpreted a living will as having a “do not resuscitate” (DNR) order. About the same percentage of respondents over-interpreted DNR orders as meaning “comfort care” or “end-of-life” care only. The study shows clearly that having a living will and/or a DNR order makes it much more likely that physicians will withhold treatments that a patient actually wants. Even more clearly involuntary are futility policies that grant immunity to physicians who deny care that the patient or surrogate expressly

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wants. Legalizing assisted suicide will make matters worse than they already are by expanding the population of people who are eligible to have their lives ended by medical professionals. The Disability Rights Amici have a great deal of experience with incorrect terminal prognoses, and the involuntary denial of care and self-fulfilling prophesy that can result from a “terminal” label.

The more vulnerable members of the disability and aging communities should not be viewed as expendable. And that is the crux of the Disability Rights Amici’s disagreement with appellants. There are at least three responses to the petitioners’ frequent claim that the dangers of assisted suicide have been disproven by the experience in Oregon and Washington: 1) the language of the Oregon and Washington assisted suicide statutes, which leave gaping holes in patient protection but provide a blanket of immunity based on a claim of “good faith” to participants in the death; 2) the common sense factual and legal analyses by numerous courts that have considered the issue; and 3) cases of mistake and abuse which have come to light despite the law’s minimal reporting requirements, the admitted lack of investigation by Oregon state authorities, and the impact of strict health care confidentiality laws.

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35 DHS News Release: No authority to investigate Death with Dignity case, DHS says, March 4, 2005
First, nothing in the provisions of the Oregon and Washington assisted suicide statutes\(^{36}\) prohibits an heir or caregiver from suggesting assisted suicide to an ill person, or taking the person to the doctor to make a request. If the person has a speech impairment, such as due to a stroke, or speaks another language, the laws provide that a patient may communicate “through a person who is familiar with the patient’s manner of communicating.” See, e.g., Oregon DWD Act, 127.800 § 1.01(3). The statutes allow an heir to be a witness to the assisted suicide request as long as the second witness is not an heir. In addition, both witnesses can be complete strangers who merely check the patient’s identification. In either case, the witnesses’ certification that the patient is not being coerced is seriously lacking in foundation and persuasive value. Moreover, the physicians’ ability to detect coercion is similarly in doubt. The median duration of the physician-patient relationship in Oregon is reported as 13 weeks.\(^{37}\) The majority of doctors who prescribe under the Oregon assisted suicide law are referrals by Compassion and Choices, the leading lobby group for these laws.\(^{38}\) In addition, once the prescription for lethal drugs is

\(^{36}\) Oregon Death With Dignity Act, ORS 127.865, Washington Death With Dignity Act, RCW 70.245


issued, there are no further witness requirements, including at the time of ingestion of the lethal drugs and death. As Washington elder law attorney Margaret Dore has written:

Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi...  

The Oregon Reports include data on whether the prescribing doctor or other health care provider was present when the lethal dose was ingested or at the death. In about half the cases, no such person was present. Assuming for the sake of discussion that healthcare provider witnesses would report a lack of consent or intentional self-administration, in the other half of the cases, there is no evidence of consent or intentional self-administration.

Second, a recent California assisted suicide case granting a demurrer without leave to amend provides a comprehensive and persuasive review of previous court rulings, *O’Donnell v. Harris*, San Diego Superior Court Case No. 37-2015-00016404-CU-CR-CTL (July 24, 2015), giving realistic weight to the many dangers

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that legalizing assisted suicide poses, particularly in an aging population in which, according to federal estimates, one in ten elders are abused.\textsuperscript{41}

Since "Aid in Dying" is quicker and less expensive, there is a much greater potential for its abuse, e.g., greedy heirs-in-waiting, cost containment strategies, impulse decision-making, etc. Moreover, since it can be employed earlier in the dying process, there is a substantial risk that in many cases it may bring about a patently premature death. For example, consider that a terminally ill patient, not in pain but facing death within the next six months, may opt for "Aid in Dying" instead of working through what might have been just a transitory period of depression. Further, "Aid in Dying" creates the possible scenario of someone taking his life based upon an erroneous diagnosis of a terminal illness, which was, in fact, a misdiagnosis that could have been brought to light by the passage of time. After all, doctors are not infallible.

Furthermore, "Aid in Dying" increases the number and general acceptability of suicide, which could have the unintended consequence of causing people who are not terminally ill (and not, therefore, even eligible for "Aid in Dying") to view suicide as an option in their unhappy life. For example, imagine the scenario of a bullied transgender child, or a heartsick teenaged girl whose first boyfriend just broke up with her, questioning whether life is really worth living. These children may be more apt to commit suicide in a society where the terminally ill are routinely opting for it.

\textit{Id.} at 8. This is wholly consistent with the issues discussed in the report of the New York Task Force on Life and the Law (see footnote 6 of this brief).

Additional deficiencies of patient protections in the Oregon and Washington assisted suicide laws include the fact that no treatment for depression is required.\textsuperscript{42} Moreover, as previously noted, the top five reasons that prescribing physicians report for assisted suicide requests are psycho-social reactions to disability. Two of them are loss of autonomy (92%) and feelings of being a burden on others (40%).\textsuperscript{43} Nevertheless, neither the Oregon nor Washington laws require disclosures about consumer directed home care options that could alleviate these feelings, nor do they ensure that such home care will be provided if desired. The Disability Rights Amici’s experience is that most doctors know little or nothing about home and community based long-term care.

Moreover, under the statute, the state has no authority (or resources) to investigate abuses. The blanket immunities granted to participants in the death, and the impact of patient confidentiality laws, present formidable barriers to uncovering mistakes, coercion and abuse. Despite these obstacles, some cases have come to light.\textsuperscript{44} These further emphasize the critical importance of applying equal protection


\textsuperscript{44} The Disability Rights Education & Defense Fund has compiled brief descriptions of some of these cases, with citations to source materials, entitled “Oregon and Washington State Abuses and Complications.” (https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf)
principles to protect people with disabilities, whether terminal or not, from the dangers inherent in a public policy of legalized assisted suicide.

CONCLUSION

People with disabilities in New York are seriously threatened by physician-assisted suicide. The Disability Rights Amici request this Court to recognize that, cloaked in the false rhetoric of “death with dignity,” and “aid in dying,” physician-assisted suicide threatens the civil rights, and the lives, of a profoundly oppressed and marginalized minority.

The Disability Rights Amici are aware that our members have not been declared a “suspect class” entitled to strict scrutiny analysis of statutes that discriminate against us. However, we hope that the time will come when old, ill and disabled people are recognized as a class entitled to strict scrutiny protection. That is the expansion of constitutional rights that we hope to see. As we have argued above, people with disabilities, whether those disabilities are terminal or nonterminal, deserve equal protection under the laws and professional standards pertaining to suicide prevention and homicide law enforcement. We urge this Court to give compelling and dispositive weight to protecting old, ill and disabled people from the risks of mistake, coercion and abuse inherent in a public policy of assisted suicide, and to uphold the Supreme Court’s ruling in this important case.
Respectfully submitted,

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Dated: New York, NY
January 6, 2015

By: ____________________________
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DISABILITY RIGHTS EDUCATION AND
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ON INDEPENDENT LIVING, NEW
YORK ASSOCIATION ON
INDEPENDENT LIVING, REGIONAL
CENTER FOR INDEPENDENT LIVING
AND UNITED SPINAL ASSOCIATION
SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

SARA MYERS, STEVE GOLDENBERG, ERIC A.
SEIFF, HOWARD GROSSMAN, M.D., SAMUEL C.
KLAGSBRUN, M.D., TIMOTHY E. QUILL, M.D.,
JUDITH K. SCHWARTZ, PhD., CHARLES A.
THORNTON, M.D., and END OF LIFE CHOICES NEW
YORK,

Plaintiffs-Appellants,

v.

ERIC SCHNEIDERMAN, in his official capacity as
ATTORNEY GENERAL OF THE STATE OF NEW
YORK,

Defendant-Respondent.

- and -

JANET DIFIORE, in her official capacity as DISTRICT
ATTORNEY OF WESTCHESTER COUNTY, SANDRA
DOORLEY, in her official capacity as DISTRICT
ATTORNEY OF MONROE COUNTY, KAREN
HEGGEN, in her official capacity as DISTRICT
ATTORNEY OF SARATOGA COUNTY, ROBERT
JOHNSON, in his official capacity as DISTRICT
ATTORNEY OF BRONX COUNTY and CYRUS R.
VANCE, JR., in his official capacity as DISTRICT
ATTORNEY OF NEW YORK COUNTY,

Defendants.

N.Y. County
Clerk’s Index No. 151162/15

NOTICE OF MOTION FOR LEAVE
TO FILE BRIEF AS AMICI CURIAE

PLEASE TAKE NOTICE that upon the annexed affirmation of Neil Merkl, Esq.,
dated the 30th day of December 2015, and the accompanying brief, and all the pleadings and
prior proceedings had herein, proposed amicus the New York Catholic Conference, by its
attorneys Kelley Drye & Warren LLP, will move this Court at a term thereof to be held in the
Appellate Division, First Department, at the Courthouse located at 27 Madison Avenue, New
York, New York on the 8th of January 2016, without oral argument or the appearance of counsel,
for an Order granting petitioner leave to file the accompanying brief as amicus curiae, in support of Respondent Eric Schneiderman in his official capacity as Attorney General of the State of New York, and in opposition of the appeal of Plaintiffs-Appellants from the Decision and Order Supreme Court of the State of New York (Kenney, J.), entered on October 19, 2015 in the above-captioned action, granting Defendant-respondent's motion dismissing the complaint pursuant to CPLR 3211(a)(7) together with such other and further relief as the Court may deem just and proper.

PLEASE TAKE FURTHER NOTICE that answering papers, if any, must be served at least two days before the return date. The motion will be submitted on the papers, and your personal appearance in opposition is neither permitted nor required.

Dated: New York, New York
       December 30, 2015

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By:  

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SUPREME COURT OF THE STATE OF NEW YORK
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N.Y. County
Clerk’s Index No. 151162/15

AFFIRMATION OF NEIL MERKL IN SUPPORT OF
MOTION BY NEW YORK STATE CATHOLIC CONFERENCE
FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE

NEIL MERKL, an attorney admitted to practice before the courts of the State of
New York, affirms the following under penalty of perjury:

1. I am a member of the bar of the State of New York and a member of
the firm of Kelley Drye & Warren LLP, attorneys for Proposed Amicus New York State
Catholic Conference (the “Catholic Conference”).
2. I submit this affirmation in support of the Catholic Conference's motion for leave to file a brief as *amicus curiae* in the above-captioned matter.

3. I am fully familiar with the facts set forth in this affirmation, either from personal knowledge or from documents in the files of my firm.

4. Annexed as Exhibit A is the proposed Brief of *Amicus Curiae* in support of the affirmance of the lower court's order (the "Proposed Amicus Brief").

**The Appeal**

1. The Catholic conference moves for leave to submit the amicus brief in opposition to the appeal of Sara Myers, Steve Goldenberg, Eric A. Seiff, Howard Grossman, M.D., Samuel C. Klagsbrun, M.D., Timothy E. Quill, M.D., Judith K. Schwarz, Ph.D., Charles A. Thornton, M.D. and End of Life Choices New York (collectively, "Appellants"). Appellants seek to overturn the decision and order of the Supreme Court, New York County, dismissing their complaint, entered on October, 2016 (the "October 19 Order").

2. This action was filed by Appellants against the Attorney General of the State of New York and several county District Attorneys; the Attorney General’s Office and Appellants’ counsel voluntarily discontinued the action against the District Attorneys. Appellants sought a declaratory judgment that the current New York State ban on assisted suicide (N.Y. Penal Law § 125.15 and § 125.30) is unconstitutional, and a permanent injunction barring their prosecution for assisting in suicides. The Attorney General responded on behalf of all Defendants, and sought the dismissal of the complaint. The Supreme Court, granted the Attorney General's motion in its October 19 Order, and dismissed the complaint in its entirety. Appellants filed this appeal, asking this Court to reverse the October 19 Order and reinstate their complaint.

3. The Catholic Conference, as *amicus curiae*, urges this Court to affirm the Decision and Order of the Supreme Court.
Interest of the *Amicus Curiae*

4. The Catholic Conference has been organized by the Roman Catholic Bishops of New York State as the institution by which the Roman Catholic Bishops speak cooperatively and collegially in the field of public policy and public affairs. The Catholic Conference promotes the social teaching of the Catholic Church in such areas as education, family life, respect for human life, health care, social welfare, immigration, civil rights, criminal justice, the environment, and the economy.

5. The Catholic Conference carries out advocacy with legislative and executive officials of the New York State government on public policy matters that relate to these areas of interest. When permitted by court rules and practice, the Catholic Conference participates as a party and files briefs as *amicus curiae* in litigation of importance to the Catholic Church and the common good of the people of the State of New York.

6. This action involves issues of great interest to the Catholic Church and the people of New York. The Catholic Conference has consistently opposed any legislative or judicial initiative to legalize assisted suicide. For a number of years, the Catholic Conference has conducted extensive advocacy in the New York State Legislature and with the Executive Branch towards that end. When Appellant Timothy Quill filed a federal action in 1994, seeking to legalize assisted suicide in New York, the Catholic Conference filed *amicus* briefs in opposition. When the matter reached the United States Supreme Court in 1997, the interests of the New York State Catholic Conference were represented by the United States Catholic Conference which filed an *amicus* brief, as did several other Catholic organizations representing Catholic health care entities and professionals. (The Quill decisions were cited and relied upon by the Court below in the October 19 Order.

7. In addition to the issue of assisted suicide, the Catholic Conference has a vital interest in questions of euthanasia and end-of-life decision-making. For many
years the Catholic Conference has conducted extensive advocacy on such issues as the health
care proxy law, surrogate decision-making for the general population and for persons with
developmental disabilities.

8. The Catholic Church in New York State also operates the largest
network of non-governmental health care providers. Catholic health-care institutions
provide holistic health services in an atmosphere of respect for the value and dignity of all
human life, with special attention to the poor and vulnerable. Catholic ministries include
over two dozen hospitals, over fifty nursing homes, hospice programs, and home health
agencies, and long-term home health care programs. Catholic health care institutions
employ thousands of workers of all faiths. The vast majority of these institutions care for
elderly and terminally ill patients who are regularly making end-of-life decisions, and who
would be directly impacted by a decision to legalize assisted suicide.

The Matter on Appeal

9. The brief proposed by the Catholic Conference will demonstrate that
by upholding the Legislation’s prohibition against assisted suicide the lower court acted in
accord with longstanding moral, ethical and legal principles recognized by this State for
hundreds of years. The decision moreover affects millions of New York State citizens,
including, its most vulnerable, the sick, the elderly and terminally ill.

10. Catholic health care institutions operate in accordance with the
teachings and doctrines of the Catholic Church. The Catholic Church has always taught that
the direct, intended taking of an innocent human life is always gravely immoral. Pope John
Paul II, Evangelium Vitae (The Gospel of Life), par. 53-57. More specifically, Catholic
teaching condemns suicide as an offense against God's law. Id., at par. 66.

11. The Second Vatican Council condemned crimes against life "such as
any type of ... euthanasia, or willful suicide". Second Vatican Ecumenical Council, Pastoral

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Constitution on the Church in the Modern World Gaudium et Spes, no. 27. The Congregation for the Doctrine of the Faith, which is the office of the Holy See specifically dedicated to promoting and protecting Catholic doctrine on faith and morals throughout the world, also specifically condemned suicide and euthanasia as violations of God's law. Congregation for the Doctrine of the Faith, Declaration on Euthanasia (1980). These teachings are also presented in the Catechism of the Catholic Church.

12. Catholic healthcare institutions, therefore, have a direct stake in the issues resolved in this case. To provide specific guidance to Catholic health care institutions in the United States, the Catholic bishops of the United States have issued their Ethical and Religious Directives for Catholic Health Care Services (henceforth the "Ethical and Religious Directives"). The bishops explain that theological foundation for Catholic health care is the inherent and inalienable dignity of every human being, made in the image and likeness of God:

13. The *Quill* decision cited by the lower court, moreover, acknowledged valid policy reasons supporting the Legislature's decision. These reasons are in accord with the teachings of the Catholic Church, and principles of ethics and justice that have prevailed for two thousand years.

14. With respect to the specific issues of euthanasia or suicide, the bishops present the unequivocal teaching of the Church and suicide and euthanasia are never morally acceptable options (Ethical and Religious Directives, Part V, Introduction).

15. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. (Ethical and Religious Directives, par. 60; see also par. 70)
16. Petitioner, therefore, seeks leave to file as *amicus curiae* because the issues presented on this appeal present profound moral and ethical issues directly affecting the dignity of human life and the ethical responsibility of the State to millions of its citizens including its most vulnerable -- the elderly, the terminally ill and those in need of long term medical care.

17. No previous application has been made to this Court or any judge thereof for the relief sought herein.

18. Accordingly, Proposed Amicus Catholic Conference requests permission to submit the Proposed Amicus Brief to set out for this Court ethical, moral and legal principles supporting the decision of the lower court.

Dated: New York, New York
December 30, 2015

[Signature]

Neil Merkl
New York Supreme Court
Appellate Division—First Department

SARA MYERS, STEVE GOLDENBERG, ERIC A. SEIFF, HOWARD GROSSMAN, M.D., SAMUEL C. KLAGSBRUN, M.D., TIMOTHY E. QUILL, M.D., JUDITH K. SCHWARZ, PH.D., CHARLES A. THORNTON, M.D. and END OF LIFE CHOICES NEW YORK,

Plaintiffs-Appellants,

— against —

ERIC SCHNEIDERMAN, in his official capacity as ATTORNEY GENERAL OF THE STATE OF NEW YORK,

Defendant-Respondent,

— and —

JANET DIFIORE, in her official capacity as DISTRICT ATTORNEY OF WESTCHESTER COUNTY, SANDRA DOORLEY, in her official capacity as DISTRICT ATTORNEY OF MONROE COUNTY, KAREN HEGGEN, in her official capacity as DISTRICT ATTORNEY OF SARATOGA COUNTY, ROBERT JOHNSON, in his official capacity as DISTRICT ATTORNEY OF BRONX COUNTY and CYRUS R. VANCE, JR., in his official capacity as DISTRICT ATTORNEY OF NEW YORK COUNTY,

Defendants.

BRIEF FOR AMICUS CURIAE
NEW YORK CATHOLIC CONFERENCE

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Preliminary Statement

Amicus Curiae New York State Catholic Conference ("the Catholic Conference") through their counsel, Edward T. Mechmann, Esq., submit this brief in opposition to the appeal of Sara Myers, Steve Goldenberg, Eric A. Seiff, Howard Grossman, M.D., Samuel C. Klagsbrun, M.D., Timothy E. Quill, M.D., Judith K. Schwarz, Ph.D., Charles A. Thornton, M.D. and End of Life Choices New York (collectively, "Appellants"), seeking to overturn the decision by the Supreme Court, New York County, dismissing their complaint.

The action was filed by Appellants against the Attorney General of the State of New York and several county District Attorneys. They sought a declarative judgment that the current New York State ban on assisted suicide (N.Y. Penal Law § 125.15 and § 125.30) is unconstitutional, and a permanent injunctive barring their prosecution for assisting in suicides. The Attorney General responded on behalf of all Defendants, and sought the dismissal of the complaint. The Supreme Court granted the Attorney General's motion and dismissed the complaint in its entirety. Appellants filed this appeal, asking this Court to reverse the judgment of the Supreme Court and reinstate their complaint.

The Catholic Conference, as Amicus Curiae, here urges this Court to affirm the judgment of the Supreme Court.

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1 Counsel would like to express his gratitude for the invaluable assistance of Alexis N. Carra, a graduate student at Fordham University, for her significant contributions to the writing of this brief.
**Interest of the *Amicus Curiae***

The Catholic Conference has been organized by the Roman Catholic Bishops of New York State as the institution by which the Bishops speak cooperatively and collegially in the field of public policy and public affairs. The Catholic Conference promotes the social teaching of the Catholic Church in such areas as education, family life, respect for human life, health care, social welfare, immigration, civil rights, criminal justice, the environment, and the economy. The Catholic Conference carries out advocacy with legislative and executive officials of the New York State government on public policy matters that relate to these areas of interest. When permitted by court rules and practice, the Catholic Conference participates as a party and files briefs as *amicus curiae* in litigation of importance to the Catholic Church and the common good of the people of the State of New York.

This action involves issues of great interest to the Catholic Church and the people of New York. The Catholic Conference has consistently opposed any legislative or judicial initiative to legalize assisted suicide. For a number of years, the Catholic Conference has conducted extensive advocacy in the New York State Legislature and with the Executive Branch towards that end. When Appellant Timothy Quill filed a federal action in 1994, seeking to legalize assisted suicide in
New York, the Catholic Conference filed *amicus* briefs in opposition. When the matter reached the United States Supreme Court in 1997, the interests of the New York State Catholic Conference were represented by the United States Catholic Conference, which filed an *amicus* brief, as did several other Catholic organizations representing Catholic health care entities and professionals.

In addition to the issue of assisted suicide, the Catholic Conference has a vital interest in questions of end-of-life decision-making. For many years, the Catholic Conference has conducted extensive advocacy and public education on such issues as the health care proxy law, surrogate decision-making for the general population and for persons with developmental disabilities.

The Catholic Church in New York State also operates the largest network of non-governmental health care providers. Catholic health-care institutions provide holistic health services in an atmosphere of respect for the value and dignity of all human life, with special attention to the poor and vulnerable. Our ministries include over two dozen hospitals, over fifty nursing homes, hospice programs, and home health agencies, and long-term home health care programs. Catholic health care institutions employ thousands of workers of all faiths. The vast majority of these institutions care for elderly and terminally ill patients who are regularly making end-of-life decisions, and who would be directly impacted by a decision to legalize assisted suicide.
Catholic health care institutions operate in accordance with the teachings and doctrines of the Catholic Church. The Catholic Church has always taught that the direct, intended taking of an innocent human life is always gravely immoral. Pope John Paul II, *Evangelium Vitae (The Gospel of Life)* (1995), par. 53-57. More specifically, Catholic teaching condemns suicide as an offense against God's law. *Id.*, at par. 66.

The Second Vatican Council condemned crimes against life "such as any type of … euthanasia, or willful suicide". Second Vatican Ecumenical Council, Pastoral Constitution on the Church in the Modern World *Gaudium et Spes* (1965), no. 27. The Congregation for the Doctrine of the Faith, which is the office of the Holy See specifically dedicated to promoting and protecting Catholic doctrine on faith and morals throughout the world, also specifically condemned suicide and euthanasia as violations of God's law. Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980). These teachings are also presented in the *Catechism of the Catholic Church* (1994).

To provide specific guidance to Catholic health care institutions in the United States, the Catholic bishops of the United States have issued their *Ethical and Religious Directives for Catholic Health Care Services* (2009) (hereinafter *Ethical and Religious Directives*). The bishops explain that the theological foundation for Catholic health care is the inherent and inalienable dignity of every
human being, made in the image and likeness of God:

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options. (Ethical and Religious Directives, Part V, Introduction)

With respect to the specific issue of euthanasia or suicide, the bishops present the unequivocal teaching of the Church:

Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. (Ethical and Religious Directives, par. 60; see also par. 70)

The bishops of New York State, who are the constituent members of the Catholic Conference, are responsible for teaching these religious beliefs, and ensuring that they are adhered to in all Catholic institutions in the state.
I. The Present Ban on Assisted Suicide Does Not Violate the Due Process or Equal Protection Clause of the New York State Constitution

Appellants argue that the current ban on assisted suicide violates the Due Process and Equal Protection Clauses of the New York State Constitution. They argue, in the alternative, that assisted suicide is a fundamental right and that the ban lacks a rational basis. These arguments should be rejected, because the ban does not infringe a fundamental right, and is completely consonant with New York State's long-standing, rational, and compelling interest in deterring suicide.

A. Legalizing Assisted Suicide Would Contradict A Well-Established State Interest In Preventing Suicides

New York State has long maintained a policy to prevent suicides. This has always been recognized as a legitimate governmental objective. Indeed, the Supreme Court of the United States, in relation to the New York ban on assisted suicide, has said:

prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia... These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end. *Vacco v. Quill*, 521 U.S. 793, 808-9 (1997)

This strong state interest in preventing suicides is evident not only in the Penal Law, as Appellants suppose, but also in provisions of other current laws, and
in numerous government programs and policies.

For example, the Mental Hygiene Law, Article 9, contains an extensive and detailed approach to preventing suicide. It requires evaluation and even recommends involuntary hospitalization and treatment for anyone who is likely to cause "serious harm to himself or others". N.Y. Mental Hyg. § 9.39(a). The statute explicitly includes "threats of or attempts at suicide" under this definition of harm. *Id.* This practice is followed in hospitals around the state, and involves the efforts of doctors, nurses, lawyers, and judges. It represents a substantial investment of resources by the state in preserving the lives of those who are contemplating suicide.

If assisted suicide were to be legalized, however, some classes of patients expressing the desire to commit suicide would not be treated under the Mental Hygiene Law, but would be provided with the lethal medication necessary to carry out their suicides instead. This would mean that, in the eyes of the law, some lives matter more than others. Namely, the state would have an interest against suicide "downstairs" (i.e., for the patient in the emergency room who expresses a desire to kill himself), but not "upstairs" (i.e., for the terminally ill patient in a ward upstairs who expresses the same desire). This is an irrational distinction that is utterly rejected by the current law -- both patients have expressed their desire to commit suicide, and there is no reason to treat them differently. The fact that the patient
upstairs has a terminal illness does not render his life any less valuable than that of
the patient downstairs, and the state should not treat his life as unworthy of
protection.

This is especially incoherent given that the New York State Office of Mental
Health (OMH) recognizes suicide as a serious statewide public health concern and
considers suicide prevention a significant priority. See generally, The New York
State Office of Mental Health, https://www.omh.ny.gov/omhweb/suicide_
prevention/ (last visited Dec. 29, 2015). In conjunction with the Suicide
Prevention Center of New York, which operates with funding from OMH, New
York State spends millions of dollars each year on efforts to reduce suicide
attempts. See generally, The Suicide Prevention Center of NY,
also collaborates with numerous private organizations whose mission is to prevent
suicides. Local governments likewise spend a great deal of energy and resources
to deter suicide, particularly among young people. The message against suicide is
consistent and virtually unanimous. No government agency, and no private
organization -- except the Appellants -- advocates in favor of suicide as a healthy
option.

B. The Legalization of Assisted Suicide Cannot Be Limited to the
Terminally Ill

There is every reason to believe that granting the Appellants the relief they
request would actually increase the incidence of suicides in the general population, thus running counter to the state's overall goal in preserving life. In this action, the Appellants insist that they only seek assisted for patients who are mentally competent and terminally ill, but these criteria will inevitably be expanded.

As other state courts have already found, the standards for defining the eligible population cannot be limited. For example, adopting the Appellant's class definition would lead to drawing a "line between terminally ill patients who can self-administer lethal drugs and those who cannot. Yet this would arguably amount to discrimination based upon physical disability." *Sampson v. State*, 31 P.3d 88, 97 (Alaska 2001). Further, the purported "right" to assisted suicide would hinge on a "vague, unverifiable, and subjective standard" since the "mental competency of terminally ill patients is uniquely difficult to determine." *Id.* Indeed, the criteria proposed by the Appellants are so vague that they could be expanded to permit children to commit assisted suicide, so long as they are terminally ill and mentally competent.

In fact, these concerns have already become reality in the European nations that have legalized assisted suicide. Belgium, the Netherlands, and Switzerland have all seen assisted suicide extend to those who "feel old" (Switzerland) or people who experience "psychic suffering" (the Netherlands). United States Conference of Catholic Bishops Secretariat of Pro-Life Activities, *Assisted Suicide*
issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/
upload/suicidenonterminal2014edits.pdf (last visited Dec. 29, 2015). Both
Belgium and the Netherlands have gone so far as involuntary euthanasia -- killing
people who did not even ask for death, including children. United States
Conference of Catholic Bishops Secretariat of Pro-Life Activities, Assisted Suicide
and Euthanasia: From Voluntary to Involuntary, http://www.usccb.org/issues-and-
action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/assisted-

This is not an accident. Advocates have openly and repeatedly stated that
their ultimate goal is to permit assisted suicide for anyone who desires it,
regardless of their medical condition. See, e.g., Assisted Suicide and Euthanasia:
Beyond Terminal Illness, supra. (quotations from advocates cited therein).

The inevitable expansion of assisted suicide is also being proposed in
Canada, even prior to the effective date of its legalization. The Supreme Court of
Canada granted mentally competent and terminally ill adults the right to commit
assisted suicide, but did not define "adult". Aware of this ambiguity, a task force
of medical professionals and ethicists then recommended that, "Access to
physician-assisted dying should not be impeded by the imposition of arbitrary age

The inevitability of expansion can be seen in the Appellants' own argument. They have insisted that assisted suicide should be a viable option for patients who have determined that their suffering has become "unbearable". Yet there is no definition as to what constitutes "unbearable suffering". The views of different patients and different doctors will inevitably be in conflict with regards to the nature and extent of suffering. This raises concerns as to who decides what suffering qualifies, and what kinds of suffering actually qualify. Any type of suffering could potentially be cited as grounds for assisted suicide. Again, this means that there are no limiting principles, and no way to ensure that a decision permitting suicide would be applied in an even-handed and rational way.

As a result, legalization of assisted suicide would extend to those beyond the class of people anticipated by the Appellants, and undermine the larger statewide effort to deter suicide in society. Studies have shown that when assisted suicide is legalized, overall suicide rates go up for the general population. David Albert Jones and David Paton, How does legalization of physician assisted suicide affect rates of suicide?, South. Med. J., October 2015, 108:599. The World Health Organization has warned that media coverage of suicide can lead to "imitative suicidal behaviours" especially among young or depressed people. World Health

C. The Distinction Between Withholding Medical Treatment and Intentionally Causing Death is Rational

The Appellants erroneously conflate withholding medical treatment and prescribing a lethal dosage of medication. In doing so, they blur the distinction between withholding action and committing an action, and they disregard the importance of causality and intent – elements that all indispensable in any proper and rational application of the law.

Although they both may result in death, forgoing medical treatment, as in the withdrawal of life support, and administering lethal medication, as in assisted suicide, are not the same and cannot be treated as such. The physician who administers a lethal dosage of medication is committing a particular action (i.e., prescribing medication for the patient), whereas the physician who withholds life support is omitting a particular treatment (i.e., forgoing life support for the patient).

As stated by the Supreme Court, "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." Vacco, 521 U.S. at 802. Put in simpler terms, in the first scenario, the cause of death is the underlying illness, but in the second scenario, the cause of
death is the lethal medication. This is a logical distinction. Yet this distinction also has explicit legal significance because "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide." *Id.* at 800.

With regards to intent, there is a significant difference between *intentionally* causing death and *unintentionally* causing death; "[t]he law has long used actors' intent or purpose to distinguish between two acts that may have the same result." *Id.* at 803. For example, accidental or unintentional killings are considered forms of manslaughter, whereas intentional and purposeful killings are considered forms of murder. When applied to medicine, the physician who administers lethal medication to a patient explicitly intends the death of the patient; he engages in an intentional killing. However, in the case of the physician who withholds a particular treatment, the physician may not intend the death of the patient, but the death may still occur as a result of the patient's underlying condition.

This important distinction, therefore, is well-established in the law and is entirely rational.

**D. Legalizing Assisted Suicide Would Violate the State's Compelling Interest in Protecting Vulnerable Persons**

Appellants argue that the current ban on assisted suicide serves no legitimate state interest. Yet granting the relief they seek would betray a clear, well-established and compelling state interest in protecting vulnerable persons.
This policy is embodied in the New York State Constitution, which states that "The aid, care and support of the needy are public concerns and shall be provided by the state." N.Y. Const. art. XVII § 1. The Court of Appeals has said, "care for the needy is not a matter of "legislative grace"; it is a constitutional mandate." Fayad v. Novello, 96 N.Y.2d 418, 428 (2001). Indeed, the Court of Appeals has stated that it is "an expression of the existence of a positive duty on the state to aid the needy" and "fundamental part of the social contract." Tucker v. Toia, 43 N.Y.2d 1, 7 (1977).

The State's "positive duty" to aid the needy would certainly not be satisfied by legalizing assisted suicide. In 1994, the New York State Task Force on Life and the Law issued a report that strongly recommended against the legalization of assisted suicide. Remarkably, the Appellant's brief does not even mention this landmark report. Prominent in the Task Force's reasons was the risk to poor and vulnerable persons:

"In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care." New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context, (May 1994), https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/.
They went on to warn:

"No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care." *Id.*

These structural problems in the American medical system have certainly not been corrected in the years since the Task Force's report. Studies consistently show that disparities exist in access to and quality of healthcare across numerous demographic categories, particularly race, sex, socioeconomic status, and geographic location. *See, e.g.*, Centers for Disease Control and Prevention, 2014 *National Healthcare Quality and Disparities Report*, http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf.

These inequities are exacerbated by the economic pressures of the current medical system, where cost containment is a priority. In this environment, there will undoubtedly be pressure on poor patients to choose suicide rather than putting an economic burden on their families. In fact, there have been several reported cases where insurance companies have denied coverage for life-sustaining treatments, only to offer to cover suicide drugs instead. *See, e.g.*, Katerina Tinko, *How California’s New Assisted Suicide Law Could Especially Hurt the Poor*, The Daily Signal (October 6, 2015), http://dailysignal.com/2015/10/06/how-californias-


People with mental illness are also at a higher risk. A large number of people who request assisted suicide are suffering from treatable depression. "Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated." Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* 34-35 (1998). Yet in Oregon, shockingly few patients who request assisted suicide are referred to mental health professionals for evaluation and treatment — less than 3% in 2013. Oregon Public Health Division, *Oregon’s Death with Dignity Act—2013*, http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf. It has been long recognized that the elderly and poor are not adequately
served in their mental health needs, which would make them vulnerable to suicide.

Geriatric Mental Health Alliance of New York, *Barriers to Meeting the Mental Health Needs of Older Adults*, http://www.networkofcare.org/library/Barriers%20to%20Meeting%20the%20Mental%20Health%20Needs%20of%20Older%20Adults,.pdf (last visited Dec. 29, 2015).

All these factors taken together, create a grave risk to many vulnerable needy people, many of whom already lack access to adequate health care, and may therefore feel impelled to end their lives. This is a matter of particular concern to the Catholic Church, and to Catholic health care institutions and professionals.

The bishops of the United States have stated, "While the common good embraces all, those who are weak, vulnerable, and most in need deserve preferential concern. A basic moral test for any society is how it treats those who are most vulnerable."


By prohibiting assisted suicide, current New York law fulfills the compelling state interest in protecting the needy, as promised by Article XVII of the New York State Constitution. It embodies the special concern for the poor that has been a hallmark of New York public policy dating at least back to the Progressive Era. Overturning the ban would betray this proud tradition.
E. Assisted Suicide is not a Fundamental Right

Appellants seek to have assisted suicide considered a "fundamental right", contending that the decisions by the Supreme Court in Vacco and Glucksberg are no longer binding precedent. Their argument should be rejected, because it relies on an erroneous interpretation of the Supreme Court's recent decision in Obergefell v. Hodges, 576 U.S. ___, 135 S.Ct. 2584 (2015).

It is undeniable that the Court in Obergefell relied on a different constitutional test for determining a "fundamental right" than it had used in Glucksberg and Vacco. Obergefell, 135 S.Ct. at 2602. The Court was clearly influenced by the unique status of marriage in American law and society, and the fact that it had long been recognized as a fundamental right. Obergefell 135 S.Ct. at 2598. However, the Court specifically excluded its earlier rulings on assisted suicide from being affected by its ruling. The Court stated that its reasoning in Glucksberg remained valid, saying that while "that approach may have been appropriate for the asserted right there involved (physician-assisted suicide), it is inconsistent with the approach this Court has used in discussing other fundamental rights, including marriage and intimacy." Obergefell 135 S.Ct. at 2602.

It is clear that under the Supreme Court's standard in Glucksberg, assisted suicide cannot be considered a fundamental right. The test of whether a right is fundamental is whether it is "objectively, deeply rooted in this Nation’s history and
tradition," and "implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." Glucksberg, 521 U.S. at 720–721.

Assisted suicide certainly fails that test. There is no comparison whatsoever between the way our society and law have considered and treated marriage and suicide. Society has always encouraged marriage and has placed it in a position of honor and esteem; it has long been deemed a "fundamental right"; it pervades the law, affecting legal relationships in virtually every area; and it has always considered it to be a joyous event to be celebrated with family and friends. In contrast, suicide has never been found by the Supreme Court to be a "fundamental right"; it has never been considered an inherent component of individual liberty; it has always been specifically prohibited by law; there has always been a concerted effort to discourage it; and it has always been considered nothing other than a terrible tragedy.

Appellants’ reliance on Obergefell is thus completely misplaced. The Supreme Court’s decisions and reasoning in Glucksberg and Vacco remain valid and authoritative.

II. Legalizing Assisted Suicide Would Threaten Religious Freedom for Health Care Institutions and Individuals

Appellants have based their arguments entirely on the theory that the only provisions of law relevant to assisted suicide are those contained in Article 125 of
the Penal Law. However, there are provisions in the Public Health Law that would be directly affected by the legalization of assisted suicide, with the result that Catholic institutions and individuals would be forced to violate the doctrines of the Catholic Church. This is a grave and unjustifiable violation of their religious liberty. It is a particular danger since there are insufficient conscience protections in current law.

The Palliative Care Information Act requires hospitals and practitioners to provide information, access or referrals for all "end of life options" that are "appropriate." N.Y. Pub. Health § 2997-c. In the statute, "appropriate" is defined as "consistent with applicable legal, health and professional standards; the patient's clinical and other circumstances; and the patient's reasonably known wishes and beliefs." Id. § 2997-c(1)(a). If legalized, assisted suicide would clearly be deemed "consistent with applicable legal… standards" and "appropriate" as an "end of life option" within the meaning of this statute.

This would impose upon the attending physician, and the facility itself, a duty to provide any patient with a "terminal illness or condition" with "information and counseling regarding palliative care and end-of-life options appropriate to the patient, including but not limited to: the range of options appropriate to the patient." Id. § 2997-c(2)(a). So every hospital, nursing home, and physician would be required to tell every patient with a terminal diagnosis how he or she can
commit suicide.

Similarly, the Palliative Care Access Act requires hospitals to enact policies that guarantee patients access to "palliative care", which is defined as "health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life." *Id.* § 2997-d. If assisted suicide were legalized, this statute could be construed to require hospitals and practitioners to provide patients with information and access to deadly drugs that they could use to kill themselves, under the rubric of "end-of-life-care... to prevent or relieve pain and suffering."

This would create an inevitable and irreconcilable conflict between the legalization of assisted suicide and the religious freedom for Catholic individuals and institutions.

Catholic doctrine is unequivocal in prohibiting assisted suicide under any circumstances, and forbids any Catholic institution or individual from participating in it in any way. The Church has specifically taught that "To concur with the intention of another person to commit suicide and to help in carrying it out through so-called 'assisted suicide' means to cooperate in, and at times to be the actual perpetrator of, an injustice which can never be excused, even if it is requested."

*Evangelium Vitae, supra,* at par. 66; *see also Ethical and Religious Directives,*
supra, par. 60. Catholics are always forbidden from cooperating in the immoral acts of others by "participating directly and voluntarily in them... [or] ordering, advising, praising, or approving them." Catechism of the Catholic Church, no. 1868. These religious tenets are not unique to Catholicism, but are shared by many other faiths. Pew Research Center, Religious Groups' Views on End-of-Life Issues (November 2013), http://www.pewforum.org/files/2013/11/end-of-life-religious-groups-views.pdf (last visited Dec. 29, 2015).

The Church also considers any law that authorizes an objectively immoral act such as assisted suicide to be invalid, and holds that "[t]here is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection". Evangelium Vitae, supra, at par. 73. Under the teachings of the Church, all Catholics must adhere to these teachings as a matter of faith. Second Vatican Ecumenical Council, Dogmatic Constitution on the Church Lumen Gentium (1965), par. 25; Catechism of the Catholic Church, no. 891-92; Code of Canon Law, can. 750.

The Catholic faith and assisted suicide are thus utterly incompatible. Legalization would place Catholic individuals and institutions in an irreconcilable dilemma -- either obey the civil laws or violate the doctrines of their faith. This would be a substantial and unreasonable burden on the religious beliefs of Catholic health care providers. Yet this conflict would be particularly stark because of the
lack of sufficient conscience protections in existing law.

The US Supreme Court has taken a very narrow vision of the Free Exercise Clause of the First Amendment, which offers little prospect for a religious institution or individual to obtain an exemption from a law of general applicability. See Catholic Charities v. Serio, 7 N.Y.3d 510, 521-22 (2006). Even under New York State's less restrictive constitutional standard, there is no guarantee that a religious objection would prevail. *Id.* at 527-28 (rejecting a New York State constitutional challenge despite a "serious" burden on religious belief). As a result, the legalization of assisted suicide by judicial decree could leave Catholic institutions and individuals with no protection under either the State or Federal Constitutions from being forced to violate their faith.

Nor are there adequate statutory protections for religious believers under New York or Federal law. The Education Law does guarantee that physicians may refuse to provide medical treatment if it conflicts with their religious beliefs, but it does not grant any protection to religious institutions. N.Y. Educ. § 6527(4)(c) Even with respect to individual physicians, it is limited to an objection to "treatment", which may not permit physicians to refuse to inform or refer for assisted suicide. This also does not offer any protection to other medical staff, such as physicians, nurses, pharmacists, or other non-professional staff members. *Cf. Id.* § 6909 (comparable provision to § 6527, regarding special provisions for
the practice of nursing, but without a conscientious objection clause).

The federal Patient Protection and Affordable Care Act gives protection to health care "entities" (i.e., institutions and individuals) against discrimination by the federal or state government, "on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing". 42 U.S.C. § 18113(a). However, the statute does not create an explicit or implicit private right of action, so enforcement is left solely in the discretion of the Office for Civil Rights of the Department of Health and Human Services. Id. § 18113(d). This could leave hospitals and health care workers with no vehicle to protect their rights. See, e.g., Cenzon-DeCarlo v. Mt. Sinai Hospital, 626 F.3d 695 (2nd Cir. 2010) (a federal conscience protection statute relating to abortion did not contain an implied private right of action). This could leave health care institutions and professionals vulnerable to discrimination by government agencies, with no effective recourse.

As a result, Catholic institutions themselves may be prevented from following the Ethical and Religious Directives and ensuring that staff members do not assist in suicides. For example, if adverse employment action is taken against a staff member who participates in a suicide, an employment discrimination complaint could be brought on the theory that the staff member was wrongly
discharged based on religious or moral beliefs that permit assisted suicide. See, e.g., Larson v. Albany Medical Center, 252 A.d.2d 936 (3rd Dept., 1998) (permitting an action under N.Y. Exec. § 296 for violation of a person's moral beliefs against abortion).

The lack of sufficient conscience protection could also give rise to medical malpractice claims against religious medical professionals and institutions. Once legalized, the option of assisted suicide could become a component of the standard of care for those with terminal illnesses, and physicians would be required to inform the patient of the option, cooperate with a request, or refer the patient to another doctor who will comply. Likewise, assisted suicide could be part of the standard of care for hospitals and nursing homes, imposing on them a duty to comply with a request. As a result, if a physician or facility declined to offer the suicide option based on their religious or moral objections, it could be construed as a violation of the duty to ensure informed consent, due to the failure to disclose treatment alternatives. N.Y. Pub. Health § 2805-d(1); Karlin v. IVF America, Inc., 93 N.Y.2d 282 (1999). It could also be deemed to be tantamount to patient abandonment. 76 N.Y. Jur. Malpractice § 151.

In the absence of adequate statutory conscience protection, there is no reason to expect the medical profession itself to develop sufficient internal guidelines to fully protect the integrity of religious institutions and individuals. For example,
the American Medical Association, while upholding the rights of physicians to
practice according to their conscience, still insists that they must inform and refer
patients for medical options that violate the doctor's beliefs. American Medical
Association, *Code of Medical Ethics, Opinion 10.06 - Physician Exercise of
Conscience*, http://www.ama-assn.org/ama/pub/physician-resources/medical-
ethics/code-medical-ethics/opinion1006.page (last visited Dec. 29, 2015). And in
Canada, a government advisory panel consisting of medical professionals and
bioethicists, which was convened to recommend national policies for the
legalization of assisted suicide, recommended that physicians and institutions with
faith-based objections must inform patients of suicide, and refer them to those who
Dying, *supra*.

Given the inadequate constitutional and statutory protections, the
legalization of assisted suicide by court decree would seriously endanger the
religious liberty of Catholic institutions and individuals, by forcing them to violate
the doctrines of the Catholic Church.
Conclusion

The Supreme Court correctly rejected the Appellant's effort to have assisted suicide legalized in New York State. This court should affirm that judgment.

Dated: New York, New York
      December 30, 2015

Respectfully submitted,

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I hereby certify pursuant to 22 NYCRR § 600.10 that the foregoing brief was prepared on a computer using Microsoft Word.

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Dated: New York, New York
December 29, 2015

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On March 14, 2015 The New York Times in an Editorial entitled “Offering a Choice to the Terminally Ill” implicitly endorsed the model legislation being proposed in 23 states based on the current law in Oregon. While laudatory in its goal, the legislation is far from sufficient and fails to provide a method of preventing suffering to thousands of dying people. The Oregon law is a law of exclusivity and is severely limited in scope as seen in the small number of people that have been able to make the request for aid in dying. (From implementation through 2014 only 1327 people have asked for the medication, see http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/prescriptionhistory.pdf) It diminishes patient’s rights, has not kept up with science or the patient’s rights movement and is far less encompassing than the compassion and choices afforded to people in Switzerland and other European counties. For a comprehensive review of the approaches taken by other counties see See “Dying With Dignity”, -A Legal Approach to Assisted Death by Giza Lopes, 2015 Prager. The Switzerland program, in place since 1942, has a limited role for physicians and allows others to assist.

Only a few dying patients in Oregon can meet the criteria of being competent, being determined to be within six months of death, make both a verbal request to a physician and then after a 15 day waiting period a second request in writing, and must swallow the medicine without assistance. Unfortunately, this model expressed in the pending legislation is being proposed with out though as to other models that exist that are more compassionate in ending needless suffering. Lets have a patient centered process rather than a physician centered one.


A brief quote quickly gets to the point.

We would go further. Oregon insists that the lethal dose is self-administered, to avoid voluntary euthanasia. To the patient the moral distinction between taking a pill and asking for an injection is slight. But the practical consequence of this stricture is to prevent those who are incapacitated from being granted help to die. Not surprisingly, some of the fiercest campaigners for doctor-assisted dying suffer from ailments such as motor neurone disease, which causes progressive paralysis. They want to know that when they are incapacitated, they will be granted help to die, if that is their wish. Allowing doctors to administer the drugs would ensure this.

Oregon’s law covers only conditions that are terminal. Again, that is too rigid. The criterion for assisting dying should be a patient’s assessment of his suffering, not the nature of his illness. Some activists for the rights of the disabled regard the idea that death could be better than a chronic condition as tantamount to declaring disabled people to be of lesser worth. We regard it as an expression of their autonomy. So do many disabled people. Stephen Hawking has described keeping someone alive against his wishes as the “ultimate indignity”.

One other neurodegenerative disease is worth special mention and special attention in the law. Huntington’s Disease (HD). HD’s cause is known, a single gene mutation that produces a mutant protein that in the brain slowly kills brain cells. There is no cure, and no treatment that stops this endless progression into total loss of all functions. Unlike ALS or Parkinson’s disease, where the individual is unaware that they will have the disease until symptoms appear, HD is genetic, if a parent has it, the offspring have a 50% risk and people who have had the gene test may know years in advance of symptoms of their fate. They have time to think of their choices.

HD is a cruel fate. Initial personality changes, slowly turn to involuntary movements, slurred speech, falling, emotional problems, loss of executive functioning. Then it gets worse with dysphagia, lose of speech and swallowing abilities, lose of movement, incontinence, dystonia, and lose of independence. Finally the feeding tube is inserted, and rigidity sets in, painful muscle spasms, all of which can last years, while often the person is aware of what is happening and then the final fetal position. Late stage HD can last years until death, all the time needing 24/7 care and supervision. Common painful conditions that arise in HD include severe chorea, dystonia, occult fractures and sprains, pressure sores, urinary retention and severe constipation. In late stage HD, severe muscle rigidity, contractures, chorea, and immobility can all cause pain. The list of symptoms is too long for this paper.

People with HD have seven times the national average for suicide. Death with dignity is not available. Some symptoms, in some people, may be treated for sometime during early and middle stages. Hospices, which was established to address dying cancer patients in an era when treatments and cures were much less than today, is limited to the last six months and is not an effective alternative. For a description of how a good hospice program helps people obtain the highest quality of life, meeting their priories, choosing to end active treatments rather than suffer, while maintaining some control see “Being Mortal: Medicine and What Matters in the End’ by Dr. Atul Gawanda. Unfortunately even the best hospice program does not work for people faced with years of late stage HD symptoms.

A case study under the Vermont death with dignity law. Laura, 55, was a person with HD. She had several stays at a hospital where she was determined to be incompetent and then placed in a nursing home in Vermont, a State with a death with dignity law. Laura decided it was her time and she stopped eating. She was not so incompetent as to prevent her from returning her food trays. It took her 67 days to pass. A long time to suffer and unable to avail herself of the death with dignity law due to the proximity to death and the incompetence determination. At no time during the 67 days did anyone say that she is so close to death that she should be afforded a faster less painful option. See: “New York’s physician-assisted suicide bill excludes some patients, death with dignity advocates claim” Times Union August 1, 2015 http://www.timesunion.com/tuplus-local/article/New-York-s-physician-assisted-suicide-bill-6419728.php

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1 See Understanding Behavior in Huntington’s Disease 2nd ed. by Paulsen, J. published HDSA
So lets examine the Oregon law’s criteria in light of this disease.

**Terminal diagnosis** - The Medicare law establishing the Hospice program defines this as: “An individual is considered to be “terminally ill” if the individual has a medical prognosis that the individual’s life expectancy is 6 months or less”. It was enacted as part of the Tax Equity and Fiscal Responsibility Act of 1982, a law designed to contain Medicare and Medicaid cost. There is no legislative history explaining how six months was chosen. See Senate Conference Report, S. No. 97-530. Evidence points to Congress being concerned with the cost of the new program, See http://www.painlaw.org/access-to-hospice/#3, footnote 3. Congress established a maximum cap formula where the denominator was the average cost of care of a cancer patient during the last six months of life. See 97-530 page 37. There is no compelling reason to maintain this definition for a different program in light of the scientific changes that can prolong life through artificial means and the evolving social change that says there are situations when continuing to live is no longer worth the pain and suffering. The six month provision was carried over from the hospice program simply because it was there and without any basis.

It should be noted that federal law specifically prohibits the use of federal funds for aid in dying. Public Law 105-12, 111 Stat. 23, April 30, 1997

There are no miracle cures for HD. Gene silencing, the most advanced research today, is scheduled to have its first human trial, stage one, with 36 participants in Europe and Canada in 2015. As with all stage one trials the goal is to determine if the patient survives. The theory is that, if effective, the technique will reduce the amount of mutant protein for a short period of time. It will not close the holes in the brain. It is hoped that if successful, injections in to the brain four times a year will reduce the mutant protein so as to delay the on-set of the disease or slow it in people already showing symptoms. It will not cure someone already in the later stages of the disease. This is unlike cancer research where science has advanced and options are available.

**Six months of death**-When a person with HD is within six months of death, they are unable to speak, write or swallow. The six months was chosen because it is the eligibility date for entry into hospice. The decisions around the costs of care, extended suffering and proximity to death supporting entry into hospice are not the same as a person with HD. The Oregon model was developed in light of the AIDS epidemic of the 1980-90s before the treatments were available. Death by AIDS was accompanied by extreme suffering. A far better model would be to have the patient determine when life is no longer worth living as discussed in “Being Mortal:Medicine and What Matters in the End”.

**Written and oral requests**- A person with HD loses these abilities. Notice that it is a request not a demand. The doctor makes the decision and not the patient. A much better approach is to allow a health care proxy to make the decision at a point in the progression of the disease that is declared by the patient and clearly observable. This returns control to the patient.

**Competent**. How is that determined and why should someone who loses their abilities not be able to make a decision prior to that as is done in other health care proxy situations and have it carried out at the set time. The only reason that I have heard is that if the person was competent they could change their mind. It is a guess. So we allow the person to suffer rather than accept the last know desire and guess at an alternative.
Self Swallow-A person with HD loses this ability. In some places the medicine can be placed in the feeding tube. We must consider that alternative methods exits and provide choices. In Belgium the doctor administers the drugs.

Let's create a law that allows the greatest patient choice and is focused around the nature of the illness and its progression rather than a cookie cutter, one solution for all approach taken by the legislation being proposed by Compassion and Choices. Death, which happens to every living thing, has a circle of business surrounding the event, life insurance, estate planning, funeral planning, hospice, but no patient control over the final event.

Here is my proposed amendment.

Not withstanding any law to the contrary, a person with Huntington’s disease shall have the right to appoint a health care agent who shall have the right to request aid in dying for the person with Huntington’s disease at a time in the progression of the disease that the person with Huntington’s disease has designated in the appointment document. The appointment document shall be written and in the format required for the execution of a Will. The appointment of this health care agent shall survive any subsequent mental or physical incompetency of the appointing individual. When so requested by such a health care agent, a doctor may administer the medication for the purpose of ending the life of the individual with Huntington’s disease in a humane and dignified manner.

Examples of a time in the progression of the disease shall include but not be limited to: having pneumonia, needing a feeding tube, the inability to self feed, or when placement in a nursing home is required. However, the designated event may not be at a time when the individual scores 7 or more on the standard Total Functional Capacity Rating Scale.

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The views expressed herein are those of the author and not HDSA
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