WHO DECIDES?
MEDICAL AID IN DYING

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Introduction

Life is precious, but it ends eventually for all of us, including about 150,000 New Yorkers each year. No dying person should have to endure more suffering than he or she is willing to endure. Every dying person who is mentally competent should have the right to die, if possible, in a way that she or he decides and controls, consistent with his or her values and beliefs. For those who are dying the issue is not whether they will die, but instead how they are going to die and who makes the decision.

Medical aid in dying should be an available option. It occurs when a terminally ill, mentally competent adult patient, who is likely to die within six months, requests and then takes prescribed medicines, which must be self-administered, to achieve a peaceful death.

Patients with mental capacity have a legally recognized right to end their suffering by having life sustaining treatment withheld or withdrawn, such as a feeding tube, ventilator, or dialysis. They do not even have to be terminally ill. Patients also may voluntarily stop eating and drinking. Another option which hastens death is palliative sedation. It is appropriate for some patients who have uncontrollable symptoms, usually pain. Health care agents can and often do make decisions, in accordance with the wishes of patients, to hasten the deaths of patients. Medical aid in dying is another reasonable end-of-life option, a better choice for some terminally ill patients.

My 50 year career has been devoted to justice, justice for poor people as a legal services for the poor lawyer for 10 years, justice for prisoners in our state prisons as the Executive Director of Prisoners' Legal Services of New York and justice for patients as the Executive Director of End of Life Choices for 14 years. I deeply care about justice and I hate human suffering, particularly unnecessary suffering. Health justice demands that the terminally ill have access to medical aid in dying so that they may make the choice not have to endure unnecessary suffering.

Having carefully studied the issue of medical aid in dying for 16 years I can state with absolute certainty that **when medical aid in dying is an open, legal end of life option, appropriately regulated, it is a safe, humane, and ethical medical treatment that benefits patients and families, and causes no harm to anyone.** Having reviewed arguments in opposition, it seems clear as well that there is a lack of adequate understanding of how medical aid in dying laws have worked, very successfully, in various states which have authorized the option.

There were unquestionably many understandable fears and concerns raised before medical aid in dying became legal. However, with over 45 years of cumulative experience in states where medical aid in dying is authorized, studies and reports, based on facts and evidence, consistently show that none of the problems expected or predicted by opponents or skeptics have emerged.

So, today, while those who oppose medical aid in dying continue to raise the same fears and concerns, they are now unfounded and lack validity.

Medical aid in dying occurs now in states other than where it is legal. Some patients will attempt to end their suffering on their own, often failing as exemplified by testimony from Scott Baracco at the Assembly Health Committee hearing on medical aid in dying in Albany, in April 2018. He discussed the failed attempt of his deceased girl friend to end her life because of extreme suffering near the very end of her life, after she had courageously fought for years to stay alive.

A key question for the legislature and for those contemplating the issue of medical aid in dying is whether it should continue as an illegal, underground, unregulated practice which puts doctors, patients and family members at risk, or should it be legalized, and appropriately regulated, with safeguards and protections for all involved and for those who choose not to be involved. The answer is clear.

Medical Aid in Dying is Starkly Different from assisted suicide

It is important to note that medical aid in dying is not assisted suicide. Suicides are committed by those who could live but choose to die, generally by people with mental illness, in isolation, often impulsively and by violent means. They are tragic. To the contrary, medical aid in dying is available only to terminally ill patients who will soon die; the process usually takes several weeks; it occurs almost always after consultation with and support of family and with at least 2 physicians; and it is empowering. Knowing that they now have a last resort option, patients can, once they obtain the medications, go on living as fully and as purposely as possible.

A recent statement by the American Association of Suicidology entitled, “SUICIDE” IS NOT THE SAME AS “PHYSICIAN AID IN DYING” makes 15 points of distinction between MAID and suicide. In its conclusion the statement says in part:

“The American Association of Suicidology is dedicated to preventing suicide, but this has no bearing on the reflective, anticipated death a physician may legally help a dying patient facilitate. In fact, we believe that the term “physician-assisted *suicide*” in itself constitutes a critical reason why these distinct death categories are so often conflated and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of the AAS”. (See http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf).

Additionally, the term “assisted suicide” is rejected by the American Public Health Association, American Academy of Hospice and Palliative Medicine, the American Medical Women’s Association, the American Medical Student Association, and the American Psychological Association.

Many Lessons of Legal Medical Aid in Dying

We have learned many important positive lessons over more than 45 years of experience with medical aid in dying. These lessons refute concerns and fears raised. One of the most important lessons is that dying patient are not rushing to nor are they feeling pressured to access medical aid in dying, a concern expressed by opponents. In fact, only about 1 in 300 deaths in Oregon, which has had a medical aid in dying law for 20 years, occurs by medical aid in dying. The vast majority of dying patients want to live as long as possible and so the option of medical aid in dying, while giving great comfort to those who are dying, is used very infrequently. Other important lessons learned are:

- There is evidence that family members of those who request medical aid in dying feel better prepared and accepting of the death, and that there are no negative effects. (See “Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying”, Journal of Pain and Symptom Management, Volume 38, Issue 6 (2009);807-815.)

- There is also evidence that deaths by medical aid in dying are at least as good, and in some cases better deaths than others. (See "Quality of Death and Dying in Patients who Request Physician-Assisted Death", Journal of Palliative Medicine, Volume 14, Number 4 (2011);445-450). And those deaths are quicker without lingering for what can be weeks with VSED or palliative sedation.
- About 90% of those who end their lives by using aid in dying are receiving hospice care, which means that even hospice cannot meet all the needs of all dying patients. In this regard consider what the former CEO of the Oregon Hospice Association said in an article published in the Sacramento Bee (Dec.9, 2015); "I voted against the referendum because I believed it was unnecessary if terminally ill Oregonians had access to high-quality hospice and palliative care. However, I came to realize that it was arrogant of me to believe that hospice and palliative care professionals could meet all the needs of the dying. Oregon is consistently rated among the best states for providing hospice and palliative care. Yet, even with the best care, some patients still suffer intolerably and want the option to take prescription medication to die painlessly, peacefully and quickly in their sleep." Then consider the testimony of Dr. Thomas Madejski, President of the Medical Society of the State of New York at the New York State Assembly Committee on Health hearing in April. He mentioned the "sacred principle that physicians are dedicated to healing and preserving life, not ending it." However, there comes a time near the end of life when healing and preserving life is no longer possible. And, physicians also have an equally important ethical obligation to reduce suffering. They are not ending their patients' lives when they prescribe medications that patients must ingest themselves any more than, and I would suggest less than when they withdraw life

sustaining treatment from a patient knowing the patient is not prepared and willing to die and where the end result is death.

- Almost all of those who access medical aid in dying have health insurance, and most are college educated. (See https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf).
- There is no evidence of any slippery slope. Medical aid in dying is only for the terminally ill, and only for the mentally competent who can clearly express their wishes. There is no movement to extend medical aid in dying beyond the terminally ill and no evidence that it will lead to euthanasia in this country.
- A comprehensive cancer center in Seattle which implemented a program for patients who might want medical aid in dying found that "Overall, our Death with Dignity program has been well accepted by patients and clinicians". (See N Engl J Med 2013; 368:1417-1424). It is inconceivable that such a program would have been started or continued were there problems with the way in which Washington's medical aid in dying law was implemented.
- There is no evidence of disproportionate impact on vulnerable populations. (See "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in ''vulnerable groups", Journal of Medical Ethics 2007; 33;591–597.)
- Nor is there any evidence of any coercion or abuse. With regard to those with disabilities, consider, particularly a letter from the Executive Director of Disabilities Rights Oregon in 2016 where he categorically states that "DRO has not received a

complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act" (letter dated Feb. 10, 2016).

People with Disabilities

Some in the disability community are opposed to medical aid in dying while other organizations such as the Disability Rights Legal Center and the NYCLU support it. Opponents raise fears, based on historical and continuing discrimination. However, facts and evidence reveal that their fears concerning medical aid in dying are unfounded as indicated in the letter mentioned above.

Consider what was said by Kathryn Carroll, a policy analyst at the Center for Disability Rights at the Albany hearing. "The disabled community is concerned with losing our chance to live," she said. However, despite the historical and continuing discrimination against people with disabilities, this is not a legitimate focus of concern for those with disabilities. You only die by medical aid in dying if you decide to do so and only if you are terminally ill and mentally competent. And, you cannot do so unless you have gone through the rigorous process mandated by the Medical Aid in Dying Act, summarized more fully below. You need to make an oral request of your doctor. You then need to make a written request witnessed by two people who declare. You then must be determined to be terminally ill and mentally competent by two doctors. And, you must be given a significant amount of information. And, if you decide that you are ready to die by medical aid in dying, you must then self-ingest the medicine.

Compare this mandatory statutory process, which has many additional safeguards, with what happens in another scenario. A patient who may be on a ventilator, as acclaimed physicist Steven Hawking was (and who supported medical aid in dying) decides that suffering has become unbearable. A demand could be made by the patient to have the ventilator withdrawn and if the patient had decision making capacity the request would be honored. As a matter of standard of care an assessment of the patient would likely be done to determine if there were things that could help improve the quality of life of the patient sufficiently so the patient would choose not to die. However, unlike under the Medical Aid in Dying Act, mandated statutory safeguards simply do not exist in this situation. And, the decision could be made which would result in death without the patient even being terminally ill. In both cases, withdrawal of life sustaining treatment and medical aid in dying, the intention of the patient, which is where the focus should be, is to end suffering and to die, and in both cases the result is death. These situations can't be logically distinguished. However, again, in the case of medical aid in dying there are many statutory safeguards. Finally, a health care agent could make the same decision for the patient to have the ventilator withdrawn if the patient lacked decision making capacity, without even knowing the wishes of the patient but acting in the patient's best interest.

For people with disabilities who might make a decision to access aid in dying, consider what Paul Spiers had to say in a talk he gave in 2004. Paul Spiers died in 2013. He was a forensic neuropsychologist. He was on the faculty at the Boston University School of Medicine and at the Massachusetts Institute of Technology. And he was a wheelchair-user since a fall from horseback some 15 years before his death that left him paralyzed from the chest down. This is what he said:

> "As a wheelchair-user, the principle of choice is one that is very important to me. It is also the driving force and the core principle of the Americans with Disabilities Act…
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> Those in the disability community will get no argument from me that the disabled are often viewed as having an existence that others may not feel is worth living, that we are more vulnerable to discrimination and have been discriminated against by many institutional groups, including the medical profession.

> Some seem to fear legislation similar to the law in Oregon because they believe it will invite further discrimination. Indeed, many people probably will choose to end their lives because of the very limitations or handicaps that many Americans with disabilities live with every day. I will not dispute this." But Dr Spiers then makes the excellent point that people with disabilities are far more vulnerable where laws governing aid in dying do not exist. He says., "If, as our opponents maintain, the life of a person with a disability is less valued by society, then such patients are far better protected in Oregon where the process is transparent and has safeguards".
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> He continues, "If I should face such a scenario in the future and were I to lose what little control I have left over my body, then I will still want the right to make such a choice, but it would be a choice that should only be available to me if I carried a terminal diagnosis. It might not be your choice, or that of ten other people with disabilities or who use wheelchairs, but just as I would never presume to make a choice for you, please do not presume to make a choice for me. You do not have to somehow protect me from myself, from others, or from society just because I am a wheelchair-user. I prefer to protect myself." (Excerpt from transcript of talk given at a meeting of the National Association of Protection & Advocacy Systems, June 11, 2004, Washington, D.C.)

Medical Aid in Dying Legislation in New York

Legislative efforts to establish medical aid in dying as a right began in New York in 2015. The current bills, A. 2383-a (Paulin) and S. 3151-a (Savino), the Medical Aid in Dying Act, are comprehensive and patterned after laws in other states which permit aid in dying and which have worked as intended.

As mentioned above, there are virtually no statutory safeguards and protections pertaining to decisions by patients (or their agents) where death results, such as withdrawing life sustaining treatments, or voluntarily stopping eating and drinking, or palliative sedation. However, there are numerous safeguards and protections in the Medical Aid in Dying Act.

Some of the key provisions are summarized below.

1. To legally request medical aid in dying (MAID), a patient must be at least 18 years of age and have a terminal illness as defined, confirmed by an attending physician and a consulting physician.

2. A patient must make an oral and a written request (on a form provided in law) for MAID. The written request must be witnessed by 2 adults who attest that the patient: 1) has capacity; 2) is acting voluntarily; and 3) is not being coerced.

3. One witness shall NOT be: 1) a relative; 2) a person entitled to a portion of the patient's estate; 3) an owner, operator or employee of a health care facility where the patient resides or is being treated; or 4) the patient's attending physician, consulting physician or mental health professional, if applicable, who determines capacity.

4. If either the attending or consulting physician believes the patient lacks capacity, the physician must refer the patient for evaluation by a mental health professional. Only patients subsequently found to have capacity may proceed.

5. A patient may rescind his or her request for medication at any time without regard to capacity.

6. Patients must be able to self-administer the medication.

7. An attending physician must have primary responsibility for the care of the patient requesting MAID and the treatment of the patient's terminal illness.

8. Attending physician responsibilities: 1) determine that the patient has a terminal illness; 2) determine that the patient has capacity, made an informed decision, and made the request for aid in dying voluntarily and without coercion; 3) inform the patient of the need for a consulting physician's confirmation, and refer if requested; 4) refer the patient to a mental health professional for evaluation if the physician believes the patient lacks capacity; 5) provide information and counseling regarding palliative care; 6) ensure the patient is making an informed decision by discussing with the patient the patient's diagnosis and prognosis, the potential risks associated with taking the medication, the probable result of taking the medication, the possibility that the patient may choose to obtain the medication but not take it, the feasible alternatives or additional treatment options including hospice and palliative care; 7) discuss with the patient the importance of taking the medication with someone else present and not taking the medication in public; 8) inform the patient that he/she can rescind the request for medication at any time; 9) document in the patient's medical records all MAID actions as specified; 10) ensure that all appropriate steps have been carried out in accordance with the MAID act; 11) offer the patient an opportunity to rescind the patient's request prior to writing the MAID prescription.

9. The consulting physician must: 1) examine the patient and medical records; and 2) confirm in writing that the patient i) has a terminal illness, ii) has capacity, iii) is making an informed decision, and iv) is acting voluntarily and without coercion.

10. A mental health professional asked to determine the capacity of a patient must, in writing, report to the attending and consulting physicians his/her conclusions whether the patient has

capacity. If the mental health professional determines that the patient lacks capacity, the patient may not receive MAID.

11. A patient requesting MAID shall not be considered "suicidal", and a patient who self-administers aid in dying medication shall not be deemed to have committed suicide.

The rigorous statutory process to obtain medications under the Medical Aid in Dying Act providse numerous and quite extensive safeguards for patients and others involved so that dying patients are more than sufficiently protected.

Conclusion

Some New Yorkers have bad deaths with unendurable suffering. Medical aid in dying is an option which dying patients should have available to end that suffering and achieve a peaceful death.

There are a great many valid reasons why dying New Yorkers should have the option of medical aid in dying. There are no compelling arguments in opposition.

The Medical Aid in Dying Act should be enacted.

Edward T. Mechmann & Alexis N. Carra, Physician-Assisted Suicide and the New York State Constitution, 81 ALB. L. REV. 1335 (2018)
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PHYSICIAN-ASSISTED SUICIDE AND THE NEW YORK STATE CONSTITUTION

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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*,[1] 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.

I. THE BACK STORY

For decades, advocates have been campaigning for the legalization of PAS.[2] In the early 1990s, this gained considerable public attention due to the activities of Dr. Jack Kevorkian.[3] Oregon legalized assisted suicide by legislation in 1994, and was the first state to do so.[4] Other legislative efforts failed, however, most prominently in unsuccessful ballot initiatives in Washington in 1991 and California in 1992.[5]

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* Mr. Mechmann (J.D. Harvard 1984) is the Director 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.

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[1] Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017).

[2] 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.

[3] *See Jack Kevorkian: Doctor (1928-2011)*, BIOGRAPHY, https://www.biography.com/people/jack-kevorkian-9364141 (last updated Dec. 3, 2015).

[4] *See 20 Years with Oregon's Assisted Suicide Law*, OR. RIGHT TO LIFE (Oct. 25, 2017), https://www.ortl.org/2017/10/pasdwdapress/.

[5] *See California Proposition 161, the Aid-in-Dying Act (1992)*, BALLOTPEDIA, https://ballotpedia.org/California_Proposition_161,_the_Aid-in-Dying_Act_(1992) (last visited Apr. 17, 2018); *Washington Aid-in-Dying, Initiative 119 (1991)*, BALLOTPEDIA, https://ballotpedia.org/Washington_Aid-in-Dying,_Initiative_119_(1991) (last visited Apr. 17,

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.[6] The Task Force is an advisory body with medical, legal, and ethical experts appointed by the Governor "who assist the State in developing public policy on issues related to medicine, law, and ethics."[7] 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.[8]

PAS advocates also pursued a litigation strategy. In 1994, lawsuits were filed in Washington and New York seeking to convince the federal courts that PAS was a protected right under the United States Constitution.[9] This was decisively defeated in 1997 when a unanimous Supreme Court rejected the federal constitutional arguments in *Washington v. Glucksberg*[10] and *Vacco v. Quill*.[11]

Undaunted, advocates returned to the legislative arena. Helped by the publicity surrounding the assisted suicide of Brittany Maynard in 2014,[12] they have been met with some successes.[13]

2018).

[6] *See Task Force on Life and the Law*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/task_force/ (last visited Apr. 17, 2018).

[7] *See About the Task Force on Life and the Law*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/regulations/task_force/about.htm (last visited Apr. 17, 2018).

[8] N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 120 (1994).

[9] *See* Ronald Sullivan, *Suit Challenges New York's Law Banning Doctor-Assisted Suicide*, N.Y. TIMES, July 22, 1994, at B3.

[10] Washington v. Glucksberg, 521 U.S. 702, 728 (1997).

[11] Vacco v. Quill, 521 U.S. 793, 809 (1997).

[12] *See* Lindsey Beyer, *Brittany Maynard, as Promised, Ends Her Life at 29*, WASH. POST (Nov. 2, 2014), https://www.washingtonpost.com/news/morning-mix/wp/2014/11/02/brittany-maynard-as-promised-ends-her-life-at-29/?utm_term=.d2e712ff9ae4.

[13] 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. *See California*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/California/ (last visited Apr. 17, 2018); *Colorado*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/colorado/ (last visited Apr. 17, 2018); *District of Columbia*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/district-of-columbia/ (last visited Apr. 17, 2018);

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.[14]

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.[15] 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 Freedoms (an evangelical Christian organization), and Agudath Israel (which represents Orthodox Jewish concerns); as well as secular groups like Democrats for Life of New York.[16] On the national level, leading medical organizations are opposed to legalizing PAS, such as the American Medical Association, the National Hospice & Palliative Care Organization, and the American Nurses Association, as well as disabilities rights and religious organizations.[17]

II. 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.[18] In 2015, End of Life Choices New York, along with several doctors and patients, filed suit in state

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Vermont, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/vermont/ (last visited Apr. 17, 2018); *Washington*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/states/vermont/ (last visited Apr. 17, 2018).

[14] The bill was approved once in the Assembly Health Committee in 2016, but no further action was taken on the bill. *See* Assemb. B. 10059, 239th Legis. Reg. Sess. (N.Y. 2016); S.B. 7579, 239th Legis. Reg. Sess. (N.Y. 2016).

[15] *See Aid in Dying*, END OF LIFE CHOICES N.Y., http://endoflifechoicesny.org/advocacy/proposed-legislation/aid-in-dying/ (last visited Apr. 17, 2018); *Campaign Updates*, COMPASSION & CHOICES, https://www.compassionandchoices.org/new-york/campaign-updates/ (last visited Apr. 17, 2018).

[16] *See About New York Alliance Against Assisted Suicide*, N.Y. ALLIANCE AGAINST ASSISTED SUICIDE, https://nosuicideny.org/about/ (last visited Apr. 17, 2018).

[17] *See id.*

[18] *See* Sampson v. State, 31 P.3d 88, 99–100 (Alaska 2001); Krischer v. McIver, 697 So. 2d 97, 104 (Fla. 1997); People v. Kevorkian, 527 N.W.2d 714, 724 (Mich. 1994); Morris v. Brandenburg, 2016-NMSC-027, 376 P.3d 836, 857; *see also* Donaldson v. Lungren, 4 Cal. Rptr. 2d 59, 65 (Ct. App. 1992) (citations omitted) (refusing to grant constitutional protection, an appellate court rather than the state high court).

court seeking to overturn New York's ban on assisted suicide.[19] The case essentially argued that the word "suicide" in the Penal Law did 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[20] and Equal Protection Clauses.[21]

Initially, we were concerned about whether the Attorney General would defend the current law.[22] In a series of same-sex marriage cases, the United States and state attorney generals declined to defend their laws,[23] 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 plaintiffs' arguments.[24] The plaintiffs appealed, again presenting their constitutional and statutory arguments.[25] The Appellate Division also rejected all the plaintiffs' arguments and unanimously affirmed the judgment of the trial court.[26] At that point, it appeared that the case was at an end.

However, the Court of Appeals granted leave to appeal.[27] This was deeply concerning to PAS opponents. The conventional wisdom, at least with the U.S. Supreme Court, is that when a court of last resort takes a discretionary case, it is likely to reverse the lower court.[28] It indeed seemed strange that the Court of Appeals

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[19] *See* Myers v. Schneiderman, 85 N.E.3d 57, 60 (N.Y. 2017).

[20] *See id.* at 61.

[21] *See id.*

[22] The initial named defendants included several county District Attorneys, but the Attorney General took over the full defense of the case. Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *1 n.1 (Sup. Ct. Oct. 16, 2015).

[23] *See* Matt Apuzzo, *Holder Sees Way to Curb Bans on Gay Marriage*, N.Y. TIMES (Feb. 24, 2014), https://www.nytimes.com/2014/02/25/us/holder-says-state-attorneys-general-dont-have-to-defend-gay-marriage-bans.html.

[24] *See Myers*, 2015 N.Y. Misc. LEXIS 3770, at *12. 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. *See id.* at *4–5.

[25] *See* Myers v. Schneiderman, 31 N.Y.S.3d 45, 49 (App. Div. 2016).

[26] *See id.* at 55–56.

[27] *See* Myers v. Schneiderman, 85 N.E.3d 57, 61 (N.Y. 2017).

[28] *See* Casey C. Sullivan, *The Sixth Circuit Is the Most Reversed Appeals Court, if You Care*, FINDLAW: U.S. SIXTH CIR. (Feb. 17, 2017), http://blogs.findlaw.com/sixth_circuit/2017/02/the-sixth-circuit-is-the-most-reversed-appeals-court-if-you-care.html ("[W]hen the Supreme Court takes up a case, reversal is the norm."); *see also* Kedar S. Bhatia, *Stat Pack for October Term 2016*, SCOTUSBLOG 3 (June 28, 2017), http://www.scotusblog.com/wp-content/uploads/2017/06/SB_Stat_Pack_2017.06.28.pdf (finding

would take up a case that five lower court judges had found to be without merit.[29]

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.[30] Some of the briefs in support of the plaintiffs were filed by parties that we expected to have great influence on the Court, including the New York Civil Liberties Union, leaders of the New York State Assembly, and Professor Vincent Bonventre.[31]

The oral argument showed that the five judges of the Court[32] 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.[33]

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

III. ASSISTED SUICIDE AND THE CONSTITUTION

Prior to *Myers*, the last major constitutional decision by the Court of Appeals was *Hernandez v. Robles*,[34] in which the Court declined to find a right to same-sex marriage.[35] 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.[36] Although the *per curiam* opinion in *Myers* is organized

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that seventy-nine percent of cases were reversed by the United States Supreme Court during the October 2016 term).

[29] *Myers*, 31 N.Y.S.3d at 55–56; Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *12 (Sup. Ct. Oct. 16, 2015).

[30] 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.

[31] Brief for New York Law Professors as Amici Curiae Supporting Plaintiffs-Appellants at 1, *Myers*, 85 N.E.3d (No. 151162/15); Brief for Amicus Curiae New York Civil Liberties Union, *Myers*, 85 N.E.3d (No. 115162/15); Brief for Amici Curiae in Support of Appellants at 1, *Myers*, 85 N.E.3d, 85 N.E.3d 57 (N.Y. 2017) (No. 151162/15).

[32] 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. *See* Claire Hughes, *N.Y.'s Highest Court to Hear "Aid in Dying" Appeal*, TIMES UNION, May 29, 2017, https://www.timesunion.com/local/article/N-Y-s-highest-court-to-hear-aid-in-dying-appeal-11181154.php.

[33] *Myers*, 85 N.E.3d at 60.

[34] Hernandez v. Robles, 855 N.E.2d 1 (N.Y. 2006).

[35] *Id.* at 5.

[36] *Id.* at 6.

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.[37]

IV. 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."[38] All of the judges at every level who ruled on the *Myers* case flatly rejected this attempt of linguistic circumvention.[39]

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 lethal doses of medication to end their lives.[40] 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."[41] 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)."[42] This logically includes physicians. Moreover, in *Glucksberg*, the Court even noted that "for over 700 years, the Anglo-American common-law tradition has punished or

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[37] *See Myers*, 85 N.E.3d at 60.

[38] *See* Morris v. Brandenburg, 2016-NMSC-027, 376. P.3d 836, 841 (N.M. 2015); *Myers*, 85 N.E.3d at 61; Assemb. B. 10059, 239th Legis. Reg. Sess. § 2899-O(1)(B) (N.Y. 2016).

[39] *Myers*, 85 N.E.3d at 62; Myers v. Schneiderman, 31 N.Y.S.3d 45, 50 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *8 (Sup. Ct. Oct. 16, 2015). The Plaintiffs offered this primarily as a statutory argument. *Myers*, 85 N.E.3d at 61. But it is also very significant for the constitutional arguments and we address it as such.

[40] *See Myers*, 85 N.E.3d at 62.

[41] N.Y. PENAL LAW § 125.15(3) (McKinney 2018).

[42] *Id.* § 125.25 (Commission Staff Notes).

otherwise disapproved of both suicide and assisting suicide."[43] Accordingly, "the prohibitions against assisting suicide never contained exceptions for those who were near death," including "those who [were] hopelessly diseased or fatally wounded."[44]

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."[45] 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."[46]

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 legislation, the physician has to certify that he informed the patient of "the probable result of taking the medication"[47] — 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."[48] 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.[49]

This attempt to redefine "suicide" into something else was thus properly rejected by the Court of Appeals, the Appellate Division, and the Supreme Court of New York, New York County.[50] The traditional legal wisdom of giving words their ordinary meaning

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[43] Washington v. Glucksberg, 521 U.S. 702, 711 (1997) (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 294–95 (1990) (Scalia, J., concurring)).

[44] *Glucksberg*, 521 U.S. at 714–15 (quoting Blackburn v. State, 23 Ohio St. 146, 163 (1872)).

[45] *See* Brief of Plaintiffs-Appellants at 17, Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017) (No. 151162/15).

[46] Assemb. B. 10059, 239th Legis. Reg. Sess., § 2899-D(8) (N.Y. 2016).

[47] *Id.* § 2899-D(7)(c).

[48] *Id.* § 2899-E(1).

[49] *See* N.Y. PENAL LAW § 20.00 (McKinney 2018) ("When one person engages in conduct which constitutes an offense, another person is criminally liable for such conduct when, acting with the mental culpability required for the commission thereof, he . . . intentionally aids such person to engage in such conduct.").

[50] *Myers*, 85 N.E.3d at 62; Myers v. Schneiderman, 31 N.Y.S.3d 45, 51 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *12 (Sup. Ct. Oct. 16, 2015).

held firm.[51]

V. 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.[52] 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."[53] They relied on this definition to try to draw an analogy with PAS to argue that if the first is acceptable then the second should be.[54]

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."[55] 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.[56] 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.[57] Plaintiffs attempted to argue that in "aid-in-dying" the

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[51] *Myers*, 85 N.E.3d at 62; *Myers*, 31 N.Y.S.3d at 51; *Myers*, 2015 N.Y. Misc. LEXIS 3770, at *8.

[52] *See Myers*, 85 N.E.3d at 72; *Myers*, 31 N.Y.S.3d at 48–49.

[53] Brief of Plaintiffs-Appellants at 6, *Myers*, 85 N.E.3d (No. 151162/15).

[54] *Id.* at 6–7.

[55] *Sedation to Unconsciousness in End-of-Life Care*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/sedation-unconsciousness-end-life-care (last visited Apr. 18, 2018).

[56] Press Release, Ctr. to Advance Palliative Care, Palliative Sedation: Myth vs. Fact (Jan. 6, 2010), https://www.capc.org/about/press-media/press-releases/2010-1-6/palliative-sedation-myth-vs-fact/.

[57] *Palliative Sedation: The Ethical Controversy*, MEDSCAPE,

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.[58] 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."[59] 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"[60] 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 Judge Garcia in *Myers*, a physician who "administers terminal sedation does not intend to kill the patient, though that may be the eventual result."[61] 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."[62] The Court thus properly rejected Plaintiff's attempt to conflate the assisted suicide and palliative sedation.

VI. SUICIDE IS NOT THE SAME AS DECLINING MEDICAL TREATMENT

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.[63]

In his concurrence in *Myers*, Judge Garcia explained that "[w]hen

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https://www.medscape.org/viewarticle/499472 (last visited Apr. 18, 2018).

[58] Vacco v. Quill, 521 U.S. 793, 802 (1997).

[59] *Id.*

[60] *Id.*

[61] Myers v. Schneiderman, 85 N.E.3d 57, 89 (N.Y. 2017) (Garcia, J., concurring).

[62] *Id.*

[63] *See* Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (citing *In re* Storar, 420 N.E.2d 64, 71 (N.Y. 1981)) ("[T]he right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life.").

a patient refuses life-sustaining treatment and succumbs to illness, the cause of death is the underlying disease."[64] In contrast, when "lethal medication is ingested, the cause of death is not the pre-existing illness, but rather, the prescribed medication."[65] 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."[66] For example, under the Penal Law, unintentional killings are treated differently than those that are done intentionally.[67] When applied to PAS, the 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.

VII. 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

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[64] *Myers*, 85 N.E.3d at 89 (Garcia, J., concurring).

[65] *Id.*

[66] Vacco v. Quill, 521 U.S. 793, 802 (1997) (citation omitted).

[67] *Compare* N.Y. PENAL LAW § 125.10 (McKinney 2018) (defining criminally negligent homicide), *with id.* § 125.25 (2018) (defining second degree murder, requiring intent on the part of the actor).

slide towards euthanasia."[68] 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.

A. The PAS Ban Supports Current Efforts to Prevent Suicides

Suicide is a serious public health concern. It is the second leading non-disease cause of death for whites and for all those ages ten to fifty-four;[69] it kills almost as many people as homicides and motor vehicle accidents combined;[70] and the number of deaths from suicide has increased over twenty-six percent over the previous decade.[71] 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.[72] Suicide prevention is also a major component of state initiatives aimed at schools.[73] 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.[74] In Oregon, for example, the overall suicide rate is forty-two percent higher than the national average.[75] 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.[76] Even popular culture is aware

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[68] *Myers*, 85 N.E.3d at 64 (quoting *Vacco*, 521 U.S. at 808–09).

[69] OFFICE OF QUALITY AND PATIENT SAFETY, N.Y. STATE DEP'T OF HEALTH, ANNUAL REPORT OF VITAL STATISTICS: NEW YORK STATE 2014 53 (2016).

[70] *Id.*

[71] *Id.* at 56.

[72] *See* SUICIDE PREVENTION OFFICE, N.Y. STATE OFFICE OF MENTAL HEALTH, 1,700 TOO MANY: NEW YORK STATE'S SUICIDE PREVENTION PLAN 2016-2017 (2016).

[73] *See, e.g.*, N.Y.'S SAFE SCHOOLS, SUICIDE: SCHOOL GUIDE FOR PREVENTING SUICIDE, https://safeschools.ny.gov/sites/default/files/Suicide.pdf.

[74] David Albert Jones & David Paton, *How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?*, 108 S. MED. J. 599, 599, 602–03 (2015).

[75] XUN SHEN & LISA MILLET, OR. HEALTH AUTH., SUICIDES IN OREGON: TRENDS AND ASSOCIATED FACTORS 2003-2012 3 (2012).

[76] *See* Madelyn S. Gould & Alison M. Lake, *The Contagion of Suicidal Behavior*, *in* INST. OF MED. & NAT'L RES. COUNCIL, CONTAGION OF VIOLENCE: WORKSHOP SUMMARY 68, 68, 70

of it, for example in the increase in suicides after a suicide of a prominent celebrity.[77] The current ban on assisted suicide is thus a way to prevent an increased suicide rate, which would be undermined by legalizing PAS.

B. 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."[78] In countries where it has been legalized, there has been a recent surge in support of extending PAS to those who simply feel old, isolated, or experience various forms of psychiatric suffering.[79] Belgium and the Netherlands have even gone so far as allowing involuntary euthanasia—killing people who did not even ask for death, including children.[80] 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 percent), loss of autonomy (87.4 percent), and loss of dignity (67.1 percent)."[81]

Ultimately, there is a fine line between assisted suicide and euthanasia. In voluntary euthanasia, the physician brings about the patient's death directly at the patient's request.[82] Yet "[t]he common thread, more significant than the conceptual difference, is the use of a lethal dosage of medication intended to end the patient's life."[83] Judge Fahey mused that, "[i]f 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?"[84] Once legalized, assisted suicide cannot be effectively contained.

There is also no limiting principle for what constitutes a

(2013), https://www.ncbi.nlm.nih.gov/books/NBK207262/ (last visited Mar. 19, 2018).

[77] *See id.* at 69.

[78] Myers v. Schneiderman, 85 N.E.3d 57, 80 (N.Y. 2017) (Fahey, J., concurring).

[79] *See id.* at 85–86.

[80] *See id.* at 82.

[81] PUB. HEALTH DIV., OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT: 2017 DATA SUMMARY 6 (2017). Only 21 percent cited "Inadequate pain control or concern about it." *Id.* at 10.

[82] *Myers*, 85 N.E.3d at 78, 79 (Fahey, J., concurring).

[83] *Id.* at 78.

[84] *Id.* at 81.

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."[85] In Oregon, some patients who requested lethal drugs did not use them until almost three years after their first request,[86] even though the law is supposed to encompass those whose prognosis is death within six months.[87] Yet advocates have openly and repeatedly stated that their ultimate goal is to permit assisted suicide for anyone who desires it, regardless of their medical condition.[88]

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,"[89] and would prefer for there to be no legal limits and for the medical community to self-regulate.[90] 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.[91] 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.[92]

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[85] *Id.* at 91 (Garcia, J., concurring) (citation omitted).

[86] PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 11.

[87] *Id.* at 4.

[88] SECRETARIAT OF PRO-LIFE ACTIVITIES, U.S. CONFERENCE OF CATHOLIC BISHOPS, ASSISTED SUICIDE AND EUTHANASIA: BEYOND TERMINAL ILLNESS 2, 5 (2017), http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/suicidenonterminal2014edits.pdf ("A Dutch 'End-of-Life Clinic,' established by a pro-euthanasia group in 2012, provides euthanasia for patients whose regular physicians deny their request, including cases of 'a psychiatric or psychological condiction, dementia, or being tired of living.'").

[89] Kathryn L. Tucker, *End of Life Liberty in DC*, JURIST (Dec. 15, 2016), http://www.jurist.org/hotline/2016/12/end-of-life-liberty-in-dc.php.

[90] *Id.* Ms. Tucker is a leading advocate for PAS and was an attorney for the *Myers* Plaintiffs. *Id.*; Brief of Plaintiffs-Appellants at i, *Myers*, 85 N.E.3d (No. 151162/15).

[91] *See Myers*, 85 N.E.3d at 69–70, 74 (Rivera, J. concurring) (arguing that the state's interest in protecting life diminishes as the patient gets closer to death and that at the last stages before death the state's interest may be outweighed by the liberty interest of the patient); *id.* at 94 (Garcia, J., concurring) (disagreeing with Judge Rivera's assertion that the interest of the state diminishes as the patient nears death).

[92] *Id.* at 74 (Rivera, J., concurring).

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."[93] As such, the State views the PAS ban as encouraging "the unconditional treatment of the terminally-ill and preserv[ing] the critical element of trust in a doctor-patient relationship at a time often marked by intense fear, uncertainty, and vulnerability."[94]

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

The ban on assisted suicide is supported by a well-established and legitimate state interest in protecting vulnerable persons.[95] Studies consistently show that disparities exist in access to, and quality of, healthcare across demographic categories, particularly race, sex, socioeconomic status, and geographic location.[96] These inequities are exacerbated by the economic pressures of the current medical system, where cost containment is a priority.[97] 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.[98] 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."[99]

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.[100] People with mental illness are also at a higher risk. A

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[93] *Id.* at 93 (Garcia, J., concurring).

[94] *Id.* at 94.

[95] *Id.* at 64 (per curiam) (quoting Vacco v. Quill, 521 U.S. 793, 808–09 (1997)).

[96] *See, e.g.*, U.S. DEP'T OF HEALTH AND HUM. SERVS., 2014 NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 6 (2015).

[97] *See, e.g.*, Katrina Trinko, *How California's New Assisted Suicide Law Could Especially Hurt the Poor*, DAILY SIGNAL (Oct. 6, 2015), http://dailysignal.com/2015/10/06/how-californias-new-assisted-suicide-law-could-especially-hurt-poor/.

[98] *See id.*

[99] *Myers*, 85 N.E.3d at 83 (Fahey, J., concurring).

[100] LIFESPAN OF GREATER ROCHESTER, WEILL CORNELL MED. CTR. OF CORNELL UNIV. & N.Y.C. DEP'T FOR THE AGING, UNDER THE RADAR: NEW YORK STATE ELDER ABUSE

large number of people who request assisted suicide are suffering from treatable depression.[101] 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."[102] Depressed individuals who request physician-assisted suicide generally are not likely to be treated for the underlying depressive disorder.[103] In Oregon, only 3.5% of those who request the drugs are referred for psychiatric evaluation in 2017.[104]

Disabled people are especially vulnerable. Legalizing assisted suicide would "convey a societal value judgment that such 'indignities' as physical vulnerability and dependence mean that life no longer has any intrinsic value."[105] 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.[106] 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."[107]

VIII. THE CONSTITUTIONAL ANALYSIS

Having outlined the reasons and justifications for the law, the constitutional analysis can then fall into place. The plaintiffs claimed violations of both the Due Process and Equal Protection Clauses of the State Constitution.[108] The Court of Appeals has been firm that the New York State Constitution provides independent protections for individual rights.[109] The Court has maintained that

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PREVALENCE STUDY: SELF-REPORTED PREVALENCE AND DOCUMENTED CASE SURVEYS, 2–3 (2011), https://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf ("141 out of 1,000 older New Yorkers have experienced an elder abuse event since turning age 60.").

[101] *See* HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE, 34–35 (1998).

[102] *Myers*, 85 N.E.3d at 85 (Fahey, J., concurring).

[103] *See* HENDIN, *supra* note 101, at 34–36.

[104] PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 10.

[105] *Myers*, 85 N.E.3d at 84 (Fahey, J., concurring).

[106] *See* PUB. HEALTH DIV., OR. HEALTH AUTH., *supra* note 81, at 6.

[107] *Myers*, 85 N.E.3d at 84 (Fahey, J., concurring).

[108] *Id.* at 62 (per curiam).

[109] *See, e.g.*, People v. P.J. Video, Inc., 501 N.E.2d 556, 561 (N.Y. 1986) ("[W]e have frequently applied the State Constitution, in both civil and criminal matters, to define a

it "is the final authority as to the meaning of the New York Constitution";[110] 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.[111]

A. 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.[112] 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.[113]

In recent years, scholars have identified two major—and arguably incompatible—conceptual approaches to this issue, each associated with a particular Supreme Court decision—*Obergefell*[114] and *Glucksberg*.[115] 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.'"[116] On the

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broader scope of protection than that accorded by the Federal Constitution in cases concerning individual rights and liberties.").

[110] Hernandez, v. Robles, 855 N.E.2d 1, 9 (N.Y. 2006).

[111] *Id.* (first citing *P.J. Video*, 501 N.E.2d at 560; then quoting Under 21, Catholic Home Bureau for Dependent Children v. New York, 482 N.E.2d 1, 7 n.6) (internal citations omitted).

[112] *Myers*, 85 N.E.3d at 63.

[113] *See, e.g.*, Whole Women's Health v. Hellerstedt, 136 S. Ct. 2292, 2326–28 (2016) (Thomas, J., dissenting).

[114] Obergefell v. Hodges, 135 S. Ct. 2584 (2015).

[115] Washington v. Glucksberg, 521 U.S. 702 (1997); *see, e.g.*, Katherine Watson, Note & Comment, *When Substantive Due Process Meets Equal Protection: Reconciling* Obergefell *and* Glucksberg, 21 LEWIS & CLARK L. REV. 245, 247, 249–50 (2017) (exploring *Obergefell*'s and *Glucksberg*'s divergent approaches to Due Process analysis).

[116] *Glucksberg*, 521 U.S. at 720–21 (first quoting Moore v. East Cleveland, 431 U.S. 494,

other hand, *Obergefell* applied a broader standard in determining if a liberty interest constitutes a fundamental right, saying that "[h]istory and tradition guide and discipline [our] inquiry but do not set its outer boundaries."[117] 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."[118]

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*.[119] In fact, aside from two brief and tangential references in one of the concurrences,[120] 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.[121] In *Glucksberg*, the Supreme Court exhaustively catalogued the rejection of assisted suicide in Anglo-American legal history,[122] and the Court of Appeals in *Myers* adopted that analysis.[123] That history is unequivocal in rejecting any notion of a right to commit suicide, much less enlisting the assistance of another to do so.[124] 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.[125]

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503 (1977); then citing Snyder v. Massachusetts, 291 U.S. 97, 105 (1934); then quoting Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937)) (internal citations omitted).

[117] *Obergefell*, 135 S. Ct. at 2598 (citing Lawrence v. Texas, 539 U.S. 558, 572 (2003)).

[118] *Id.* at 2602. Justice Roberts, in dissent, argued that the Court had effectively overruled *Glucksberg*. *Id.* at 2621 (Roberts, C.J., dissenting). The Court of Appeals certainly did not see it that way. *See* Myers v. Schneiderman, 85 N.E.3d 57, 63 (N.Y. 2017) (quoting *Glucksberg*, 521 U.S. at 710, 728) (applying *Glucksberg* standard).

[119] *Myers*, 85 N.E.3d at 63 (quoting *Glucksberg*, 521 U.S. at 710, 728); Myers v. Schneiderman, 31 N.Y.S.3d 45, 49, 51–52 (App. Div. 2016); Myers v. Schneiderman, No. 151162/15, 2015 N.Y. Misc. LEXIS 3770, at *10–12 (Sup. Ct. 2015) (finding the case indistinguishable from *Vacco*, where the U.S. Supreme Court cited *Glucksberg* to support that New York's assisted suicide statute does not infringe on any fundamental rights).

[120] *See Myers*, 85 N.E.3d at 65, 75 (Rivera, J., concurring).

[121] *See id.* at 63 (per curiam).

[122] *Glucksberg*, 521 U.S. at 710–18.

[123] *See Myers*, 85 N.E.3d at 63 (quoting *Glucksberg*, 521 U.S. at 710, 728).

[124] *See Glucksberg*, 521 U.S. at 710–18.

[125] *See supra* note 18 and accompanying text.

The plaintiffs' attempt to analogize PAS to a patient's right to decline medical treatment[126] 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."[127] 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.[128]

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.[129] 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[130] would produce an absurd result—the right to PAS would be given greater constitutional protection than the right to decline treatment.[131]

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.[132] 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.[133] *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

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[126] *Myers*, 85 N.E.3d at 63 (citations omitted).

[127] *Id.*

[128] *Cf. id.* (quoting *Glucksberg*, 521 U.S. 702, 710, 728 (1997)) ("In *Washington v. Glucksberg*, the United States Supreme Court 'examin[ed] our Nation's history, legal traditions, and practices,' and concluded that 'the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause' of the Federal Constitution.").

[129] *See, e.g.*, Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (citations omitted).

[130] *Myers*, 85 N.E.3d at 60.

[131] *Compare id.* at 63 (articulating plaintiffs' argument that assisted suicide is a fundamental right), *with Rivers*, 495 N.E.2d at 341 (stating that the right to decline medical treatment is only a liberty interest).

[132] *See* Obergefell v. Hodges, 135 S. Ct. 2584, 2593, 2595, 2604 (2015).

[133] *See id.* at 2598–99 (citing Loving v. Virginia, 388 U.S. 1, 12 (1967); Zablocki v. Redhail, 434 U.S. 374, 384 (1978); Turner v. Safley, 482 U.S. 78, 95 (1987)).

they could be full participants in society in the future.[134] Assisted suicide plainly has none of these 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.[135]

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.[136] 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.[137] As the Court of Appeals has said, "[r]ational basis scrutiny is highly indulgent towards the State's classifications. Indeed, it is 'a paradigm of judicial restraint.'"[138] The *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[.]"[139]

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, preventing suicide in the general population, and more.[140] Relying also on interests identified by the Supreme Court in *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."[141]

B. For Equal Protection: Distinctions Matter

The plaintiffs also claimed that the ban on assisted suicide

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[134] *See Obergefell*, 135 S. Ct. at 2600, 2604.

[135] *See 14th Amendment Timeline*, AM. BAR ASS'N, https://www.americanbar.org/groups/public_education/initiatives_awards/law-day-2017/fourteenth_amendmenttimeline.html (last visited Apr. 18, 2018) (providing a chronological overview of Supreme Court Fourteenth Amendment jurisprudence).

[136] *Myers*, 85 N.E.3d at 64 (citing People v. Knox, 903 N.E.3d 1149, 1152 (N.Y. 2009)).

[137] *Myers*, 85 N.E.3d at 64.

[138] Hernandez v. Robles, 855 N.E.2d 1, 12 (N.Y. 2006) (first citing Heller v. Doe, 509 U.S. 312, 320–21 (1993); then quoting Affronti v. Crosson, 746 N.E.2d 1049, 1052 (N.Y. 2001)) (internal citations omitted).

[139] *Myers*, 85 N.E.3d at 64 (quoting *Knox*, 903 N.E.3d at 1154).

[140] *Myers*, 85 N.E.3d at 64 (quoting Vacco v. Quill, 521 U.S. 793, 808–09 (1997)).

[141] *Myers*, 85 N.E.3d at 65 (citing Washington v. Glucksberg, 521 U.S. 702, 731–33 (1997)).

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.[142]

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 no broader in coverage than the Federal provision[.]'"[143] 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."[144]

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.[145] 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."[146]

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 plaintiffs' arguments.[147] 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

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[142] *Myers*, 85 N.E.3d at 62.

[143] *Hernandez*, 855 N.E.2d at 9 (*quoting* Under 21, Catholic Home Bureau for Dependent Children v. New York, 482 N.E.2d 1, 7 n.6 (1985)).

[144] Heller v. Doe, 509 U.S. 312, 319–20 (1993) (quoting Fed. Commc'ns Comm'n v. Beach Commc'ns, 508 U.S. 307, 313 (1993)) (internal citations omitted).

[145] *See Myers*, 85 N.E.3d at 62 (citing *Vacco*, 521 U.S. at 793, 797).

[146] *Beach Commc'ns*, 508 U.S. at 313 (1993) (citing Sullivan v. Stroop, 496 U.S. 478, 485 (1990); Bowen v. Gilliard, 483 U.S. 587, 600–03 (1987); United States R.R. Ret. Bd. v. Fritz, 449 U.S. 166, 174–79 (1980); Dandridge v. Williams, 397 U.S. 471, 484–85 (1970)).

[147] *Myers*, 85 N.E.3d at 65.

law was not irrationally treating similar persons differently, but rather was treating different 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.[148] The concurring opinions did not even discuss the Equal Protection argument at all except to assert agreement with the *per curiam* opinion.[149]

IX. CONCLUSION

The Court's *per curiam* opinion in *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.[150]

The decision in *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 *Glucksberg* and *Vacco* and demonstrate that there is no basis for courts to discover a right to PAS in state constitutions. The strong *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.

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[148] *Myers*, 85 N.E.3d at 62.

[149] *Id.* at 66 n.2 (Rivera, J., concurring); *id.* at 78 (Fahey, J., concurring); *id.* at 87 (Garcia, J., concurring).

[150] *Id.* at 57, 60.

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

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[1] Oregon's Death With Dignity Act – 2017, page 10, Oregon Public Health Division http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf

[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[4] 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

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[4] "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context", New York State Task Force on Life and the Law, May 1994 available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/ (accessed December 29, 2016).

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,[5] 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.

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[5] *See* Peter Singer, *Taking Life: Humans, in* PRACTICAL ETHICS, 175-217 (2d ed. 1993).

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 nonconsensual 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

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[6] E.B. Lamont et al., "Some elements of prognosis in terminal cancer," *Oncology (Huntington*), Vol. 9, August 13, 1999, pp. 1165-70; M. Maltoni, et al., "Clinical prediction of survival is more accurate than the Karnofsky performance status in estimating lifespan of terminally-ill cancer patients," *European Journal of Cancer*, Vol. 30A, Num. 6, 1994, pp. 764-6; N.A. *Christakis* and T.J. *Iwashyna*, "Attitude and Self-Reported Practice Regarding Prognostication in a National Sample of Internists," *Archives of Internal Medicine*, Vol. 158, Num. 21 November

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.[7] 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,"[8] 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

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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.[9] In the State of Connecticut's Suicide Prevention Plan 2020, risk factors for people with chronic conditions and disabilities[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.[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,[12] to

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[9] See Older Adult Suicide Prevention Resources, available at http://www.sprc.org/populations/older-adults (accessed December 29, 2016).

[10] State of Connecticut, Suicide Prevention Plan 2020, page 44, http://www.preventsuicidect.org/files/2015/04/Suicide-Prevention-Plan-2010.pdf (accessed December 29, 2016).

[11] Letter by Dr. Herbert Hendin, MD, http://noassistedsuicideny.org/wp-content/uploads/2015/03/SPI-memo-2015-16-session.pdf (accessed December 29, 2016).

[12] Charles H. Baron, Clyde Bergstresser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg, and Sidney H. Wanzer. "A Model State Act to Authorize and Regulate Physician-Assisted Suicide." Harvard Journal on Legislation 33, (1996): 1-34. Final Exit Network mission: http://www.finalexitnetwork.org/Mission.html. (http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1013&context=lsfp accessed December 29, 2016).

repeated introductions of bills with expansive definitions of "terminal,"[13] to Oregon's interpretations of "terminal" under the Oregon law,[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[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 *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; *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

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[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." http://www.gencourt.state.nh.us/legislation/2014/HB1325.pdf (accessed December 29, 2016).

[14] "Diabetics eligible for physician-assisted suicide in Oregon, state officials say" (Washington Times, January 11, 2018) (https://www.washingtontimes.com/news/2018/jan/11/diabetics-eligible-physician-assisted-suicide-oreg/).

[15] Gunderson, Martin and Mayo, David J., "Restricting Physician-Assisted Death to the Terminally Ill" (PDF) *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

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[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).

[17] Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[18] *Id* at page 10

[19] Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY, 595 (Apr. 2000).

> 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.[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."[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 Weylander 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.[22]

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[20] Brendan D. Kelly et al., *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box,* 181 British J. Psychiatry 278, 279 (2002).

[21] National Council on Disability, *Assisted Suicide: A Disability Perspective* at 27- 28, *available at* http://www.ncd.gov/publications/1997/03241997.

[22] Evan J. Kemp, *Could You Please Die Now?,* Wash. Post, Jan. 5, 1997, at C1.

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]

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[23] Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED 54 (Jan. 2, 1997).

[24] Ganzini et al., *supra* note 7, at 600.

[25] James V. Lavery, et al, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*. LANCET, 358 (9279), 366 (2001).

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.[26] 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.[27] Moreover, terminally ill persons who request assisted

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[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/).

[27] *See* H. Hendin and K. Foley, *Physician-Assisted Suide in Oregon: A Medical Perspective*, 106 MICH. L. REV.

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

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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. 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

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[30] Kenneth R. Stevens, Jr., M.D., *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*, Physicians for Compassionate Care Educational Foundation, March 4, 2009, available at **http://www.pccef.org/DOWNLOADS/AssistedSuicidesbyCC2009report.pdf** (accessed December 29, 2016)

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[i], 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

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[31] F Mirarchi, et al., TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders, Journal of Emergency Medicine, Volume 42, Issue 5, pages 511-520 (May 2012) (http://www.jem-journal.com/article/S0736-4679(11)00853-5/abstract?cc=y=).

[32] Fine & Mayo, Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act, Ann Intern Med 2003; 138: 743-746. (http://portal.mah.harvard.edu/templatesnew/departments/MTA/MAHEthics/uploaded_documents/Texas%20Advance%20Directive%20Act.pdf (accessed December 29, 2016) .

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,[33] and the impact of strict health care confidentiality laws.

First, nothing in the provisions of the Oregon and Washington assisted suicide statutes[34] 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.

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[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.[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.[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.. . .[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.[38] Assuming *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.[39]

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[35] Oregon's Death With Dignity Act – 2017, *supra*, page 11.

[36] See footnote 34 and additional authorities discussed in M Golden, Why Assisted Suicide Must Not Be Legalized, Part C.1. Safeguards in Name Only/Doctor Shopping, http://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#marker43 (accessed December 29, 2016)

[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* http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html (accessed December 29, 2016)

[38] Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[39] Mark S. Lachs, M.D., M.P.H., and Karl A. Pillemer, Ph.D., "Elder Abuse," N Engl J Med 2015; 373:1947-1956,

> 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

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November 12, 2015 (http://www.nejm.org/doi/full/10.1056/NEJMra1404688) (accessed December 29, 2016) ; *See* D. Heitz, "U.S. Official: Elder Abuse is 'Broad and Widespread'," Healthline News (Jan. 27, 2014), *available at* http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714 (accessed December 29, 2016).

[40] "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context", New York State Task Force on Life and the Law, May 1994.

[41] *See* L. Ganzini, et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psych., 595, 598 (April 2000); L. Ganzini, et al., *Attitudes of Oregon Psychiatrists Towards Assisted Suicide*, 153 AM. J. PSYCH, 1469 – 75 (1996).

autonomy (91%) and feelings of being a burden on others (44%).[42] 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.[43] 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.

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[42] *See* Oregon's Death With Dignity Act – 2017, *supra*, page 10.

[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)

Myers v. Schneiderman

Justia Opinion Summary

The Court of Appeals rejected Plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as defined by Plaintiffs and also rejected Plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests.

Plaintiffs filed this action requesting declaratory and injunctive relief to permit "aid-in-dying," which would allow a mentally competent, terminally ill patient to obtain a prescription from a physician to cause death. The Attorney General filed a motion to dismiss on the grounds that Plaintiffs failed to state a cause of action and did not present a justiciable controversy. Supreme Court granted the motion. The Appellate Division affirmed as modified, declaring that the assisted suicide statutes provide a valid statutory basis to prosecute physicians who provide aid-in-dying and that the statutes do not violate the New York Constitution. The Court of Appeals affirmed, holding (1) the State Constitution's Due Process Clause does not encompass a fundamental right to physician-assisted suicide; and (2) the State's prohibition is rationally related to a number of legitimate state interests, and heightened scrutiny is unwarranted.

Myers v Schneiderman 2017 NY Slip Op 06412 Decided on September 7, 2017 Court of Appeals Per Curiam Published by New York State Law Reporting Bureau pursuant to Judiciary Law § 431. This opinion is uncorrected and subject to revision before publication in the Official Reports.

Decided on September 7, 2017
No. 77

[*1]Sara Myers et al., Plaintiffs, Eric A. Seiff, et al., Appellants,

v

Eric Schneiderman, & c., Respondent, et al., Defendants.

Edwin G. Schallert, for appellants.

Anisha S. Dasgupta, for respondent.

Michael R. Aiello, et al.; New York State Catholic Conference; Not Dead Yet, et al.; New York Civil Liberties Union; Alan A. Pfeffer et al.; Agudath Israel of America; New York Chapter of the National Academy of Elder Law Attorneys; American Medical Student Association, et al.; Richard N. Gottfried, et al.; Betty Rollin, et al.; National Association of Criminal Defense Lawyers; Vincent Bonventre, et al.; Unitarian Universalist Association, et al.; Compassion & Choices, amici curiae.

Per Curiam:

Plaintiffs ask us to declare a constitutional right to "aid-in-dying," which they define (and we refer to herein) as the right of a mentally competent and terminally ill person to obtain a prescription for a lethal dosage of drugs from a physician, to be taken at some point to cause death. Although New York has long recognized a competent adult's right to forgo life-saving medical care, we reject plaintiffs' argument that an individual has a fundamental constitutional right to aid-in-dying as they define it. We also reject plaintiffs' assertion that the State's prohibition on assisted suicide is not rationally related to legitimate state interests.

I. FACTUAL AND PROCEDURAL HISTORY

Plaintiffs filed the instant action against New York State's Attorney General and [*2]several District Attorneys,[FN1] requesting declaratory and injunctive relief to permit "aid-in-dying," whereby a mentally competent, terminally ill patient may obtain a prescription from a physician to cause death. Plaintiffs request a declaratory judgment that physicians who provide aid-in-dying in this manner are not criminally liable under the State's assisted suicide statutes — Penal Law § 120.30 and § 125.15 (3)[FN2]. They further request an injunction prohibiting the prosecution of physicians who issue such prescriptions to terminally ill, mentally competent patients.

When the complaint was filed, plaintiffs included three mentally competent, terminally ill patients. Two of those plaintiffs have died, and the third is in remission. Plaintiffs also include individual medical providers who assert that fear of prosecution has prevented them from exercising their best professional judgment when counseling and treating their patients. They are joined by organizational plaintiff End of Life Choices, which sued on its own behalf and on behalf of its clients, for whom it provides "information and counseling on informed choices in end of-of-life decisionmaking."

The Attorney General moved to dismiss the complaint on the grounds that plaintiffs failed to state a cause of action and did not present a justiciable controversy (see CPLR 3211 [a] [7], [2]). Supreme Court granted the motion, and plaintiffs appealed. The Appellate Division modified on the law, declaring that the assisted suicide statutes provide a valid statutory basis to prosecute physicians who provide aid-in-dying and that the statutes do not violate the State Constitution, and as so modified, affirmed (140 AD3d 51, 65 [1st Dept 2016]). Plaintiffs appealed to this Court as of right, pursuant to CPLR 5601 (b) (1).

On appeal, plaintiffs argue that the State's assisted suicide statutes do not prohibit aid-in-dying as a matter of law, and that the Appellate Division's "literal" interpretation of the statutes is flawed. Alternatively, plaintiffs contend that application of the assisted suicide statutes to aid-in-dying violates their equal protection and due process rights under the State Constitution.

[*3]II. REVIEWABILITY

"On a motion to dismiss pursuant to CPLR 3211, the pleading is to be afforded a liberal construction" (Leon v Martinez, 84 NY2d 83, 87—88 [1994], citing CPLR 3026). "We accept the facts as alleged in the complaint as true, accord plaintiffs the benefit of every possible favorable inference, and determine only whether the facts as alleged fit within any cognizable legal theory" (id.). "However, 'allegations consisting of bare legal conclusions, as well as factual claims inherently incredible or flatly contradicted by documentary evidence are not entitled to such consideration'" (Simkin v Blank, 19 NY3d 46, 52 [2012], quoting Maas v Cornell Univ., 94 NY2d 87, 91 [1999]; see Connaughton v Chipotle Mexican Grill, Inc., 29 NY3d 137, 142-143 [2017]).

We reject plaintiffs' argument that the lower courts improperly resolved numerous factual issues. This case involves questions of law, including: whether aid-in-dying constitutes assisted suicide within the meaning of the Penal Law; whether a competent terminally ill person has a fundamental right to physician-assisted suicide; and whether denying a competent, terminally ill patient aid-in-dying violates that patient's right to equal treatment under the law. As there are no countervailing reasonable interpretations, these questions can be decided without any factual development.

III. PLAINTIFFS' STATUTORY CLAIM

Plaintiffs initially assert that we should interpret the assisted suicide statutes to exclude physicians who provide aid-in-dying. Such a reading would run counter to our fundamental tenets of statutory construction, and would require that we read into the statutes words and meaning wholly absent from their text (see Majewski v Broadalbin-Perth Cent. Sch. Dist., 91 NY2d 577, 583 [1998]).

"The governing rule of statutory construction is that courts are obliged to interpret a statute to effectuate the intent of the Legislature, and when the statutory language is clear and unambiguous, it should be construed so as to give effect to the plain meaning of the words used" (People v Finnegan, 85 NY2d 53, 58 [1995] [internal quotation omitted]). "[C]ourts may not reject a literal construction [of a statute] unless it is evident that a literal construction does not correctly reflect the legislative intent" (Matter of Schinasi, 277 NY 252, 259 [1938]).

"Suicide" is not defined in the Penal Law, and therefore "we must give the term its ordinary and commonly understood meaning" (People v Ocasio, 28 NY3d 178, 181 [2016] [internal quotations omitted]). Suicide has long been understood as "the act or an instance of taking one's own life voluntarily and intentionally" (Webster's Collegiate Dictionary [11th ed 2003]; see Webster's American Dictionary of the English Language [ed 1828]). Black's Law Dictionary defines "suicide" as "[t]he act of taking one's own life," and "assisted suicide" as "[t]he intentional act of providing a person with the medical means or the medical knowledge to [*4]commit suicide" (10th ed 2014). Aid-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide.

The assisted suicide statutes apply to anyone who assists an attempted or completed suicide. There are no exceptions, and the statutes are unqualified in scope, creating an "irrefutable inference . . . that what is omitted or not included was intended to be omitted or excluded" (People v Jackson, 87 NY2d 782, 788 [1996] [internal quotation omitted]). Furthermore, this Court previously resolved any doubt as to the scope of the ban on assisted suicide. In People v Duffy, we explained that "section 125.15 (3)'s proscription against intentionally causing or aiding a suicide applies even where the defendant is motivated by 'sympathetic' concerns, such as the desire to relieve a terminally ill person from the agony of a painful disease" (79 NY2d 611, 615 [1992], citing Staff Notes of the Commission on Revision of the Penal Law, Proposed New York Penal Law, McKinney's Spec. Pamph. [1964], at 339).

As written, the assisted suicide statutes apply to a physician who intentionally prescribes a lethal dosage of a drug because such act constitutes "promoting a suicide attempt" (Penal Law § 120.30) or "aid[ing] another person to commit suicide" (Penal Law § 125.15 [3]). We therefore reject plaintiffs' statutory construction claim.

IV. PLAINTIFFS' CONSTITUTIONAL CLAIMS

Alternatively, plaintiffs claim that the assisted suicide statutes, if applied to aid-in-dying, would violate their rights under the Equal Protection and Due Process Clauses of our State Constitution. We reject those claims.

A. Equal Protection

Plaintiffs allege that the assisted suicide statutes violate the State Equal Protection Clause because some, but not all, patients may hasten death by directing the withdrawal or withholding of life-sustaining medical assistance. Plaintiffs therefore contend that the criminalization of aid-in-dying discriminates unlawfully between those terminally ill patients who can choose to die by declining life-sustaining medical assistance, and those who cannot.

Our State's equal protection guarantees are coextensive with the rights protected under the federal Equal Protection Clause (see People v Aviles, 28 NY3d 497, 502 [2016]; Esler v Walters, 56 NY2d 306, 313—314 [1982]). In Vacco v Quill, the United States Supreme Court held that New York State's laws banning assisted suicide do not unconstitutionally distinguish between individuals (521 US 793, 797 [1997]). As the Court explained, "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally, laws that apply evenhandedly to all unquestionably comply with equal protection" (id. at 800 [emphasis in original]). The Supreme Court has not retreated from that conclusion, and we see no reason to hold otherwise.

B. Due Process

In support of their due process argument, plaintiffs assert that their fundamental right to self-determination and to control the course of their medical treatment encompasses the right to choose aid-in-dying. They further assert that the assisted suicide statutes unconstitutionally burden that fundamental right.

In Washington v Glucksberg, the United States Supreme Court "examin[ed] our Nation's history, legal traditions, and practices," and concluded that "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause" of the Federal Constitution (521 US 702, 710, 728 [1997]). We have, at times, held that our State Due Process Clause provides greater protections than its federal counterpart (see Aviles, 28 NY3d at 505), and therefore Supreme Court precedent rejecting plaintiffs' claim as a matter of federal constitutional due process is not dispositive. Accordingly, we turn to whether the right claimed here falls within the ambit of that broader State protection.

Contrary to plaintiffs' claim, we have 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. In Schloendorff v Society of New York Hospital, we held that a surgeon who performed an operation without the patient's consent committed an assault and, in that context, we noted that "[e]very human being of adult years and sound mind has a right to determine what shall be done with [such person's] own body" (211 NY 125, 129—130 [1914]). Matter of Storar likewise concerned the right to refuse life-sustaining medical treatment when the patients were not mentally competent (52 NY2d 363, 377 [1981]). In Rivers v Katz, holding that involuntarily committed mental patients have a fundamental right to refuse antipsychotic medication, we concluded that a patient's right "to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life" (67 NY2d 485, 492 [1986]).

We have consistently adopted the well-established distinction between refusing life-sustaining treatment and assisted suicide (see Matter of Bezio v Dorsey, 21 NY3d 93, 103 [2013]; Matter of Fosmire v Nicoleau, 75 NY2d 218, 227 [1990]; Storar, 52 NY2d at 377 n 6). The right to refuse medical intervention is at least partially rooted in notions of bodily integrity, as the right to refuse treatment is a consequence of a person's right to resist unwanted bodily invasions (see Cruzan v Director, Mo. Dept. of Health, 497 US 261, 269-270 [1990]; Schloendorff, 211 NY at 130). In the case of the terminally ill, refusing treatment involves declining life-sustaining techniques that intervene to delay death. Aid-in-dying, by contrast, involves a physician actively prescribing lethal drugs for the purpose of directly causing the patient's death. As the Court stated in Matter of Fosmire v Nicoleau, "[i]n many if not most instances the State stays its hand and permits fully competent adults to engage in conduct or make personal decisions which pose risks to their lives or health," however, "[t]he State will [*5]intervene to prevent suicide" (75 NY2d at 227).

"[M]erely declining medical care, even essential treatment, is not considered a suicidal act" (id.). Although we do not reach the issue addressed by Judge Rivera's concurrence on this appeal, the Supreme Court has noted that "the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational," and it turns on "fundamental legal principles of causation and intent" (Vacco, 521 US at 801). As a general matter, the law has "long used actors' intent or purpose to distinguish between two acts that may have the same result" (id. at 802; see also Bezio, 21 NY3d at 103, quoting Von Holden v Chapman, 87 AD2d 66, 70 [4th Dept 1982]).

The right asserted by plaintiffs is not fundamental, and therefore the assisted suicide statutes need only be rationally related to a legitimate government interest (see People v Knox, 12 NY3d 60, 67 [2009]). "The rational basis test is not a demanding one" (id. at

69); rather, it is "the most relaxed and tolerant form of judicial scrutiny" (Dallas v Stanglin, 490 US 19, 26 [1989]). Rational basis involves a "strong presumption" that the challenged legislation is valid, and "a party contending otherwise 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" (id. at 69). A challenged statute will survive rational basis review so long as it is "rationally related to any conceivable legitimate State purpose" (People v Walker, 81 NY2d 661, 668 [1993] [citation omitted]). "Indeed, courts may even hypothesize the Legislature's motivation or possible legitimate purpose" (Affronti v Crosson, 95 NY2d 713, 719 [2001] [citation omitted]). At bottom, "[t]he rational basis standard is a paradigm of judicial restraint" (id. [citation omitted]).

As to the right asserted here, the State pursues a legitimate purpose in guarding against the risks of mistake and abuse. The State may rationally seek to prevent the distribution of prescriptions for lethal dosages of drugs that could, upon fulfillment, be deliberately or accidentally misused. The State also has a significant interest in preserving life and preventing suicide, a serious public health problem (see Bezio, 21 NY3d at 104; Storar, 52 NY2d at 377; see also Glucksberg, 521 US at 729). As summarized by the Supreme Court, the State's interests in prohibiting assisted suicide 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" (Vacco, 521 US at 808-809). These legitimate and important State interests further "satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end" (id. at 809).

These interests are long-standing. As the Supreme Court observed, "[t]he earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828" (Glucksberg, 521 US at 715 [citation omitted]). New York's Task Force on Life and the Law, [*6]which was first convened in 1984, carefully studied issues surrounding physician-assisted suicide and "unanimously concluded that [l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable" and that the "potential danger[s] of this dramatic change in public policy would outweigh any benefit that might be achieved" (id. at 719 [citation omitted]). The Legislature has periodically examined that ban — including in recent years — and has repeatedly rejected attempts to legalize physician-assisted suicide in New York.

The Legislature may conclude that those dangers can be effectively regulated and specify the conditions under which it will permit aid-in-dying. Indeed, the jurisdictions that have permitted the practice have done so only through considered legislative action (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]; Wash Rev Code §§ 70.245.010 - 70.245.904 [enacted in 2008]; 18 Vt Stat Ann ch 113 [enacted in 2013]; California End of Life Option Act, Cal. Health & Safety Code pt 1.85 [enacted in 2015]; Colorado Rev Stat §§ 25-48-101 - 25-48-123 [enacted in 2016]; D.C. Act 21-577 [enacted in 2016]), and those courts to have considered this issue with respect to their own State Constitutions have rejected similar constitutional arguments (see Morris v Brandenburg, 2016-NMSC-027, 376 P3d 836, 843 [2016]; Sampson v State of Alaska, 31 P3d 88 [Alaska 2001]; Krischer v McIver, 697 So 2d 97, 104 [Fla 1997]; People v Kevorkian, 447 Mich 436, 446, 527 NW2d 714, 717 [1994]; see also Donaldson v Lungren, 2 Cal App 4th 1614, 1622, 4 Cal Rptr 2d 59, 63 [Cal Ct App 1992])[FN3]. At present, 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 (see Glucksberg, 521 US at 731-733).

V. CONCLUSION

Our Legislature has a rational basis for criminalizing assisted suicide, and plaintiffs have no constitutional right to the relief they seek herein. Accordingly, the order of the Appellate Division should be affirmed, without costs.

RIVERA, J. (concurring):

Our state and federal constitutions guarantee heightened due process protections against unjustified government interference with the liberty of all persons to make certain deeply personal choices (NY Const, art I, § 6; US Const, 14th Amend; see also Rivers v Katz, 67 NY2d [*7]485, 492-493 [1986]; Obergefell v Hodges, 135 S Ct 2584, 2597 [2015]). This conception of liberty is grounded in notions of individual freedom, personal autonomy, dignity, and self-determination (see Rivers, 67 NY2d at 493; Planned Parenthood of Southeastern Pa. v Casey, 505 US 833, 857 [1992]; Lawrence v Texas, 539 US 558, 562 [2003] ["Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct."]; John P. Safranek, M.D. & Stephen J. Safranek, Can the Right to Autonomy Be Resuscitated After Glucksberg?, 69 U Colo L Rev 731, 733-742 [1998])[FN4]. "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" (Casey, 505 US at 851).

On this appeal, the plaintiffs essentially seek a declaration that mentally competent, terminally-ill patients have an unrestricted State constitutional right to physician-prescribed medications that hasten death. I concur with the Court that this broad right as defined by plaintiffs is not guaranteed under the New York State Constitution, and that the State has compelling and legitimate interests in prohibiting unlimited and unconditional access to physician-assisted suicide [FN5]. These interests, however, are not absolute or unconditional. In particular, the State's interests in protecting and promoting life diminish when a mentally-competent, terminally-ill person approaches the final stage of the dying process that is agonizingly painful and debilitating. In such a situation, the State cannot prevent the inevitable, and its interests do not outweigh either the individual's right to self-determination or the freedom to choose a death that comports with the individual's values and sense of dignity. Given that the State already permits a physician to take affirmative steps to comply with a patient's request to hasten death, and that the State concedes that the Legislature could permit the practice sought by [*8]plaintiffs, the State's interests lack constitutional force for this specific sub-group of patients. Considering the State's sanctioning of terminal sedation in particular, the statute does not survive rational basis review. Therefore, in my view, 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.[FN6]

I.

"Death will be different for each of us. For many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms" (Washington v Glucksberg, 521 US 702, 736 [1997] [O'Connor, J. concurring]). Justice O'Connor's poignant description of the end of life is familiar to plaintiffs, who included, at the time the complaint was filed, three mentally competent, terminally-ill adults. These patient-plaintiffs expressed a desire for more than pain management; they sought to maintain a sense of dignity, autonomy, and personal integrity in the face of death, which they claimed had been compromised by both their respective illnesses and by the State's prohibition on assisted suicide. They requested judicial recognition of a right to decide how and when to die by accessing medication that would permit each of them to put an immediate end to their respective suffering.

Two of these patient-plaintiffs have since passed. When the complaint was filed, one plaintiff was 62 years old and suffered from Lou Gehrig's disease, a neurodegenerative condition without a cure. As the disease took hold, she was in constant pain and "fe[lt] trapped in a torture chamber of her own deteriorating body," fully aware of all that was transpiring to her physically and, worse yet, that the agonizing pain would persist for the rest of her days. She sought relief in the form of prescription medications that she could ingest "to achieve a peaceful death."

The other deceased patient-plaintiff was 57 years old and terminally ill with acquired immune deficiency syndrome (AIDS). A regimen of several medications kept him alive. He suffered from a variety of ailments and, as a consequence, had part of his foot amputated. He developed laryngeal carcinoma, which necessitated a tracheotomy that made it difficult for him to speak. He took more than 24 medications either through his feeding tube or [*9]by injection, and required morphine for pain management. He slept 19 hours a day and spent most of his five waking hours cleaning and maintaining his feeding and oxygen tubes, and taking his daily medications and injections. According to the complaint, he "wishe[d] to have the comfort of knowing that, if and when his suffering [became] unbearable, he [could] ingest medications prescribed by his doctor to achieve a peaceful death."

The surviving patient-plaintiff is in his eighties. He developed cancer and, after surgery to remove his bladder, suffered a recurrence but is now in remission. The complaint states that he wants "to be sure that if the cancer progresses to a terminal state, and he finds himself in a dying process he determines to be unbearable, he has available to him the option of aid-in-dying."

These patient-plaintiffs, joined by a group of physicians practicing end-of-life care and the non-profit End of Life Choices New York, challenge the application of New York's Penal Law to physicians who are willing to provide mentally competent, terminally-ill patients, like the named patient-plaintiffs, with a prescription for medication that they could ingest to end their lives before they succumb to the ravages of their illnesses. These providers maintain that aid-in-dying is a medically and ethically appropriate treatment that should be legally available to patients. They are supported by several amici, including professional organizations such as the American Medical Student Association, American Medical Women's Association, American College of Legal Medicine, National Academy of Elder Law Attorneys, and amici representing several surviving family members who have witnessed the death of a loved one, and who describe the emotional impact and stress endured by the family caregivers.

The stories retold by patient-plaintiffs and amici family survivors describe the painful and harrowing experiences many terminally-ill patients endure in the final stage of life. The dying process, candidly recounted, illustrates the struggle of the terminally ill to live and die on their own terms, and is a vivid reminder of the fragility of human existence. It also provides necessary context for the legal analysis.

II.

Constitutional limits on governmental interference with individual liberty have long included protection of the fundamental right to bodily integrity (Rivers, 67 NY2d at 492; Matter of Bezio v Dorsey, 21 NY3d 93, 119 [2013]; Glucksberg, 521 US at 720; Vacco v Quill, 521 US 793, 807 [1997]). Courts have recognized that decisions about what may or may not be done to one's body are "central to personal dignity and autonomy" and so are subject to heightened scrutiny (Casey, 505 US at 851; Cruzan v Dir., Missouri Dep't of Health, 497 US 261, 278 [1990]). While we have not defined its outer limit, "[t]his Court has repeatedly construed the State Constitution's Due Process Clause to provide greater protection than its federal counterpart as construed by the Supreme Court" (People v LaValle, 3 NY3d 88, 127 [2004]; see [*10]also People v Scott, 79 NY2d 474, 496 [1992]).

Patients in New York State unquestionably have certain fundamental rights regarding medical treatment. In Rivers v Katz, this Court stated 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" (67 NY2d at 492). The Court continued,

"[i]n 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 or her] medical treatment in order to insure that the greatest possible protection is accorded [his or her] autonomy and freedom from unwanted interference with the furtherance of [his or her] own desires" (id. at 493).

A few years later, this Court noted that "the State rarely acts to protect individuals from themselves, indicating that the State's interest is less substantial when there is little or no risk of direct injury to the public. This is consistent with the primary function of the State to preserve and promote liberty and the personal autonomy of the individual" (Matter of Fosmire v Nicoleau, 75 NY2d 218, 227 [1990]). As such, the "fundamental common-law right [of refusing medical treatment] is coextensive with the patient's liberty interest protected by the due process clause of our State Constitution" (Rivers, 67 NY2d at 493).

While this language may seem to countenance aid-in-dying, there are important caveats. First, the right to refuse medical treatment, while fundamental, "is not absolute and in some circumstances may have to yield to superior interests of the State" (Fosmire, 75 NY2d at 226). If a challenged statute infringes on a fundamental right, "it must withstand strict scrutiny and is void unless necessary to promote a compelling State interest and narrowly tailored to achieve that purpose" (Golden v Clark, 76 NY2d 618, 623 [1990]). It is for the courts "to weigh the interest of the individual against the interests asserted on behalf of the State to strike an appropriate balance" (Fosmire, 75 NY2d at 226-227). Second, the Court has, as the per curiam makes clear, consistently distinguished between refusing life-sustaining or life-saving medical treatment and assisting suicide (see Bezio, 21 NY3d at 103; Fosmire, 75 NY2d at 227; Matter of Storar, 52 NY2d 363, 377 n 6 [1981]; per curiam at 9-11). Across these cases the Court has held that an individual has a fundamental right to refuse medical treatment but, implicitly, not to physician-assisted suicide.

Even though this Court's precedent establishes that the right to control medical treatment generally does not extend to assisted suicide, because the criminal statutes challenged on this appeal effect a curtailment of patients' liberty, the State's prohibition must still be rationally related to a legitimate government interest (People v Knox, 12 NY3d 60, 67 [2009]). The Court here highlights how the State's legitimate interest in protecting life has led it to make a [*11]rational distinction between permitting a patient to refuse life-sustaining medical treatment and a ban on assisted suicide (per curiam at 12-13; see e.g. Bezio, 21 NY3d at 103). This interest extends to protecting the lives of the terminally ill, as does the rational link between this interest and prohibiting assisted suicide. There are several bases on which the State may justify prohibiting physician-assisted suicide for the terminally ill in most cases: a terminal diagnosis may be incorrect, or at least underestimate the time a patient has left; palliative care can often reduce a patient's will to die, whether caused by physical pain or depression, and thus prolong life; vulnerable, terminally-ill patients could face external influences encouraging them to hasten their deaths, such as familial or financial pressure; the fear of opening the door to voluntary and involuntary euthanasia; and, finally, the possible negative impact on the integrity and ethics of the medical profession.

I agree, on constraint of this prior case law, that the right of a patient to determine the course of medical treatment does not, in general, encompass an unrestricted right to assisted suicide, and the State's prohibition of this practice in the vast majority of situations is rationally related to its legitimate interests. Nevertheless, this conclusion does not support the State's position that its interests are always superior to and outweigh the rights of the terminally ill. In particular, when these patients are facing an impending painful death, their own interest may predominate. For the reasons I discuss, in those limited circumstances in which a patient seeks access to medical treatment options that end pain and hasten death, with the consent of a treating physician acting on best professional judgment, the State's interest is diminished and outweighed by the patient's liberty interest in personal autonomy.

III.

The liberty interest protected by our State Constitution is broader than the right to decline medical treatment. At its core, liberty is the right to define oneself through deeply personal choices that form a lifetime of human experience (Casey, 505 US at 851; Rivers, 67 NY2d at 493). As we have stated "to preserve and promote liberty and the personal autonomy of the individual" is "the primary function of the State" (Fosmire, 75 NY2d at 227).

An individual's interests in autonomy and freedom are not less substantial when facing the choice of how to bear the suffering and physical pain of a terminal illness at the end of life. Self-determination includes the freedom to make decisions about how to die just as surely as it includes decision making about life's most private matters — e.g. sexuality, marriage, procreation, and child rearing — all choices that reflect personal beliefs and desires (see e.g. Lawrence, 539 US at 567; Brooke S.B. v Elizabeth A.C.C., 28 NY3d 1, 26 [2016]). As the United States Supreme Court has recognized, "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality" Cruzan, 497 US at 281).

For the terminally ill patient who is experiencing intractable pain and suffering [*12]that cannot be adequately alleviated by palliative care, plaintiffs and amici affirm that the ability to control the end stage of the dying process and achieve a peaceful death may lead to a renewed sense of autonomy and freedom [FN7]. So while the State's interest in protecting life is paramount, the law requires that we balance that interest against those of an individual facing an imminent and unbearably painful death. Contrary to the State's argument, the government's interest in protecting life diminishes as death draws near, as that interest "does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die" (Glucksberg, 521 US at 746 [1997] [Stevens, J. concurring]; see also Wilkinson v Skinner, 34 NY2d 53, 58 [1974] ["The requirements of due process are not static; they vary with the elements of the ambience in which they arise."]). In such cases, patients have "a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives" that outweighs the State's interest in essentially prolonging the agony (Glucksberg, 521 US at 737).

Certainly, the State may "stay its hand" by doing nothing to assist a terminally ill patient, thus letting the dying process take its natural course (Fosmire, 75 NY2d at 227). However, this is not the approach chosen by the State of New York. The reality is that the State already permits a patient to choose medical measures that hasten death in ways that require active, deliberate assistance of a physician. These measures are not passive. For example, the State permits the turning off of ventilators, the removal of breathing tubes, and the removal of intravenous life-sustaining nourishment and medications, even when the physician and patient know this will lead rapidly to certain death. As such, the State currently allows a physician, with a patient or a guardian's informed consent, and in the exercise of the physician's professional judgment, to affirmatively assist in bringing about a terminally-ill patient's death (see Pub Health Law §§ 2994-e [1]; 2994-f [1]).

These processes are widely considered appropriate and humane end-of-life [*13]treatments that recognize the dignity of the individual patient. The justifications for allowing a physician to take active steps to precipitate a patient's death were powerfully noted in 2010, in the context of changes to the Public Health Law that now allows guardians of mentally-incompetent patients to withdraw or withhold life-sustaining treatments. Supporters of the bill wrote that,

"[l]ost in the gaps of existing law, many families have witnessed what they knew to be the ardent desires of their incapacitated loved ones go unfulfilled for weeks and months, while every participant — from the patient, to family members, to the professionals providing care — has anguished. At the same time, families have been frozen by the lack of legal means to honor the deeply personal wishes of their loved ones" (Letter from Healthcare Association of New York State, Bill Jacket, 2010, AB 7729, ch 8).

The Assembly Memorandum in Support described the legislation as necessary because mentally-incompetent patients "may linger, through unnecessary medical intervention, in a state of irrevocable anguish," and "are, as a class, uniquely disqualified from health care rights essential to the humane and dignified treatment to which every other citizen is entitled" (2001 NY Assembly Bill A08466D).

Plaintiffs and amici Surviving Family Members similarly describe how terminally-ill patients, deprived of a legal path to bring about a death in line with their wishes, suffer excruciatingly through the final moments of their lives as their loved ones and caregivers watch helplessly. The complaint, plaintiffs' affidavits, and amici briefs are filled with accounts of patients who would have chosen aid-in-dying if the option were available. One account describes an elderly man whose bones were so riddled with cancer they would spontaneously break, even when he was lying in bed without bearing weight. Despite receiving opioids and other medications around the clock, he found his pain and suffering unbearable. He wanted to know his options for a peaceful death and the only option the physician was able to offer was for him to voluntarily stop eating and drinking. Another describes a man suffering from a degenerative motor neuron disease who, eight years after diagnosis, was wheelchair bound, had lost control of his bladder and bowels, as well as the ability to cough up food caught in his lungs, experienced his limbs atrophy, and "everything which he had previously identified as degrading about dying." Ultimately he too chose to stop eating and drinking. He remained conscious during the 12 days that followed until his death, at one point developing terminal agitation that caused "sudden uncontrollable fits of yelling and violent thrashing" that led to him being strapped to his bed.

The State argues a dichotomy between active and passive physician conduct differentiates aid-in-dying from other sanctioned end-of-life treatments. This binary is unpersuasive in this context. First, it does not conform with the experience of all physicians (TE [*14]Quill, et al., Palliative Options of Last Resort, 278(23) JAMA 2099, 2102 [Dec 17, 1997] ["[T]here is nothing psychologically or physically passive about taking someone off a mechanical ventilator who is incapable of breathing on his or her own."). Second, the withdrawal of nourishment is anything but passive, as patients without an underlying disease die if they are prevented from eating and drinking. Third, and in contrast, the physician's role in aid-in-dying is "passive" in a practical sense, for it is the patient who administers the lethal medication, often spatially and temporally distant from the moment the physician provided the prescription (id.). In some cases, the patient never ingests the dosage.[FN8]

Apart from the fact that the State permits these non-passive actions to hasten death for the terminally ill, the State's interest in prohibiting aid-in-dying for this particular sub-group of patients is further weakened by its sanctioning of terminal sedation. This end-of-life treatment consists of the intravenous administration of sedatives and pain medication, often coupled with the withholding of nutrition and hydration, to a terminally-ill patient (J M van Delden, Terminal Sedation: Source of a Restless Ethical Debate, 33(4) J Med Ethics 187, 187 [2007]). In 2003, the American Medical Association issued a policy statement supporting the practice, which it calls "palliative sedation to unconsciousness," as "an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation" (see The AMA Code of Medical Ethics' Opinions on [*15]Sedation at the End of Life, 15(5) Virtual Mentor 428-429 [May 2013]).[FN9]

For this sub-group of terminally ill patients, the State recognizes this as a lawful means to end life [FN10]. As in Glucksberg, the "parties and amici agree that . . . a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death" (Glucksberg, 521 US at 736-37 [O'Connor, J. concurring]). The difference between injecting a drug that sedates a patient while simultaneously quickening death and prescribing lethal medication is not meaningful in the constitutional sense. Regardless of the method, the purpose of the physician's act and the patient's goal in both situations is to expedite the dying process and avoid the severe pain, suffering, and indignity associated with the last stage of a terminal illness. In these cases, a patient's "interest in refusing medical care is incidental to [the patient's] more basic interest in controlling the manner and timing of her death" (Glucksberg, 521 US at 742 [1997] [Stevens, J. concurring]). Moreover, by sanctioning a patient's right to refuse medical treatment, which leads to certain death, this Court has, like the United States Supreme Court, "in essence, authorized affirmative conduct that would hasten [a patient's] death" (id. at 743).

The State and my colleagues rely on an analysis of physician intent to differentiate aid-in-dying from terminal sedation and the withholding or withdrawal of life-saving treatment (per curiam at 10-11; J. Fahey concurring op at 4; J. Garcia concurring op at 6). The argument presumes that physicians who adopt aid-in-dying intend to cause the patient's death, while physicians who perform these other treatments intend solely to alleviate the patient's pain, and death is merely a potential unintended consequence. My colleagues quote Vacco v Quill for the proposition that the law "has long used actors' intent or purpose to distinguish between two acts [*16]that may have the same result" (521 US 793, 802 [1997]; per curiam at 11; J. Fahey concurring op at 4; J. Garcia concurring op at 5). This is irrelevant, because in every case involving individual liberty, the constitutional question turns on the nature and expanse of the patient's right to autonomy and bodily integrity as weighed against the State's interest, not the intent of a third party who assists the patient in receiving the proper medical treatment (Rivers, 67 NY2d at 498)[FN11]. Besides, we do not defer to federal analysis when we construe our broader state constitutional due process clause (LaValle, 3 NY3d at 127).

Moreover, this intent-based analysis fails even on its own terms. Simply put, it is impossible, as a practical matter, to distinguish between these various end-of-life practices based on a third party's state of mind. When a physician removes a patient from a life-sustaining apparatus, or declines to administer life-saving procedures, the physician's intent, in accord with the wishes of the patient, is to precipitate the death of the patient. A physician who complies with a patient's constitutionally protected choice to forego life-sustaining treatment knows that when a ventilator is withdrawn, for example, the patient will soon die [FN12]. To argue otherwise is to ignore the reality of the physician's actions and the patient's wishes.

Even the primary distinction cited by the State and my colleagues does not hold in all cases because, as the State concedes, the drugs involved in terminal sedation are known to cause a patient's death in certain cases. A physician providing this medical option knows very well about the potential immediate consequence and must forewarn the patient (see AMA Code of Medical Ethics' Opinions on Sedation at the End of Life at 428). Furthermore, while sedation may be necessary to alleviate a patient's pain, the withdrawal of nourishment, which forms part of the treatment, can only serve to bring about death (see David Orentlicher, The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia, 24 Hastings Const L [*17]Q 947, 957 [Summer 1997]). Resolution of the constitutional question requires consideration of the patient's rights; not a speculative exploration of the physician's intent.

Terminal sedation is intended to initiate what must be described for what it is: a slow-acting lethal process. While it may fall under the umbrella of palliative care (see Glucksberg, 521 US at 737-738 [O'Connor, J. concurring]), terminal sedation is not solely a method of pain management but is instead a procedure that hastens the inevitable death of the patient. It places the patient in a condition where choosing to struggle against death is no longer possible. It facilitates the patient's choice to end life.

If terminally-ill patients may exercise their liberty interest by choosing to be terminally sedated, the State has no compelling rationale, or even a rational interest, in refusing a mentally-competent, terminally-ill patient who is in the final stage of life the choice of a less intrusive option — access to aid-in-dying — which may better comport with the patient's autonomy and dignity. It is also an option which lessens the time patients and their families are forced to wait for the inevitable — often by no more than days and possibly much less.

IV.

Concerns about allowing aid-in-dying for the sub-group I have identified are misplaced. Consider, first, the State's interest in preserving life. Admittedly, the State has compelling interests that justify prohibiting assisted suicide as a general matter, but those interests are diminished and do not outweigh the individual's liberty interest in the case of a competent terminally-ill patient in the final stage of life, with no cure or recourse other than inadequate pain management, facing a death the patient feels is bereft of dignity. As the State's own policies regarding terminal sedation attest, it has accepted that its interest in preserving life should cede to the rights of a patient in this condition. Acknowledgment of the individual's right to decide when and how to end life in the limited situations I have discussed does not undermine the sacredness of life or devalue the patient any more than terminal sedation does. Instead, by honoring a patient's wishes, the State recognizes the individual's right to full autonomy and to make a choice that reflects deeply held beliefs about life and death.

Nor does the State's general interest in preventing suicide and avoiding misdiagnosis outweigh the liberty interests in aid-in dying for mentally-competent, terminally-ill patients facing imminent, agonizing death. The State's interests for this group of patients are not comparable to cases involving persons without terminal illnesses who are able to manage their illness and its debilitating effects, or those who for any number of personal reasons do not want to hasten death with a lethal prescription. There is no possibility of an erroneous terminal diagnosis for these patients as aid-in-dying would only be available in the last stage of life, when the end is imminent and certain. The fear that allowing aid-in-dying will result in patient coercion or be the first step to government-sanctioned euthanasia is as misplaced as the notion [*18]that terminal sedation inevitably leads to government-sanctioned euthanasia [FN13]. Permitting these patients to choose whether to experience the short time that remains under conditions some may find unbearable is a recognition of the importance of individual autonomy and the limits of the State's ability to interfere with a patient's most intimate personal decisions (Rivers, 67 NY2d at 492-493; Obergefell, 135 S Ct at 2597).

The State's argument that aid-in-dying would make it more difficult to ensure adequate medical treatment for those with untreated pain and depression is a valid interest in support of the State's prohibition on physician-assisted suicide as a general matter.

However, it does not outweigh the interests of the terminally ill for whom pain treatment is inadequate and whose choice is not motivated by depression and helplessness, but by the desire to exercise autonomy to achieve a peaceful death, one that honors individuality and dignity (see Glucksberg, 521 US at 746-74 [1997] [Stevens, J. concurring]). Nor can it be said to be rational when the State already permits terminal sedation.

The State's other argument, that aid-in-dying undermines the integrity and ethics [*19]of the medical profession as it is incompatible with the physician's role as a healer,[FN14] is not uniformly accepted and is contradicted by the experiences of some medical professionals [FN15]. The plaintiff-physicians who treat the terminally ill and amici representing the American Medical Student Association, American Medical Women's Association, and American College of Legal Medicine, describe how inhibiting a physician's exercise of best professional judgment when counseling a patient about end-of-life choices undermines the doctor-patient relationship. Indeed, aid-in-dying is openly practiced in various parts of the country without having [*20]compromised the profession [FN16] — the physician standard of care is governed by statutes and professional guidelines that have ensured the quality and careful application of this end of life treatment [FN18]. By all measures, the State fails to address that the [*21]"time-honored line between healing and harming" does not provide much guidance for practices like terminal sedation or aid-in-dying (Glucksberg, 521 US at 731 [citations and quotation marks omitted]). For this sub-group of patients, healing, as understood as a restoration of bodily health, is no longer a possibility.

In addition to the interests asserted by the State, my colleagues "hypothesize" an additional concern in avoiding misuse of a patient's dosage (per curiam at 11-12). Yet, the risk of the drugs involved in aid-in-dying being "deliberately or accidentally misused" is no more than with any other drug with the potential to cause severe injury or death that a physician may legally prescribe (see Office of the New York State Comptroller, Prescription Opioid Abuse and Heroin Addiction in New York State [June 2016], available at https://www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf [accessed August 29, 2017]). At most, this simply shows that the State may regulate this area, as other states have done.[FN19]

V.

"It is the province of the Judicial branch to define, and safeguard, rights provided [*22]by the New York State Constitution, and order redress for violation of them" (Campaign for Fiscal Equity, Inc. v State, 100 NY2d 893, 925 [2003]). Although a liberty interest is at stake here, the Court implies and Judge Garcia argues that this question is best addressed by the Legislature (per curiam at 13; J. Garcia concurring op at 17). "The Court, however, plays a crucial and necessary function in our system of checks and balances. It is the responsibility of the judiciary to safeguard the rights afforded under our State Constitution" (People v LaValle, 3 NY3d 88, 128 [2004]). We may not abdicate that role to any other branch of government (Campaign for Fiscal Equity, 100 NY2d at 925).

Mentally-competent, terminally-ill patients, with no cure or recourse other than inadequate pain management or palliative sedation to unconsciousness, and who face certain, imminent, excruciating death, are situated quantitatively and qualitatively differently from other individuals, even others living with terminal illnesses. State interests that animate the prohibition on physician aid-in-dying for these patients are diminished as death draws near and ultimately are outweighed by these patients' liberty interest and extant rights to self-determination and bodily integrity. The compelling state interests that bar physician assisted suicide in general are not, for this group, dispositive. When the State already permits physicians to instigate other processes that precipitate death, there is no compelling basis for depriving such patients of an option that can better comport with their sense of dignity, control, and independence. Our 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.

FAHEY, J. (concurring):

Experience teaches us that arguably benign policies can lead to unanticipated results. I write separately to expand on certain risks that would be associated with legalizing physician-assisted suicide in New York and that justify its prohibition.

I.

Several significant rationales exist for criminalizing physician-assisted suicide, each of which would constitute a legitimate legislative purpose for the statute challenged here. The per curiam opinion, which I join, outlines many of these legitimate government interests (see per curiam op at 12; see also Washington v Glucksberg, 521 US 702, 728-735 [1997] [holding that Washington State's then-ban on assisted suicide did not violate substantive due process under the Fourteenth Amendment of the Federal Constitution]).

I focus on two, closely related rationales. First, the Legislature may reasonably [*23]criminalize assisted suicide because to permit the practice would open the door to voluntary and non-voluntary euthanasia. To use the familiar metaphor, it would place New York on a slippery slope toward legalizing non-voluntary euthanasia. Second, the Legislature may reasonably criminalize physician-assisted suicide because a right to assisted suicide by the terminally ill in circumscribed last-resort situations would inevitably expand to include persons who are not terminally ill.

I begin by discussing matters of terminology in regard to physician-assisted dying and the legal landscape in the United States. Physician-assisted suicide, the topic of this appeal, differs conceptually from euthanasia. In euthanasia, a physician brings about the death of a patient, whereas, in physician-assisted suicide, it is the patient who kills himself or herself, with the assistance of a physician. 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.

In the United States, physician-assisted suicide has been legalized and is regulated in Oregon (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]); Washington (see Wash Rev Code §§ 70.245.010 - 70.245.904 [enacted in 2008]); Vermont (see 18 Vt Stat Ann ch 113 [enacted in 2013]); California (see End of Life Option Act, Cal. Health & Safety Code pt 1.85 [enacted in 2015]); Colorado (see Rev Stat §§ 25-48-101 - 25-48-123 [enacted in 2016]); and the District of Columbia (see D.C. Act 21-577 [enacted in 2016]). Each of these jurisdictions expressly permits physician-assisted suicide by statute,[FN1] and in each one physician-assisted suicide is limited to mentally competent patients, 18 years of age or older, who have been diagnosed with a terminal illness that will lead to death within six months.

By contrast, euthanasia is legal in no jurisdiction in the United States. Here, "euthanasia" refers to active euthanasia, i.e., the intentional killing of a patient, motivated by the physician's concern for the patient's suffering or "indignity." This concept of euthanasia does not include practices — sometimes referred to as passive euthanasia but more often not described as euthanasia at all — in which a physician lets a patient die (see generally James Rachels, Active and Passive Euthanasia, 292 New England Journal of Medicine 78 [1975]; Thomas D. Sullivan, Active and Passive Euthanasia: An Impertinent Distinction?, 3 Human Life Review 40 [1977], both reprinted in Bonnie Steinbock, Alastair Norcross, Killing and Letting Die 112-119, 131-138 [1994]; Daniel Callahan, Killing and Allowing to Die, 19 Hastings Center Report, Special Supplement 5 [1989], reprinted in Michael Boylan, Medical Ethics 199-202 [2000]; L.W. [*24]Sumner, Assisted Death: A Study in Ethics and Law 19 & n 46 [2011]). Such essentially passive physician practices, now generally considered unobjectionable in proper circumstances, include, for example, removing a patient from a machine that would prolong the patient's life or withdrawing nutrition and hydration from a patient undergoing palliative sedation.

I respectfully disagree with Judge Rivera's view that the difference between palliative sedation and physician-assisted suicide "is not meaningful in the constitutional sense" (concurring op of Rivera, J., at 17). Instead, I would follow the Supreme Court's analysis in Vacco v Quill (521 US 793 [1997]).

"[A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and to cease doing useless and futile or degrading things to the patient when the patient no longer stands to benefit from them. The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, must, necessarily and indubitably, intend primarily that the patient be made dead. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.

"The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. Put differently, the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences" (id. at 801-803 [internal quotation marks, square brackets, and citations omitted]; see also id. at 808 n 11).[FN2]

Finally, there is an important distinction between voluntary and non-voluntary [*25]euthanasia. Voluntary euthanasia is euthanasia in accordance with the request of a mentally competent patient. Non-voluntary euthanasia is euthanasia performed on someone who, because of a factor such as infancy, mental incompetence, coma, etc., is not able to choose euthanasia and has never recorded a directive expressing his or her will in regard to euthanasia. Involuntary euthanasia, not implicated here, would be euthanasia performed on a person who is able to give consent, but has not done so, either because the person was not asked or because he or she withheld consent (see generally L.W. Sumner, Assisted Death: A Study in Ethics and Law at 17).

II.

The practice of physician-assisted suicide and euthanasia in the Netherlands provides us with a disturbing preview of what it would be rational to expect upon legalization. In what follows, I concentrate on that country, which has the longest history of socially accepted euthanasia, while adding comments on other jurisdictions that have legalized euthanasia or physician-assisted suicide. It will be clear from the foregoing section that the practices to be discussed below are euthanasia and physician-assisted suicide, not palliative sedation or removal of a patient from life support or other treatment.

In the Netherlands in 2002, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act was enacted to legalize and regulate long-standing pre-existing practices of physician-assisted suicide and voluntary euthanasia. Under that statute, a physician may end the life of a patient who is experiencing unbearable suffering without hope of relief, at the patient's explicit request, either by administering a lethal dosage of medication (euthanasia) or by prescribing a pharmaceutical means of suicide (physician-assisted suicide) (see generally Government of the Netherlands, Is euthanasia allowed?, at https://www.government.nl/topics/euthanasia/contents/is-euthanasia-allowed [accessed August 21, 2017]).

In 2015, euthanasia and physician-assisted suicide accounted for 5,516 reported deaths in the Netherlands, almost four percent of all deaths in the country, estimated at around 140,000 per annum (see Regional Euthanasia Review Committees, Annual Report 2015, at 16, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]). The proportion of deaths attributed to euthanasia and physician-assisted suicide had more than doubled over ten years (see Regional Euthanasia Review Committees, Annual Report 2005, at 2, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017] [1,933 cases of euthanasia and assisted suicide were reported in 2005]).

The most immediately striking aspect of end-of-life decision-making in the Netherlands is that no legal or ethical distinction is drawn between physician-assisted suicide and [*26]euthanasia. Similarly, physician-assisted suicide and euthanasia were made legal at the same time as one another in both Belgium (2002) and Luxembourg (2009). In Canada, a 2015 Supreme Court of Canada decision striking down a prohibition on assisted suicide led to a June 2016 law legalizing both "the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death" (physician-assisted suicide) and "the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death" (euthanasia) (Statutes of Canada 2016, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts [medical assistance in dying], available at http://www.parl.ca/Document Viewer/en/42-1/bill/C-14/royal-assent [accessed August 21, 2017]; see also https://openparliament.ca/bills/42-1/C-14 [accessed August 21, 2017]). The movement from allowing physician-assisted suicide to permitting euthanasia is facile; indeed, it apparently has not even been perceived as a transition in some societies outside the United States that have legalized the former practice.

It is true, as I have already noted, that in the United States active euthanasia is nowhere legal, whereas physician-assisted suicide is permitted in six states and the District of Columbia. I am not convinced, however, that this state of affairs will last. The evidence from the Netherlands, Belgium, Luxembourg, and Canada suggests it will not. Moreover, the line between physician-assisted suicide and euthanasia is difficult to defend. 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? "[T]his would arguably amount to discrimination based upon physical disability" (Sampson v State, 31 P3d 88, 97 [Alaska 2001] [upholding as constitutional a criminal statute prohibiting intentionally aiding another person to commit suicide]; see also e.g. Dan W. Brock, Voluntary Active Euthanasia, 22 Hastings Center Report 10, 10 [1992]). In practice, it appears that in Oregon a feeding tube is sometimes used to enable a patient who wishes to commit suicide using prescription medication, but has lost mobility, to ingest the lethal prescription (see Disability Rights Education & Defense Fund, Some Oregon and Washington State Assisted Suicide Abuses and Complications, Self-Administration, at https://lozier institute.org/a-reality-check-on-assisted-suicide-in-oregon [accessed August 21, 2017]).

Indeed, this concern about the transition from physician-assisted suicide to euthanasia was recognized by the United States Supreme Court, which observed that "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them," and that "not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to 'physician-assisted suicide' is likely, in effect, a much broader license, which could prove extremely difficult to police and [*27]contain" (Glucksberg, 521 US at 733 [internal quotation marks and citations omitted]). Justice Souter expanded on the point, noting that "[p]hysicians, and their hospitals, have their own financial incentives, too, in this new age of managed care. Whether acting from compassion or under some other influence, a physician who would provide a drug for a patient to administer might well go the further step of administering the drug himself; so, the barrier between assisted suicide and euthanasia could become porous" (Glucksberg, 521 US at 784-785 [Souter, J., concurring]).

Based on the current experience in the Netherlands, an expansion from physician-assisted suicide, by a patient taking a prescription of fatal drugs, to euthanasia, by a nurse or physician administering a prescription of fatal drugs, seems all but inevitable. Certainly the fear of that expansion, if physician-assisted suicide were legalized in New York, is reasonable.

III.

The Netherlands has displayed another very disturbing trend: the countenancing of both voluntary euthanasia and non-voluntary euthanasia. A study conducted in 2005 revealed that 2410 people in the Netherlands, 1.8% of all deaths in the Netherlands that year, died as a result of voluntary euthanasia or physician-assisted suicide,[FN3] while 0.4% of all deaths, or some 560 people, died as "the result of the use of lethal drugs not at the explicit request of the patient" (A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act, 356 N Engl J Med 1957 [Table 1] [2007] [emphasis added], available at http://www.nejm.org/doi/full/10.1056/NEJMsa071143#t=articleTop [accessed August 21, 2017]; see also J. Pereira, Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls, 18 Curr Oncol e38 [2011], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3070710 [accessed August 21, 2017]). In other words, for every five people who died in the Netherlands as a result of euthanasia or physician-assisted suicide in the immediate wake of the legalization and regulation of the practices, one died without explicitly requesting death and thus in violation of the law. Such cases involved, [*28]for example, patients who were "unconscious . . . or incompetent owing to young age" (A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act), and it was more common for the euthanasia to be justified by discussion with the patient's relatives than by past discussion with the patient (see id.).

A similar study of euthanasia and physician-assisted suicide in Belgium revealed a large proportion of patients who received euthanasia without an explicit request, some 32% of those who received euthanasia (see K. Chambaere et al., Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey, 182 Canadian Medical Association Journal 895, 896, 897 [Table 1] [2010], available at http://www.cmaj.ca/content/182/9/895 [accessed August 21, 2017]). Typically, in Belgian cases of non-voluntary euthanasia, the patient is in a coma or suffering from dementia, and relatives or other caregivers are consulted in advance regarding the euthanasia (see id. at 898-899).

In studying the modern experience in the Benelux nations, we are, of course, not facing government-sanctioned forced euthanasia. The decision-makers in non-voluntary euthanasia may be well-meaning. Such consultation, however, does not render the euthanasia voluntary, and indeed brings to mind the necessity of ensuring that decision-making about ending the lives of vulnerable, terminally ill people is not entrusted entirely to those who have the financial and emotional burden of caring for them.

I am not suggesting that the legalization of voluntary euthanasia, in a society such as the Netherlands in which it was already widely practiced, necessarily increases the rate of non-voluntary euthanasia. It may not invariably do so (see A. van der Heide et al., End-of-life practices in the Netherlands under the Euthanasia Act). My point is simply that physician-assisted suicide and euthanasia are inevitably accompanied by instances of non-voluntary euthanasia, so that it is rational to predict that endorsement of physician-assisted suicide will lead to occurrences of non-voluntary euthanasia.

There is also a reasonable concern that a descent from voluntary euthanasia and physician-assisted suicide to non-voluntary euthanasia would be an especial risk in vulnerable and disadvantaged parts of society. In 1994, the New York State Task Force on Life and the Law "unanimously recommend[ed] that New York laws prohibiting assisted suicide and euthanasia should not be changed" (New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context [May 1994], Executive Summary, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought [accessed August 21, 2017])[FN4]. The Task Force reasoned that "legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. . . . The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group" (New York State Task Force, When Death Is Sought at 120, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/chap6.htm [accessed August 21, 2017]). As the Task Force observed, "[n]o matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care" (New York State Task Force, When Death Is Sought, Executive Summary, available at https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm [accessed August 21, 2017]).

Given an acceptance of physician-assisted suicide and voluntary euthanasia, such practices could come over time to be regarded as cheaper alternatives to medical treatment for the terminally ill, leading 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. "Frail and debilitated elderly people, often demented or otherwise incompetent and thereby unable to defend and assert their own interests, may be especially vulnerable to unwanted euthanasia" (Brock, Voluntary Active Euthanasia, 22 Hastings Center Report at 21).

It is true that research from Oregon suggests that such fears of non-voluntary euthanasia of the vulnerable have not yet come to pass. "[R]ates of assisted dying in Oregon . . . showed no evidence of heightened risk for the elderly, women, the uninsured . . ., people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations" (Margaret P. Battin, et al., Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups, 33 J [*29]Med Ethics 591 [2007], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652799 [accessed August 21, 2017]). Yet the experiment with physician-assisted suicide on the West Coast is still young, and the Dutch experience supports the rationality of such fears.

Another part of society that could be at significant long-term risk is the community of people who are disabled. The Disability Rights amici argue that while the plaintiffs "use the term 'dignified death' to justify assisted suicide. . . . 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" (Amicus Brief of Disability Rights Amici: Not Dead Yet et al., at 4). For the many members of the disabled community who are not terminally ill, the "indignities" that plaintiffs wish to avoid are suffered on a daily basis. Legalizing physician-assisted suicide would convey a societal value judgment that such "indignities" as physical vulnerability and dependence mean that life no longer has any intrinsic value.

A disability does not deprive life of integrity or value. There is no lack of nobility or true dignity in being dependent on others. The natural developments of old age and final illness are dependence and waning consciousness. Many disabilities come with similar challenges. 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.

IV.

Last year, the American Psychiatric Association (APA) stated its official policy on physician-assisted suicide or euthanasia of psychiatric patients: "a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death" (APA, Position Statement on Medical Euthanasia [December 2016], available at https://www.psychiatry.org/home/policy-finder [accessed August 21, 2017]). At the time, a member of the APA's ethics committee stated that he feared that Canada and the jurisdictions in the United States that have legalized physician-assisted suicide are headed in the same direction as the Netherlands and Belgium. "So far, no other country that has implemented physician-assisted suicide has been able to constrain its application solely to the terminally ill, eventually including non-terminal patients as legally eligible as well . . . This is when psychiatric patients start to be included" (Michael Cook, American Psychiatric Association takes historic stand on assisted suicide and euthanasia, BioEdge: bioethics news from around the world, December 16, 2016, available at https://www.bioedge.org/bioethics/american-psychiatric-association-takes-historic-stand-on-assisted-suicide-a/12137 [accessed August 21, 2017]).

The experience of euthanasia in the Netherlands amply justifies this assertion. Euthanasia and physician-assisted suicide in the Netherlands have not been limited to those [*30]whose pain is physical. As long as "the patient's suffering is unbearable and without prospect of improvement" (Government of the Netherlands, Is euthanasia allowed?), a person whose illness is psychiatric may request and receive euthanasia or commit physician-assisted suicide. For example, in 2013, a woman in her thirties suffering from obsessive-compulsive disorder and an eating disorder, who engaged in "prolonged and extensive eating and vomiting rituals," was considered a suitable candidate for euthanasia because she "had tried every conceivable psychotherapy and drug treatment" without success and "experienced her suffering as unbearable" (id. at 24). In 2013, there were 42 reported cases of euthanasia and physician-assisted suicide of people with psychiatric, rather than physical, conditions, as compared with 14 in 2012 and 13 in 2011 (see Regional Euthanasia Review Committees, Annual Report 2013, at 9, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]). By 2015, the number of persons with psychiatric suffering who received euthanasia in the Netherlands was 56 (see Regional Euthanasia Review Committees, Annual Report 2015, at 6, available at https://english.euthanasiecommissie.nl/documents/publications/annual-reports/2002/annual-reports/annual-reports [accessed August 21, 2017]).

A 2016 survey of the euthanasia and physician-assisted suicide of 66 patients with psychiatric suffering in the Netherlands from 2011 to 2014 found that in most cases the patient's primary psychiatric condition was a depressive disorder (S.Y.H. Kim et al., Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014, 73 JAMA Psychiatry 362 [2016], available at http://jamanetwork.com/journals/jamapsychiatry/fullarticle/2491354 [accessed August 21, 2017], at E3), ranging from "patients with chronic, severe, difficult-to-treat depressions" to a woman who had lost her husband and found life as a widow "meaningless" but "did not feel depressed at all" and "ate, drank, and slept well . . . followed the news and undertook activities" (id. at E3).

The same survey noted that most of the patients felt "social isolation or loneliness," including one who believed "that she had had a life without love and therefore had no right to exist" and "an utterly lonely man whose life had been a failure" (id. at E4). The authors of the survey concluded that the patients receiving euthanasia or physician-assisted suicide "are mostly women . . . with various chronic psychiatric conditions, accompanied by personality disorders, significant physical problems, and social isolation or loneliness" (id. at E6). It is evident that the practice of physician-assisted suicide and euthanasia 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.

Recently, the Netherlands has shown signs of taking a new path down the slope that began with physician-assisted suicide and euthanasia of the terminally ill. In 2016, the [*31]Health Minister defended a proposed law allowing healthy older people to seek euthanasia if they feel that they "do not have the possibility to continue life in a meaningful way, . . . are struggling with the loss of independence and reduced mobility,. . . have a sense of loneliness, partly because of the loss of loved ones, and . . . are burdened by general fatigue, deterioration and loss of personal dignity" (Dan Bilefsky, Christopher F. Schuetze, Dutch Law Would Allow Assisted Suicide for Healthy Older People, New York Times, Oct 14, 2016 at A5, available at https://www.nytimes.com/2016/10/14/world/europe/dutch-law-would-allow-euthanasia-for-healthy-elderly-people.html?_r=0 [accessed August 21, 2017]). The proposed law essentially would allow people who are tired of life to end their lives.

Notably, the authors of the 2016 survey observe that the requirement that there be no "prospect of improvement" has proved controversial when the people seeking euthanasia are psychiatric patients. The survey authors found that almost one-third of the patients had initially been refused euthanasia or physician-assisted suicide and that almost one-quarter of the cases "engendered disagreements among the physicians involved" (id. at E6 [emphasis added]). They noted "the . . . complicated determinations of medical futility that must incorporate patients' treatment refusals in the context of less-than-certain prognosis even among persons with treatment-resistant depression" (id.). Such disagreements are telling.

Of course, in the United States jurisdictions that permit physician-assisted suicide, the practice is currently limited to patients who have six months to live. The descent down the slippery slope in the Netherlands, however, verifies the fear that jurisdictions in this country will find it difficult to limit the application of physician-assisted dying to the terminally ill.

V.

Perhaps most disturbingly, the Dutch practice of legalized euthanasia and physician-assisted suicide has quickly been extended to young children. In the Netherlands, children "may themselves request euthanasia from the age of 12, although the consent of the parents or guardian is mandatory until they reach the age of 16. Sixteen[-] and seventeen-year-olds do not need parental consent in principle, but their parents must be involved in the decision-making process. From the age of 18, young people have the right to request euthanasia without parental involvement" (Government of the Netherlands, Euthanasia, assisted suicide and non-resuscitation on request, available at https://www.government.nl/topics/euthanasia/contents/euthanasia-assisted-suicide-and-non-resuscitation-on-request [accessed August 21, 2017]). Recently, the Dutch Pediatric Association has called for the age limit of 12 years old to be eliminated, so that "each child's ability to ask to die [w]ould be evaluated on a case-by-case basis" (Dutch paediatricians: give terminally ill children under 12 the right to die, The Guardian, June 19, 2015, available at https://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands [accessed August 21, 2017]).

This would put the Netherlands in line with Belgium. In 2014, a dozen years after the 2002 Belgian Act on Euthanasia legalized euthanasia and physician-assisted suicide for adults suffering from constant, unbearable suffering (whether physical or psychiatric) that cannot be alleviated, Belgium legalized euthanasia by lethal injection for similarly situated children, of any age, provided they possess "the capacity of discernment" and there is parental consent (Belgium passes law extending euthanasia to children of all ages, The Guardian, 13 February 2014, at https://www.theguardian.com/world/2014/feb/13/belgium-law-extends-euthanasia-children-all-ages [accessed August 21, 2017]).

The expansion of euthanasia to children needs little commentary. Our society recognizes that minors "are in the earlier stages of their emotional growth, that their intellectual development is incomplete, that they have had only limited practical experience, and that their value systems have not yet been clearly identified or firmly adopted" (People ex rel. Wayburn v Schupf, 39 NY2d 682, 687-688 [1976]). The immaturity of children makes them especially vulnerable. The Dutch extension of euthanasia to minors is further proof that it is reasonable to fear the consequences of legalizing physician-assisted suicide.[FN5]

VI.

The evidence from other countries is that legitimating physician-assisted suicide can lead to the acceptance of non-voluntary euthanasia and to the extension of physician-assisted suicide to patients, such as those suffering from depression, who are not terminally ill. Such developments, valuing the avoidance of suffering above all virtues of endurance and hope for the future, should be intensely disturbing to all of us. The risk of facilitating such a bleak prospect is a rational justification for New York's prohibition of assisted suicide.

GARCIA, J. (concurring):

I agree with and join in the Court's holdings that Penal Law § 120.30 and § 125.15 (3) encompass aid-in-dying (per curiam at Section III), and that the statutes do not violate plaintiffs' right to equal protection under the New York State Constitution (per curiam at Section IV.A.). To the extent plaintiffs' allegations overlap with those asserted in Washington v Glucksberg (521 US 702 [1997]), I also agree with the Court's conclusion that, here, our State Due Process Clause is no broader than its federal counterpart and, therefore, plaintiffs' claims must fail. I write separately because I believe the Court should go further; to the extent plaintiffs' assert a "more particularized" challenge to the assisted suicide statutes (id. at 750 [Stevens, J., concurring]), I would expressly reach — and reject — those claims.

I.

In support of their due process claim, plaintiffs argue that the assisted suicide statutes burden a fundamental right and that, even if they do not, the statutes cannot survive rational basis review. These precise arguments were asserted under the Federal Constitution in Washington v Glucksberg (521 US 702 [1997]), and were rejected by the United States Supreme Court. Accordingly, unless our State Due Process Clause supplies broader protection, plaintiffs' claim here must similarly fail.

A.

In Washington v Glucksberg, the Supreme Court rejected the plaintiffs' due process challenge to Washington's prohibition against "caus[ing]" or "aid[ing]" a suicide (521 US 702, 705 [1997]). There, the Court determined that the "right" to assistance in committing suicide asserted by the plaintiffs was "not a fundamental liberty interest protected by the Due Process Clause" of the Federal Constitution (id. at 728). Because Washington's ban on assisted suicide was "at least reasonably related" to a number of "important and legitimate" state interests, the Court concluded that it survived rational basis review and that it did not violate the Due Process Clause of the Fourteenth Amendment (id. at 735 [citation and quotation marks omitted]).

Addressing the scope of its ruling, the Court carefully framed the issue presented: "It is the [lower] court's holding that Washington's physician-assisted suicide statute is unconstitutional as applied to the class of terminally ill, mentally competent patients that is before us today" (id. at 709 n 6 [citation and quotation marks omitted])[FN6]. Accordingly, the [*32]Supreme Court's holding affirmed the validity of the Washington statute both "on its face" and "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (id. at 735 [citation and quotation marks omitted]).

The same conclusion is warranted under our State Due Process Clause.

B.

In general, our Court "use[s] the same analytical framework as the Supreme Court in considering due process cases" (Hernandez v Robles, 7 NY3d 338, 362 [2006]). While, "[w]e have, at times, held that our State Due Process Clause provides greater protections than its federal counterpart" (per curiam at 9, citing People v Aviles, 28 NY3d 497, 505 [2016]; see also People v P.J. Video, 68 NY2d 296, 302-303 [1986]), I agree with the Court's conclusion that this is not one of those times.

In Glucksberg, the Supreme Court began by considering our Nation's "history, legal traditions, and practices" with respect to aid-in-dying, emphasizing New York's pivotal role at the forefront of legislative efforts to punish assisted suicide (Glucksberg, 521 US at 710-719). Like most states, New York has "consistently condemned, and continue[s] to prohibit, assisting suicide" (id. at 719). The earliest American statute explicitly outlawing assisted suicide was enacted in New York nearly two centuries ago, with many States and Territories later following New York's example (see id. at 715 [citations omitted]). In 1857, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide (id. [citation omitted]). The Field Code was adopted in New York in 1881, and "its language served as a model for several other western States' statutes" (id. [citation omitted]). The language of the prohibition remained largely unchanged until 1965, when Penal Law § 120.30 and § 125.15 (3) were enacted as part of a "new Penal Law" that "reorganize[d] and modernize[d] penal provisions proscribing conduct which has traditionally been considered criminal" (Governor's Approval Mem, Bill Jacket, L 1965, ch 1030 at 35).

Since then, the statutes have been repeatedly reexamined, including by New York's Task Force on Life and the Law, which studied physician-assisted suicide and unanimously concluded that the "potential dangers" of such a "dramatic change in public policy would outweigh any benefit that might be achieved" (Glucksberg at 719 [citation omitted]). Despite repeated attempts to legalize aid-in-dying in New York, the Legislature has not retreated from its prohibition.

To be sure, "the common law of New York" recognizes a patient's right "to determine what shall be done with his own body and to control the course of his medical treatment" (Rivers v Katz, 67 NY2d 485, 492 [1986]; see also Schloendorff v Society of New York Hospital, 211 NY 125, 129—130 [1914]). In Matter of Storar, we explicitly recognized a competent patient's right to refuse medical treatment, even where the treatment may be necessary to preserve the patient's life (52 NY2d 363, 369 [1981]). We again recognized the right of "a [*33]competent adult to refuse treatment" in Matter of Fosmire, where we held that the patient — "an adult Jehovah's Witness [who] refused to consent to blood transfusions" — had a "right to decline the transfusions" even though they were "necessary to save her life" (75 NY2d 218, 221, 226 [1990]). And today, we reaffirm a patient's fundamental right to refuse life-saving medical care or treatment (per curiam at 1-2, 9-10).

But we have never defined this fundamental right to encompass the broad "right to die" that plaintiffs seek; rather, we have consistently reaffirmed the widely-recognized distinction between refusing life-sustaining treatment and assisted suicide (per curiam at 10, citing Matter of Bezio v Dorsey, 21 NY3d 93, 103 [2013]; Matter of Fosmire, 75 NY2d at 227; Storar, 52 NY2d at 377 n 6). This distinction "comports with fundamental legal principles of causation and intent" (Vacco v Quill, 521 US 793, 801 [1997]). When a patient refuses life-sustaining treatment and succumbs to illness, the cause of death is the underlying disease. By contrast, when a lethal medication is ingested, the cause of death is not the pre-existing illness, but rather, the prescribed medication. In addition, a physician who withdraws treatment or administers terminal sedation does not intend to kill the patient, though that may be the eventual result. Rather, 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. A physician who provides aid-in-dying, however, indisputably intends for his or her actions to directly cause the patient's death; that is the very purpose of the lethal prescription.[FN7]

New York's "consistent and almost universal tradition" has "long rejected the asserted right, and continues to explicitly reject it today" (Glucksberg, 521 US at 723). The assisted suicide statutes reflect the Legislature's longstanding and considered policy choice, and we decline to "place the matter outside the arena of public debate" by extending heightened [*34]constitutional protection (id. at 720). Accordingly, in light of New York's persistent and unambiguous legal practice, plaintiffs' asserted right to aid-in-dying is not a fundamental right under our State Due Process Clause.

Because the assisted suicide statutes do not implicate a fundamental right, they need only be "rationally related to any conceivable legitimate State purpose" (People v Walker, 81 NY2d 661, 668 [1993] [citations omitted]). As the rational basis test is "the most relaxed and tolerant form of judicial scrutiny," plaintiffs bear the "heavy burden" of defeating the "strong presumption" that the statutes are valid (City of Dallas v Stanglin, 490 US 19, 26 [1989]). Even if the State could "better promote and protect" its interests "through regulation, rather than prohibition, of physician-assisted suicide," our inquiry is "limited to the question whether the State's prohibition is rationally related to legitimate state interests" (Glucksberg, 521 US at 728 n 21). So long as this basic requirement is satisfied, we "need not weigh exactingly the relative strengths" of the various competing interests (id. at 735).[FN8]

A number of legitimate State interests support the assisted suicide statutes. First, the State has a significant interest in preserving life and preventing suicide (per curiam at 12; see also Storar, 52 NY2d at 377; Bezio, 21 NY3d at 104; Glucksberg, 521 US at 729). Suicide presents a "serious public health problem," often plaguing those who "suffer from depression or other mental disorders" — conditions that may be difficult to diagnose (Glucksberg, 521 US at 730 [citation omitted]). The availability of assisted suicide would therefore undermine the State's interest in preventing suicide in cases involving, for instance, untreated depression, coercion, or improperly managed pain.

Additionally, the State has a substantial interest in guarding against the risks of mistake and abuse. Physicians are often 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 [*35](Amicus Brief of The 39 Physicians, at 17-19). Moreover, assisted suicide presents substantial "risks . . . to the elderly, poor, socially disadvantaged, and those without access to good medical care" (Task Force, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context [May 1994]). The State has a valid interest in protecting these vulnerable groups from the societal, familial, and financial pressures that might influence a patient's decision to pursue aid-in-dying (Glucksberg, 521 US at 731; Brief of Disability Rights Amici, at 10, 15-16; Amicus Brief of The 39 Physicians, at 11).

The State has also asserted a valid interest in preserving the integrity of the medical profession. A number of medical professionals — including the American Medical Association, the Medical Society of the State of New York, the New York State Hospice and Palliative Care Association, and the New York State Task Force on Life and the

Law — expressly reject physician-assisted suicide as an accepted medical practice (e.g. Brief of The 39 Physicians, at 4-13). Many believe that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer," and could "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming" (Glucksberg, 521 US at 731 [citations and quotation marks omitted]).

The Supreme Court has recognized that these, and other, "valid and important public interests" support New York's assisted suicide statutes (Vacco, 521 US at 809). Each of these State interests, by itself, "easily satisf[ies] the constitutional requirement that a legislative classification bear a rational relation to some legitimate end" (id.); collectively, they overwhelmingly substantiate the Legislature's prohibition of aid-in-dying. Accordingly, as in Glucksberg, the assisted suicide statutes do not violate our State Due Process Clause either on their face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (Glucksberg, 521 US at 735 [citation and quotation marks omitted]).

II.

Despite the breadth of Glucksberg's holding, plaintiffs — and others — suggest that the Supreme Court left open the possibility that some other plaintiff, under some other set of circumstances, might successfully assert an as-applied challenge to an assisted suicide ban (see Glucksberg, 521 US at 738-788 [Stevens, J., concurring]; see also per curiam at 10; Morris v Brandenberg, 376 P3d 836, 847 [NM 2016]; James Bopp, Jr. & Richard E. Coleson, Three Strikes: Is An Assisted Suicide Right Out?, 15 Issues L. & Med. 3, 35-36 [1999]; Adam J. Cohen, The Open Door: Will the Right to Die Survive Washington v Glucksberg and Vacco v Quill?, 16 In Pub. Int. 79, 98-107 [1997]; Physician-Assisted Suicide, 111 Harvard Law Rev. 237, 243-45 [1997]). Although plaintiffs here assert a more particularized challenge to the assisted suicide statutes, their as-applied challenge nonetheless fails.

A.

In Glucksberg, Justice Stevens, concurring in the judgment, asserted that the Court had conceived of the plaintiffs' claim "as a facial challenge — addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition" against assisting a suicide (Glucksberg, 521 US at 740 [Stevens, J., concurring]). Specifically, Justice Stevens noted that all three of the terminally ill patient-plaintiffs had died during the pendency of the litigation, and the Court therefore "did not have before it any individual plaintiff seeking to hasten her death or any doctor who was threatened with prosecution for assisting in the suicide of a particular plaintiff" (id. at 739 [Stevens, J., concurring]). Accordingly, Justice Stevens contended that the Court's holding left open "the possibility that some applications of the statute might well be invalid" (id. [Stevens, J., concurring]).

Writing for the majority, Chief Justice Rehnquist conceded that the Court's opinion did not "absolutely foreclose" the possibility that "an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge" (id. at 735 n 24, citing id. at 750 [Stevens, J., concurring]). But to the extent the Court left open the prospect of a successful future due process challenge, its concession was a narrow one. The Court made clear: "[G]iven our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by [the] respondents here" (id. at 735 n 24 [emphasis added]; see also Vacco, 521 US at 809 n 13). In the twenty years since Glucksberg was decided, not a single plaintiff has asserted a successful constitutional challenge to an assisted suicide ban.

B.

Plaintiffs here explicitly seek to present the "more particularized" as-applied challenge purportedly "not foreclose[d]" by Glucksberg (Glucksberg, 521 US at 739 [Stevens, J., concurring]). As detailed in the complaint, plaintiffs' allegations encompass a number of diverse parties whose experiences span the myriad stages of terminal illness.[FN9]

At the time the complaint was filed, plaintiffs included three competent, terminally ill patients who sought "to declare unconstitutional the application of New York penal law" to their respective circumstances. These patient-plaintiffs requested, among other things, [*36]the option to "ingest medications prescribed by [their] doctor[s] to achieve a peaceful death."

Plaintiffs also include a number of medical providers, including physicians whose patients "have requested" assistance to "help them die peacefully and with dignity." As alleged in the complaint, each physician-plaintiff, in the course of his current medical practice, "regularly encounters 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." In some of those cases, "even symptomatic relief is impossible to achieve without the use of terminal sedation." An "[u]ncertainty about the application" of the assisted suicide statutes deters these medical professional from "exercising [their] best professional judgment to provide aid-in-dying."

Plaintiffs allege, among other things, that the assisted suicide statutes "violate[] the patient [p]laintiffs' rights (and the rights of the physician [p]laintiffs' mentally-competent, terminally-ill patients . . . and [End of Life Choices New York]'s mentally-competent-terminally-ill clients) . . . in violation of the Due Process Clause of the New York Constitution." They seek a declaration that "the application" of the assisted suicide statutes to plaintiffs' conduct violates the New York Constitution, as well as an order enjoining defendants "from prosecuting [p]laintiffs for seeking or providing aid-in-dying."

C.

Plaintiffs' challenge, though more particularized, is not meaningfully "different" from the claims rejected in Glucksberg (521 US at 735 n 24). Given our holding that the Due Process Clause of the New York State Constitution does not provide heightened protection to the asserted liberty interest, plaintiffs must show, with respect to their as-applied challenge, that the assisted suicide statutes no longer survive rational basis review. Plaintiffs cannot make the requisite showing because, despite the uniquely compelling interests of the terminally ill "facing an impending painful death" (J. Rivera concurring op at 10), the State's asserted interests subsist even where a patient is "in the final stage of life" (J. Rivera concurring op at 20).

The legitimate interests advanced by the State support the assisted suicide statutes irrespective of a patient's proximity to death or eligibility for terminal sedation. For instance, the State may permissibly conclude that its interest in preserving life does not "diminish" merely because a patient's death may be "certain" or "imminent" (J. Rivera concurring op at 2, 27). Rather, research demonstrates that "suicidal feelings in terminally ill people" are often "remediable through other means, including pain management, hospice services and counseling," notwithstanding the patient's impending or imminent death (Brief of Disability Rights Amici, at 21). In the State's view, this data may undermine any assurance that, in the "last stage of life," a patient's "choice is not motivated by depression and helplessness, but by the desire to exercise autonomy to achieve a peaceful death" (J. Rivera concurring op at 22-23).

The risk of misuse similarly persists regardless of a patient's "stage of the dying [*37]process" (J. Rivera concurring op at 2). Indeed, "many patients prescribed [lethal] drugs do not ultimately take them" (J. Rivera concurring op at 15 n 5), creating a substantial danger that the dosage will be deliberately or accidentally misused. While that risk may be "no more" than with other dangerous drugs (J. Rivera concurring op at 26), the State's legitimate interest does not fail merely because the assisted suicide statutes do not "cover every evil that might conceivably have been attacked" (McDonald v Board of Election Commissioners of Chicago, 394 US 802, 809 [1969]). Moreover, given the lethal repercussions of misuse — the dosage is deliberately designed to cause death — the Legislature's targeted effort to address this uniquely acute risk is certainly rational (Williamson v Lee Optical Co, 348 US 483, 489 [1955] [noting that the State may act "one step at a time, addressing itself to the phase of the problem which seems most acute"]).

Nor does the State's interest in promoting sound medical ethics dissipate as death draws near (J. Rivera concurring op at 23-26). To the contrary, the State has asserted that the assisted suicide statutes encourage the unconditional treatment of the terminally ill and preserve the critical element of trust in a doctor-patient relationship at a time often marked by intense fear, uncertainty, and vulnerability. Even assuming this asserted rationale is "not uniformly accepted" (J. Rivera concurring op at 23), skepticism of aid-in-dying unquestionably remains among well-regarded medical professionals, including a number of the State's amici in this case. The State is entitled to adopt this legitimate medical perspective, which, by itself, adequately substantiates the assisted suicide statutes.

In any event, the State may permissibly conclude that an absolute ban on assisted suicide is the most reliable, effective, and administrable means of protecting against its inherent dangers (per curiam at 14; see also Glucksberg, 521 US at 731-733). Indeed, the State's legitimate interest in promoting a bright-line rule is particularly evident when considering the challenges posed by regulation. For instance, Judge Rivera's proposed rule, which would permit aid-in-dying in the "last painful stage of life," would purportedly apply only where a patient qualifies as "mentally competent" and "terminally ill"; where the patient is "experiencing intractable pain and suffering"; where "pain treatment is inadequate"; where death is "certain" and "imminent"; and where the patient's choice "is not motivated by depression and helplessness" (J. Rivera concurring op at 2, 3, 11, 23, 27). But the concurrence fails to offer any concrete guidance regarding how these amorphous threshold eligibility determinations should be made. Faced with these complex and delicate calculations, the Legislature may rationally conclude that the clarity and certainty of an absolute ban best protects against the inherent risks of physician-assisted suicide.

III.

The Due Process Clause of our State Constitution does not encompass a fundamental right to physician-assisted suicide, and the State's prohibition is rationally related to [*38]a number of legitimate government interests — interests that support the assisted suicide statutes irrespective of a patient's "stage of the dying process" (J. Rivera concurring op at 2, 11). To the extent a hypothetical future plaintiff — presenting a "quite different" set of circumstances — might come forward, the prospect of a successful constitutional challenge is never "absolutely foreclose[d]" (Glucksberg, 521 US at 735 n 24). But in light of the Court's holding today — and our unanimous conclusion that heightened scrutiny is unwarranted — it is difficult to conceive of such a case. Plaintiffs' claims are better addressed to the Legislature.

* * * * * * * * * * * * * * * * *

Order affirmed, without costs. Opinion Per Curiam. Judges Rivera, Stein, Fahey, Garcia and Wilson concur, Judge Rivera in a concurring opinion, Judge Fahey in a separate concurring opinion, and Judge Garcia in a separate concurring opinion in which Judge Stein concurs. Chief Judge DiFiore and Judge Feinman took no part.

Decided September 7, 2017

Footnotes

Footnote 1: Plaintiffs discontinued the action against the District Attorneys after entering into a stipulation that all parties would be bound by any result reached in the litigation between plaintiffs and the Attorney General.

Footnote 2: Penal Law § 120.30 provides that "[a] person is guilty of promoting a suicide attempt when [such individual] intentionally causes or aids another person to attempt suicide." Penal Law § 125.15 (3) provides that "[a] person is guilty of manslaughter in the second degree when . . . [such person] intentionally causes or aids another person to commit suicide."

Footnote 3: The Supreme Court of Montana has held that a statutory consent defense protects physicians from prosecution for physician-assisted suicide, but it did not reach the constitutional question (see Baxter v State, 2009 MT 449, ¶ 50, 354 Mont 234, 251, 224 P3d 1211, 1222 [2009]).

Footnote 4: There is a rich debate taking place over centuries discussing the meaning of the term "dignity," and the significance of the concept remains controversial today (see generally Richard E. Ashcroft, Making Sense of Dignity, 31 J Med Ethics 679 [2005]). As used here, the term is intended to evoke an individual's freedom to pursue autonomously chosen goals as well as an individual's need to be free from debasement and humiliation, broadly conceived (id. at 681).

Footnote 5: I agree with the Court's analysis that what plaintiffs call "aid-in-dying" is assisted-suicide within the meaning of our criminal law (per curiam at 5-7), and that the plaintiffs' equal protection claim is without merit (id. at 7-8). I address only the rights of the terminally ill under the State Due Process Clause.

Footnote 6: Lest my intention be misconstrued, I do not write to expound on plaintiffs' State due process rights as limited by their complaint, but rather to address the State's position that its interests outweigh the rights of all terminally-ill patients regardless of their condition.

Footnote 7: It is worth noting that in her Glucksberg concurrence, Justice O'Connor was operating on the assumption that all dying patients in Washington and New York could obtain palliative care that would relieve their suffering. As a result, she did not reach the narrower question of "whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death" (Glucksberg, 521 US at 737-738 [O'Connor, J. concurring]). As plaintiffs and amici allege, and as medical science indicates, palliative care is not always an option for a terminally ill patient in severe pain approaching death.

Footnote 8: Not all physicians who prescribe a patient a lethal dosage necessarily know for certain that the patient will die from taking the prescription, as many patients prescribed these drugs do not ultimately take them. Many patients simply want to regain a modicum of control over the dying process (see Glucksberg, 521 US at 751 n 15 [Stevens, J. concurring]). The ranges vary from state to state. In California, under the End of Life Option Act, 173 physicians prescribed 191 individuals lethal medication between June 9, 2016, and December 31, 2016. Of the 191 prescribed patients, 111 (58.1%) were reported by their physician to have died following ingestion of lethal medication and 21 (11.0%) died without ingestion of the prescribed drugs. The outcome of the remaining 59 (30.9%) individuals was undetermined at the time of the report (California Department of Public Health, California End of Life Option Act 2016 Data

Report [2016] at 3, available at: https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH%20End%20of%20Life%20Option%20Act%20Report.pdf [accessed August 29, 2017]).

Footnote 9: The statement recommends ethical guidelines for physicians using the practice, such as only using it for patients in the final stage of a terminal illness when their symptoms have been unresponsive to aggressive treatment, and stresses that it is not appropriate when the patient's suffering is primarily existential (AMA Code at 429). These guidelines are not dissimilar from those codified in aid-in-dying statutes across the country (see Or Rev Stat Ann §§ 127.800 - 127.897 [enacted in 1997]), and in the bill currently before the legislature (Proposed Medical Aid in Dying Act, NY Assembly Bill A02383 [Jan 19, 2017]).

Footnote 10: Determining whether terminal sedation is appropriate is a decision for physicians and patients (see AMA Code of Medical Ethics' Opinions on Sedation at the End of Life at 428).

Footnote 11: Due to the conceptual murkiness of determining whether a physician's act is active or passive, and whether death is intended or merely foreseen by a physician, some experts on palliative care advise that considerations of "the patient's wishes and competent consent are more ethically important [than these concerns about the physicians's mindset]" (Quill, Palliative Options of Last Resort, at 2102).

Footnote 12: Arguably, at least as long as the patient remains conscious, it may be possible for a patient who has asked for a ventilator or nourishment to be withdrawn to change course and decide to resume life-sustaining treatment. Terminal sedation, however, initiates a process whereby the patient cannot object once sedated and inevitably ends in the patient's death.

Footnote 13: The prediction that sanctioning aid-in-dying would put New York State on a slippery slope toward legalizing non-voluntary euthanasia is far from certain. Studies of two decades of euthanasia in the Netherlands "show no evidence of a slippery slope [leading to non-voluntary euthanasia]. . . . Also, there is no evidence for a higher frequency of euthanasia among the elderly, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations" (JA Rietjens, et al., Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?, 6(3) J Bioeth Inq 271 [2009], at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733179/ [accessed August 29, 2017]; see also MP Battin, et al., Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups, 33(10) J Med Ethics 591 [2007]). This finding is mirrored in the data from Oregon, which shows no evidence of heightened risk in any of the above categories (id.).

Footnote 14: The State does not adopt Judge Garcia's argument that the opinion of some medical professionals alone is enough for this statute to survive rational basis scrutiny as applied to this sub-group (J. Garcia concurring op at 15). And with good reason: such a low threshold risks rendering our rational basis test meaningless.

Footnote 15: For example, the New York State Academy of Family Physicians, representing over six thousand physicians and medical students, recently decided to support aid-in-dying ("Physician's group endorses medical aid-in-dying legislation," The Legislative Gazette [June 25, 2017], available at: http://legislativegazette.com/physicians-group-endorses-medical-aid-in-dying/ [accessed August 29, 2017]). Also, this year the Medical Society of the State of New York decided to conduct a survey of physicians in the State to determine their attitudes towards aid-in-dying, citing public support and changes in the law elsewhere (see "New York's medical society will survey doctors on attitudes towards physician assisted dying," WXXI News [April 24, 2017], available at: http://wxxinews.org/post/new-york-s-medical-society-will-survey-doctors-attitudes-toward-physician-assisted-dying [accessed August 29, 2017]). This included a survey commissioned by Compassion & Choices, a non-profit organization focusing on end-of-life care, which indicates that 77 percent of New Yorkers support access to aid-in-dying (Compassion & Choices, New York 2015-16 Research Report, available at: https://www.compassionandchoices.org/wp-content/uploads/2017/02/2NY-POLL-INFO.pdf [accessed August 29, 2017]).

Footnote 16: Notably, a 2003 survey of doctors and nurses published by the Journal of the American Medical Association indicated that aid-in-dying was being practiced clandestinely throughout the country (see Diane E. Meier, MD et al, Characteristics of Patients Requesting and Receiving Physician-Assisted Death, 163(13) Arch Intern Med 1537 [2003], available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/215798 [accessed August 29, 2017]). . Several amici point out that in those states where aid-in-dying is lawful — Oregon, Washington, Vermont and California [FN17] Colorado has recently adopted a ballot measure permitting aid-in-dying (Colo End of Life Options Act, Prop 106 [2016]).

Footnote 18: The decisions from other states cited by the Court to demonstrate that assisted suicide has nowhere yet been deemed a fundamental right by a high court in the United States do not affect the analysis, as plaintiffs rely on the guarantees afforded by the New York State Constitution and our Court's broad interpretation of the state Due Process Clause. To the extent some of the cases cited by the per curiam analyze their own state constitutions in a manner similar to that employed by the per curiam here (per curiam at 13-14), I note that not all are based on their respective state's due process clause (see People v Kevorkian, 447 Mich 436, 538, 527 NW2d 714, 758 [Mich 1994]). Further, the analysis is not uniform across these cases. For example, in Morris v Brandenburg (2016-NMSC-027, 376 P3d 836, 841 [NM 2016]), the most recent case cited by the per curiam, the Supreme Court of New Mexico reversed the trial court, which had found a statute that prohibited aid-in-dying violated the New Mexico State Constitution's guarantee to protect life, liberty, and happiness. However, in that case, the State conceded that it did not "have an interest in preserving a painful and debilitating life that will end imminently." The court found that the State had, instead, a legitimate interest in providing protections to ensure that decisions regarding aid-in-dying are informed, independent, and procedurally safe (id. at 855). The court ultimately determined that the right to aid-in-dying is best defined by the legislature, which is better equipped to develop appropriate safeguards than the judiciary (points also made by the courts in the Florida and Alaska cases [Krischer v McIver, 697 So 2d 97, 104 (Fla 1997); Sampson v State of Alaska, 31 P3d 88,98 (Alaska 2001)]). A dissenting judge in the Michigan case also argued that the State's interest in the preservation of life dwindles as a terminally-ill patient suffering great pain seeks to hasten death through physician-prescribed medications (Kevorkian, 447 Mich at 538 [Mallett, J., dissenting]). Thus, to the extent these cases may be instructive, they reveal that the constitutional analysis of aid-in-dying is specific to each state's constitutional jurisprudence and interests.

Footnote 19: Although the State's authority to regulate the exercise of a terminally-ill patient's access to aid-in-dying medications is not directly presented in this appeal, some regulation of this medical treatment option would fall within the State's power over public health matters (see Viemeister v White, 179 NY 235, 238 [1904]).

Footnote 1: In Montana, a terminally ill patient's consent to physician-assisted suicide constitutes a defense to a charge of homicide under a state criminal statute, as interpreted by the Montana Supreme Court (see Baxter v State, 224 P3d 1211, 1222 [Mont 2009]).

Footnote 2: See generally Sullivan, Active and Passive Euthanasia: An Impertinent Distinction?, in Steinbock and Norcross at 136; R.G. Frey, Intention, Foresight, and Killing, in Tom L. Beauchamp, Intending Death: The Ethics of Suicide and Euthanasia 69-70 (1996); Greg Beabout, Morphine Use for Terminal Cancer Patients: An Application of the Principle of Double Effect, 19 Philosophy in Context 49 (1989), reprinted in P.A. Woodward, The Doctrine of Double Effect 298-311 (2001).

Footnote 3: This figure includes 1,933 reported cases and 477 unreported cases. The study classified actions as euthanasia or physician-assisted suicide if the physician administered, supplied, or prescribed drugs with the explicit intention of hastening death, and at the explicit request of the patient, resulting in the patient's death. Not classified as instances of euthanasia or physician-assisted suicide were situations in which medical treatment was withheld or withdrawn, or measures to alleviate pain or other symptoms (such as palliative sedation) were intensified.

Footnote 4: In 1985, the New York State Task Force on Life and the Law was established by Governor Mario Cuomo, commissioned with "a broad mandate to recommend public policy on issues raised by medical advances" (https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/preface.htm [accessed August 21, 2017]).

Footnote 5: There is also evidence of an extension of the practice of physician-assisted suicide to non-physicians in the Nethelands. A Dutch "suicide counselor" was acquitted of helping a 54-year-old woman kill herself, despite advising her on the quantity of drugs to be taken to be certain of death (T. Sheldon, Dutch court acquits suicide counsellor of breaking the law, 334 BMJ 228 [2007], available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1790785 [accessed August 21, 2017]).

Footnote 6: Although the lower court's holding "was not limited to a particular set of plaintiffs before it" (id. at 709 n 6, quoting id. at 739 [Stevens, J., concurring]), the Court determined that it had nonetheless ruled on the statute's constitutionality "as applied to members of a group" — an approach that is "not uncommon" (id. at 709 n 6, citing Compassion in Dying v Washington, 79 F.3d 790, 798 n 9 [9th Cir 1996 en banc]).

Footnote 7: Judge Rivera's assertion that "the intent of a third party who assists the patient" is "irrelevant" to the legal analysis (J. Rivera concurring op at 18) ignores the factual foundation of plaintiffs' claim: plaintiffs seek a constitutional right not only to hasten death, but to the affirmative assistance of another in doing so. As the Supreme Court explained, "[t]he law has long used actors' intent or purpose to distinguish between two acts that may have the same result," and on this basis, "many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide" (Vacco, 521 US at 803). Comporting with this fundamental legal principle, the State may rationally distinguish between various end-of-life practices.

Footnote 8: The analysis in Judge Rivera's concurring opinion — which concludes that the State's interests "do not outweigh" a patient's right as death draws near (J. Rivera concurring op at 2; see also id. at 10, 12, 21, 23, 27) — bears little resemblance to our well-established rational basis review. Rational basis is not a balancing test. Rather, under this relaxed standard, plaintiffs' claims must fail so long as any conceivable legitimate State interest supports the challenged legislation (Affronti, 95 NY2d at 719 [citation omitted]). As discussed below, the assisted suicide statutes "easily satisfy" this requirement (Vacco, 521 US at 809).

Footnote 9: Given the breadth and nature of plaintiffs' allegations, outlined briefly below, I agree with Judge Rivera's implicit determination that plaintiffs' claims encompass the "sub-group of patients" who have entered the "final stage of the dying process" (J. Rivera concurring op at 2-3). Our disagreement concerns the merits — rather than the scope — of these claims.