APL-2016-00129
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COURT OF APPEALS
STATE OF NEW YORK

SARA MYERS, STEVE GOLDENBERG,

Plaintiffs,

ERICA A SEIFF, HOWARD GROSSMAN, M.D., SAMUEL C. KLAGSBRUN, M.D., TIMOTHY E. QUILL, M.D., JUDITH K. SCHWARTZ, PH.D., CHARLES A. THORNTON, M.D., and END OF LIFE CHOICES NEW YORK

Plaintiffs-Appellants,

—against—

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

Defendant-Respondent,

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

Defendants.

BRIEF OF *AMICUS CURIAE* AMERICAN MEDICAL STUDENT ASSOCIATION, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AND AMERICAN COLLEGE OF LEGAL MEDICINE

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Medicine

April 17, 2017

CORPORATE DISCLOSURE STATEMENT

The American Medical Student Association, American Medical Women's Association, and American College of Legal Medicine are independent not-for-profit corporations with no parents, subsidiaries, or affiliates.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The American Medical Student Association ("AMSA"), American Medical Women's Association ("AMWA"), and American College of Legal Medicine ("ACLM") (collectively, "*amici curiae*") are membership associations comprised of medical professionals, attorneys, and public health professionals and advocates dedicated to improving medical care and promoting public health.

AMSA is a national organization representing the concerns of physicians-in-training, dedicated to improving both medical training and medical care to the entire American population.

AMWA is a national organization focused on the advancement of women within the medical profession and the improvement of women's health. Its membership is comprised of physicians, medical students, and other health care professionals across all specialties.

ACLM is a national organization primarily consisting of dually degreed health care professionals and attorneys, predominantly holding MD and JD degrees. It promotes the continued professional advancement of its members, as well as non-member physicians, non-member attorneys, and other interested professionals, through education, research, publications, and interdisciplinary and collaborative exchanges of information.

As part of their missions to improve medical care and the public health, *amici curiae* support end-of-life care policies that improve patient quality of life, preserve patient autonomy, and protect the integrity of the practice of medicine. Under this framework and after a careful review of the evidence, *amici curiae* support the availability of aid in dying—the practice of a physician prescribing medication to a mentally competent, terminally ill patient that the patient may self-administer to bring about a peaceful death—under the current standard of care.

As national organizations of medical professionals, attorneys, and public health professionals and advocates, *amici curiae* will assist the Court in understanding the current evidence supporting the availability of aid in dying and its acceptance as a valid medical practice for end-of-life care. *Amici Curiae* believe that their perspective and arguments will not be adequately presented by the parties or other *amici curiae.*

ARGUMENT

The question before the Court is whether the Appellate Division erred in dismissing Plaintiffs-Appellants' claim for a declaration that New York's Assisted Suicide Statute does not criminalize the provision of aid in dying, or if so, that the application of this Statute would violate the Due Process Clause and the Equal Protection Clause of the New York Constitution.

The lower courts erroneously held as a matter of law that the Assisted Suicide Statute prohibits aid in dying without properly engaging in a review of the evidence from nearly two decades of clinical experience with aid in dying in Oregon, Washington, Vermont, Montana, California and, most recently, Colorado that demonstrates that aid in dying is distinct from assisted suicide. On the contrary, aid in dying is an appropriate medical practice that serves a critical role in the continuum of end-of life care alongside other medical practices that are universally recognized as valid medical practices, such as terminal sedation.

The lower courts also erred in holding that criminalizing aid in dying under the Assisted Suicide Statute does not violate the Due Process and Equal Protection Clauses of the New York Constitution. Criminalizing aid in dying is neither narrowly tailored nor rationally related to the state's interests. Empirical evidence demonstrates that aid in dying supports important public health goals: it improves patients' experiences in their dying days and end-of-life care overall, does not have a disproportionate effect on vulnerable populations, and is appropriately used as a last resort in a very small subset of eligible patients.

I. The Appellate Division Erred in Holding that the Assisted Suicide Statute Prohibits Aid in Dying.

The Appellate Division erroneously held as a matter of law that the Assisted Suicide Statute prohibits aid in dying. By employing a dictionary definition of "suicide," the Appellate Division ignored evidence that supports a meaningful distinction between aid in dying and suicide. These factual issues could not be properly resolved on a motion to dismiss.

Interpreting aid in dying as assisted suicide is at odds with the Statute's purpose and legislative history,[1] which does not prohibit these other permissible end-of-life care options.[2] In holding that the Assisted Suicide Statute prohibits aid in dying, the Appellate Division improperly resolved factual issues regarding, *inter alia*, whether aid in dying is a medically and ethically appropriate treatment practice for terminally ill patients, is indistinguishable from other lawful medical practices that result in a patient's death, and is distinguishable as a cause of death from the patient's underlying terminal illness.[3]

Rather than assisting healthy individuals intentionally take their lives, aid in dying is a valid medical option for mentally competent, terminally ill patients who face intractable pain and suffering, despite advances in palliative care. Aid in dying is part of a continuum of end-of-life care that includes medical practices

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[1] *See People v. Ryan*, 274 N.Y. 149, 152 (1937) ("The legislative intent is the great and controlling principle. . . . In the interpretation of statutes, the spirit and purpose of the act and the objects to be accomplished must be considered. . . . Literal meanings of words are not to be adhered to or suffered to 'defeat the general purpose and manifest policy intended to be promoted.'") (citation omitted).

[2] *See* N.Y. Penal Law § 1.05(1) (stating the purpose of the law to "proscribe conduct which unjustifiably and inexcusably causes or threatens substantial harm to individual or public interests.").

[3] For example, in states explicitly providing for aid in dying, death certificates must list the underlying terminal disease as the cause of death rather than any physician assistance. *See, e.g.*, Wash. Rev. Code § 70.245.

such as terminal sedation, which do not constitute suicide.[4] Indeed, a growing trend of medical professional and public health organizations, clinicians, and the public support aid in dying as a valid end-of-life medical practice entirely distinguishable from assisted suicide.

A. Aid in Dying is an Appropriate Medical Option in the Continuum of End-of-Life Care and is Distinct From Assisted Suicide.

The decision by the Appellate Division ignores an important factual distinction—that suicide and aid in dying are fundamentally different mental and physical processes. These factual distinctions are critical to the appropriate interpretation of the Assisted Suicide Statute.

Suicide refers to the often desperate, senseless, and tragic act of an individual, cutting short what would likely be a long life. Aid in dying, by contrast, is the choice by a mentally competent, terminally ill patient—a patient who is facing an unbearable dying process marked by extreme anguish (i.e., severe or intractable pain that cannot be relieved by other available medical therapies,

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[4] The lower court found "a direct causative link between the medication proposed to be administered by plaintiff physicians and their patients' demise." Order at 9-10 (R. 470-71). This finding misconstrues the underlying factual scenario of aid in dying, a process through which only the patient can administer drugs after they have been prescribed by a physician. There is a question of fact as to whether the prescribing of the medicines is a causative link to the patient's demise, and even if there were to be such a finding of fact, there remains a question as to whether this causative link is legally distinguishable from the causative link of terminal or palliative sedation to a patient's demise.

fear, and the loss of autonomy and dignity)—to control the manner of his impending death and spend his last days of life without needless suffering.

Suicide is often the result of a patient's unawareness that he or she is suffering from a treatable, temporary problem, and that he or she can overcome the urge to commit suicide. Aid in dying arises from an accurate understanding of incurable physical conditions. Unlike those seeking suicide, those who seek aid in dying have no misunderstanding as to whether or not their illnesses can be treated and allow them to live long and healthy lives; they cannot. The data show that patients who choose aid in dying do so as a result of a careful, fully vetted deliberation, always in consultation with their physician and usually in consultation with their families and other personal advisors, by applying well-reasoned logic that is consistent with the values that they have embraced for years or decades. *See, e.g.*, Arthur Chin et al., *Legalized Physician-Assisted Suicide in Oregon—the First Year's Experience*, 340 N. Eng. J. Med. 577, 582 (1999), http://www.nejm.org/doi/full/10.1056/NEJM199902183400724 (stating that many physicians reported "the decision to request a lethal prescription was consistent with a long-standing belief about the importance of controlling the manner in which they died").

Instead of a form of suicide, aid in dying is more properly viewed as one choice in the end-of-life care continuum, which already incorporates state-recognized treatment options that are intended to relieve suffering but may also likely hasten a patient’s death. Such options include “palliative sedation” (also termed “terminal sedation”), withholding or withdrawing life sustaining measures, and supporting patients who voluntarily stop eating and drinking. Palliative sedation is the monitored use of medications to relieve refractory and unendurable distress by patients with a terminal illness by inducing varied degrees of unconsciousness and withholding other life-sustaining measures. The right to this option has been recognized the United States Supreme Court, the American Medical Association, and other authoritative medical literature. *See Washington v. Glucksberg*, 521 U.S. 702, 736–37 (1997) (O’Connor, J., concurring) (“[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.”); American Medical Association, *Opinion 2.201 - Sedation to Unconsciousness in End-of-Life Care* (May 2013), http://journalofethics.ama-assn.org/2013/05/coet1-1305.html (stating that physicians have an obligation to relieve pain and suffering of dying patients in their care, which includes providing effective palliative treatment); Paul Rousseau, *Palliative Sedation in the Management of Refractory Symptoms*, 2 J. Supportive Oncology 181 (2004), https://www.researchgate.net/publication/26307271_Palliative_sedation_therapy_d oes_not_hasten_death_Results_from_a_prospective_multicenter_study; Susan D. Bruce et al., *Palliative Sedation in End-of-Life Care: The Process of Palliative Sedation*, 8 J. Hospice & Palliative Nursing 320 (2006), http://www.medscape.com/viewarticle/550666_1; Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994).

While the increasing recognition of palliative sedation is a positive development, it does not negate the importance of the right to additional end-of-life options, including aid in dying. For some patients, palliative sedation may be an acceptable option, but others may not choose an induced coma and lingering demise over the week or longer it takes for dehydration and starvation to result in death. *See* Timothy E. Quill, *Voluntary Stopping of Eating and Drinking (VSED), Physician-Assisted Death (PAD), or Neither in the Last Stage of Life? Both Should be Available as a Last Resort*, 13 Annals Fam. Med. 408 (2015), http://www.annfammed.org/content/13/5/408.short?rss=1 (noting that voluntary stopping of eating and drinking takes one to two weeks with a series of medical and social challenges, whereas aid in dying results in a peaceful death in a very short time). Aid in dying is an important option for those suffering intolerably who do not want to submit to palliative sedation.

B. Views of the Medical and Public Health Community Reflect that Aid in Dying is a Valid Medical Practice Distinguishable From Assisted Suicide.

Mounting empirical evidence and growing clinical experience have led to affirmative support for aid in dying from many medical associations as well as support from a majority of physicians. This recognition demonstrates that aid in dying is a valid medical practice for terminally ill patients and is distinct from assisted suicide.

A*mici curiae* AMWA, AMSA, and ACLM have all adopted policies recognizing aid in dying. In 2007, AMWA adopted a policy position supporting the availability of aid in dying alongside the provision of palliative care, the withdrawal or withholding of life-sustaining measures, and providing only supportive care to patients who voluntarily stop eating or drinking. *American Medical Women's Association Position Paper on Aid in Dying* (Sept. 2007), http://www.amwa-doc.org/wp-content/uploads/2013/12/Aid_in_Dying1.pdf. In October 2013, AMWA also endorsed clinical practice guidelines intended to assist physicians who practice in states that have the opportunity to aid patients in dying. *See* American Medical Women's Association, Advocacy History & Timeline, https://www.amwa-doc.org/our-work/advocacy/timeline/.

Principles adopted by AMSA include "Principles Regarding Physician Aid in Dying" that state that AMSA supports "the passage of aid in dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death." American Medical Student Association, *2015 AMSA Preamble, Principles Regarding Physician Aid in Dying*, at 79 (2015), http://www.amsa.org/wp-content/uploads/2015/03/PPP-2015.pdf.

ACLM has also adopted a policy recognizing "patient autonomy and the right of a mentally competent, though terminally ill, person to hasten what might otherwise be objectively considered a protracted, undignified, or painful death," provided that it is done in accordance with a law regulating such a right. American College of Legal Medicine, *ACLM Policy on Aid in Dying* (2008), http://c.ymcdn.com/sites/www.aclm.org/resource/collection/11da4cff-c8bc-4334-90b0-2abbe5748d08/Policy_On_Aid_In_Dying.pdf?hhSearchTerms=%22aid +and+dying%22.

Support for aid in dying has also grown among physicians. In a 2014 national survey of more than 17,000 American physicians representing 28 medical specialties, a majority of respondents favored allowing patients with an incurable and terminal disease to have the option to choose aid in dying. *See* Leslie Kane, *Medscape Ethics Report 2014, Part 1: Life, Death, and Pain*, Medscape Ethics Center (Dec. 16, 2014), *http://www.medscape.com/features/slideshow/public/ethics2014-part1#5*.

Likewise, a majority of respondents favored allowing aid in dying in a more recent survey of more than 7,500 physicians from more than 25 specialties. *See* Shelly Reese, *Medscape Ethics Report 2016: Life, Death, and Pain*, Medscape (Dec. 23, 2016), http://www.medscape.com/features/slideshow/ethics2016-part2.

While support among physicians for aid in dying is growing, it is not new. An October 2005 national survey of 677 physicians and 1,057 members of the public revealed that a majority of both groups believe that physicians should be permitted to practice aid in dying. *See News and Innovations*, 20 J. Pain & Palliative Care Pharmacotherapy 83, 92 (2006). A 2001 survey found that 51% of responding physicians in Oregon supported the ODWDA and legalization of physician-assisted dying. Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 J. Am. Med. Ass'n 2363, 2366 (2001), http://jamanetwork.com/journals/jama/fullarticle/193817.

Along with growing physician support, the public increasingly favors the availability of aid in dying. A 2014 poll of Connecticut voters conducted by Quinnipiac University showed that voters supported aid in dying by a margin of almost two to one. Press Release, Quinnipiac University Poll, Connecticut Voters Back Suicide Bill Almost 2-1, Quinnipiac University Poll Finds (Mar. 6, 2014), http://www.nbcconnecticut.com/news/local/Connecticut-Voters-Back-Suicide-Bill-

Almost-2-1--248729261.html. Similarly, a poll released by the Pew Research Center in January 2006 found that 60% of Americans believe a person has a moral right to end their own life if they are faced with great pain and no hope of improvement (an increase of nearly twenty percentage points since 1975) and 53% believe a person has a moral right to end their life if suffering from an incurable disease. News Release, The Pew Research Center, *More Americans Discussing – and Planning – End-of-Life Treatment; Strong Public Support for Right to Die* at 2, 8, 12 (Jan 5, 2006), http://www.people-press.org/files/legacy-pdf/266.pdf. According to the same study, by more than eight to one (84% to 10%), the public approves of laws that let terminally ill patients make decisions about whether to be kept alive through medical treatment. *See id.* at 4.

This broad affirmative support for aid in dying from medical associations, physicians, and the American public reflects the mounting empirical evidence and growing consensus that aid in dying serves as a valid end-of-life option for many terminally ill patients. Such support makes clear that aid in dying is not factually similar to assisted suicide, but rather a valid medical practice for terminally ill patients.

II. The Appellate Division Erred in Dismissing Plaintiffs-Appellants' Claims Under the Due Process Clause and Equal Protection Clause of the New York Constitution.

The Appellate Division erred in dismissing Plaintiffs-Appellants' claims under the Due Process Clause and Equal Protection Clause of the New York Constitution.[5] The choice of a mentally competent, terminally ill patient to seek a peaceful death through aid in dying implicates one of the most private, intimate medical decisions a patient will face. The right to seek aid in dying is within the existing fundamental right to self-determination with respect to one's body and to control the course of one's medical treatment protected by the New York Constitution. This right to direct one's own medical treatment encompasses the right to choose end-of-life options, such as terminal sedation or withdrawal of life support, as well as aid in dying.

A law that impinges upon a fundamental right is subject to strict scrutiny, whereas one that does not burden a fundamental right must bear a rational relationship to a government interest. *See Hope v. Perales*, 83 N.Y.2d 563, 577 (1994). Criminalizing aid in dying is neither narrowly tailored to serve a compelling state interest nor rationally related to a state interest. The State has an undeniable interest in preserving life and preventing suicide, preserving the

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[5] *See, e.g.*, *Rivers v. Katz*, 67 N.Y.2d 485, 492 (1986) ("It is a firmly established principle of the common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his own body and to control the course of his medical treatment.") (citations and quotation marks omitted).

integrity of the medical profession, and ensuring the welfare of vulnerable groups and *amici curiae* strongly support public policies that promote those interests. But significant empirical evidence demonstrates that criminalizing aid in dying does not support these interests. *See*, *e.g.*, Margaret Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. Med. Ethics 591, 591, 594 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652799/ (finding no evidence of heightened risk to vulnerable groups, and no evidence of aid-in-dying to patients not determined by two physicians to be gravely ill). Indeed the nearly two decades of clinical experience with aid in dying that have followed the May 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context,*[6] of the New York State Task Force on Life and the Law — which expressed concerns about the impact of aid in dying on vulnerable patients — have rendered the task force's concerns unfounded.

Most importantly, the State's interest in protecting life and preventing suicide, while undeniably significant, is not served by imposing criminal liability on physicians who provide aid in dying. Preventing suicide carries the potential to enable individuals to go on to lead healthy productive lives. In contrast,

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[6] *Available at* http://rci.rutgers.edu/~tripmcc/phil/taskforceonlifeandthelaw-whendeathissought-executivesummary.pdf.

criminalizing aid in dying extends a patient's suffering and the frustration of the loss of control and autonomy of a patient’s dying process without meaningfully extending the patient’s life. Not only is no life saved by criminalizing aid in dying, but denying the patient the autonomy to determine how much agony to endure before death arrives could cause profound psychological suffering, including resentment, frustration, and a sense of being powerless and captive to a miserable final stage of dying. Even though progressive illness has robbed the patient of much, the empirical evidence demonstrates that aid in dying improves patients’ and their families’ experiences in their dying days and serves to end intractable suffering.

In addition, the availability of aid in dying actually improves end-of-life care overall, promoting the State’s interest in ensuring that all patients receive appropriate medical treatment for pain and other debilitating conditions. Clinical experience also demonstrates that the practice of aid in dying by medical professionals can be appropriately governed under the current standard of care framework that governs the practice of medicine and the provision of all other medical services, including other end-of-life care options such as the withdrawal of life-sustaining measures or palliative sedation.

Finally, the data from clinical experience with aid in dying demonstrate that aid in dying does not have a disproportionate effect on vulnerable populations and is appropriately used as a last resort in a very small subset of eligible patients. The current standard of care for aid in dying includes important safeguards to prevent abuse and to ensure that patients do not use aid in dying because end-of-life care is inadequate, because of coercion or treatable mental health conditions, or because the patient desires not to burden others.

A. The Availability of Aid in Dying is Positive for Patients and Their Families.

The availability of aid in dying has psychological benefits, even for the many terminally ill patients who do not ultimately ingest the medication they obtain through aid in dying. Consistently, the three most frequently cited concerns motivating aid in dying requests are loss of autonomy, decreasing ability to participate in activities making life enjoyable, and loss of dignity. *See, e.g.* Or. Health Auth., Pub. Health Div., *Death With Dignity Ann. Rep.* (2015), http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx [hereinafter "2015 Oregon Death With Dignity Annual Report"]; Wash. State Dep't of Health, *2015 Death with Dignity Act Rep.*, http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf [hereinafter "2015 Washington Death with Dignity Act Report"]; Barbara Coombs Lee, *Oregon's Experience with Aid in Dying: Findings From the Death with Dignity Laboratory*, 1330 Annals. N.Y. Acad. Sci. 94 (2014), https://www.compassionandchoices.org/wp-content/uploads/2016/02/BCL-Annals-rebuild-12-2014.pdf.[7] Simply providing the option to consider aid in dying bolsters the terminally ill patient's sense of autonomy, control, and choice.

A study in which a 33-item Quality of Death and Dying Questionnaire was administered to patients who had received aid in dying prescriptions, patients who had requested but not received prescriptions, and patients who had not pursued aid in dying found that those patients receiving aid in dying prescriptions had higher quality ratings on items measuring symptom control and on items related to preparedness for death than those who did not pursue aid in dying or those who began the process but did not complete a request. Kathryn A. Smith et al., *Quality of Death and Dying in Patients who Request Physician-Assisted Death*, 14 J. Palliative Med. 445 (2011), http://www.worldrtd.net/sites/default/files/u22/Smith%20Goy%20and%20Ganzini.pdf. The authors concluded that aid in dying may meet the goal of relieving

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[7] *See also* Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 Arch. Internal Med. 489, 490 (2009) (finding that the chief reasons for pursuing aid in dying were loss of independence, wanting to control the time and manner of death and die at home, and the prospect of worsening pain or quality of life and the inability to care for themselves); Linda Ganzini et al., *Experiences of Oregon Nurses and Social Workers with Hospice Patients Who Requested Assistance with Suicide*, 347 N. Eng. J. Med. 582, 584 (2002).

worries about future discomfort, pain, and loss of control, and a request was not a reflection of poor care.[8] *See id.*

In addition, the data show that the availability of aid in dying is positive for patients' families. A study comparing family members of patients who requested aid in dying with family members of decedents who did not found "little impact on mental health outcomes." Linda Ganzini et al., *Mental Health Outcomes of Family Members of Oregonians Who Request Physician Aid in Dying*, 38 J. Pain & Symptom Mgmt. 807, 813 (2009), http://www.jpsmjournal.com/article/S0885-3924(09)00707-6/pdf. But families of patients who requested aid in dying felt more prepared for the death, felt more accepting of their loved one's death, and were less likely to agree that they wanted more opportunities to care for the loved one. *See id*.[9]

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[8] *Compare* Susan W. Tolle et al., *Characteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, 15 J. Clinical Ethics 111, 118 (2004), http://www.eutanasia.ws/hemeroteca/t336.pdf (finding that overall symptom distress predicted whether a patient initially *considered* the option of aid in dying), *with* Ganzini, *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, *supra*, at 584 (finding that the most important reasons for *receiving* an aid-in-dying prescription were "desire to control the circumstances of death, a desire to die at home, the belief that continuing to live was pointless, and being ready to die" rather than symptom distress).

[9] *See also* Smith, *Quality of Death*, *supra*; Ganzini, *Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide*, *supra* at 586 (surveying hospice workers and reporting that family caregivers of aid-in-dying patients were more likely to feel positive meaning in caring for the patient and were more prepared for and accepting of the death than family caregivers of patients who had not requested aid in dying); Elizabeth Trice Loggers et al., *Implementing a Death With Dignity Program at a Comprehensive Cancer Center*, 368 N. Eng. J. Med. 1417, 1420 (2013), http://www.nejm.org/doi/pdf/10.1056/NEJMsa1213398 (finding that patients, caregivers, and family members "frequently express gratitude after the (continued…)

B. The Availability of Aid in Dying Improves Overall End-of-Life Care.

The data show that the availability of aid in dying improves end-of-life medical care overall by improving physician self-education and awareness of palliative care options, increasing referrals to hospice care and improving pain management, and improving communications about end-of-life care between physicians and patients.

The availability of aid in dying increases physician knowledge of, and comfort with, end-of-life treatment options. A study of 2,641 physicians eligible to prescribe aid in dying in Oregon found that 76% of physicians reported efforts to improve their knowledge of the use of pain medication in the terminally ill and 79% of physicians reported that their confidence in prescribing of pain medications had improved. *See* Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *supra*, at 2366. The study also found that 69% of physicians reported efforts to improve their recognition of psychiatric disorders, such as depression. *See id.* at 2365*; see also* Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138 Annals Internal Med. 208 (2003),

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patient receives the prescription, regardless of whether it was ever filled or ingested, typically referencing an important sense of control in an uncertain situation").

http://annals.org/aim/article/716012/professional-organizations-position-statements-physician-assisted-suicide-case-studied-neutrality; Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 Annals Internal Med. 267 (1996), http://annals.org/aim/article/709383/oregon-s-assisted-suicide-vote-silver-lining.

In another study, hospice nurses and social workers in Oregon reported observing between 1998 and 2003 an increase in physicians' knowledge of palliative care and an increase in physician's willingness to refer patients to hospice and to care for hospice patients. *See* Elizabeth R. Goy et al., *Oregon Hospice Nurses and Social Workers' Assessment of Physician Progress in Palliative Care Over the Past 5 Years*, 1 Palliative & Supportive Care 215 (2004), http://docplayer.net/37314146-Oregon-hospice-nurses-and-social-workers-assessment-of-physician-progress-in-palliative-care-over-the-past-5-years.html. Ganzini found that a third of physicians increased referrals to hospice following the availability of aid in dying and perceived that the availability of hospice for their patients had increased since the passage of the ODWDA. Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, *supra*, at 2365.

Since aid in dying became available in Oregon, the state's pain management practices have improved. The annual Progress Report Card on state pain policies published by the University of Wisconsin School of Medicine and Public Health's Pain & Policy Studies Group[10] rated Oregon's pain policy as a C+ in 2000 and 2003, but then improving to a B+ in 2006–2007 and then an A since 2008. University of Wisconsin School of Medicine and Public Health, *Achieving Balance in State Pain Policy: A Progress Report Card* (2006), https://scholarworks.iupui.edu/bitstream/handle/1805/699/achievingbalanceinstatepainpolicy-aprogressreportcard-2006.pdf?sequence=1 ; University of Wisconsin School of Medicine and Public Health, *Achieving Balance in State Pain Policy: A Progress Report Card* (2013), http://www.acscan.org/content/wp-content/uploads/2014/07/PRC-2013.pdf.

The availability of aid in dying also improves communication between physicians and patients regarding end-of-life care options. The United States Government Accountability Office examined the key components of end-of-life care programs in Arizona, Florida, Oregon, and Wisconsin and reported that physicians working with hospice-based palliative care providers in Oregon "are more comfortable discussing end-of-life issues with their patients since the 1997 enactment in Oregon of the Death with Dignity Act ("ODWDA"), which focused attention in the state on end-of-life care and the options available to individuals."

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[10] The report is supported by the American Cancer Society, the American Cancer Society Cancer Action Network, Inc., and the LIVESTRONG Foundation.

U.S. Gov't Accountability Office, *End-of-life Care: Key Components Provided by Programs in Four States*, GAO-08-66, at 14 (2007), http://www.gao.gov/new.items/d0866.pdf. The report also states that the passage of the ODWDA "helped create an environment in Oregon where end-of-life issues are discussed more openly." *Id.* Similarly, Ganzini et al. found that physicians perceived that more patients found conversations regarding the ODWDA to be more helpful than upsetting, regardless of whether the physician supported or opposed aid in dying. Ganzini, *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care since Passage of the Oregon Death with Dignity Act*, *supra*, at 2368.

C. Aid in Dying Does Not Impact the Integrity or Ethics of the Medical Profession.

Aid in dying has been openly practiced in several states for many years. Oregon, Washington, Vermont, and California have statutes affirmatively making aid in dying available in these states, and Colorado recently adopted a ballot measure permitting aid in dying. *See* Or. Rev. Stat. §§ 127.800–127.897 (1994) (fully implemented in 1998); Wash. Rev. Code § 70.245 (2008), Vt. Stat. Ann. tit. 18, §§ 5281-5292 (2013), Cal. Health & Safety Code § 443.1, *et seq.* (2016); Colo. Prop. 106 (2016). Aid in dying is also practiced in Montana without death with dignity statutes.[11] Clinical experience from these states demonstrates that the availability of aid in dying has not undermined the integrity or ethics of the medical profession. On the contrary, the provision of aid in dying can be governed by the current standard of care framework that governs all medical practice. [12]

A standard of care for providing aid in dying has emerged through clinical experience in the states where aid in dying is available and careful review by the medical profession. This standard of care is well-documented among the Oregon, Vermont, and Washington statutes, clinical practice guidelines, and the policy statements of physician and public health organizations supporting aid in dying. *See* Or. Rev. Stat. §§ 127.800-127.897; Wash. Rev. Code § 70.245; Vt. Stat. Ann. tit. 18, §§ 5281-5292; *see also* D. Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliative Med. 259 (2016),

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[11] In December 2009, the Montana Supreme Court held that the state's homicide statute did not encompass the provision of aid in dying, thereby legalizing aid in dying in the state. *See Baxter v. Montana*, 224 P.3d 1211, 1215–16 (2009). In 2011, certain physicians in Hawaii began an open practice of aid in dying based on their understanding that it was not prohibited by the state's laws, in spite of an opinion by the state Attorney General stating the contrary. S*ee, e.g.*, *5 Hawaii Doctors Offer Assisted Suicide to Terminally Ill Patients*, Am. Med. News (Apr. 17, 2012), http://www.amednews.com/article/20120417/profession/304179996/8/; Letter from Heidi Rian, Deputy Attorney General, to Joshua Booth Green, Senator (Dec. 8, 2011), http://www.adfmedia.org/files/HawaiiAGLegalOpinion.pdf.

[12] In New York, as in other states, the medical profession and medical care is governed by professional practice standards, referred to as the standard of care, rather than specific statutes or regulations that prohibit or give affirmative permission to provide specific types of care. 61 Am. Jur. 2d, *Physicians, Surgeons, and Other Healers §* 189 (updated Aug. 2014). The development of a standard of care in medicine is left to physicians and regulated by state Medical Boards. *See Gonzales v. Oregon*, 546 U.S. 243, 271 (1985) (based on clinical experience in these states) (quoting *Hillsborough Cnty. v. Automated Med.Labs., Inc.*, 471 U.S. 707,719 (1985)).

https://www.compassionandchoices.org/wp-content/uploads/2016/04/Clinical-Criteria-for-Aid-in-Dying.pdf; American Medical Student Association, 2014 AMSA Preamble, Purposes and Principles at 76, http://www.amsa.org/AMSA/Libraries/Misc_Docs/2014PPP.sflb.ashx.

Current state oversight of the practice of medicine (e.g., licensure, Medical Review Boards) can regulate the provision of aid in dying as it does all other medical practices. For example, when aid in dying was decriminalized in Montana, the Montana Board of Medical Examiners stated that a complaint about a physician's practice of aid in dying would be subject to the same review applicable to any other medical practice. *See Montanans Against Assisted Suicide (MAAS) v. Bd. of Med. Exam'rs*, No. ADV-2012-1057, slip op. at 3 (Mont. Dist. Ct. Dec. 13, 2013). The Vermont legislature also understood that aid in dying would be governed adequately by existing professional standards. When enacting the Patient Choice at the End of Life Act, the legislature included a three-year "sunset" on the specific statutory requirements for aid in dying, after which aid in dying in the state would be regulated as any other medical service. State of Vermont, *Summary of the Acts and Resolves of the 2013 Vermont General Assembly*, 2013 Vt. Acts & Resolves 292, http://www.leg.state.vt.us/reports/2013ExternalReports/292522.pdf.

D. Vulnerable Populations are Not Negatively Impacted By the Availability of Aid in Dying.

Amici curiae appreciate the need for safeguards on the availability of aid in dying to ensure that vulnerable populations are not unduly affected and that patient choices are not based in lack of competence, are not a result of coercion, and do not reflect the patient's desire not to burden others. But there is no evidence of coercion or disproportionate impact on vulnerable populations as a result of the availability of aid in dying. Far from demonstrating any disproportionate effect on the vulnerable, the data demonstrate that those who received aid in dying are equally divided between genders and mostly white, well-educated, insured, receiving hospice services, and dying of cancer or amyotrophic lateral sclerosis (ALS). *See, e.g.*, 2015 Oregon Death With Dignity Annual Report, *supra*; 2015 Washington Death with Dignity Act Report, *supra*; Coombs Lee, *Oregon's Experience with Aid in Dying, supra*.

Researchers found "no evidence of a heightened risk" to the elderly, minors, women, uninsured patients, poor patients, racial and ethnic minorities, patients with non-terminal physical disabilities or chronic non-terminal illnesses, or patients with psychiatric illness (including depression and Alzheimer's disease). Margaret Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands*, *supra* (reviewing data from Oregon and the Netherlands). They also found that "no one received physician-assistance in dying who was not determined by two physicians to be terminally ill—that is, no one received such assistance for disability alone." *Id.* at 594. The researchers concluded: "We found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups." *Id.* at 597.

Likewise, the executive director of the disability advocacy group Disability Rights Oregon testified before the APHA in 2007 that he had no knowledge of any cases in Oregon to contradict the findings of that report and that his organization had never received a complaint that a person with disabilities was coerced to make use of aid in dying. Coombs Lee, *Oregon's Experience with Aid in Dying*, *supra* (citing Declaration of Robert Joondeph, Executive Director Oregon Advocacy Center, submitted to APHA Nov. 2007). Nearly a decade later, this organization still has not received evidence of exploitive or coercive use of aid in dying in the state of Oregon. *See* Letter from Bob Joondeph, Executive Director of Disability Rights Oregon (Feb. 10, 2016) ("[Disability Rights Oregon] has still not received a complaint of exploitation or coercion of an individual with disabilities in the use of Oregon's Death with Dignity Act").

In addition, an analysis of the cost of care at the end of life and potential savings attributable to aid in dying indicates that aid in dying is not likely to save material amounts of money in absolute or relative terms, either for particular institutes or for the nation as a whole. *See* Ezekiel J. Emanuel & Margaret P. Battin, *What are the Potential Cost Savings from Legalizing Physician-Assisted Suicide?*, 339 N. Eng. J. Med. 167, 171 (1998), http://www.nejm.org/doi/full/10.1056/NEJM199807163390306. This finding indicates that institutional self-interest is unlikely to encourage premature deaths if aid in dying is available.

Indeed, the data demonstrate that aid in dying is being used only in those circumstances where an informed, eligible patient and his or her physician deem it appropriate over all other available medical options. For instance, a survey of 1,902 physicians across the United States practicing in specialties most likely to receive aid in dying requests found that patients receiving aid in dying are making specific requests, have a substantial burden of physical pain and distress, and are expected to die of their illness within a month. *See* Diane E. Meier et al., *Characteristics of Patients Requesting and Receiving Physician-Assisted Death*, 163 Arch. Internal Med. 1537, 1537 (2003), http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/215798.

Moreover, after a careful review of the data on the availability of aid in dying, outside observers have concluded that a law permitting aid in dying poses no risk to patients. For example, a report prepared for the Vermont legislature concluded that "it is quiet [sic] apparent from credible sources in and out of

Oregon that the Death with Dignity Act has not had an adverse impact on end-of-life care and in all probability has enhanced the other options." Vt. Legislative Council, Oregon's Death with Dignity Law and Euthanasia in the Netherlands: Factual Disputes § 3E (2004), http://www.leg.state.vt.us/reports/04Death/Death_With_Dignity_Report.htm. Leading scholars that originally opposed aid in dying have reversed their standpoint based on the growing clinical evidence. Arthur Caplan, former Director of the Center for Bioethics and the University of Pennsylvania School of Medicine has stated: "I worried about people being pressured to do this . . . . But this data confirms . . . that the policy in Oregon is working. There is no evidence of abuse or coercion, or misuse of the policy." William McCall, *Assisted-Suicide Cases Down in '04*, Columbian (Vancouver, Wash.), Mar. 11, 2005, at C2.[13]

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[13] Likewise, the Supreme Court of Canada recently recognized that the extensive evidentiary record demonstrates that the standard of care for aid in dying that includes appropriate safeguards "is capable of protecting the vulnerable from abuse or error," *Carter v. Canada*, 1 S.C.R. 331, 343 (S.C.C. 2015). In so doing, the Supreme Court of Canada accepted the trial judge's findings that "there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death," that permitting aid in dying would not impede the development of palliative care in the country, and that "physicians were capable of reliably assessing patient competence, including in the context of life-and-death decisions . . . [and] that it was possible to detect coercion, undue influence, and ambivalence as part of this assessment process." *Id.* at 353, 355.

E. Aid in Dying is Used to Achieve a Dignified, Peaceful Death in a Very Small Subset of Eligible Patients.

In tandem with the improvement in overall end-of-life care, aid in dying is implemented infrequently and only a small fraction of patients who consider it go on to ingest the medication.

In Oregon, deaths resulting from aid in dying represent only 0.2% of deaths in the state each year. Coombs Lee, *Oregon's Experience with Aid in Dying*, *supra*, at 2. Moreover, one study found that terminally ill patients were about nine times more likely to consider aid in dying than to make a formal request and start the process, and nearly 200 times more likely to consider aid in dying than to follow through with obtaining a prescription. Susan W. Tolle et al., C*haracteristics and Proportion of Dying Oregonians Who Personally Consider Physician-Assisted Suicide*, 15 J. Clinical Ethics at 115, *supra*. And a 2000 survey of Oregon physicians found that they granted one of every six requests for aid in dying, and that only one in ten requests resulted in a patient ingesting the medication. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 N. Eng. J. Med. 557, 557 (2000). Just over half of the prescriptions written for aid in dying result in the patient ingesting the medication. 2015 Oregon Death With Dignity Annual Report, *supra*.

The small rate of follow-through on aid in dying considerations likely reflects finding alternatives to aid in dying during the process. Physicians reported that a third of the patients who requested aid in dying changed their minds following a substantive intervention by a physician, such as symptom management, treatment of depression, or referral to hospice. Ganzini, *Physicians' Experiences with the Oregon Death with Dignity Act*, *supra*, at 557. Qualitative interviews with physicians support that referral to hospice is especially successful among patients who are transitioning from curative to comfort treatments, who do not fully understand their options, or who have not yet experienced the benefits of hospice. *See* Linda Ganzini & Steven K. Dobscha, *Clarifying Distinctions between Contemplating and Completing Physician-Assisted Suicide*, 15 J. Clinical Ethics 119, 120 (2004) (citing Steven K. Dobscha et al., *Oregon Physicians' Responses to Requests for Assisted Suicide: A Qualitative Study*, 7 J. Palliative Med. 450 (2004)).

For the small group of patients who ingest the prescribed medication, aid in dying permits a peaceful death on the patient's own terms. Nearly all patients who use aid in dying pass away at home. *See, e.g.*, 2015 Oregon Death With Dignity Annual Report, *supra*; 2015 Washington Death with Dignity Act Report, *supra*. Patients are unconscious after a few minutes and usually succumb in under a half hour. *See, e.g.*, 2015 Oregon Death With Dignity Annual Report, *supra*; 2015 Washington Death with Dignity Act Report, *supra*.

CONCLUSION

For all these reasons, *amici curiae* AMSA, AMWA, and ACLM respectfully request that this Court reverse the ruling by the Appellate Division and remand this case to the New York Supreme Court.

April 17, 2017.

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CERTIFICATION

I certify pursuant to § 500.13(c)(1) of the Rules of Practice of this Court that the total word count for all printed text in the body of the brief is 6,971 words.

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