Reconsidering the Right to Die: The Debate over Assisted Suicide

March 22, 2018
Reconsidering the Right to Die: The Debate over Assisted Suicide

March 22, 2018

Agenda

5:00pm - 5:30pm  Registration

5:30pm - 5:45pm  Introduction
President and Dean Alicia Ouellette
Albany Law School

5:45pm - 6:15pm  Overview  *Myers v. Schneiderman* 85 N.E.3d 57
Hon. Eugene M. Fahey

6:15pm - 7:45pm  Panel Discussion

*Moderator:*
Prof. Vincent Bonventre
Albany Law School

*Panelists:*
Edward Mechmann, Esq., Director
Public Policy at Archdiocese of New York

Peter Strauss, Esq., Of Counsel
Drinker, Biddle & Reath LLP
Board of Directors of End of Life Choices of New York

Kathryn Tucker, Esq., Executive Director
End of Life Liberty Project

Stephanie Woodward, Esq., Director
Advocacy for the Center for Disability Rights

7:45pm  Reception

He was elected to the Supreme Court in 1996, and was re-elected in 2010. As a Supreme Court Justice, Judge Fahey was assigned to handle a civil calendar as well as criminal Special Term and presided over a variety of cases in Erie County as well as the outlying counties in the Eighth Judicial District. He was assigned to the Commercial Division in Erie County in January 2005 until his appointment by Governor George E. Pataki to the Appellate Division, Fourth Department in December 2006. In January 2015, Judge Fahey was nominated to the Court of Appeals by Governor Andrew Cuomo. The New York State Senate unanimously confirmed that nomination on February 9, 2015. He and his wife, Colleen Maroney-Fahey, live in Buffalo, New York. They have one daughter.

**PANELISTS**

**Edward Mechmann** is the Director of Public Policy and the Director of Safe Environment at the Archdiocese of New York. He graduated from Columbia College (BA), Harvard Law School (JD), and St. Joseph’s Seminary Institute of Religious Studies (MA). Since 1993 he has worked on public policy education and advocacy for the Archdiocese, and since 2005 he has also overseen the child protection program. Before coming to the Archdiocese, he was a state and federal prosecutor in New York City, and has served as a volunteer in West Virginia with his wife and children. He is the author of a book on the social teaching of the Church, and writes a regular blog on the homepage of the Archdiocese on faith in the public square. He is a Fourth Degree member of the Knights of Columbus, and volunteers in the community with the American Red Cross.

David C. Leven is the Executive Director Emeritus and Senior Consultant for End of Life Choices New York after serving as its Executive Director between 2002 and 2016. He is an advocate for patients, seeking to improve care and expand choice for the dying. An expert on advance care planning, patient rights, palliative care and end-of-life issues, including medical aid in dying, Mr. Leven has played a leadership role in having legislation enacted in New York to improve pain, palliative care and end-of-life care. He initiated the Palliative Care Education and Training Act, the Palliative Care Information Act, laws pertaining to health care proxies and a law requiring continuing medical education for doctors in pain, palliative care and end of life care. Mr. Leven has lectured or debated on medical aid in dying at every NYC area law school as well as at Albany, Rutgers, Syracuse and Yale law schools.
**PANELISTS**

**Peter J. Strauss** is Of Counsel to Drinker Biddle & Reath, LLP, and is Distinguished Adjunct Professor of Law at the New York Law School where he teaches Elder Law and Aging in America and is Director of the Elder Law Clinic. He is a graduate of Bowdoin College, Class of 1957, where he received Honors in Government. Prof. Strauss has practiced trusts and estates law, estate planning and guardianship law since 1963. His special expertise in the legal problems of aging and persons with disabilities has given him a national reputation and he is a frequent lecturer on those issues. He was one of the first attorneys in the country to focus on what is now known as Elder Law, was a founding member of the National Academy of Elder Law Attorneys (“NAELA”) in 1988 and was among the first four lawyers elected as a Fellow of the Academy.

Mr. Strauss has extensive experience in all aspects of estates and trusts, including planning, probate, estate and gift taxation and estate and trust administration. Best Lawyers named him as Elder Law “Lawyer of the Year” for 2012. U.S. News & World Report named the Private Client Group at his former law firm, Epstein Becker & Green, where he practiced from 1992 to July of 2014, as the best Elder Law firm in the United States in 2013. Mr. Strauss organized a special symposium at New York Law School Author in November of 2013, “Freedom of Choice at the End of Life: Patient’s Rights in a Shifting Legal and Political Landscape,” and edited a special edition of the New York Law School Law Review which included all of the papers presented at the symposium and wrote the Introduction. Mr. Strauss is also a well-known advocate for persons to have their end-of-life wishes honored and is a member of the Board of Directors of End of Life Choices, New York.

**Stephanie Woodward** is the Director of Advocacy at the Center for Disability Rights. She began working with the Center for Disability Rights as an intern in 2008 and was later hired as the Transportation Advocate before attending law school. Stephanie attended Syracuse University College of Law where she earned her J.D. with a certificate in Disability Law and Policy and her M.S.Ed. in Disability Studies. Prior to returning to CDR as the Director of Advocacy, Stephanie worked as a litigator in Miami, Florida focusing on Disability Rights law. Stephanie is a proud disabled person and member of ADAPT, a national grass-roots community that organizes to assure the civil and human rights of people with disabilities to live in freedom. Stephanie has been arrested multiple times while advocating for Disability Rights. While Stephanie’s work spans across all areas of Disability Rights, she is particularly interested in deinstitutionalization, community living, ending violence against people with disabilities, and improving access in the community.

**INTRODUCING THE KEYNOTE**

**Alicia Ouellette ’94** is the 18th President and Dean of Albany Law School. As Dean, she led the law school in the development, adoption, and implementation of a new strategic plan, led and consummated an institutional affiliation with the University at Albany, and has introduced to the Law School innovative educational programs.

Prior to her appointment as Dean, she served as Associate Dean for Academic Affairs and Intellectual Life and a Professor of Law. Her research focuses on health law, disability rights, family law, children’s rights, and human reproduction. Dean Ouellette served as an Assistant Solicitor General in the NYS-Attorney General’s office. She briefed and argued more than 100 appeals. Before that, she worked in private practice and served as a confidential law clerk to Judge Howard A. Levine on the NYS Court of Appeals. She earned 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.

**MODERATOR**

**Prof. Vincent Martin Bonventre** is the Justice Robert H. Jackson Distinguished Professor at Albany Law School. Dr. Bonventre received his PhD in Government, specializing in public law, at University of Virginia; a JD from Brooklyn Law School; and a BS from Union College. Prior to joining Albany Law School in 1990, he was a law clerk to Court of Appeals Judges Matthew J. Jasen and Stewart F. Hancock, Jr., and he was a Supreme Court Judicial Fellow selected by Chief Justice Warren Burger. Previously, he served two tours in the U.S. Army—one in military intelligence and one as trial counsel in the JAG Corps.

Dr. Bonventre is the author of the New York Court Watcher blog, founder and Editor of State Constitutional Commentary, and founder and Director of the Center for Judicial Process.
An Unfortunate Misstep: The New York Court of Appeals’ Rejection of Aid-In-Dying in

*Myers v. Schneiderman*

by Edwin G. Schallert and Kathryn L. Tucker

**Introduction**

The New York Court of Appeals recently considered a challenge to the validity and constitutionality of New York’s “Assisted Suicide Statute” as applied to aid-in-dying – the medical practice of providing a mentally-competent, terminally-ill patient with a prescription for lethal medication that the patient may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable. In considering this important issue, the Court had an opportunity to be at the forefront of the sea tide of change in public policy and opinion concerning aid-in-dying. Instead, the Court declined to uphold the fundamental liberties enshrined in the New York Constitution. Without the benefit of a factual record, the Court held that the New York Constitution does not protect a dying patient’s right to control the course of his or her medical treatment through aid-in-dying. It affirmed dismissal of the case in a decision “that future generations will look back on . . . as an unfortunate misstep.”

---

1 Edwin G. Schallert is a partner at the international law firm of Debevoise & Plimpton LLP. Schallert was counsel for the plaintiffs in *Myers v. Schneiderman*. Kathryn L. Tucker is Executive Director of the End of Life Liberty Project, an advocacy organization dedicated to protecting and expanding the rights of the terminally ill, which she founded during her tenure as Executive Director of the Disability Rights Legal Center, a leading disability rights advocacy organization. Tucker frequently represents physicians and patients seeking to expand end of life liberty, and served in this capacity in a number of the cases discussed herein, including *Myers v. Schneiderman*. The authors would like to gratefully acknowledge the significant contributions of Jared I. Kagan, Olena V. Ripnick-O’Farrell, and Brooke J. Willig, associates at the law firm of Debevoise & Plimpton LLP.

Plaintiffs in this case – patients who sought aid-in-dying and physicians and medical professionals whose ability to practice medicine and exercise professional judgment was hampered by the Assisted Suicide Statute – sought an affirmative judicial declaration that the Assisted Suicide Statute does not apply to aid-in-dying because (i) the term “suicide” in the Assisted Suicide Statute does not, as a matter of statutory construction, encompass aid-in-dying; and (ii) in the alternative, criminal proscription of aid-in-dying violates the New York State Constitution’s guarantees of equal protection and due process.

Shortly after the complaint was filed, the State filed a pre-answer motion to dismiss for failure to state a claim, arguing that aid-in-dying, by its nature and as a matter of law, constituted “assisted suicide” and that none of the complaint’s allegations provided any reason to stray from New York’s longstanding opposition to “assisted suicide.” The motion court agreed, held that plaintiffs had failed to state a claim, and rejected the state constitutional claims.

The Appellate Division, First Department affirmed the dismissal, holding that the Assisted Suicide Statue provides a valid statutory basis to prosecute physicians offering aid-in-dying and that such a prosecution would not violate the New York State Constitution. The Appellate Division flatly rejected the possibility of a distinction between aid-in-dying and suicide and found no violation of equal protection or due process.

In a 14-page per curium opinion, the Court of Appeals affirmed, flatly rejecting the possibility of a distinction between aid-in-dying and suicide and reiterating that, as a matter of law, aid-in-dying could be lawfully prosecuted under the Assisted Suicide Statute.

The New York Court of Appeals erred for three reasons. First, the Court applied the incorrect standard of review at the motion to dismiss stage. Second, the Court mischaracterized the fundamental right at issue in the case. Finally, the Court failed to recognize changing
circumstances and shifting public attitudes towards aid-in-dying. In doing so, the Court not only disregarded well-established precedent, but it ignored unique aspects of the New York State Constitution critical to the resolution of this case and failed to honor New York’s “proud tradition” of protecting fundamental liberties.

I. A Brief Explanation of Aid-in-Dying

A. What Is Aid-In-Dying?

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 may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable. It is a medically and ethically appropriate treatment option for patients facing unbearable suffering in the final stages of the dying process, one governed by professional practice standards and by the medical standard of care. A patient who requests aid-in-dying must first be determined to be mentally competent, as assessed through a number of established standards.

---

3 This term is widely accepted, including by the American Medical Women’s Association, the American Medical Students’ Association, and the American Public Health Association, among others. See Kathryn L. Tucker, At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations, 10 Harv. Health Pol’y Rev. 45, 45 (2009). In the past, this option was sometimes referred to as “physician assisted suicide” but that term has since been rejected as inaccurate and pejorative. In fact, the American Association of Suicidology recently recognized that the choice of a dying patient for a peaceful death is not, and ought not be referred to as, suicide. See also “Suicide” Is Not the Same as “Physician Aid In Dying,” Am. Ass’n of Suicidology (Oct. 30, 2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%202010.30.17%20ed%202010-30-17.pdf

medical tests, and certified to be terminally ill. Once determined to be mentally competent and terminally ill, the patient receives a prescription for a medication that, if ingested, will enable the patient to achieve a peaceful death at the time of his or her choosing. Whether the patient ultimately decides to ingest the medication is a decision and act of autonomy left to the patient.6

Aid-in-dying is largely indistinguishable from other medical practices that result in a patient’s death but that are currently lawful in New York. For example, mentally competent patients who require life-prolonging intervention, such as a ventilator or feeding tube, can direct withdrawal of the intervention and provide a “Do Not Resuscitate” direction, thereby causing death by suffocation, starvation or dehydration.7 Similarly, mentally competent, terminally ill patients can choose to engage in a practice known as VSED, “Voluntary Stopping Eating and Drinking,” whereby nutrition and liquids are withheld until the patient dehydrates. Patients with unmanageable pain can likewise request a therapy known as terminal or palliative sedation, whereby the patient is rendered unconscious by intravenously-administered sedation and is then deprived of nutrition and fluids until death invariably arrives. Each of these practices is

---

5 New York law defines a “terminal illness or condition” as one “which can reasonably be expected to cause death within six months, whether or not treatment is provided.” N.Y. Pub. Health Law § 2997-c(1)(d) (2013).

6 Many patients who obtain the prescription for aid-in-dying end up not ingesting the medication, instead dying of their underlying illness. For example, in Oregon in 2016 of the 204 patients who received the prescription, 36 did not ingest and died of other causes. http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf.

7 If the patient is mentally incapacitated, New York law permits others with legal authority to direct the withdrawal of the intervention and precipitate death. Complaint at ¶ 40, Myers v. Schneiderman, 2015 WL 6126959 (N.Y. Sup. 2015) (No. 151162/15).
considered a lawful refusal of medical treatment rather than an act of suicide, despite the active
measures taken at the patient’s direction in order to precipitate the patient’s death.

Like these medical practices, aid-in dying is considered by practitioners to be a form of
hastening the patient’s death at the hands of the terminal illness, not an act of suicide or assisted
suicide. Whereas suicide precipitates a premature death of a life of otherwise indefinite duration,
often as a result of mental illness, aid-in-dying allows individuals facing impending death to
make a rational choice to succumb to their terminal illness sooner rather than later. 8 Thus,
patients who choose aid-in-dying are not considered “suicidal,” and the death of a person who
chooses aid-in-dying is understood to be, and formally recognized as, caused by the patient’s
underlying terminal illness – not the medication the person ingests to achieve a peaceful death. 9
In each of the currently lawful medical practices, however, death is often painful, protracted, and
wrenching. By contrast, aid-in-dying provides patients with a peaceful death on their own terms.

8 Id. at ¶ 44

6126959 (N.Y. Sup. 2015) (No. 151162/15) (submitted in support of plaintiffs’ complaint);
Affidavit of Katherine Morris (Apr. 24, 2015) at ¶ 12, Myers v. Schneiderman, 2015 WL
6126959 (N.Y. Sup. 2015) (No. 151162/15) (same); David C. Leven and Timothy E. Quill,
The Clinical, Ethical and Legislative Case for Medical Aid in Dying in New York, 22
NYSBA Health L. J. 27 (2017); see also “SUICIDE IS NOT THE SAME AS “PHYSICIAN AID IN
DYING,” AM. ASS’N OF SUICIDOLOGY (Oct. 30, 2017),
http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement
%20Approved%2010%20ed%2010-30-17.pdf; see, e.g., WASH. REV. CODE ANN. §
70.245 (“the patient’s death certificate . . . shall list the underlying terminal disease as the
cause of death”).
B. Legal Status of Aid-In-Dying.

Conversations about aid-in-dying have been going on in the United States for more than a century. The first attempt to legislate aid-in-dying in the United States was swiftly defeated by the Ohio legislature in 1906. More than half a century later, in 1965, a right to die bill was introduced in the Florida legislature; despite sparking extensive debate, the bill was unsuccessful.

After a number of unsuccessful attempts, Oregon became the first state to legalize aid-in-dying by ballot initiative in 1994. The legislation faced a number of challenges, including from the U.S. Attorney General, who ordered Federal Drug Enforcement Agents to prosecute physicians and pharmacists for practicing under Oregon’s Death with Dignity law. The law did not go in effect until 2006, after the U.S. Supreme Court held in a 6-3 decision in Gonzalez v. Oregon that the Controlled Substances Act did not give the federal government the authority to interfere with physicians obeying state law and to overrule state laws on the appropriate use of medications.


12 See Aid in Dying: History & Background, at 7.


Prior to Gonzales, the Court considered, in a pair of companion cases, Washington v. Glucksberg\(^\text{15}\) and Vacco v. Quill,\(^\text{16}\) whether state laws banning aid-in-dying violated the Due Process and Equal Protection Clauses of the United States Constitution. Although the Supreme Court refrained from finding federal constitutional protection at the time,\(^\text{17}\) it left the matter open for states to determine for themselves the legality of aid-in-dying, carefully preserving the possibility that it would find constitutional protection in a future case.\(^\text{18}\)

Since Quill and Glucksberg were decided, aid-in-dying has been expressly permitted in Oregon, Washington, Vermont, California, Colorado, and Washington, D.C. through either legislation and ballot initiative.\(^\text{19}\) In Montana, aid-in-dying is permitted through a state supreme

\(^{15}\) 521 U.S. 702 (1997)

\(^{16}\) 521 U.S. 793 (1997).

\(^{17}\) See Glucksberg, 521 U.S. 702 (1997) (Washington’s ban on assisted suicide did not violate substantive due process under the U.S. Constitution); Quill, 521 U.S. 793 (1997) (New York’s prohibition on assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment when applied to a physician who provides aid-in-dying).

\(^{18}\) Glucksberg, 521 U.S. at 735 ("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."); Quill, 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).

court ruling. Presently, there are legislative efforts to legalize aid-in-dying in states that include Massachusetts, New York, New Jersey and Hawaii.

Public attitudes towards aid-in-dying have shifted significantly since Quill and Glucksberg were decided. In 2013, a pair of polls found significant public support for aid-in-dying. More recently, a 2016 poll found that 69% of Americans support aid-in-dying, as do 57% of doctors.

II. Myers v. Schneiderman

A. Theory of the Case

Myers v. Schneiderman centered on a challenge to New York’s “Assisted Suicide Statute,” which criminalizes “intentionally caus[ing] or aid[ing] another person” to commit or

---


22 See Pew Research Center, Views on End-of-Life Medical Treatments (Nov. 21, 2013), available at http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/ (60% of those polled said that a person suffering from a great deal of pain with no hope of improvement has a moral right to commit suicide); Lydia Saad, U.S. Support for Euthanasia Hinges on How It’s Described, GALLUP (May 29, 2013) (70% of those polled said that when a person has a disease that cannot be cured, doctors should be allowed by law to end the patient’s life by some painless means, if the patient requests it), available at http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx


attempt to commit suicide. Because the statute’s broad terms can be read to apply to the medical practice of providing mentally-competent, terminally-ill patients with prescriptions for life-ending medication, the statute has effectively deterred physicians in New York from providing aid-in-dying to patients who would seek it.

A number of patients, doctors, and advocacy organizations consequently came together to challenge the validity and constitutionality of the statute as applied to aid-in-dying. The plaintiffs included, among others, physicians whose ability to practice medicine and exercise professional judgment has been hampered by the Assisted Suicide Statute, including one nationally renowned palliative care specialist, Dr. Timothy Quill, who had been subjected to possible prosecution under the Assisted Suicide Statute, as well as several patients suffering from terminal illnesses who personally sought the right to be able to control the course of their medical treatment and as they approached the end of their life.

Steve Goldenberg, one of the patient plaintiffs, suffered from AIDS and from a number of health complications arising from that disease, including coronary artery disease, diabetes mellitus, macular degeneration, chronic obstructive pulmonary disease and chronic bronchitis; he had also been diagnosed with cancer of the vocal cords, the treatment of which resulted in his undergoing a tracheotomy, becoming unable to swallow food, and severely limiting his ability to

[25] See N.Y. Penal Law § 120.30 (permitting conviction for “promoting a suicide attempt,” a class E felony, when a person “intentionally causes or aids another person to attempt suicide”); id. § 125.15 (permitting conviction for manslaughter in the second degree, a class C felony, when a person “intentionally causes or aids another person to commit suicide”).


[27] Cmplt. ¶¶ 5-13, 22-36.
Sara Myers, the lead plaintiff, suffered from amyotrophic lateral sclerosis, also known as ALS or Lou Gehrig’s disease, a terminal neurodegenerative condition that causes inexorable loss of bodily function, leading to paralysis and respiratory failure. As the patient’s body increasingly fails, however, her mind remains unaffected, leading Sara Myers to describe her condition as being “trapped in a torture chamber of her own deteriorating body,” “having to endure a horrible slow death that would . . . deprive her of the integrity and dignity she had left.” Both plaintiffs joined the lawsuit in the hope that they would be able to choose whether to achieve a peaceful death on their own terms. Both, however, succumbed to their illnesses before the litigation concluded.

Plaintiffs’ complaint, filed in the New York State Supreme Court, New York County in February 2015, sought an affirmative judicial declaration that the Assisted Suicide Statute did not reach a physician who provided aid-in-dying to a mentally-competent, terminally-ill individual who has requested such aid and that neither a physician who provided nor a patient who requested aid-in-dying would be subject to prosecution under that statute. First, plaintiffs alleged that the term “suicide” in the Assisted Suicide Statute does not, as a matter of statutory construction, encompass aid-in-dying. Alternatively, plaintiffs alleged that criminal proscription of aid-in-dying would violate the New York State Constitution’s guarantees of equal protection and due process. With respect to equal protection, plaintiffs pointed to the life-ending measures that the State currently permits patients and physicians to undertake, including terminal sedation

28 Id. ¶¶ 25-28.
29 Id. ¶¶ 22-24.
30 Id. ¶¶ 3-4 & pp. 24-25.
and withdrawal of nutrition or treatment, and explained that maintaining a criminal distinction between the practices would serve no rational basis and would unlawfully discriminate against aid-in-dying. With regard to due process, they alleged that a criminal prohibition on aid-in-dying would infringe on an individual’s fundamental right to self-determination, a right enshrined in New York’s Constitution.

B. The Case is Dismissed

Shortly after the complaint was filed, the State filed a pre-answer motion to dismiss for failure to state a claim,31 arguing that aid-in-dying, by its nature and as a matter of law, constituted “assisted suicide” and that none of the complaint’s allegations provided any reason to stray from New York’s longstanding opposition to “assisted suicide.”32 Plaintiffs opposed the motion and, in accordance with settled New York law, submitted affidavits buttressing the allegations of the complaint.33 More than 300 pages of evidentiary submissions included a plethora of assertions by medical professionals and organizations attesting to aid-in-dying as a medically accepted practice and distinguishing between aid-in-dying and suicide.34 In reliance

31 The complaint named as defendants the New York State Attorney General and the District Attorneys for each district in which a plaintiff resided. Plaintiffs and the District Attorneys entered into a stipulation whereby plaintiffs agreed to discontinue the case without prejudice as to the District Attorneys and the District Attorneys agreed that they would be bound by any result reached in the litigation between plaintiffs and the Attorney General. One of the named defendants, Jane DiFiore, subsequently was appointed as the Chief Judge to the Court of Appeals, and she recused herself from consideration of Myers.


33 See, e.g., Leon v. Martinez, 84 N.Y. 2d 83, 88 (1994) (explaining that a court deciding a motion to dismiss “may freely consider affidavits submitted by the plaintiffs” (internal citation and quotation marks omitted)).
on these extensive factual allegations – which a court evaluating a motion to dismiss must credit – plaintiffs maintained that the relationship between aid-in-dying and “suicide” presented a factual question that warranted development of a full evidentiary record.\textsuperscript{35}

The motion court disagreed, holding that plaintiffs had failed to state a claim.\textsuperscript{36} In a brief abstruse opinion, the court concluded that “[t]he penal law as written is clear and concise” and that it would therefore “exceed this Court’s jurisdiction” to prohibit the district attorney “from prosecuting an alleged violation of the penal law,” an act within the wide ambit of prosecutorial discretion.\textsuperscript{37} The court also rejected the state constitutional claims out of hand, finding the case “factually and legally indistinguishable from Vacco” and quoting at length from that decision by way of explanation.\textsuperscript{38} The court further compared the case to Bezio v. Dorsey,\textsuperscript{39} a recent decision

\begin{itemize}
\item \textsuperscript{34} For example, plaintiffs submitted: materials from the American Public Health Association “[r]eject[ing] 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 death”; materials from the American Medical Women’s Association, American Medical Student Association and American College of Legal Medicine likewise distinguishing between aid-in-dying and assisted suicide; evidence showing that, in states where aid-in-dying is lawful, the cause of death for patients who choose aid-in-dying is listed as the underlying terminal disease rather than the act of taking prescription medicine; and expert affidavits from physicians explaining that aid-in-dying is part of accepted medical practice governed by professional standards. See Brief for Plaintiffs-Appellants at 8-9, Myers v. Schneiderman, 140 A.D.3d 52 (1st Dep’t 2016), (No. 151162/15).

\item \textsuperscript{35} Brief for Plaintiffs, Myers v. Schneiderman, 2015 WL 6126959 (N.Y. Sup. 2015) (No. 151162/15).

\item \textsuperscript{36} Myers v. Schneiderman, No. 151162/15, 2015 WL 6126959, at *4-5 (N.Y. Sup. Ct. Oct. 16, 2015). The court did, however, reject the State’s argument that the case should be dismissed for lack of a justiciable controversy, finding that plaintiffs had successfully pled entitlement to judicial review of the statutes in question. Id. at *2.

\item \textsuperscript{37} Id. at *3-4.

\item \textsuperscript{38} Id. at *4-5. Vacco, of course, involved a challenge to the Assisted Suicide Statute under the federal, rather than state, constitution, and it considered only equal protection, not due

1004057800v3
in which the Court of Appeals permitted the State to intervene in an inmate’s hunger strike to prevent his death, and emphasized that the Court’s jurisprudence allows only the refusal of medical treatment rather than any “self-inflicted” acts.\textsuperscript{40} It consequently dismissed the case.

C. \textbf{The Appellate Division Affirms}

Plaintiffs appealed as of right to the Appellate Division, First Department, challenging both the statutory and constitutional determinations made by the Supreme Court. First, they pointed to the wealth of factual allegations and evidentiary submissions supporting the conclusion that aid-in-dying is not assisted suicide within the meaning of the statute, and argued that the motion court had failed to address, much less credit, these assertions and had thereby improperly dismissed the complaint.\textsuperscript{41} Plaintiffs likewise pointed to numerous factual allegations – also overlooked by the trial court – that aid-in-dying is indistinguishable from currently lawful forms of medical treatment and that legal distinctions between the two may be discriminatory.\textsuperscript{42} Finally, plaintiffs criticized the court’s failure to take seriously – or even address – their due process claim. In particular, plaintiffs argued, the motion court ignored New York’s longstanding recognition of a fundamental right to self-determination with respect to

\textsuperscript{39} 21 N.Y.3d 93, 989 N.E.2d 942 (2013).

\textsuperscript{40} \textit{Myers}, 2015 WL 6126959, at *4.

\textsuperscript{41} \textit{See} Brief for Plaintiffs-Appellants, \textit{Myers v. Schneiderman}, 140 A.D.3d 52 (1st Dep’t 2016), (No. 151162/15).

\textsuperscript{42} \textit{Id.}

1004057800v3
one’s body and to control the course of one’s medical treatment, a right broader than those recognized under the Federal Constitution and one broad enough to encompass aid-in-dying.\footnote{See, e.g., 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.”); id. at 493 (“[I]t 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.”); Matter of Delio v. Westchester Cty. Med. Ctr., 129 A.D.2d. 1, 13 (N.Y. App. Div. 2d Dep’t 1987) (“The right to self-determination with respect to one’s body has a firmly established foundation in the common law.”); id. at 16 (“The primary focus . . . is upon the patient’s desires and his right to direct the course of his medical treatment rather than upon the specific treatment involved.”).}

The Appellate Division, however, affirmed dismissal of the complaint, holding that the Assisted Suicide Statue provides a valid statutory basis to prosecute physicians offering aid-in-dying and that such a prosecution would not violate the New York State Constitution.\footnote{Myers v. Schneiderman, 140 A.D.3d 51, 31 N.Y.S.3d 45 (N.Y. App. Div. 2016).} The Appellate Division flatly rejected the possibility of a distinction between aid-in-dying and suicide, finding that aid-in-dying fits the “literal description” of assisting suicide, a “straightforward” term, “since there is a direct causative link between the medication proposed to be administered by plaintiff physicians and their patients’ demise.”\footnote{Id. at 57.} Relying on a case applying the Assisted Suicide Statute to a defendant who recklessly encouraged an emotionally distraught teenager to commit suicide, the court further rejected as grounds for non-application of the statute the fact that physician prescribing the medication does not intend to cause the plaintiff’s death, essentially finding irrelevant the medical context of aid-in-dying.\footnote{Id. at 57-58 (discussing People v. Duffy, 79 N.Y.2d 611, 584 N.Y.S.2d 739, 595 N.E.2d 814 (1992)).}
Having upheld application of the Assisted Suicide Statute to aid-in-dying, the Appellate Division then quickly found no violation of equal protection, on the ground that New York’s “Equal Protection Clause is no broader in coverage than the Federal provision” and the Supreme Court in Vacco had already rejected an equal-protection challenge to the statute.\(^47\) It then addressed plaintiffs’ due process challenge, acknowledging that “the State Due Process Clause may be more protective of rights than its federal counterpart.”\(^48\) It nevertheless went on find that clause insufficient to encompass a right to aid-in-dying. Instead, the Appellate Division took a narrower view of the constitutional right to self-determination, framing it as merely “a patient’s right to refuse medical treatment” “and let nature takes its course,” one that cannot involve “affirmative” acts of autonomy involving “receiv[ing] treatment.”\(^49\) Finally, it rejected plaintiffs’ allegations that a restriction on aid-in-dying serves no rational basis, finding plaintiffs’ evidentiary submissions subject to critique and inadequate to support that conclusion.\(^50\)

**D. The Court of Appeals Affirms in a Per Curium Opinion**

Plaintiffs again appealed as of right to the New York Court of Appeals, challenging both statutory and constitutional grounds for the decision, and arguing that a full factual record was necessary to properly evaluate the merits of all three claims.\(^51\) First, plaintiffs criticized the Appellate Division’s reliance on a dictionary definition of suicide and a literal approach to the

---

\(^{47}\) *Id.* at 60 (internal quotation marks omitted).

\(^{48}\) *Id.*

\(^{49}\) *Id.* at 60-61.

\(^{50}\) *Id.* at 61-65.

\(^{51}\) *See* CPLR § 5601(b)(1) (providing for appeal as of right “from an order of the appellate division which finally determines an action where there is directly involved the construction of the constitution of the state or of the United States”).
law, which ignored the factual nuances of aid-in-dying, changing cultural understandings of the meaning of “suicide,” and the underlying purpose and legislative history of the statute.\(^5^2\)

Moreover, such an approach, plaintiffs argued, could place currently lawful forms of medical treatment—such as terminal sedation and withdrawal of treatment—within the scope of “assisted suicide,” rendering the approach necessarily flawed and inappropriate.

Second, plaintiffs challenged again the dismissal of their equal protection claim, arguing that the legal distinctions between terminally ill patients choosing end-of-life care permitted by the statute could not be sustained. Finally, plaintiffs took issue with the narrowness of the Appellate Division’s conception of New York’s right to self-determination, insisting that that fundamental right “encompasses a patient’s deeply and profoundly personal choice about how much suffering to endure in the final ravages of the dying process, just as it encompasses a patient’s right to choose other end-of-life options that precipitate death.”\(^5^3\) Plaintiffs also rejected the suggestion that Glucksberg and Vacco should bear on (let alone control) the court’s decision, emphasizing the greater breadth of New York’s Due Process Clause, the material changes in the Supreme Court’s jurisprudence on fundamental liberties in the wake of its decisions on assisted suicide, and the development of evidence that the concerns critical in causing the Supreme Court to defer to the “laboratory of the states” were without foundation.\(^5^4\)

\(^{52}\) Myers v. Schneiderman, 30 N.Y.3d 1 (2017)


\(^{54}\) See, e.g., Obergefell v. Hodges, 135 S. Ct. 2584, 2602 (2015) (recognizing that the inquiry into the existence of fundamental rights properly calls for consideration of evolving societal views and stating that fundamental rights “rise, too, from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era.”);
A large number of amici supported plaintiffs’ appeal, including medical organizations, state legislators, the NY Civil Liberties Union, the National Association of Criminal Defense Lawyers, New York chapter of the National Association of Elder Law Attorneys, New York Law Professors, and religious and ethics entities argued for reversal on varied grounds, including arguments based on statutory construction, privacy interests, the importance of independent state constitutional jurisprudence, and ethical considerations.55

The Court of Appeals56 nevertheless affirmed the Appellate Division’s ruling in a per curium opinion. In its fourteen-page decision, the Court rejected Plaintiffs’ arguments that the lower courts improperly resolved numerous factual issues and instead reiterated that, as a matter of law, aid-in-dying could be lawfully prosecuted under the Assisted Suicide Statute. Like the Appellate Division, it relied on a dictionary definition of “suicide” to promptly find that aid-in-dying “falls squarely within the ordinary meaning of the statutory prohibition on assisting a


56 The Court rendered its decision with a five-judge panel as a result of Chief Judge DiFiore’s recusal, and the untimely death of Judge Abdul-Salaam, which created an unfilled vacancy at the time of decision.
suicide,” and it relied on the Supreme Court’s decision in Vacco to dismiss Plaintiff’s equal protection claim essentially without discussion.\textsuperscript{58}

In declining to entertain a due process challenge, the Court likewise articulated a narrow understanding of the state constitution’s right to self-determination, characterizing it as a “right to choose among medical treatments, or to refuse lifesaving medical treatments.”\textsuperscript{59} In so doing, it also expressed a cramped, narrow conception of the right put forward by plaintiffs: whereas plaintiffs sought to characterize a right to aid-in-dying as a species of well-established rights to control one’s medical treatment and to exercise personal autonomy, the Court of Appeals described the right at issue as a “right to die, or [a] still broader right to obtain assistance from another to end one’s life.”\textsuperscript{60} Finding no fundamental right to aid-in-dying, the Court proceeded to find the State’s interests in prohibiting aid-in-dying—guarding against the risks of mistake and abuse, preserving life, and preventing suicide—legitimate and rationally related to the statute’s means.\textsuperscript{61} It looked to history to support this conclusion, pointing to the state’s longstanding prohibitions on assisted suicide and rejecting plaintiffs’ arguments concerning changing cultural understandings of assisted suicide and aid-in-dying.\textsuperscript{62}

Three judges concurred in the judgment, offering strikingly different views on the Court’s decision. Judge Fahey penned a lengthy concurrence to “expand on certain risks that

\textsuperscript{57} Myers v. Schneiderman, 30 N.Y.3d 1, 12, 85 N.E.3d 57, 62 (2017).

\textsuperscript{58} Id. at 13.

\textsuperscript{59} Id. at 14.

\textsuperscript{60} Id. (internal quotation marks omitted).

\textsuperscript{61} Id. at 15-16.

\textsuperscript{62} Id. at 16-17.
would be associated with legalizing physician-assisted suicide in New York and that justify its prohibition,” discussing at length the experiences of other jurisdictions that have legalized forms of “physician-assisted suicide.” Judge Garcia offered a separate concurrence to “expressly reach—and reject” the possibility that plaintiffs could “assert a more particularized challenge to the assisted suicide statutes” that would show the statutes to be constitutionally infirm.

Turning again to the State’s longstanding history of criminalizing suicide and its interest in preserving life, Judge Garcia reiterated that neither the State nor the state constitution need permit “physician-assisted suicide” and that plaintiffs’ claims were “better addressed the legislature.”

Judge Rivera, on the other hand, concurred in the decision “on constraint of th[e] prior case law” but essentially endorsed some form of aid-in-dying, laying out the circumstances under which she believed application of the Assisted Suicide Statute to patients seeking end-of-life care would, in fact, violate the New York constitution. Starting from the premise that New York’s constitutional guarantee of Due Process exceeds the Federal Constitution’s, Judge Rivera affirmed that the “liberty interest protected by our State Constitution is broader than the right to

---

63 Id. at 34 (Fahey, J., concurring).

64 Id. at 48 (Garcia, J., concurring) (quoting Glucksberg, 521 U.S. at 750 (Stevens, J., concurring)).

65 Id. at 58. These statements of course reflect a shocking abdication of an essential function of the courts to protect individual interests under the state constitution.

66 Id. at 22 (Rivera, J., concurring).
decline medical treatment,” and “includes the freedom to make decisions about how to die just as a surely as it includes decision-making about life’s most private matters.”

Although Judge Rivera conceded that the State retains legitimate interests that may counsel against aid-in-dying, she emphasized that the State’s interests “are not absolute or unconditional,” and “diminish when a mentally-competent, terminally-ill person approaches the final stage of the dying process that is inevitable” and “seeks access to medical treatment options that end pain and hasten death, with the consent of a treating physician acting on best professional judgment.” At that point, Judge Rivera stated, “the State’s interest is diminished and outweighed by the patient’s liberty interest in personal autonomy” and “the State may not unduly burden a terminally-ill patient’s access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.”

Judge Rivera also rejected several of the State’s and per curiam’s arguments in support of prohibiting aid-in-dying, finding no distinction between “active” and “passive” measures taken to end one’s life or between a physician providing aid-in-dying and one providing lawful medical treatments like terminal sedation. She therefore would have held that the “State Constitution protects the rights of these terminally-ill patients to make the deeply personal choice of how they define and experience their final moments.”

---

67 Id. at 23; see also id. at 26 (rejecting the State’s “dichotomy between active and passive physician conduct” as “unpersuasive in this context).

68 Id. at 18, 23.

69 Id. at 18, 23.

70 Id. at 24–29.

71 Id. at 34.
Plaintiffs moved for reargument of the Court of Appeals' decision, calling out the Court’s flawed narrowing of the right at issue and noting that “[a] cramped approach in expounding state constitutional rights has not served this Court well in the past.”\textsuperscript{72} The Court of Appeals, however, denied leave for reargument.\textsuperscript{73}

\section*{III. The Court of Appeals Erred}

The Court of Appeals erred in dismissing the \textit{Myers} case. In doing so, the Court not only disregarded its well-established precedent, but it ignored unique aspects of the New York State Constitution critical to the resolution of this case. In particular, the Court (1) applied the incorrect standard of review at the motion to dismiss stage; (2) mischaracterized the fundamental right at issue; and (3) failed to recognize changing circumstances and shifting public attitudes towards aid-in-dying.

Under the appropriate standard of review on a motion to dismiss, 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.”\textsuperscript{74} A plaintiff is entitled to “the benefit of every possible favorable inference,” and the Court’s

\textsuperscript{72} Citing \textit{Hernandez v. Robles}, 7 N.Y.3d 338, 380 (2005) (Kaye, C.J., dissenting). In \textit{Hernandez}, the Court of Appeals held that the fundamental right to marry did not apply to same-sex couples because “[t]he right to marry someone of the same sex . . . is not ‘deeply rooted.’” \textit{Id.} at 362. The Supreme Court recognized such a right just ten years later in \textit{Obergefell v. Hodges}, 135 S. Ct. 2584 (2015), leaving \textit{Hernandez} as a case “that future generations will look back on . . . as an unfortunate misstep.” \textit{Hernandez}, 7 N.Y.3d at 396.

\textsuperscript{73} At the time of plaintiffs’ request for reargument, the vacancy on the court had been filled and this important matter could have been reargued to a nearly full bench.

\textsuperscript{74} \textit{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).
analysis is limited to determining “only whether the facts alleged fit within any cognizable legal theory.”

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.” 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 . . . .” Further, even on a rational basis review, a plaintiff is entitled to develop facts in order to “negative every conceivable basis which might support” a law.

The Court’s decision overlooked this well-settled legal principle that a complaint should not be dismissed at the pleading stage unless a plaintiff can prove no set of facts to support a claim for relief. Its decision failed to credit the allegations of the physician Plaintiffs, who presented facts to support such a claim. Moreover, other courts that have addressed aid-in-dying have done so on a developed factual record.

---


76 *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).

77 *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).


79 See, e.g., *Carter v. Canada (Attorney General)*, 2015 SCC 5, ¶ 57 (2015) (following a full trial, striking down Canada’s assisted suicide statute as impinging on liberty); *Morris v. Brandenburg*, 376 P.3d 836 (N.M. 2016) (affirming reversal of lower court decision, following a full trial, that a dying patient has a fundamental right protected by the New Mexico constitution to choose a more peaceful death via aid-in-dying).
Judge Rivera’s concurrence recognized one such set of facts that was already presented by the physician plaintiffs in the complaint – namely a scenario involving a patient facing an excruciating and impending death seeking aid-in-dying. Rather than credit physician plaintiffs’ allegations that they “regularly encountered mentally-competent, terminally-ill patients who have no chance of recovery and for whom medicine cannot offer any hope other than some degree of symptomatic relief,” the Court denied Plaintiffs the ability to put forward proof and to make the “more particularized challenge” that the U.S. Supreme Court acknowledged in Glucksberg could establish a constitutional violation.

The Court further mischaracterized the fundamental right at issue in this case – the well-established and broad fundamental right to self-determination with respect to one’s body and to control the course of one’s medical treatment – as a “fundamental right to physician-assisted suicide.” The Court has long held that “[i]t 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.”

---

80 Myers v. Schneiderman, 30 N.Y.3d 1, 18 (2017) (Rivera, J, concurring) (given “the State’s sanctioning of terminal sedation in particular, the statute does not survive rational basis review . . . [and therefore] the State may not unduly burden a terminally-ill patient’s access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.”)

81 Compl. ¶ 43

82 521 U.S. at 734 n.24 (quoting Stevens, J., concurring).

83 Myers v. Schneiderman, 30 N.Y.3d 1, 10 (2017)

protected by the due process clause of our State Constitution.”\footnote{Id. at 493.} The Court 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.\footnote{Id. (citations and quotation marks omitted).}

The Court’s jurisprudence indicates that the fundamental right as articulated by the Court encompasses a patient’s deeply and profoundly personal choice about how much suffering to endure in the final ravages of the dying process, just as it encompasses a patient’s right to choose other end-of-life options that precipitate death.\footnote{See Delio v. Westchester Cty. Med. Ctr., 129 A.D.2d 1, 16 (2d Dep’t 1987) (“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.”).} In mischaracterizing the right at issue as a new “fundamental right to physician-assisted suicide,”\footnote{Myers v. Schneiderman, 30 N.Y.3d 1, 10 (2017)} the Court made the same mistake that it did in \textit{Hernandez v. Robles},\footnote{7 N.Y.3d 338, 380 (2005)} where it “recast[ ] plaintiffs’ invocation of their fundamental right to marry as a request for recognition of a ‘new’ right to same-sex marriage [which] misapprehend[ed] the nature of the liberty interest at stake.”\footnote{Id. at 380 (Kaye, C.J., dissenting).} There, the Court’s holding that the fundamental right to marry did not to apply to same-sex couples because “[t]he right to marry
someone of the same sex . . . is not ‘deeply rooted,’”\textsuperscript{91} was rebuked just ten years later by the U.S. Supreme Court, which recognized such a right in \textit{Obergefell v. Hodges}.\textsuperscript{92} As was the case in \textit{Hernandez}, the Court’s flawed characterization of the fundamental right in \textit{Myers} not only failed to accord with its own firmly established principles of law, but it also failed to honor New York’s “proud tradition” of protecting fundamental liberties.

Finally, the Court erred by failing to recognize changing circumstances and shifting public attitudes towards aid-in-dying. The Court’s recent jurisprudence on statutory construction recognizes that the meaning of undefined statutory terms may evolve over time. In particular, in \textit{Brooke S.B. v. Elizabeth A.C.C.},\textsuperscript{93} the Court adopted Judge Kaye’s dissent in \textit{Alison D. v. Virginia M.},\textsuperscript{94} and held that the term “parent” under the Domestic Relations Law is not limited to a biological parent. In particular, the Court held that it “agree[d] that, in light of more recently delineated legal principles, the definition of ‘parent’ established by this Court 25 years ago in \textit{Alison D.} has become unworkable when applied to increasingly varied familial relationships.”\textsuperscript{95}

The Court’s holding in \textit{Myers} thus stands in stark contrast to its established precedent that statutory terms may evolve. In holding that that “[a]id-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide,”\textsuperscript{96} the Court ignored the fact

\textsuperscript{91} \textit{Id.} at 362 (Kaye, C.J., dissenting).
\textsuperscript{92} 135 S. Ct. 2584 (2015)
\textsuperscript{93} 28 N.Y.3d 1, 14 (2016)
\textsuperscript{94} 77 N.Y.2d 651, 659 (1991) (“[I]n the absence of express legislative direction [we] have attempted to read otherwise undefined words of the statute so as to effectuate the legislative purposes.”)
\textsuperscript{95} 28 N.Y.3d at 14.
\textsuperscript{96} \textit{Myers v. Schneiderman}, 30 N.Y.3d 1, 12 (2017)
that aid-in-dying was not even a recognized concept that could have been contemplated by the Legislature as a “suicide” when it revised the Assisted Suicide Statute over 50 years ago as well as evolutions in medical care since the Assisted Suicide Statute was enacted. The Court further failed to credit any of the evidence of changing attitudes toward, and growing societal support for, aid-in-dying submitted by the Plaintiffs, including the recent polls that a clear majority of doctors and the public support aid-in-dying.97

Conclusion

The Court of Appeals failed to stand as a bulwark of protection for the fundamental rights of New Yorkers to free choice and autonomy, specifically in medical decision making. The promise of liberty under the New York Constitution was not realized in the context of end of life liberty, which undermines New York constitutional jurisprudence and leaves suffering dying patients without the autonomy to decide the profoundly personal matter of how much suffering to endure before death. This opinion will serve as an example of failed jurisprudence, an example which any sister court considering this issue under its own constitution would be wise to avoid.98

97 See, e.g. Ault, A., Doctor Support for Assisted Suicide Death Rises, but Debate Continues, MedScape (July 7, 2017), available at https://www.medscape.com/viewarticle/882334 (57% of doctors support aid-in-dying); GALLUP (May 4-8, 2016), Euthanasia Still Acceptable to Solid Majority in U.S., available at http://news.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx (69% of Americans support aid-in-dying). Growing societal support for a practice is accepted as a reason to extend federal constitutional protection, as the Supreme Court noted in Lawrence v. Texas, 539 U.S. 558 (2003). The Myers court, which ostensibly was deferential to the Supreme Court decisions in Quill and Glucksberg, failed to acknowledge that the Supreme Court’s jurisprudential approach to articulating rights worthy of protection under the United States Constitution had evolved in the years since Glucksberg to take such growing societal acceptance into account.

98 Perhaps one or more of the New York Appeals Court judges will publicly acknowledge the error of the decision, as retired United States Supreme Court Justice Lewis Powell did
Aid-in-dying is gaining recognition across the country as a medically and ethically appropriate treatment, and the Court of Appeals’ decision undoubtedly will be looked back upon as an unfortunate and embarrassing misstep by the Court.

regarding his determinative vote in Bowers v Hardwick, 478 U.S. 186 (1986) upholding a Georgia statute criminalizing homosexual sodomy. See Linda Greenhouse, Black Robes Don’t Make the Justice, but the Rest of the Closet Just Might, N.Y. TIMES (Dec. 4, 2002), http://www.nytimes.com/2002/12/04/us/black-robes-don-t-make-the-justice-but-the-rest-of-the-closet-just-might.html. Such recognition of error can play an important role in allowing an erroneous ruling to be overcome. For example, Harvard Law School professor Laurence H. Tribe, who argued on behalf of Hardwick, has articulated an opinion that Powell’s second thoughts could undercut the moral force of the opinion. Ruth Marcus, Powell Regrets Backing Sodomy Law, WASH. POST (Oct. 26, 1990), https://www.washingtonpost.com/archive/politics/1990/10/26/powell-regrets-backing-sodomy-law/a1ae2efc-bec6-47ec-bfb6-1c098e610c5b/?utm_term=.dae1dd95e754 (“The fact that a respected jurist who is indispensable to the majority conceded that on sober second thought he was probably wrong certainly will affect the way that future generations look at the decision[.]”)
Physician-Assisted Suicide and the New York State Constitution
Edward T. Mechmann and Alexis N. Carra

On September 7, 2017, the New York State Court of Appeals ruled on the most significant state constitutional case that it had been presented in several years. In *Myers v. Schneiderman*, the Court unanimously rejected a request to legalize physician-assisted suicide (PAS). This article will examine the background and the legal grounds of that historic ruling, as well as some reflections on our involvement in the case.

The Back Story

For decades, advocates have been campaigning for the legalization of PAS. In the early 1990's, this gained considerable public attention due to the activities of Dr. Jack Kevorkian. Oregon legalized assisted suicide by legislation in 1994, the first state to do so. Other legislative efforts failed, however, most prominently in unsuccessful ballot initiatives in Washington in 1991 and California in 1992.

In New York, the legalization effort was stymied in the legislative arena thanks to a report by the New York State Task Force on Life and the Law in 1994. The Task Force is an advisory body with medical, legal and ethical experts

---

1 Mr. Mechmann (J.D. Harvard 1984) is the Director and Ms. Carra (J.D. Fordham 2020 anticipated) is the Program Assistant of the Public Policy Office of the Archdiocese of New York. At both the Appellate Division and the Court of Appeals, Mr. Mechmann filed an amicus curiae brief on behalf of the New York State Catholic Conference that was written with the assistance of Ms. Carra.


3 The advocates typically reject the term "suicide" and instead prefer neologisms like "medical aid in dying". As noted below, the courts in New York have categorically rejected this attempt to change the meaning of the well-understood word "suicide" in the Penal Law.
appointed by the Governor, "who assist the State in developing public policy on issues related to medicine, law, and ethics." After substantial consultation and deliberation, the Task Force came to a very strong unanimous conclusion:

[T]he Task Force members unanimously recommend that existing law should not be changed to permit assisted suicide or euthanasia. Legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. The Task Force members concluded that the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.

PAS advocates also pursued a litigation strategy. In 1994, lawsuits were filed in Washington and in New York seeking to convince the federal courts that PAS was a protected right under the United States Constitution. This was decisively defeated in 1997 when a unanimous Supreme Court rejected the federal constitutional arguments in Washington v. Glucksberg and Vacco v. Quill.

Undaunted, advocates returned to the legislative arena. Helped by the publicity surrounding the assisted suicide of Brittany Maynard in 2014, they have met with some successes. They have so far made no progress in New York -- their principal bill has only made minimal progress in the Assembly and none in the Senate.

---

5 NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT, p.120. https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/chap6.htm.
7 Legislative measures were passed in Washington (2008 by referendum), Vermont (2013), California (2015), Colorado (2016 by referendum), and the District of Columbia (2017). Bills and referenda have failed in many other states.
8 The bill was approved once in the Assembly Health Committee in 2016, but no further action was taken on the bill. A.10059/S.7579 (2015-2016 Regular Session).
The bill is supported in New York primarily by End of Life Choices, a local advocacy group, and the New York chapter of Compassion & Choices, the leading national advocate for legalization of PAS. There is a coalition in opposition that operates under the name New York Alliance Against Assisted Suicide, which includes disabilities rights groups such as Not Dead Yet, the Center for Disability Rights and the New York Association on Independent Living, religious institutions like the New York State Catholic Conference, New Yorkers for Constitutional Freedom (an evangelical Christian organization), and Agudath Israel (which represents Orthodox Jewish concerns), as well as secular groups like Democrats for Life of New York. On the national level, leading medical organizations are opposed to legalizing PAS, such as the American Medical Association, the American Academy of Hospice and Palliative Medicine, and the American Nurses Association, as well as disabilities rights and religious organizations.9

The Myers Litigation

The advocates have also turned to the courts to seek legalization under state constitutions but their arguments have been uniformly rejected by state high courts.10 In 2015, End of Life Choices New York, along with several doctors and patients, filed suit in state court seeking to overturn New York's ban on assisted suicide. The case essentially argued that the word "suicide" in the Penal Law did

---

9 For a list of opposing organizations, see “About New York Alliance Against Assisted Suicide”, https://nosuicideny.org/about/ (last visited February 12, 2018).
not encompass PAS, and in the alternative, the ban violated the rights of terminally ill patients under the New York State Constitution’s Due Process\(^\text{11}\) and Equal Protection\(^\text{12}\) Clauses.

Initially, we were concerned about whether the Attorney General would defend the current law.\(^\text{13}\) There was the example of the series of same-sex marriage cases, in which the United States and state attorneys general declined to defend their laws, which suggested the possibility that New York’s progressive Attorney General might follow suit. However, the Attorney General’s staff defended the state law vigorously and with great skill throughout the litigation. The Plaintiffs, too, were very well represented.

The Plaintiffs met with defeat from the start. Ruling on a motion to dismiss, the Supreme Court rejected all the plaintiff’s arguments.\(^\text{14}\) The plaintiffs appealed, again presenting their constitutional and statutory arguments. The Appellate Division also rejected all the plaintiff’s arguments and unanimously affirmed the judgment of the trial court. At that point, it appeared that the case was at an end.

However, the Court of Appeals granted leave to appeal. This was deeply concerning to PAS opponents. The conventional wisdom, at least with the U.S. Supreme Court,\(^\text{15}\) is that when a court of last resort takes a discretionary case, it is

\(^{11}\) N.Y. Const. Art. 1 § 6.
\(^{12}\) N.Y. Const. Art. 1 § 11.
\(^{13}\) The initial named defendants included several county District Attorneys, but the Attorney General took over the full defense of the case.
\(^{14}\) In addition to the arguments we discuss, there were also procedural arguments in both the trial court and on appeal that are not of interest to this article.
likely to reverse the lower court. It indeed seemed strange that the Court of Appeals would take up a case that five lower court judges had found to be without merit. The case attracted considerable attention once it reached the Court of Appeals. Fourteen *amicus curiae* briefs were filed by disabilities rights, religious, legal, and medical groups and others.\(^\text{16}\) Some of the briefs in support of the plaintiffs were filed by parties that we expected to have great influence in the Court, including the New York Civil Liberties Union, leaders of the New York State Assembly, and Prof. Vincent Bonventre.

The oral argument showed that the five judges of the Court\(^\text{17}\) were deeply interested and engaged in the issue, and we were unable to discern a clear sense of where the Court might be leaning as a result of the arguments. It thus came as quite a surprise that the Court of Appeals also unanimously rejected all of the plaintiff's arguments.

This article will focus on the Court's *per curiam* opinion, fleshing out their analysis with our additional legal and factual observations.

**Assisted Suicide and the Constitution**

Prior to *Myers*, the last major constitutional decision by the Court of Appeals

\(^{16}\) The briefs can be found by searching at the Court of Appeals website for the *Myers* case at https://www.nycourts.gov/ctapps/courtpass/Public_search.aspx.

\(^{17}\) Chief Judge Janet DiFiore recused herself because she was a named defendant when she was the Westchester County District Attorney, and there was a vacancy due to the death of Judge Sheila Abdus-Salaam.
was *Hernandez v. Robles*,\(^1\(^\)\) in which the Court declined to find a right to same-sex marriage. In *Hernandez*, the Court began its analysis with an evaluation of the reasons underlying the law, and then went on to determine which constitutional standards to apply. Although the *per curiam* opinion in *Myers* is organized differently, we consider it to be analytically clearer to follow the *Hernandez* outline.

**Clear Definitions Produce Clear Thinking and Clear Law**

Regardless of whether the Court was going to decide the case on Equal Protection or Due Process grounds, the critical question was the basis for the current law. In that analysis, clear definitions are the indispensable prerequisite for clear reasoning. This was particularly important, since the *Myers* plaintiffs relied heavily on confused and misleading definitions.

**Suicide is Still Really Suicide**

In their legislative efforts as well as in both *Myers* and the New Mexico case, PAS advocates relied heavily on an argument that the word "suicide" does not encompass conduct that they define as "medical aid in dying". All of the judges at every level who ruled on the *Myers* case flatly rejected this attempt of linguistic circumvention.\(^2\)

The standard meaning of "suicide" is to take one's own life, and the meaning of "assisted suicide" certainly encompasses physicians who provide patients with


\(^{19}\) The Plaintiffs offered this primarily as a statutory argument. But it is also very significant for the constitutional arguments and we address it as such.
lethal doses of medication to end their lives. The relevant section of the New York Penal Law is very clear in defining assisted suicide as when one "intentionally... aids another person to commit suicide."\(^{20}\) The drafters of the Penal Law specifically envisioned that the statute would encompass those who gave assistance in "the more sympathetic cases (e.g., suicide pacts, assistance rendered at the request of a person tortured by painful disease, and the like)."\(^{21}\) This logically includes physicians. Moreover, in *Glucksberg*, the Court even noted, "for over 700 years, the Anglo American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide."\(^{22}\) Accordingly, "the prohibitions against assisting suicide never contained exceptions for those who were near death", including "those who [were] hopelessly diseased or fatally wounded."\(^{23}\)

However, Plaintiffs argued that a physician prescribing lethal medication to patients for the purpose of ending their lives is not assisted suicide but instead is "medical-aid-in-dying." For example, in New York State, the bill seeking to legalize PAS uses this terminology, in which "medical aid in dying" is defined as "the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death."\(^{24}\)

Yet there is no reason for a physician to provide such medication in these circumstances, other than to assist patients in suicide. Based on the proposed

---

\(^{20}\) N.Y. Penal Law § 125.15(3).
\(^{21}\) Commission Staff Notes on the Proposed New York Penal Law, §130.25.
\(^{22}\) *Glucksberg*, 521 U.S. at 711.
\(^{23}\) Id. at 714 (internal quotation marks omitted).
\(^{24}\) A. 10059/S. 7579, proposed § 2899-d(8) (2015-2016 Regular Session, emphasis added).
legislation, the physician has to certify that he informed the patient of "the probable result of taking the medication"\(^{25}\) -- that is, the patient's death -- and the patient has to make a specific request for "medication for the purpose of ending his or her life."\(^{26}\) In other words, the physician is directly in the line of causality that brings about a patient's death. He is providing the patient with the instrumentality that he knows the patient will use to commit suicide. This process is explicitly within the standard meaning of assisted suicide as defined in the statute and would be a perfect example of accessorial liability for any other offense in the Penal Law.\(^{27}\)

This attempt to redefine "suicide" into something else was thus properly rejected by the Court of Appeals, the Appellate Division, and the Supreme Court.\(^{28}\) The traditional legal wisdom of giving words their ordinary meaning held firm.\(^{29}\)

**Assisted Suicide is Not the Same As Permissible Palliative Care**

One of the central arguments offered by the Plaintiffs before each court was that a procedure they called "terminal sedation" was a lawful form of medical treatment. They defined this term as "the administration of drugs to keep the patient continuously in deep sedation, with food and fluid withheld until death arrives."\(^{30}\) They relied on this definition to try to draw an analogy with PAS to

---

\(^{25}\) *Id.* at § 2899-d(7)(c).

\(^{26}\) *Id.*, at § 2899-e.

\(^{27}\) See Penal Law § 20.00 (a person is guilty as an accessory "when, acting with the mental culpability required for the commission thereof, he ... intentionally aids such person to engage in such conduct").

\(^{28}\) *Myers*, 30 N.Y.3d at 12-13.

\(^{29}\) *Id*.

argue that if the first is acceptable, then the second should be.

But this obfuscates a crucial ethical and legal distinction between palliative sedation to unconsciousness and assisted suicide, by failing to account for the intention of the physician in providing the sedation. The American Medical Association's Code of Ethics states that while sedation to unconsciousness may be ethical under certain circumstances, it "must never be used to intentionally cause a patient's death."31 Thus, the relevant distinction is between (a) sedation to unconsciousness with the intent to cause death and (b) sedation to unconsciousness without the intent to cause death. Since assisted suicide is explicitly used to intentionally cause death, it is actually analogous to the unethical practice of (a), not the ethical practice of (b).

Their argument also fails to account for the critical difference between a situation where death is accepted and death is caused. In the case of ethical palliative sedation, it is understood that death will happen due to other causes, such as the underlying illness. In assisted suicide or palliative sedation with intent to cause death, the act of the doctor is materially different -- the cause of death is no longer the underlying illness or the withholding of nutrition or hydration, but the death is directly caused by the doctor's use of the sedative. Plaintiffs attempted to argue that in "aid in dying" the cause of death was still the underlying ailment, but the Court of Appeals and the courts below found this argument to have so little

merit that they did not even discuss it.

Similar to medical ethics, the law recognizes the crucial distinction between sedation to unconsciousness with the intent to cause death and sedation to unconsciousness without the intent to cause death. In *Vacco*, the Court noted that there are instances where physicians prescribe painkilling drugs that may also -- as an incidental effect -- hasten a patient's death.\(^{32}\) However, if the physician is acting in accord with the AMA Code of Ethics, then the physician's intent is "only to ease his patient's pain"\(^ {33}\) and not to intentionally cause death. In contrast, if the physician is prescribing the painkilling drugs to cause death, then the physician is engaging in an act of homicide -- PAS if the patient requested it, but murder if the patient did not.

The analogy that is crucial to the plaintiffs' argument thus utterly fails. As noted by the Court in *Myers*, a physician who "administers terminal sedation does not intend to kill the patient, though that may be the eventual result."\(^ {34}\) Instead, the physician "intends only to respect the patient's right to die naturally and free from intrusion, and to alleviate any pain or discomfort that may accompany that decision."\(^ {35}\) The Court thus properly rejected Plaintiff's attempt to conflate the assisted suicide and palliative sedation.

**Suicide is Not the Same As Declining Medical Treatment**

\(^{32}\) *Vacco*, 521 U.S. at 802.

\(^{33}\) Id.

\(^{34}\) *Myers*, 30 N.Y.3d at 51 (Garcia, J., concurring).

\(^{35}\) Id.
Although they both may result in death, PAS and declining unwanted medical treatment are not the same and cannot be treated as such. There are key distinctions in terms of causality and intent. These distinctions have been recognized by the Court of Appeals.36

In his concurrence in Myers, Judge Garcia explained that when "a patient refuses life-sustaining treatment and succumbs to illness, the cause of death is the underlying disease."37 In contrast, when "lethal medication is ingested, the cause of death is not the pre-existing illness, but rather, the prescribed medication."38 In other words, when a patient declines medical treatment, such as a ventilator, the patient dies from his underlying illness. There is no external agent or entity that brings about death. However, in assisted suicide, the doctor's prescription of the lethal medication is directly in the line of causality that leads to death -- without the physician issuing the prescription the patient would not have died.

The commission of assisted suicide and the declining of medical treatment are also distinguished with regards to intent. In general, there is a difference between intentionally 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."39 For example, under the Penal Law, unintentional killings are treated differently than those that are done intentionally.40 When applied to PAS, the

37 Myers, 30 N.Y.3d at 51.
38 Id.
39 Vacco, 521 U.S. at 803.
40 Compare N.Y. Penal § 125.10 and § 125.25.
intent to cause death are shared by both the physician who prescribes lethal medication and the patient himself. When a patient declines medical treatment, he does not intend death, but simply may want to avoid a burdensome treatment or accept death from the underlying condition. The physician likewise does not intend the patient’s death, but rather intends to put the patient’s decision into effect.

The Strong Justifications for the Current Law

The Court of Appeals saw those distinctions properly, and thus rejected the plaintiffs’ attempt at definitional legerdemain. In the per curiam opinion, the Court summarized many policy reasons underlying the current ban on PAS. These include "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."41 Because the Court cited these reasons in a rather conclusory fashion, we believe it is important and valuable to explain some of them more fully.

The PAS Ban Supports Current Efforts to Prevent Suicides

Suicide is a serious public health concern. It is it is the second leading non-disease cause of death for whites and for all those ages 10 and above; it kills as many people as homicides and motor vehicle accidents combined; and the number of

41 Myers, 30 N.Y.3d at 16 (quoting Vacco 521 U.S. at 808-809).
deaths from suicide has increased over 26% over the previous decade. In response, clear messages to discourage suicide are ubiquitous in New York, such as billboards, signs on bridges, and posters on mass transit urging people who are contemplating suicide that "life is worth living." The New York State Office of Mental Health recently issued a comprehensive plan to prevent suicides across the state. Suicide prevention is also major component of state initiatives aimed at schools. Legalization of PAS, even for a small class of persons, would contradict and undermine current efforts to prevent suicide.

Legalization, and the inevitable publicity surrounding cases of PAS, would also likely lead to an increase in suicides in general. Studies have shown that when assisted suicide is legalized, overall suicide rates are higher than in the general population. In Oregon, for example, the overall suicide rate is 42% higher than the national average. While correlation is not proof of causation, this pattern cannot be easily dismissed as coincidence. The phenomena of "suicide contagion" and "suicide clusters", in which one suicide leads to others within a social group, is well recognized as a substantial danger. Even popular culture is aware of it, for

47 Madelyn S. Gould and Alison M. Lake, "The Contagion Of Suicidal Behavior", from National
example in the increase in suicides after a prominent suicide of a celebrity. The current ban on assisted suicide is thus a way to prevent an increased suicide rate, which would be undermined by legalizing PAS.

**PAS Cannot Be Limited**

Judge Fahey grounded his concurrence on the fact that a right to PAS would inevitably expand beyond the terminally ill who face imminent death to those who experience what they consider "unbearable suffering".48 In countries where it has been legalized, PAS has extended to those who simply feel old, isolated, or experience various forms of psychiatric suffering.49 Belgium and the Netherlands have even gone so far as allowing involuntary euthanasia -- killing people who did not even ask for death, including children.50 Oregon regularly reports that the great majority of people who request deadly medicine are not doing so because of imminent death or intractable pain, but rather "the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (88.1%), loss of autonomy (87.4%), and loss of dignity (67.1%)."51

Ultimately, there is a fine line between assisted suicide and euthanasia. In

---

48 Myers 30 N.Y.3d at 35-37 (Fahey, J. concurring).
49 Id. at 45-46 (citations omitted).
50 Id. at 47 (citations omitted).
51 Oregon Health Authority, Public Health Division, Center for Health Statistics, "Oregon Death with Dignity Act: 2017 Data Summary", 6,
euthanasia, the physician brings about the patient's death directly at the patient's request. Yet "the common thread, more significant than the conceptual difference, is the use of a lethal dosage of medication intended to end the patient's life." Judge Fahey mused that, "If a person has the statutory or other right to physician-assisted suicide, does she lose the right to die if she suddenly becomes too physically weak to self-administer lethal prescribed drugs?" Once legalized, assisted suicide cannot be effectively contained.

There is also no limiting principle for what constitutes a subjective state of "unbearable suffering." The views of different patients and different physicians will inevitably vary. This raises concerns as to who decides what suffering qualifies and what kinds of suffering actually qualify. Similarly, Judge Garcia noted that physicians may be unable to "accurately ascertain how much time a terminally-ill patient has remaining, or may misdiagnose an illness as terminal, thereby creating a risk that patients will elect assisted suicide based on inaccurate or misleading information." In Oregon, some patients who requested lethal drugs did not use them until almost three years after their first request, even though the law is supposed to encompass those whose prognosis is death within six months. Yet advocates have openly and repeatedly stated that their ultimate goal is to permit

---

52 Myers, 30 N.Y.3d at 35 (Fahey, J. concurring).
53 Id.
54 Id. at 39 (Fahey, J. concurring).
55 Id. at 53 (Garcia, J., concurring).
56 Oregon Health Authority, supra note 51, at 11.
assisted suicide for anyone who desires it, regardless of their medical condition.  

Efforts to create procedural protections are also likely to fail. Indeed, PAS advocates openly state that they reject any legislative protections (which they call "barriers") and would prefer for there to be no legal limits and for the medical community to self-regulate. This is unequivocally at odds with the state interest in preventing mistakes and abuse of discretion, let alone the state interest in preserving life.

The question of whether legalized PAS could be limited was the subject of an interesting internal debate between Judge Rivera and Judge Garcia. Although Judge Rivera concurred in the *per curiam* judgment, she raised the question of whether PAS could be legalized for those who are at the very end of life and in unbearable pain. Yet Judge Garcia countered that the State's interests in preserving life and protecting the vulnerable still persist "irrespective of a patient's proximity to death or eligibility for terminal sedation." As such, the State views the PAS ban as encouraging "the unconditional treatment of the terminally ill and preserving the critical element of trust in a doctor-patient relationship at a time often marked by intense fear, uncertainty, and vulnerability."

---

**The PAS Ban Upholds the State's Duty to Protect Vulnerable People**

---


59 *Myers*, 30 N.Y.3d at 24 (Rivera, J. concurring).

60 *Id.* at 56 (Garcia, J., concurring).

61 *Id.* at 57.
The ban on assisted suicide is supported by a well-established and legitimate state interest in protecting vulnerable persons. Studies consistently show that disparities exist in access to and quality of healthcare across demographic categories, particularly race, sex, socioeconomic status, and geographic location. These inequities are exacerbated by the economic pressures of the current medical system, where cost containment is a priority. In this environment, pressure will inevitably be felt by low-income 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. Over time, this could lead "to a particular risk of non-voluntary euthanasia when a patient's socioeconomic disadvantages, uninsured status, and/or dementia or mental incompetence make it impossible for the patient to advocate vigorously for his or her health care." 

Likewise, the risks presented by assisted suicide present a special danger for the elderly, people suffering from mental illness, and disabled people. The widespread and under-reported problem of elder abuse highlights the risk of undue influence in end-of-life decisions. People with mental illness are also at a higher

---

64 Myers, 30 N.Y.3d at 43 (Fahey, J., concurring).
risk. A large number of people who request assisted suicide are suffering from treatable depression. Indeed, legalized assisted suicide in the Netherlands has "already descended to the level of condoning the suicide or killing of people whose primary suffering is not physical pain, but chronic depression." And it is clear that depressed people who request suicide drugs are not likely to be treated for depression. In Oregon, only 3.5% of those who request the drugs are referred for psychiatric evaluation.

Disabled people are especially vulnerable. Legalizing assisted suicide would "convey a societal value judgment" that indignities such as "physical vulnerability and dependence mean that life no longer has any intrinsic value." Indeed, as seen in Oregon, that is precisely the message that is being received, since the vast majority of requests for lethal drugs are due to concerns about losing life functions - essentially, a fear of becoming disabled. Yet as Judge Fahey noted, "[t]here is no lack of nobility or true dignity in being dependent on others...It would be a profound mistake to equate limits imposed on a person's life with the conclusion that such a life has no value."

On to the Constitutional Analysis

Having outlined the reasons and justifications for the law, the constitutional

---

66 Herbert Hendin, Seduced by Death: Doctors, Patients, and Assisted Suicide 34-35 (1998).
67 Myers, 30 N.Y.3d at 46 (Fahey, J., concurring).
68 Oregon Health Authority, supra note 51, at 10.
69 Id. at 44 (Fahey, J., concurring).
70 Oregon Health Authority, supra note 51.
71 Id. at 44 (Fahey, J., concurring).
analysis can then fall into place. The Plaintiffs claimed violations of both the Due Process and Equal Protection Clauses of the State Constitution. The Court of Appeals has been firm that the New York State Constitution provides independent protections for individual rights. The Court has maintained that it is "the final authority as to the meaning of the New York Constitution"; although it is not bound to follow the standards set by the United States Supreme Court, it does rely heavily on it:

The governing principle is that our Constitution cannot afford less protection to our citizens than the Federal Constitution does, but it can give more. We have at times found our Due Process Clause to be more protective of rights than its federal counterpart, usually in cases involving the rights of criminal defendants or prisoners. In general, we have used the same analytical framework as the Supreme Court in considering due process cases, though our analysis may lead to different results. By contrast, we have held that our Equal Protection Clause "is no broader in coverage than the Federal provision."

PAS Fails the Fundamental Right Tests

The threshold question is whether PAS is an unenumerated "fundamental right" under the state constitution and thus is protected under the Due Process Clause. The question of how to identify and define a "fundamental right" has long bedeviled the courts. The very legitimacy of different levels of scrutiny for regulations of different kinds of unenumerated rights has itself been hotly contested.

In recent years, scholars have identified two major -- and arguably

---

72 Hernandez, 7 N.Y.3d at 361-62 (citations omitted).
73 See, e.g., Whole Women's Health v. Hellerstedt, 136 S.Ct. 2292, 2326-28 (Thomas, J., dissenting).
incompatible -- conceptual approaches to this issue, each associated with a particular Supreme Court decision -- Obergefell and Glucksberg.\textsuperscript{74} The Glucksberg test is whether the claimed right 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."\textsuperscript{75} On the other hand, Obergefell applied a broader standard in determining if a liberty interest constitutes a fundamental right, saying that "History and tradition guide and discipline the inquiry but do not set its outer boundaries".\textsuperscript{76} However, in Obergefell the Supreme Court specifically excluded its earlier rulings on assisted suicide from being affected by its new standard, stating that its reasoning in Glucksberg regarding assisted suicide remained "appropriate", as opposed to "other fundamental rights, including marriage and intimacy."\textsuperscript{77}

Despite being asked to do so by the plaintiffs, the courts at all levels of the Myers litigation held to the Glucksberg test and refused to apply the more expansive approach of Obergefell. In fact, aside from two brief and tangential references in one of the concurrences, the Court of Appeals did not even discuss Obergefell.

Having made this critical choice of the standard of review, the Court of Appeals, and the lower courts before it, had no trouble in agreeing with the Supreme Court and finding that PAS fails the Glucksberg test. In Glucksberg, the


\textsuperscript{75} Glucksberg, 521 U.S. at 720–721.

\textsuperscript{76} Obergefell v. Hodges, 135 S.Ct. 2584, 2628 (2015).

\textsuperscript{77} \textit{Id.} at 2602; Justice Roberts, in dissent, argued that the Court had effectively overruled Glucksberg. \textit{Id.} at 2621. The Court of Appeals certainly did not see it that way.
Supreme Court exhaustively catalogued the rejection of assisted suicide in Anglo-American legal history,\(^78\) and the Court of Appeals in *Myers* adopted that analysis.\(^79\) That history is unequivocal in rejecting any notion of a right to commit suicide, much less enlisting the assistance of another to do so. The Court's conclusion is also supported by the fact that in the twenty years since *Glucksberg* and *Vacco*, every other state's highest court that has been asked to recognize PAS as a constitutional right has refused to do so.\(^80\)

The plaintiffs' attempt to analogize PAS to a patient's right to decline medical treatment was unpersuasive. The Court of Appeals has "never defined one's right to choose among medical treatments, or to refuse life-saving medical treatments, to include any broader right to die or still broader right to obtain assistance from another to end one's life."\(^81\) This is a crucial point, because it implicitly denies that assisted suicide is even a constitutionally-recognizable liberty interest, which is an indispensable requirement if it were to be considered a fundamental right. In fact, even the right to decline treatment has not been held to be a fundamental right, but rather has been considered just a liberty interest.\(^82\) So if the Court accepted the plaintiffs' flawed analogy between PAS and declining treatment, it would still not support the notion that PAS is a fundamental right. Indeed, to grant the plaintiffs the ruling they desired would produce an absurd result — the right to

---

\(^78\) *Glucksberg*, 521 U.S. at 710-17.

\(^79\) *Myers*, 30 N.Y.3d at 63.

\(^80\) See cases cited at note 10.

\(^81\) *Myers*, 30 N.Y.3d at 51 (Garcia J., concurring).

\(^82\) See, e.g., *Rivers*, 67 NY 2d at 492-93 (and cases cited therein).
PAS would be given greater constitutional protection than the right to decline treatment.

Even if the Court had applied the Obergefell test, the case would not have come out differently. Obergefell addressed whether to recognize social evolution about marriage, an existing institution that had already been deeply established in the law and long recognized as a fundamental right and a crucial component of society. It built on a series of major decisions going back over fifty years that expanded notions of liberty in sexual and intimate relationships, in recent years particularly centering on marriage and homosexuality. Obergefell was specifically dedicated to eliminating barriers to marriage for a class of persons who had experienced a history of disparate legal treatment and social obloquy, and to protect their dignity and that of their children so they could be full participants in society in the future. Assisted suicide plainly has none of the characteristics, and there is thus no reason for a court to stretch the Obergefell standard so broadly as to encompass it. Indeed, outside of the area of sexuality and intimate relationships, the Supreme Court has not identified any new fundamental rights in decades.

Having rejected the idea that PAS was a fundamental right, the Court was thus obliged to apply the rational basis standard in its Due Process analysis. Rational basis gives great weight to the judgment of the legislature, and will invalidate a statute only if it bears no rational relationship to a legitimate government purpose. As the Court of Appeals has said, "Rational basis scrutiny is

83 See, e.g., Obergefell, 135 S.Ct at 2599-2600.
highly indulgent towards the State's classifications... Indeed, it is "a paradigm of judicial restraint."\textsuperscript{84} The \textit{Myers} Court said that the challenger bears "the heavy burden of showing that a statute is so unrelated to the achievement of any combination of legitimate purposes as to be irrational."\textsuperscript{85}

Using this standard, the Myers court easily found the ban on PAS to be rationally related to many legitimate government objectives. As discussed at length above, the state has strong interests in protecting vulnerable people from potential abuse, prevent diversion of dangerous drugs, preventing suicide in the general population, and more. Relying also on interests identified by the Supreme Court in \textit{Vacco} the Court easily concluded that "the Legislature of this State has permissibly concluded that an absolute ban on assisted suicide is the most reliable, effective, and administrable means of protecting against its dangers."\textsuperscript{86}

\textbf{For Equal Protection, Real Distinctions Matter}

The plaintiffs also claimed that the ban on assisted suicide violated the state Equal Protection Clause, arguing that the current law treated terminally ill patients who wished aid in dying differently from patients who wished to decline life-sustaining treatment.

In evaluating Equal Protection claims, the Court of Appeals has followed the approach of the Supreme Court: "we have held that our Equal Protection Clause "is

\textsuperscript{84} \textit{Hernandez}, 7 N.Y.3d at 365.
\textsuperscript{85} \textit{Myers}, 30 N.Y.3d at 15.
\textsuperscript{86} \textit{Id.} at 17.
no broader in coverage than the Federal provision."87 The Supreme Court has described this standard:

A classification neither involving fundamental rights nor proceeding along suspect lines is accorded a strong presumption of validity. Such a classification cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose.... Instead, a classification "must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."88

Since the Court found that PAS is not a fundamental right, the rational basis test is applied to the Equal Protection analysis just as it was to the Due Process analysis. Again, this standard is extremely deferential to the judgment of the legislature: "a statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."89

Given the clear and rational distinction between declining treatment and suicide, the Court of Appeals and the lower courts before it had no trouble dismissing the plaintiff's arguments. As noted above, this contention was based on misleading analogies and definitions, particularly their failure to appreciate the ethical and legal significance of causation and intent in making this distinction. Once the proper definitions were understood, it was clear that the law was not irrationally treating similar persons differently, but rather was treating different

87 Hernandez, 7 N.Y.3d at 362 (quoting Under 21 v. City of New York, 65 N.Y.2d 344, 359 n.6 (1985)).
cases differently -- an entirely legitimate legislative act. Indeed, the Court found so little merit in the Equal Protection claim that it dealt with it in two perfunctory paragraphs.\textsuperscript{90} The concurring opinions did not even discuss the Equal Protection argument at all except to assert agreement with the \textit{per curiam} opinion.

\textbf{Conclusion}

The Court's \textit{per curiam} opinion in \textit{Myers} was brief and unequivocal, and was strengthened by the concurrences of Judges Fahey and Garcia. Together with the Supreme Court Justice and the Justices of the Appellate Division, the five Judges of the Court of Appeals presented a unified front -- every Judge who considered Plaintiffs' arguments rejected them.

The decision in \textit{Myers} was a decisive defeat for PAS. Together with the earlier defeat in New Mexico, we hope that it will have the same effect as \textit{Glucksberg} and \textit{Vacco} and demonstrate that there is no basis for courts to discover a right to PAS in state constitutions. The strong \textit{per curiam} opinion and concurrences of Judges Fahey and Garcia provide a template for other state courts to rule on similar cases. The Court of Appeals wisely held that the debate over assisted suicide belongs in the legislative arena based on policy arguments, and should not be terminated by courts by constitutionalizing it.

\textsuperscript{90} \textit{Myers}, 30 N.Y.3d at 13.
WHY DISABILITY RIGHTS ORGANIZATIONS OPPOSE LEGALIZATION OF ASSISTED SUICIDE

By Stephanie Woodward, JD and Diane Coleman, JD

In the 2017 New York Court of Appeals case Myers v. Schneiderman, 30 N.Y.3d 1 (2017), Not Dead Yet led the filing of an amicus brief joined by ten other national and state disability organizations: 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”). The brief supported the rulings of the lower courts in the case and explained why disability rights groups break ranks with their usual progressive allies when it comes to a public policy of assisted suicide.

Plaintiffs in the Myers case argued for a constitutional right to assisted suicide for people diagnosed with a terminal illness, but the Court rejected plaintiffs’ arguments. Had the Court found such a right, New York would have faced a number of related questions, including:

• 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?
• Why should such a right be limited to "aid" only from doctors? What about family members, friends, or advocates?

When a constitutional or statutory right to physician-assisted suicide is under consideration, it must be understood and evaluated from the perspective of the class of people
who will be most adversely impacted were such a right to be established: people with disabilities, whether their conditions are terminal or not.

Although pain and fear of pain are often raised as the primary reason for enacting assisted suicide laws, the top five reported reasons doctors issue lethal prescriptions are disability-related: “loss of autonomy,” “less able to engage in activities,” “loss of dignity,” “loss of control of bodily functions,” and “feelings of being burden.”¹ “[P]atients’ interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors.”²

Research has shown that:

[t]he 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.’³

Disability rights organizations advocate for legal and social change to address these very issues. That these issues may make a person wish to die is not disputed; but disability rights organizations know that these feelings are not inevitable, that their causes are and have been successfully addressed and, most importantly, that these emotions do not justify a lethal response

---


² 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”).

³ Block SD & Billings JA, Patient Requests to Hasten Death. Evaluation and Management in Terminal Care, Archives of Internal Medicine, 154(18):2039-47 (Sept. 26, 1994).
from medical providers.

Far from increasing the autonomy of people, assisted suicide allows doctors to decide who is eligible – i.e., whose condition is "terminal" and whose desire to commit suicide is "rational." This places disabled persons at great risk of unequal treatment for several reasons. First, although terminal prognoses are often wrong, the seriously terminally ill are a subset of all people with disabilities. Oregon’s data on the reasons underlying assisted suicide requests show that virtually all who are given a lethal prescription are disabled. Second, doctors are generally unaware of how to address and remedy the disability-related concerns of their patients. Third, assisted suicide is also dangerous because in many cases it is cheaper than ongoing treatment. Our current healthcare system, with its for-profit insurance and managed care companies, contains pressures both subtle and overt which may coerce patients to use assisted suicide. These are precisely the issues and concerns described in the 1994 report of the New York State Task Force on Life and the Law and discussed by the U.S. Supreme Court in Vacco v. Quill, 521 U.S. 793 (1997).

Assisted suicide proponents use the term “dignified death” to justify assisted suicide. When this term is examined, however, the "indignities" nondisabled (and some newly disabled) people invariably describe are the need for assistance in daily activities like bathing, dressing, and other realities of having a disability. Legalizing assisted suicide enshrines in law the prejudice that death is preferable to receiving the assistance that many disabled people rely on.

The Disability Rights Amici in Myers represent the 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.

The risks of assisted suicides based on mistakes, coercion, and abuse constitute compelling State interests for 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.

I. 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 seen in the context of the United States' long and tragic history of state-sanctioned discrimination against disabled people. The U.S. Supreme Court has acknowledged that at least one form of discrimination – the practice of withholding lifesaving medical assistance by medical professionals from severely disabled children – demonstrates a "history of unfair and often grotesque mistreatment" arising from this country’s legacy of "prejudice and ignorance," and continuing well into the 20th century. City of Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432 (1985).

This history of prejudice, unfortunately, continues into the present. Peter Singer, Tenured Professor of Bioethics at Princeton University, has advocated for actively killing infants with severe disabilities in the belief that they will not lead a "good" life and will burden their parents and society. Legalization of assisted suicide is another expression of that prejudice.

---

B. Assisted Suicide Denies People with Disabilities, Including Those With and Without Terminal Conditions, the Benefit of the State’s Suicide Prevention Protections

Although not all disabled people have a terminal prognosis, all patients with a terminal prognosis are, or are likely to become, disabled: that is, to require assistance with major life activities such as eating, toileting, dressing, bathing and more. 42 U.S.C. § 12102. Assisted suicide singles out disabled people who have a terminal prognosis for different treatment than other suicidal people receive. A nondisabled person who told their doctor that they wished to kill themselves would be referred to suicide prevention services, while a disabled person with a terminal prognosis will be assisted to commit suicide. Thus, assisted suicide is a lethal form of discrimination against disabled people because the presence of disability is used to justify the double standard of providing suicide assistance only to suicidal people with disabilities, including those labeled “terminal,” but suicide prevention to the rest of society.

Proponents of assisted suicide wish to immunize physicians for assisting the suicides of persons with "terminal" disabilities or conditions; this reverses the general presumption that suicide is irrational and is a "cry for help." Proponents seek to invalidate longstanding protections of old, ill, and disabled people in order to permit doctors to facilitate suicide, an act that would be a crime but for the person's disability and a label of “terminal.” This denies persons with severe health impairments the benefit of suicide prevention laws and programs. Indeed, the proponents would guarantee that their suicide attempts will result in death – unlike those of the majority of other persons with suicidal ideation who attempt suicide. A practice that a state expends resources to prevent will instead be actively facilitated based on a "terminal" diagnosis, no matter how unreliable that diagnosis may be, how effectively the person’s underlying concerns can be addressed by other measures, nor how great the risk of non-
consensual death through mistake, coercion, and abuse.

States throughout the country actively discourage suicide 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, proponents argue that the disabled person's life is intrinsically less worthy of state protection than a nondisabled person's life.

Perhaps no belief 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, prejudices, and barriers preventing assistance with activities of daily living do so. In contrast, assisted suicide gives legal force to the idea that life with a disabling condition is not worth living.

The State's interest [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.

Assisted suicide proponents attempt to justify this double standard by the false belief that people with disabilities who have a terminal prognosis are going to die soon anyway. This argument fails for several reasons.

First, terminal predictions by doctors are uncertain and unreliable.6 Many people with

---

disabilities have outlived an incorrect terminal prognosis. This medical uncertainty, and the potential for an unduly grim prognosis, is of particular concern in cases of people with severe new injuries or severe medical declines such as a stroke, major heart attack, or ALS. In such cases, knowledgeable and genuine suicide prevention is essential.

Second, the Oregon State Health Division’s assisted suicide data (the “Oregon Reports”) show that non-terminal people with disabilities are receiving lethal prescriptions, presumably based on incorrect prognoses. The state reports reveal that some people outlived their 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. Moreover, this does not include those who may have outlived their prognosis but for the lethal drugs.

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

Suicide prevention professionals also view these issues as treatable. A wealth of literature

---

23, 1998, pp. 2389-95; J. Lynn et al., “Prognoses of seriously ill hospitalized patients on the days before death: implications for patient care and public policy,” New Horizons, Vol. 5, Num. 1, February 1997, pp. 56-61. Also: “17 percent of patients [outlived their prognosis] in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses. … When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the Journal of the American Medical Association.” See Nina Shapiro, “Terminal Uncertainty,” Seattle Weekly, January 14, 2009.

7 Oregon’s Death With Dignity Act – 2017, supra, page 11

8 Id., page 10
addresses elder suicide prevention.\textsuperscript{9} In the State of Connecticut’s Suicide Prevention Plan 2020, risk factors for people with chronic conditions and disabilities\textsuperscript{10} are identified as follows:

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.

Dr. Herbert Hendin, CEO and Medical Director of Suicide Prevention Initiatives based in New York City, has 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.\textsuperscript{11}

Finally, lobby groups that support a public policy of assisted suicide have openly advocated expanding eligibility for assisted suicide beyond those with a six-month terminal prognosis. From the 1996 Harvard Model Act and the current goals of Final Exit Network,\textsuperscript{12} to

\textsuperscript{9} See Older Adult Suicide Prevention Resources, available at \url{http://www.sprc.org/populations/older-adults} (accessed December 29, 2016).


repeated introductions of bills with expansive definitions of “terminal,”\textsuperscript{13} to Oregon’s interpretations of “terminal” under the Oregon law,\textsuperscript{14} it is clear that broad assisted suicide eligibility for people with non-terminal disabilities is the goal of this movement. Their sometimes admitted incremental strategy\textsuperscript{15} is “Politics 101,” despite any current claims to the contrary they may make in the courts, legislatures, and media.

C. Assisted Suicide Denies People with Disabilities the Benefit of Suicide Prevention Laws and the Enforcement of Homicide Laws, in Violation of the ADA

In 1990, responding to the history of discrimination against people with disabilities, Congress enacted the Americans with Disabilities Act (“ADA”), 42 U.S.C. § 12101 \textit{et seq.} To address and remedy the “serious and pervasive social problem” of discrimination against individuals with disabilities, Congress 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; \textit{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 factors violates the ADA because the presence or absence of disability determines whether or not a state:

- Enforces its laws requiring health professionals to protect individuals who pose a danger

\textsuperscript{13} 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.” \url{http://www.gencourt.state.nh.us/legislation/2014/HB1325.pdf} (accessed December 29, 2016).


\textsuperscript{15} Gunderson, Martin and Mayo, David J., "Restricting Physician-Assisted Death to the Terminally Ill" (PDF) \textit{Hastings Center Report}, November-December 2002 (pp. 17-23).
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 virtually absolute legal immunity on the doctor and other participants in the death of that person. All State suicide-prevention procedures are set aside. The mere presence of a disability will be the basis for this disparate treatment.

II. Assisted Suicide Poses Serious, Unavoidable Threats to People with Disabilities That States Have a Significant Interest in Preventing

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, which is grounded in the law of preventing battery or unwanted touching, and assisted suicide). This prohibition is firmly grounded in the potential harm that a public policy of medically assisted suicide poses to the lives of people with disabilities.

A. States Have a Critical Interest in Ensuring that Assisted Suicide Decisions Are Not Coerced or Made by Others

Some persons killed under assisted suicide laws may "choose" suicide under pressure from others. States have a significant interest in preventing that pressure from driving people to end their lives. There is no way to ensure that persons are not unduly pressured by family members for financial, emotional, or other reasons.

Similarly, given that the cost of assisted suicide is significantly lower than the cost of
ongoing treatment, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not limiting care and thereby pressuring a person to request assisted suicide for financial reasons.

B. It is Dangerous and Discriminatory to Assume that the Suicide of a Disabled Person, Whether Terminal or Nonterminal, is "Rational"

"[T]hose who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." Glucksberg, 521 U.S. at 730. "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.16 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 44% of overall assisted suicide requests involved this fear, and 55% in 2017.17

In the most recent reporting year, 2017, Oregon physicians referred only 3.5% of persons who requested assisted suicide for a consultation to determine whether their judgment was impaired, and only 4.9% were referred over all the reported years.18 More than half of psychiatrists were "not at all confident" they could assess whether a psychiatric condition impaired a person's judgment in a single consultation; only six percent were "very confident" that they could.19 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

---

16 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).
18 Id at page 10
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{20}

The supposed “safeguard” of psychiatric referral is insufficient to ensure that suicidal people with disabilities are acting voluntarily.

C. The Uncertainty of "Terminal Prognosis" Means that Disabled People Who Are Not Terminal Will Receive the Lethal Prescription of Assisted Suicide

As noted above, the diagnosis and prognosis of a "terminal condition" is inherently uncertain. Because terminal conditions are often misdiagnosed, assisted suicide will be available for many people with disabilities who are not “terminally ill” within any predictable time frame. The risks to recently disabled people, such as those with significant spinal cord injuries and strokes, are particularly great. Perhaps unlike the general public, "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.”\textsuperscript{21} Evan Kemp, former Director of the Equal Employment Opportunity Commission, wrote in 1997:

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.\textsuperscript{22}

\textsuperscript{20} Brendan D. Kelly et al., \textit{Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box}, 181 British J. Psychiatry 278, 279 (2002).


D. Policies Embodying the View that Disability Intrinsically Deprives Life of Dignity and Value Are Dangerous and Discriminatory

Many people identified as candidates for assisted suicide could benefit from supportive care or treatment, such as counseling, peer support, pain medication, or in-home consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, and restore independence, control, and choice.

The lack of this type of assistance and support, rather than any intrinsic aspect of disability, is the primary motivation for suicide. As a physician at New York’s Memorial Sloan-Kettering Cancer Center has stated, 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."23 Rather than expanding choice, assisted suicide will reduce access to services by which disabled people can choose to live.

Assisted suicide proponents argue for a simplistic mental "competency" or “capacity” determination for assisted suicide. One study noted that "the focus on competence may distract from adequate attention and resources on the person and their circumstances ...."24 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."25

24 Ganzini et al., supra note 7, at 600.
III. THE CREATION OF A CONSTITUTIONAL OR LEGISLATIVE 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, Whether Terminal or Nonterminal, Are the Precise
Class of People Who Will Be Affected if a Right to Assisted Suicide is Found

In the 1980's, courts dismissed the state interest in protecting the lives of 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 treatment and services, many of the disabled
individuals involved and others that followed would be alive today, as a leading bioethicist has
admitted. Even in those cases, the courts specifically distinguished active physician-assisted
suicide from the right to refuse treatment. Before this Court is the request to obliterate this
distinction. Against the backdrop of these and other cases, a line must be drawn against the very
real threat to the lives of people with disabilities that will result from a right to assisted suicide
through active measures.

B. There Are No Safeguards Adequate to Protect People with Disabilities from
Assisted Suicide

1. Limiting Assisted Suicide to Terminally Ill Persons Will Fail to
Protect Nonterminal 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 nonterminal disabilities. History demonstrates that assisted suicide has not and will
not be limited to terminally ill persons. Moreover, terminally ill persons who request assisted

---

26 H Brody, A bioethicist offers an apology, Lansing City News, October 6, 2004 (http://dredf.org/public-
policy/assisted-suicide/a-bioethicist-offers-an-apology/).
suicide are, or fear they will become, disabled.

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 disability itself and/or dependence on others. Medical professionals, jurists, and the public ignore underlying treatable depression, lack of pain relief, in-home long term care services or other supports, and exhaustion from confronting interpersonal and societal discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless" and "suffering needlessly," they are really expressing fear of severe disability. Proponents translate this fear into a supposedly “rational” policy of assisted suicide. They argue that the wish to die is “rational” and, therefore, 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. Doctors frequently assess 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-prolonging treatment.”28 Research demonstrates that suicidal feelings in terminally ill people are remediable through other means, including pain management, hospice services and counseling.29 As long as physicians believe, however, that a person with a severe illness or 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

1613 (2008).
28 S. Miles, Physicians and Their Patients' Suicide, 271 JAMA 1786 (1994).
29 Most death requests, even in terminally ill people, are propelled by despair and treatable depression. H. Hendin and Gerald Klerman, Physician-Assisted Suicide: The Dangers of Legalization, 150 AM. J. OF PSYCH. 143 (Jan.1 1993).
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 is not acting "voluntarily," to find another doctor who will
prescribe the lethal dose. The majority of Oregon assisted suicides involve assisted suicide
“friendly” doctors referred by Compassion and Choices, the leading lobby group for assisted
suicide bills.\(^{30}\)

2. Limiting Assisted Suicide to "Voluntary" Requests Will Fail to
   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. Disability rights advocates are profoundly disturbed by
the advocacy for a right to assisted suicide in a society which refuses to find a right to adequate
health care and in-home personal assistance services and technology supports to live. The trend
to managed health care, with its emphasis on cost containment, further constrains the choices and
endangers the lives of people with disabilities. The “choice” disabled people are offered is death
but not life.

Without health care, consumer-directed personal care services, and access to competent
palliative and hospice care, people with disabilities do not receive what they need to live as
independently and with as much autonomy as possible. Without the professional commitment to
provide essential services, 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.

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. Assisted Suicide Prevents People with Disabilities, Whether Terminal or Nonterminal, From Receiving Equal Protection of Laws Pertaining to Suicide Prevention and Homicide

Proponents urge society to minimize and ignore the risks of abuse impacting vulnerable people. Ample evidence already exists of non-voluntary and involuntary withholding and withdrawal of treatment. For example, in a study published in 2011 in the Journal of Emergency Medicine\(^1\), 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.\(^{31}\) 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 wants.\(^{32}\) Legalizing assisted suicide will make already troubling matters worse by expanding the population of people who are eligible to have their lives ended by medical professionals. People with disabilities 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 must not be viewed as expendable.

Proponents frequently claim that the dangers of assisted suicide have been disproven by the experience in Oregon and Washington. Their claim, however, ignores at least three problems with the practice of assisted suicide in those States: 1) the Oregon and Washington assisted suicide statutes provide a blanket of “good faith” immunity to participants in the death, which shrouds gaping loopholes in patient protection; 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 minimal reporting requirements, the lack of investigation by Oregon state authorities, and the impact of strict health care confidentiality laws.

First, nothing in the provisions of the Oregon and Washington assisted suicide statutes 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). An interested party can thus request assisted suicide on behalf of a person with a communication disability.

The statutes allow an heir to be a witness to the assisted suicide request as long as the second witness is not an heir. Alternately, 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.

33 Oregon Public Health Division, DHS News Release: No authority to investigate Death with Dignity case, DHS says, March 4, 2005
34 Oregon Death With Dignity Act, ORS 127.865, Washington Death With Dignity Act, RCW 70.245
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.\textsuperscript{35} 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.\textsuperscript{36}

In addition, once the prescription for lethal drugs is 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... \textsuperscript{37}

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.\textsuperscript{38} Assuming \textit{arguendo} 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 provides a comprehensive and persuasive review of previous court rulings, giving realistic weight to the many dangers that legalizing assisted suicide poses, particularly in an aging population in which, according to federal estimates, one in ten elders are abused.\textsuperscript{39}

\begin{thebibliography}{9}
\bibitem{35} Oregon’s Death With Dignity Act – 2017, \textit{supra}, page 11.
\bibitem{37} Margaret Dore, Esq., “‘Death with Dignity’: A Recipe for Elder Abuse and Homicide (Albeit Not by Name),” 11 Marquette Elder’s Advisor 387, 2010, available at \url{http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html} (accessed December 29, 2016)
\end{thebibliography}
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.

_O' Donnell v. Harris_, San Diego Superior Court Case No. 37-2015-00016404-CU-CR-CTL, pg 8 (July 24, 2015) (granting demurrer without leave to amend). This analysis is consistent with the issues discussed in the report of the New York Task Force on Life and the Law.40

The Oregon and Washington assisted suicide laws include no requirement for treatment of depression.41 As previously discussed, 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 (91%) and feelings of being a burden on others (44%).

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 community’s experience is that most doctors know little or nothing about home and community based long-term care.

Moreover, under the statutes, 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. These cases emphasize the critical importance of applying equal protection 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 are seriously threatened by physician-assisted suicide. Cloaked in the false rhetoric of “death with dignity,” and “aid in dying,” physician-assisted suicide threatens the civil rights, and the lives, of an already oppressed and marginalized minority. 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 from the dangers of mistake, coercion and abuse inherent in a public policy of assisted suicide.

---


43 The Disability Rights Education & Defense Fund, an Amicus, has compiled brief descriptions of some of these cases, with citations to source materials, entitled “Oregon and Washington State Abuses and Complications.” Available at https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf accessed December 29, 2016)
An Unfortunate Misstep: The New York Court of Appeals’ Rejection of Aid-In-Dying in *Myers v. Schneiderman*

by Edwin G. Schallert and Kathryn L. Tucker

Introduction

The New York Court of Appeals recently considered a challenge to the validity and constitutionality of New York’s “Assisted Suicide Statute” as applied to aid-in-dying – the medical practice of providing a mentally-competent, terminally-ill patient with a prescription for lethal medication that the patient may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable. In considering this important issue, the Court had an opportunity to be at the forefront of the sea tide of change in public policy and opinion concerning aid-in-dying. Instead, the Court declined to uphold the fundamental liberties enshrined in the New York Constitution. Without the benefit of a factual record, the Court held that the New York Constitution does not protect a dying patient’s right to control the course of his or her medical treatment through aid-in-dying. It affirmed dismissal of the case in a decision “that future generations will look back on . . . as an unfortunate misstep.”

---

1 Edwin G. Schallert is a partner at the international law firm of Debevoise & Plimpton LLP. Schallert was counsel for the plaintiffs in *Myers v. Schneiderman*. Kathryn L. Tucker is Executive Director of the End of Life Liberty Project, an advocacy organization dedicated to protecting and expanding the rights of the terminally ill, which she founded during her tenure as Executive Director of the Disability Rights Legal Center, a leading disability rights advocacy organization. Tucker frequently represents physicians and patients seeking to expand end of life liberty, and served in this capacity in a number of the cases discussed herein, including *Myers v. Schneiderman*. The authors would like to gratefully acknowledge the significant contributions of Jared I. Kagan, Olena V. Ripnick-O’Farrell, and Brooke J. Willig, associates at the law firm of Debevoise & Plimpton LLP.

Plaintiffs in this case – patients who sought aid-in-dying and physicians and medical professionals whose ability to practice medicine and exercise professional judgment was hampered by the Assisted Suicide Statute – sought an affirmative judicial declaration that the Assisted Suicide Statute does not apply to aid-in-dying because (i) the term “suicide” in the Assisted Suicide Statute does not, as a matter of statutory construction, encompass aid-in-dying; and (ii) in the alternative, criminal proscription of aid-in-dying violates the New York State Constitution’s guarantees of equal protection and due process.

Shortly after the complaint was filed, the State filed a pre-answer motion to dismiss for failure to state a claim, arguing that aid-in-dying, by its nature and as a matter of law, constituted “assisted suicide” and that none of the complaint’s allegations provided any reason to stray from New York’s longstanding opposition to “assisted suicide.” The motion court agreed, held that plaintiffs had failed to state a claim, and rejected the state constitutional claims.

The Appellate Division, First Department affirmed the dismissal, holding that the Assisted Suicide Statue provides a valid statutory basis to prosecute physicians offering aid-in-dying and that such a prosecution would not violate the New York State Constitution. The Appellate Division flatly rejected the possibility of a distinction between aid-in-dying and suicide and found no violation of equal protection or due process.

In a 14-page *per curium* opinion, the Court of Appeals affirmed, flatly rejecting the possibility of a distinction between aid-in-dying and suicide and reiterating that, as a matter of law, aid-in-dying could be lawfully prosecuted under the Assisted Suicide Statute.

The New York Court of Appeals erred for three reasons. First, the Court applied the incorrect standard of review at the motion to dismiss stage. Second, the Court mischaracterized the fundamental right at issue in the case. Finally, the Court failed to recognize changing
circumstances and shifting public attitudes towards aid-in-dying. In doing so, the Court not only disregarded well-established precedent, but it ignored unique aspects of the New York State Constitution critical to the resolution of this case and failed to honor New York’s “proud tradition” of protecting fundamental liberties.

I. A Brief Explanation of Aid-in-Dying

A. What Is Aid-In-Dying?

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 may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable. It is a medically and ethically appropriate treatment option for patients facing unbearable suffering in the final stages of the dying process, one governed by professional practice standards and by the medical standard of care. A patient who requests aid-in-dying must first be determined to be mentally competent, as assessed through a number of established

---

3 This term is widely accepted, including by the American Medical Women’s Association, the American Medical Students’ Association, and the American Public Health Association, among others. See Kathryn L. Tucker, At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations, 10 Harv. Health Pol’y Rev. 45, 45 (2009). In the past, this option was sometimes referred to as “physician assisted suicide” but that term has since been rejected as inaccurate and pejorative. In fact, the American Association of Suicidology recently recognized that the choice of a dying patient for a peaceful death is not, and ought not be referred to as, suicide. See also “Suicide” Is Not the Same as “Physician Aid In Dying,” Am. Ass’n of Suicidology (Oct. 30, 2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf

medical tests, and certified to be terminally ill.\(^5\) Once determined to be mentally competent and terminally ill, the patient receives a prescription for a medication that, if ingested, will enable the patient to achieve a peaceful death at the time of his or her choosing. Whether the patient ultimately decides to ingest the medication is a decision and act of autonomy left to the patient.\(^6\)

Aid-in-dying is largely indistinguishable from other medical practices that result in a patient’s death but that are currently lawful in New York. For example, mentally competent patients who require life-prolonging intervention, such as a ventilator or feeding tube, can direct withdrawal of the intervention and provide a “Do Not Resuscitate” direction, thereby causing death by suffocation, starvation or dehydration.\(^7\) Similarly, mentally competent, terminally ill patients can choose to engage in a practice known as VSED, “Voluntary Stopping Eating and Drinking,” whereby nutrition and liquids are withheld until the patient dehydrates. Patients with unmanageable pain can likewise request a therapy known as terminal or palliative sedation, whereby the patient is rendered unconscious by intravenously-administered sedation and is then deprived of nutrition and fluids until death invariably arrives. Each of these practices is

---

\(^5\) New York law defines a “terminal illness or condition” as one “which can reasonably be expected to cause death within six months, whether or not treatment is provided.” N.Y. Pub. Health Law § 2997-c(1)(d) (2013).


\(^7\) If the patient is mentally incapacitated, New York law permits others with legal authority to direct the withdrawal of the intervention and precipitate death. Complaint at ¶ 40, *Myers v. Schneiderman*, 2015 WL 6126959 (N.Y. Sup. 2015) (No. 151162/15).
considered a lawful refusal of medical treatment rather than an act of suicide, despite the active measures taken at the patient’s direction in order to precipitate the patient’s death.

Like these medical practices, aid-in dying is considered by practitioners to be a form of hastening the patient’s death at the hands of the terminal illness, not an act of suicide or assisted suicide. Whereas suicide precipitates a premature death of a life of otherwise indefinite duration, often as a result of mental illness, aid-in-dying allows individuals facing impending death to make a rational choice to succumb to their terminal illness sooner rather than later. Thus, patients who choose aid-in-dying are not considered “suicidal,” and the death of a person who chooses aid-in-dying is understood to be, and formally recognized as, caused by the patient’s underlying terminal illness – not the medication the person ingests to achieve a peaceful death.

In each of the currently lawful medical practices, however, death is often painful, protracted, and wrenching. By contrast, aid-in-dying provides patients with a peaceful death on their own terms.

---

8 Id. at ¶ 44

B. Legal Status of Aid-In-Dying.

Conversations about aid-in-dying have been going on in the United States for more than a century. The first attempt to legislate aid-in-dying in the United States was swiftly defeated by the Ohio legislature in 1906. More than half a century later, in 1965, a right to die bill was introduced in the Florida legislature; despite sparking extensive debate, the bill was unsuccessful.

After a number of unsuccessful attempts, Oregon became the first state to legalize aid-in-dying by ballot initiative in 1994. The legislation faced a number of challenges, including from the U.S. Attorney General, who ordered Federal Drug Enforcement Agents to prosecute physicians and pharmacists for practicing under Oregon’s Death with Dignity law. The law did not go in effect until 2006, after the U.S. Supreme Court held in a 6-3 decision in Gonzalez v. Oregon that the Controlled Substances Act did not give the federal government the authority to interfere with physicians obeying state law and to overrule state laws on the appropriate use of medications.

---


12 See Aid in Dying: History & Background, at 7.


Prior to *Gonzales*, the Court considered, in a pair of companion cases, *Washington v. Glucksberg*\(^1\) and *Vacco v. Quill*,\(^2\) whether state laws banning aid-in-dying violated the Due Process and Equal Protection Clauses of the United States Constitution. Although the Supreme Court refrained from finding federal constitutional protection at the time,\(^3\) it left the matter open for states to determine for themselves the legality of aid-in-dying, carefully preserving the possibility that it would find constitutional protection in a future case.\(^4\)

Since *Quill* and *Glucksberg* were decided, aid-in-dying has been expressly permitted in Oregon, Washington, Vermont, California, Colorado, and Washington, D.C. through either legislation and ballot initiative.\(^5\) In Montana, aid-in-dying is permitted through a state supreme

---

\(^1\) 521 U.S. 702 (1997)


\(^3\) See *Glucksberg*, 521 U.S. 702 (1997) (Washington’s ban on assisted suicide did not violate substantive due process under the U.S. Constitution); *Quill*, 521 U.S. 793 (1997) (New York’s prohibition on assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment when applied to a physician who provides aid-in-dying).

\(^4\) *Glucksberg*, 521 U.S. at 735 (“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.”); *Quill*, 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).

court ruling. Presently, there are legislative efforts to legalize aid-in-dying in states that include Massachusetts, New York, New Jersey and Hawaii.

Public attitudes towards aid-in-dying have shifted significantly since Quill and Glucksberg were decided. In 2013, a pair of polls found significant public support for aid-in-dying. More recently, a 2016 poll found that 69% of Americans support aid-in-dying, as do 57% of doctors.

II. Myers v. Schneiderman

A. Theory of the Case

Myers v. Schneiderman centered on a challenge to New York’s “Assisted Suicide Statute,” which criminalizes “intentionally caus[ing] or aid[ing] another person” to commit or

---


22 See Pew Research Center, Views on End-of-Life Medical Treatments (Nov. 21, 2013), available at http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/ (60% of those polled said that a person suffering from a great deal of pain with no hope of improvement has a moral right to commit suicide); Lydia Saad, U.S. Support for Euthanasia Hinges on How It’s Described, GALLUP (May 29, 2013) (70% of those polled said that when a person has a disease that cannot be cured, doctors should be allowed by law to end the patient’s life by some painless means, if the patient requests it), available at http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx


attempt to commit suicide. Because the statute’s broad terms can be read to apply to the medical practice of providing mentally-competent, terminally-ill patients with prescriptions for life-ending medication, the statute has effectively deterred physicians in New York from providing aid-in-dying to patients who would seek it.

A number of patients, doctors, and advocacy organizations consequently came together to challenge the validity and constitutionality of the statute as applied to aid-in-dying. The plaintiffs included, among others, physicians whose ability to practice medicine and exercise professional judgment has been hampered by the Assisted Suicide Statute, including one nationally renowned palliative care specialist, Dr. Timothy Quill, who had been subjected to possible prosecution under the Assisted Suicide Statute, as well as several patients suffering from terminal illnesses who personally sought the right to be able to control the course of their medical treatment and as they approached the end of their life.

Steve Goldenberg, one of the patient plaintiffs, suffered from AIDS and from a number of health complications arising from that disease, including coronary artery disease, diabetes mellitus, macular degeneration, chronic obstructive pulmonary disease and chronic bronchitis; he had also been diagnosed with cancer of the vocal cords, the treatment of which resulted in his undergoing a tracheotomy, becoming unable to swallow food, and severely limiting his ability to

---

25 See N.Y. Penal Law § 120.30 (permitting conviction for “promoting a suicide attempt,” a class E felony, when a person “intentionally causes or aids another person to attempt suicide”); id. § 125.15 (permitting conviction for manslaughter in the second degree, a class C felony, when a person “intentionally causes or aids another person to commit suicide”).


27 Cmplt. ¶¶ 5-13, 22-36.
Sara Myers, the lead plaintiff, suffered from amyotrophic lateral sclerosis, also known as ALS or Lou Gehrig’s disease, a terminal neurodegenerative condition that causes inexorable loss of bodily function, leading to paralysis and respiratory failure. As the patient’s body increasingly fails, however, her mind remains unaffected, leading Sara Myers to describe her condition as being “trapped in a torture chamber of her own deteriorating body,” “having to endure a horrible slow death that would . . . deprive her of the integrity and dignity she had left.” Both plaintiffs joined the lawsuit in the hope that they would be able to choose whether to achieve a peaceful death on their own terms. Both, however, succumbed to their illnesses before the litigation concluded.

Plaintiffs’ complaint, filed in the New York State Supreme Court, New York County in February 2015, sought an affirmative judicial declaration that the Assisted Suicide Statute did not reach a physician who provided aid-in-dying to a mentally-competent, terminally-ill individual who has requested such aid and that neither a physician who provided nor a patient who requested aid-in-dying would be subject to prosecution under that statute. First, plaintiffs alleged that the term “suicide” in the Assisted Suicide Statute does not, as a matter of statutory construction, encompass aid-in-dying. Alternatively, plaintiffs alleged that criminal proscription of aid-in-dying would violate the New York State Constitution’s guarantees of equal protection and due process. With respect to equal protection, plaintiffs pointed to the life-ending measures that the State currently permits patients and physicians to undertake, including terminal sedation

28 Id. ¶¶ 25-28.
29 Id. ¶¶ 22-24.
30 Id. ¶¶ 3-4 & pp. 24-25.
and withdrawal of nutrition or treatment, and explained that maintaining a criminal distinction between the practices would serve no rational basis and would unlawfully discriminate against aid-in-dying. With regard to due process, they alleged that a criminal prohibition on aid-in-dying would infringe on an individual’s fundamental right to self-determination, a right enshrined in New York’s Constitution.

B. The Case is Dismissed

Shortly after the complaint was filed, the State filed a pre-answer motion to dismiss for failure to state a claim, arguing that aid-in-dying, by its nature and as a matter of law, constituted “assisted suicide” and that none of the complaint’s allegations provided any reason to stray from New York’s longstanding opposition to “assisted suicide.” Plaintiffs opposed the motion and, in accordance with settled New York law, submitted affidavits buttressing the allegations of the complaint. More than 300 pages of evidentiary submissions included a plethora of assertions by medical professionals and organizations attesting to aid-in-dying as a medically accepted practice and distinguishing between aid-in-dying and suicide. In reliance

---

31 The complaint named as defendants the New York State Attorney General and the District Attorneys for each district in which a plaintiff resided. Plaintiffs and the District Attorneys entered into a stipulation whereby plaintiffs agreed to discontinue the case without prejudice as to the District Attorneys and the District Attorneys agreed that they would be bound by any result reached in the litigation between plaintiffs and the Attorney General. One of the named defendants, Jane DiFiore, subsequently was appointed as the Chief Judge to the Court of Appeals, and she recused herself from consideration of Myers.


33 See, e.g., Leon v. Martinez, 84 N.Y. 2d 83, 88 (1994) (explaining that a court deciding a motion to dismiss “may freely consider affidavits submitted by the plaintiffs” (internal citation and quotation marks omitted)).
on these extensive factual allegations – which a court evaluating a motion to dismiss must credit – plaintiffs maintained that the relationship between aid-in-dying and “suicide” presented a factual question that warranted development of a full evidentiary record.\textsuperscript{35}

The motion court disagreed, holding that plaintiffs had failed to state a claim.\textsuperscript{36} In a brief abstruse opinion, the court concluded that “[t]he penal law as written is clear and concise” and that it would therefore “exceed this Court’s jurisdiction” to prohibit the district attorney “from prosecuting an alleged violation of the penal law,” an act within the wide ambit of prosecutorial discretion.\textsuperscript{37} The court also rejected the state constitutional claims out of hand, finding the case “factually and legally indistinguishable from Vacco” and quoting at length from that decision by way of explanation.\textsuperscript{38} The court further compared the case to Bezio v. Dorsey,\textsuperscript{39} a recent decision

\textsuperscript{34} For example, plaintiffs submitted: materials from the American Public Health Association “[r]eject[ing] 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 death”; materials from the American Medical Women’s Association, American Medical Student Association and American College of Legal Medicine likewise distinguishing between aid-in-dying and assisted suicide; evidence showing that, in states where aid-in-dying is lawful, the cause of death for patients who choose aid-in-dying is listed as the underlying terminal disease rather than the act of taking prescription medicine; and expert affidavits from physicians explaining that aid-in-dying is part of accepted medical practice governed by professional standards. See Brief for Plaintiffs-Appellants at 8-9, Myers v. Schneiderman, 140 A.D.3d 52 (1st Dep’t 2016), (No. 151162/15).


\textsuperscript{36} Myers v. Schneiderman, No. 151162/15, 2015 WL 6126959, at *4-5 (N.Y. Sup. Ct. Oct. 16, 2015). The court did, however, reject the State’s argument that the case should be dismissed for lack of a justiciable controversy, finding that plaintiffs had successfully pled entitlement to judicial review of the statutes in question. Id. at *2.

\textsuperscript{37} Id. at *3-4.

\textsuperscript{38} Id. at *4-5. Vacco, of course, involved a challenge to the Assisted Suicide Statute under the federal, rather than state, constitution, and it considered only equal protection, not due
in which the Court of Appeals permitted the State to intervene in an inmate’s hunger strike to prevent his death, and emphasized that the Court’s jurisprudence allows only the refusal of medical treatment rather than any “self-inflicted” acts. It consequently dismissed the case.

C. The Appellate Division Affirms

Plaintiffs appealed as of right to the Appellate Division, First Department, challenging both the statutory and constitutional determinations made by the Supreme Court. First, they pointed to the wealth of factual allegations and evidentiary submissions supporting the conclusion that aid-in-dying is not assisted suicide within the meaning of the statute, and argued that the motion court had failed to address, much less credit, these assertions and had thereby improperly dismissed the complaint. Plaintiffs likewise pointed to numerous factual allegations – also overlooked by the trial court – that aid-in-dying is indistinguishable from currently lawful forms of medical treatment and that legal distinctions between the two may be discriminatory. Finally, plaintiffs criticized the court’s failure to take seriously – or even address – their due process claim. In particular, plaintiffs argued, the motion court ignored New York’s longstanding recognition of a fundamental right to self-determination with respect to

40 Myers, 2015 WL 6126959, at *4.
41 See Brief for Plaintiffs-Appellants, Myers v. Schneiderman, 140 A.D.3d 52 (1st Dep’t 2016), (No. 151162/15).
42 Id.
one’s body and to control the course of one’s medical treatment, a right broader than those recognized under the Federal Constitution and one broad enough to encompass aid-in-dying.\textsuperscript{43}

The Appellate Division, however, affirmed dismissal of the complaint, holding that the Assisted Suicide Statue provides a valid statutory basis to prosecute physicians offering aid-in-dying and that such a prosecution would not violate the New York State Constitution.\textsuperscript{44} The Appellate Division flatly rejected the possibility of a distinction between aid-in-dying and suicide, finding that aid-in-dying fits the “literal description” of assisting suicide, a “straightforward” term, “since there is a direct causative link between the medication proposed to be administered by plaintiff physicians and their patients’ demise.”\textsuperscript{45} Relying on a case applying the Assisted Suicide Statute to a defendant who recklessly encouraged an emotionally distraught teenager to commit suicide, the court further rejected as grounds for non-application of the statute the fact that physician prescribing the medication does not intend to cause the plaintiff’s death, essentially finding irrelevant the medical context of aid-in-dying.\textsuperscript{46}

\textsuperscript{43} See, e.g., 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.”); id. at 493 (“[I]t 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.”); Matter of Delio v. Westchester Cty. Med. Ctr., 129 A.D.2d. 1, 13 (N.Y. App. Div. 2d Dep’t 1987) (“The right to self-determination with respect to one’s body has a firmly established foundation in the common law.”); id. at 16 (“The primary focus . . . is upon the patient’s desires and his right to direct the course of his medical treatment rather than upon the specific treatment involved.”).


\textsuperscript{45} Id. at 57.

\textsuperscript{46} Id. at 57-58 (discussing People v. Duffy, 79 N.Y.2d 611, 584 N.Y.S.2d 739, 595 N.E.2d 814 (1992)).
Having upheld application of the Assisted Suicide Statute to aid-in-dying, the Appellate Division then quickly found no violation of equal protection, on the ground that New York’s “Equal Protection Clause is no broader in coverage than the Federal provision” and the Supreme Court in *Vacco* had already rejected an equal-protection challenge to the statute.\(^47\) It then addressed plaintiffs’ due process challenge, acknowledging that “the State Due Process Clause may be more protective of rights than its federal counterpart.”\(^48\) It nevertheless went on find that clause insufficient to encompass a right to aid-in-dying. Instead, the Appellate Division took a narrower view of the constitutional right to self-determination, framing it as merely “a patient’s right to refuse medical treatment” “and let nature takes its course,” one that cannot involve “affirmative” acts of autonomy involving “receiv[ing] treatment.”\(^49\) Finally, it rejected plaintiffs’ allegations that a restriction on aid-in-dying serves no rational basis, finding plaintiffs’ evidentiary submissions subject to critique and inadequate to support that conclusion.\(^50\)

**D. The Court of Appeals Affirms in a *Per Curium* Opinion**

Plaintiffs again appealed as of right to the New York Court of Appeals, challenging both statutory and constitutional grounds for the decision, and arguing that a full factual record was necessary to properly evaluate the merits of all three claims.\(^51\) First, plaintiffs criticized the Appellate Division’s reliance on a dictionary definition of suicide and a literal approach to the

\(^{47}\) *Id.* at 60 (internal quotation marks omitted).

\(^{48}\) *Id.*

\(^{49}\) *Id.* at 60-61.

\(^{50}\) *Id.* at 61-65.

\(^{51}\) See CPLR § 5601(b)(1) (providing for appeal as of right “from an order of the appellate division which finally determines an action where there is directly involved the construction of the constitution of the state or of the United States”).
law, which ignored the factual nuances of aid-in-dying, changing cultural understandings of the meaning of “suicide,” and the underlying purpose and legislative history of the statute.\footnote{\textit{Myers v. Schneiderman}, 30 N.Y.3d 1 (2017)} Moreover, such an approach, plaintiffs argued, could place currently lawful forms of medical treatment—such as terminal sedation and withdrawal of treatment—within the scope of “assisted suicide,” rendering the approach necessarily flawed and inappropriate.

Second, plaintiffs challenged again the dismissal of their equal protection claim, arguing that the legal distinctions between terminally ill patients choosing end-of-life care permitted by the statute could not be sustained. Finally, plaintiffs took issue with the narrowness of the Appellate Division’s conception of New York’s right to self-determination, insisting that that fundamental right “encompasses a patient’s deeply and profoundly personal choice about how much suffering to endure in the final ravages of the dying process, just as it encompasses a patient’s right to choose other end-of-life options that precipitate death.”\footnote{See \textit{Brief for Plaintiffs-Appellants at 30, Myers v. Schneiderman}, 30 N.Y.3d 1 (2017) (No. 151162/15).} Plaintiffs also rejected the suggestion that \textit{Glucksberg} and \textit{Vacco} should bear on (let alone control) the court’s decision, emphasizing the greater breadth of New York’s Due Process Clause, the material changes in the Supreme Court’s jurisprudence on fundamental liberties in the wake of its decisions on assisted suicide, and the development of evidence that the concerns critical in causing the Supreme Court to defer to the “laboratory of the states” were without foundation.\footnote{See, e.g., \textit{Obergefell v. Hodges}, 135 S. Ct. 2584, 2602 (2015) (recognizing that the inquiry into the existence of fundamental rights properly calls for consideration of evolving societal views and stating that fundamental rights “rise, too, from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era.”);}
A large number of amici supported plaintiffs’ appeal, including medical organizations, state legislators, the NY Civil Liberties Union, the National Association of Criminal Defense Lawyers, New York chapter of the National Association of Elder Law Attorneys, New York Law Professors, and religious and ethics entities argued for reversal on varied grounds, including arguments based on statutory construction, privacy interests, the importance of independent state constitutional jurisprudence, and ethical considerations.55

The Court of Appeals56 nevertheless affirmed the Appellate Division’s ruling in a per curiam opinion. In its fourteen-page decision, the Court rejected Plaintiffs’ arguments that the lower courts improperly resolved numerous factual issues and instead reiterated that, as a matter of law, aid-in-dying could be lawfully prosecuted under the Assisted Suicide Statute. Like the Appellate Division, it relied on a dictionary definition of “suicide” to promptly find that aid-in-dying “falls squarely within the ordinary meaning of the statutory prohibition on assisting a

---

55 See Brief of Amicus Curiae New York Civil Liberties Union, Brief of Amici Curiae New York State Legislators, Brief of Amicus Curiae Compassion and Choices, Brief of Amicus Curiae American Medical Student Association, American Medical Women’s Association, and American College of Legal Medicine, Brief of Amicus Curiae Unitarian Universalist Association, New York Society for Ethical Culture and Professor Robert A. Thurman, Brief of Amicus Curiae New York Law Professors, Brief of Amicus Curiae National Association of Criminal Defense Lawyers, Brief of Amicus Curiae New York Chapter of the National Academy of Elder Law Attorneys, Brief of Surviving Family Members, and Brief of Amicus Curiae Alan and Charise Pfeffer, Myers v. Schneiderman, 30 N.Y.3d 1 (2017) (No. 151162/15). Four amicus briefs were filed in support of Defendant’s position. See Brief of Amicus Curiae Disability Rights Amici, Brief of Amicus Curiae New York State Catholic Conference, Brief of Amicus Curiae, and Brief of Amicus Curiae Agudath Israel of America, Myers v. Schneiderman, 30 N.Y.3d 1 (2017) (No. 151162/15).

56 The Court rendered its decision with a five-judge panel as a result of Chief Judge DiFiore’s recusal, and the untimely death of Judge Abdul-Salaam, which created an unfilled vacancy at the time of decision.
suicide,” and it relied on the Supreme Court’s decision in *Vacco* to dismiss Plaintiff’s equal protection claim essentially without discussion.\(^5^7\)

In declining to entertain a due process challenge, the Court likewise articulated a narrow understanding of the state constitution’s right to self-determination, characterizing it as a “right to choose among medical treatments, or to refuse lifesaving medical treatments.”\(^5^9\) In so doing, it also expressed a cramped, narrow conception of the right put forward by plaintiffs: whereas plaintiffs sought to characterize a right to aid-in-dying as a species of well-established rights to control one’s medical treatment and to exercise personal autonomy, the Court of Appeals described the right at issue as a “right to die, or [a] still broader right to obtain assistance from another to end one’s life.”\(^6^0\) Finding no fundamental right to aid-in-dying, the Court proceeded to find the State’s interests in prohibiting aid-in-dying—guarding against the risks of mistake and abuse, preserving life, and preventing suicide—legitimate and rationally related to the statute’s means.\(^6^1\) It looked to history to support this conclusion, pointing to the state’s longstanding prohibitions on assisted suicide and rejecting plaintiffs’ arguments concerning changing cultural understandings of assisted suicide and aid-in-dying.\(^6^2\)

Three judges concurred in the judgment, offering strikingly different views on the Court’s decision. Judge Fahey penned a lengthy concurrence to “expand on certain risks that


\(^{5^8}\) *Id.* at 13.

\(^{5^9}\) *Id.* at 14.

\(^{6^0}\) *Id.* (internal quotation marks omitted).

\(^{6^1}\) *Id.* at 15-16.

\(^{6^2}\) *Id.* at 16-17.
would be associated with legalizing physician-assisted suicide in New York and that justify its prohibition,” discussing at length the experiences of other jurisdictions that have legalized forms of “physician-assisted suicide.” Judge Garcia offered a separate concurrence to “expressly reach—and reject” the possibility that plaintiffs could “assert a more particularized challenge to the assisted suicide statutes” that would show the statutes to be constitutionally infirm.

Turning again to the State’s longstanding history of criminalizing suicide and its interest in preserving life, Judge Garcia reiterated that neither the State nor the state constitution need permit “physician-assisted suicide” and that plaintiffs’ claims were “better addressed the legislature.”

Judge Rivera, on the other hand, concurred in the decision “on constraint of th[e] prior case law” but essentially endorsed some form of aid-in-dying, laying out the circumstances under which she believed application of the Assisted Suicide Statute to patients seeking end-of-life care would, in fact, violate the New York constitution. Starting from the premise that New York’s constitutional guarantee of Due Process exceeds the Federal Constitution’s, Judge Rivera affirmed that the “liberty interest protected by our State Constitution is broader than the right to

---

63 Id. at 34 (Fahey, J., concurring).

64 Id. at 48 (Garcia, J., concurring) (quoting Glucksberg, 521 U.S. at 750 (Stevens, J., concurring)).

65 Id. at 58. These statements of course reflect a shocking abdication of an essential function of the courts to protect individual interests under the state constitution.

66 Id. at 22 (Rivera, J., concurring).
decline medical treatment,” and “includes the freedom to make decisions about how to die just as a surely as it includes decision-making about life’s most private matters.”67

Although Judge Rivera conceded that the State retains legitimate interests that may counsel against aid-in-dying, she emphasized that the State’s interests “are not absolute or unconditional,” and “diminish when a mentally-competent, terminally-ill person approaches the final stage of the dying process that is inevitable” and “seeks access to medical treatment options that end pain and hasten death, with the consent of a treating physician acting on best professional judgment.” 68 At that point, Judge Rivera stated, “the State’s interest is diminished and outweighed by the patient’s liberty interest in personal autonomy” and “the State may not unduly burden a terminally-ill patient’s access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.”69

Judge Rivera also rejected several of the State’s and per curiam’s arguments in support of prohibiting aid-in-dying, finding no distinction between “active” and “passive” measures taken to end one’s life or between a physician providing aid-in-dying and one providing lawful medical treatments like terminal sedation.70 She therefore would have held that the “State Constitution protects the rights of these terminally-ill patients to make the deeply personal choice of how they define and experience their final moments.”71

67 Id. at 23; see also id. at 26 (rejecting the State’s “dichotomy between active and passive physician conduct” as “unpersuasive in this context).
68 Id. at 18, 23.
69 Id. at 18, 23.
70 Id. at 24-29.
71 Id. at 34.
Plaintiffs moved for reargument of the Court of Appeals' decision, calling out the Court’s flawed narrowing of the right at issue and noting that “[a] cramped approach in expounding state constitutional rights has not served this Court well in the past.” The Court of Appeals, however, denied leave for reargument.

III. The Court of Appeals Erred

The Court of Appeals erred in dismissing the Myers case. In doing so, the Court not only disregarded its well-established precedent, but it ignored unique aspects of the New York State Constitution critical to the resolution of this case. In particular, the Court (1) applied the incorrect standard of review at the motion to dismiss stage; (2) mischaracterized the fundamental right at issue; and (3) failed to recognize changing circumstances and shifting public attitudes towards aid-in-dying.

Under the appropriate standard of review on a motion to dismiss, 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.” A plaintiff is entitled to “the benefit of every possible favorable inference,” and the Court’s

---

72 Citing Hernandez v. Robles, 7 N.Y.3d 338, 380 (2005) (Kaye, C.J., dissenting). In Hernandez, the Court of Appeals held that the fundamental right to marry did not apply to same-sex couples because “[t]he right to marry someone of the same sex . . . is not ‘deeply rooted.’” Id. at 362. The Supreme Court recognized such a right just ten years later in Obergefell v. Hodges, 135 S. Ct. 2584 (2015), leaving Hernandez as a case “that future generations will look back on . . . as an unfortunate misstep.” Hernandez, 7 N.Y.3d at 396.

73 At the time of plaintiffs’ request for reargument, the vacancy on the court had been filled and this important matter could have been reargued to a nearly full bench.

analysis is limited to determining “only whether the facts alleged fit within any cognizable legal theory.”\textsuperscript{75}

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.”\textsuperscript{76} 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 . . . .”\textsuperscript{77} Further, even on a rational basis review, a plaintiff is entitled to develop facts in order to “negative every conceivable basis which might support” a law.\textsuperscript{78}

The Court’s decision overlooked this well-settled legal principle that a complaint should not be dismissed at the pleading stage unless a plaintiff can prove no set of facts to support a claim for relief. Its decision failed to credit the allegations of the physician Plaintiffs, who presented facts to support such a claim. Moreover, other courts that have addressed aid-in-dying have done so on a developed factual record.\textsuperscript{79}

\textsuperscript{75} Leon v. Martinez, 84 N.Y.2d 83, 87-88 (1994) (citation and quotation marks omitted).

\textsuperscript{76} 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).

\textsuperscript{77} 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).

\textsuperscript{78} Affronti v. Crosson, 95 N.Y.2d 713, 719 (2001) (upholding constitutionality of statute on rational basis review following trial).

\textsuperscript{79} See, e.g., Carter v. Canada (Attorney General), 2015 SCC 5, ¶ 57 (2015) (following a full trial, striking down Canada’s assisted suicide statute as impinging on liberty); Morris v. Brandenburg, 376 P.3d 836 (N.M. 2016) (affirming reversal of lower court decision, following a full trial, that a dying patient has a fundamental right protected by the New Mexico constitution to choose a more peaceful death via aid-in-dying).
Judge Rivera’s concurrence recognized one such set of facts that was already presented by the physician plaintiffs in the complaint – namely a scenario involving a patient facing an excruciating and impending death seeking aid-in-dying. Rather than credit physician plaintiffs’ allegations that they “regularly encountered mentally-competent, terminally-ill patients who have no chance of recovery and for whom medicine cannot offer any hope other than some degree of symptomatic relief,” the Court denied Plaintiffs the ability to put forward proof and to make the “more particularized challenge” that the U.S. Supreme Court acknowledged in Glucksberg could establish a constitutional violation.

The Court further mischaracterized the fundamental right at issue in this case – the well-established and broad fundamental right to self-determination with respect to one’s body and to control the course of one’s medical treatment – as a “fundamental right to physician-assisted suicide.” The Court has long held that “[i]t 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.” Rivers recognized that the “common-law right is co-extensive with the patient’s liberty interest

---

80 *Myers v. Schneiderman*, 30 N.Y.3d 1, 18 (2017) (Rivera, J, concurring) (given “the State’s sanctioning of terminal sedation in particular, the statute does not survive rational basis review . . . [and therefore] the State may not unduly burden a terminally-ill patient’s access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.”)

81 Compl. ¶ 43

82 521 U.S. at 734 n.24 (quoting Stevens, J., concurring).

83 *Myers v. Schneiderman*, 30 N.Y.3d 1, 10 (2017)

protected by the due process clause of our State Constitution.”  

The Court 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. 

The Court’s jurisprudence indicates that the fundamental right as articulated by the Court encompasses a patient’s deeply and profoundly personal choice about how much suffering to endure in the final ravages of the dying process, just as it encompasses a patient’s right to choose other end-of-life options that precipitate death. In mischaracterizing the right at issue as a new “fundamental right to physician-assisted suicide,” the Court made the same mistake that it did in *Hernandez v. Robles*, where it “recast[ ] plaintiffs’ invocation of their fundamental right to marry as a request for recognition of a ‘new’ right to same-sex marriage [which] misapprehend[ed] the nature of the liberty interest at stake.” There, the Court’s holding that the fundamental right to marry did not to apply to same-sex couples because “[t]he right to marry

85 *Id.* at 493.

86 *Id.* (citations and quotation marks omitted).

87 *See Delio v. Westchester Cty. Med. Ctr.*, 129 A.D.2d 1, 16 (2d Dep’t 1987) (“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.”).

88 *Myers v. Schneiderman*, 30 N.Y.3d 1, 10 (2017)


90 *Id.* at 380 (Kaye, C.J., dissenting).
someone of the same sex . . . is not ‘deeply rooted,’”\(^{91}\) was rebuked just ten years later by the U.S. Supreme Court, which recognized such a right in *Obergefell v. Hodges*.\(^{92}\) As was the case in *Hernandez*, the Court’s flawed characterization of the fundamental right in *Myers* not only failed to accord with its own firmly established principles of law, but it also failed to honor New York’s “proud tradition” of protecting fundamental liberties.

Finally, the Court erred by failing to recognize changing circumstances and shifting public attitudes towards aid-in-dying. The Court’s recent jurisprudence on statutory construction recognizes that the meaning of undefined statutory terms may evolve over time. In particular, in *Brooke S.B. v. Elizabeth A.C.C.*,\(^{93}\) the Court adopted Judge Kaye’s dissent in *Alison D. v. Virginia M.*,\(^{94}\) and held that the term “parent” under the Domestic Relations Law is not limited to a biological parent. In particular, the Court held that it “agree[d] that, in light of more recently delineated legal principles, the definition of ‘parent’ established by this Court 25 years ago in *Alison D. has become unworkable when applied to increasingly varied familial relationships*.”\(^{95}\)

The Court’s holding in *Myers* thus stands in stark contrast to its established precedent that statutory terms may evolve. In holding that that “[a]id-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide,”\(^{96}\) the Court ignored the fact

---

\(^{91}\) *Id.* at 362 (Kaye, C.J., dissenting).

\(^{92}\) 135 S. Ct. 2584 (2015)

\(^{93}\) 28 N.Y.3d 1, 14 (2016)

\(^{94}\) 77 N.Y.2d 651, 659 (1991) (“[I]n the absence of express legislative direction [we] have attempted to read otherwise undefined words of the statute so as to effectuate the legislative purposes.”)

\(^{95}\) 28 N.Y.3d at 14.

\(^{96}\) *Myers v. Schneiderman*, 30 N.Y.3d 1, 12 (2017)
that aid-in-dying was not even a recognized concept that could have been contemplated by the Legislature as a “suicide” when it revised the Assisted Suicide Statute over 50 years ago as well as evolutions in medical care since the Assisted Suicide Statute was enacted. The Court further failed to credit any of the evidence of changing attitudes toward, and growing societal support for, aid-in-dying submitted by the Plaintiffs, including the recent polls that a clear majority of doctors and the public support aid-in-dying.\(^97\)

**Conclusion**

The Court of Appeals failed to stand as a bulwark of protection for the fundamental rights of New Yorkers to free choice and autonomy, specifically in medical decision making. The promise of liberty under the New York Constitution was not realized in the context of end of life liberty, which undermines New York constitutional jurisprudence and leaves suffering dying patients without the autonomy to decide the profoundly personal matter of how much suffering to endure before death. This opinion will serve as an example of failed jurisprudence, an example which any sister court considering this issue under its own constitution would be wise to avoid.\(^98\)

---

\(^97\) See, e.g. Ault, A., *Doctor Support for Assisted Suicide Death Rises, but Debate Continues*, MedScape (July 7, 2017), available at https://www.medscape.com/viewarticle/882334 (57% of doctors support aid-in-dying); GALLUP (May 4-8, 2016), *Euthanasia Still Acceptable to Solid Majority in U.S.*, available at http://news.gallup.com/poll/193082/euthanasia-acceptable-solid-majority.aspx (69% of Americans support aid-in-dying). Growing societal support for a practice is accepted as a reason to extend federal constitutional protection, as the Supreme Court noted in *Lawrence v. Texas*, 539 U.S. 558 (2003). The Myers court, which ostensibly was deferential to the Supreme Court decisions in *Quill* and *Glucksberg*, failed to acknowledge that the Supreme Court’s jurisprudential approach to articulating rights worthy of protection under the United States Constitution had evolved in the years since *Glucksberg* to take such growing societal acceptance into account.

\(^98\) Perhaps one or more of the New York Appeals Court judges will publicly acknowledge the error of the decision, as retired United States Supreme Court Justice Lewis Powell did
Aid-in-dying is gaining recognition across the country as a medically and ethically appropriate treatment, and the Court of Appeals’ decision undoubtedly will be looked back upon as an unfortunate and embarrassing misstep by the Court.

regarding his determinative vote in Bowers v Hardwick, 478 U.S. 186 (1986) upholding a Georgia statute criminalizing homosexual sodomy. See Linda Greenhouse, Black Robes Don’t Make the Justice, but the Rest of the Closet Just Might, N.Y. TIMES (Dec. 4, 2002), http://www.nytimes.com/2002/12/04/us/black-roses-don-t-make-the-justice-but-the-rest-of-the-closet-just-might.html. Such recognition of error can play an important role in allowing an erroneous ruling to be overcome. For example, Harvard Law School professor Laurence H. Tribe, who argued on behalf of Hardwick, has articulated an opinion that Powell’s second thoughts could undercut the moral force of the opinion. Ruth Marcus, Powell Regrets Backing Sodomy Law, WASH. POST (Oct. 26, 1990), https://www.washingtonpost.com/archive/politics/1990/10/26/powell-regrets-backing-sodomy-law/a1ae2efc-bec6-47ec-bfb6-1c098e610c5b/?utm_term=.dae1dd95e754 (“The fact that a respected jurist who is indispensable to the majority conceded that on sober second thought he was probably wrong certainly will affect the way that future generations look at the decision[.]”)