APL-2016-00129
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Court of Appeals

STATE OF NEW YORK

SARA MYERS, STEVE GOLDENBERG,

Plaintiffs,

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

Plaintiffs-Appellants,

—against—

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

Defendant-Respondent,

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

Defendants.

BRIEF FOR *AMICI CURIAE* IN SUPPORT OF APPELLANTS

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April 17, 2017

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INTEREST OF *AMICUS CURIAE*

This *amicus* brief is submitted on behalf of New York State Assembly Members Richard N. Gottfried, Amy Paulin, Michael Blake, Sandra R. Galef, Ellen C. Jaffee, Linda B. Rosenthal and Phillip G. Steck, and New York State Senator Brad Hoylman. These seven Assembly Members and one Senator from the New York State Legislature (the "Legislature") are experienced reading, interpreting and drafting legislation, and are familiar with end-of-life issues confronting their constituents and their constituents' families and loved ones. For example, Assembly Member Richard N. Gottfried has chaired the Assembly Health Committee since May 1987 and has been the Assembly sponsor of almost all legislation relating to end-of-life decision-making and practices enacted in New York during the past three decades. These elected representatives do not undertake the submission of this brief lightly. Aid-in-dying is a topic freighted with historical, religious, and most importantly the ultimate personal significance. The named legislators, therefore, have affixed their names to this brief as true friends of the court to give assistance resolving the reach of New York's Assisted-Suicide Statute (N.Y. Penal Law §§ 120.30, 125.15(3)). They do so on behalf of themselves and as elected representatives of New Yorkers whose well-being is at stake in this matter.

SUMMARY OF POSITION

As legislators, these *amici* have amassed many decades in the aggregate of reading and drafting legislation. When crafting a statute, contemplating its application to then unknown and unknowable future circumstances is difficult or impossible. To address these inherent difficulties in the legislative process, the courts have long looked to legislative history and rules of statutory construction to assist with applying statutes in changed circumstances.

In the years since the enactment of the criminal law against assisted suicide, advances in medical technology have enabled physicians to greatly prolong lives of intense suffering. New York law and the medical profession have evolved to embrace actions by physicians—with the consent of terminally-ill competent patients, and in some circumstances with the consent of an agent or surrogate of a no-longer-competent patient—that in another era might have been regarded as criminal or unethical. The anti-suicide criminal statute must be read in keeping with this evolution.

In the view of these *amici*, the principles of statutory interpretation strongly militate against applying the Assisted-Suicide Statute to criminalize a physician's compassionate professional role in providing his or her patient medical aid in dying. Any such extension must instead come, if at all, from the legislative branch.

In the absence of a broad criminal prohibition, *amici* support reasonable regulation of medical aid in dying, not a penal prohibition.

ARGUMENT

I. IN ORDER TO PROMOTE JUSTICE AND EFFECT THE OBJECTS OF THE LAW, THE ASSISTED-SUICIDE STATUTE SHOULD NOT BE READ TO REACH A PHYSICIAN'S ACTS RELATED TO AID-IN-DYING

A. The Disputed Statutory Language

Section 125.15 of New York's Penal Law states that "[a] person is guilty of manslaughter in the second degree when . . . he intentionally causes or aids another person to commit suicide." N.Y. Penal Law § 125.15. Similarly, Penal Law § 120.30 provides "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." N.Y. Penal Law § 120.30.

Three aspects of this statutory language require consideration in this case. Most centrally, the Court must determine whether the act of a mentally-competent, terminally-ill patient to cease his or her suffering is "suicide." Second, the Court must consider whether the general prohibition against any "person" applies to a physician engaged in good-faith professional medical practice. And most narrowly, whether a physician providing access to a prescription medication comprises aid to commit suicide. As to each of these issues, the named *amici* urge that the answer is no.

B. Rules of Statutory Construction

New York State (the "State") has an extensive set of canons of statutory construction that are included in McKinney's Consolidated Laws of New York.[1] N.Y. Stat. Law § 1 *et seq.* (McKinney). In accordance with those canons, the courts of this State historically accorded penal statutes a narrow construction. *Id.* at § 271 ("Generally, penal statutes are strictly construed against the State and in favor of the accused."); *People v. Benc*, 288 N.Y. 318, 323 (1942). The Penal Law includes its own rule of construction: "[t]he general rule that a penal statute is to be strictly construed does not apply to this chapter, but the provisions herein must be construed according to the fair import of their terms to promote justice and effect the objects of the law." N.Y. Penal Law § 5.00 (McKinney) (emphasis added); *see also People v. Eulo*, 63 N.Y.2d 341, 356-57 (1984). Penal Law § 1.05 sets out the purposes of the Penal Law, including "[t]o proscribe conduct which unjustifiably and inexcusably causes or threatens substantial harm to individual or public interests." N.Y. Penal Law § 1.05 (McKinney). These provisions require courts to seek guidance in the terms of the statute, promotion of "justice," and the specific "objects" of the statute.

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[1] As professor Eric Lane explained in *How to Read a Statute in New York: A Response to Judge Kaye and Some More*, 28 Hofstra L. Rev. 85, 107 n.156 (1999), New York's "canons are collected and published as part of New York's privately published code" but are not "legislatively enacted rules of interpretation."

In addition, in *People v. Vetri*, 309 N.Y. 401 (1955), this Court distinguished between the forms of construction to be applied to acts that are *malum in se* and acts that are merely *malum prohibitum*. *Id.* at 405. In particular, those acts categorized as *malum prohibitum* were subject to strict construction. *Id.* (citing *People v. Taylor*, 192 N.Y. 398, 400 (1908); *People v. Werner*, 174 N.Y. 132, 134 (1903)).

C. Applying the Assisted-Suicide Statute to Good-Faith Professional Medical Prescription Writing is Neither Just nor Consonant with the Objects of the Law

The Penal Law provides guidance with respect to statutory construction. The Assisted-Suicide Statute must be "construed according to the fair import of [its] terms to promote justice and effect the objects of the law," N.Y. Penal Law § 5.00 (McKinney) (emphasis added), and to "proscribe conduct which unjustifiably and inexcusably causes or threatens substantial harm to individual or public interests," *id.* at § 1.05 [1].

Despite these admonitions, the entirety of the substantive analysis of the statutory language at the trial court level comprised the conclusion that "[t]he penal law as written is clear and concise, therefore analysis of the legislative intent is irrelevant." (IAS Order[2] at 8) (R. 13). The mere fact that the trial court found the

[2] For simplicity and consistency, the citation format of Brief for Plaintiffs-Appellants have been adopted here.

words of the statute "clear and concise" did not obviate the need for an analysis of those words with a focus on justice and statutory objectives.

Tacitly conceding that the trial court's analysis was incomplete, the Appellate Division went a bit further. Order at 9-10 (R. 470-71). The key consideration of the Appellate Division's decision was the definition of "suicide" in the Merriam-Webster's Collegiate Dictionary. *Id.* at 9 (R. 470). The Appellate Division also cited to this Court's decision in *People v. Duffy,* 79 N.Y.2d 611 (1992), which referred in *dicta* to the "Staff Notes of the Commission on Revision of the Penal Law and Criminal Code . . . which reflected the Commission's conclusion that section 125.15(3) 'applies even where the defendant is motivated by 'sympathetic' concerns.'" *Id.* at 10-11 (R. 471-72). At bottom, however, the Appellate Division's analysis was subject to the same flaws as the trial court's.

Amici respectfully assert that both the Supreme Court and the Appellate Division erred in failing to adequately consider the promotion of justice and the objects of the law in their analyses. Indeed, those concepts were effectively ignored in the analysis.

As to the consideration of justice, two groups are treated unjustly by the lower-court interpretations: mentally-competent terminally-ill patients and their physicians. Justice does not require that the suffering of a mentally-competent terminally-ill patient must be drawn out until the disease reaches its inevitable

conclusion. Simply put, justice does not demand extreme physical suffering. Indeed, justice ought to include empowering a suffering dying patient with the *option* of avoiding further suffering.

That concepts of justice were given insufficient weight in the analysis is made clear by the fact that mentally-competent terminally-ill patients are lumped together with any person who seeks to foreshorten his or her life. Failure to consider the "individual or public interests" of those affected by the statute leads to untenable results. For example, the case of the healthy 17-year old in *People v. Duffy*, 79 N.Y.2d 611 (1992), is considered legally indistinguishable from that of Plaintiff Sara Myers who was in "constant pain" and felt "trapped in a torture chamber of her own deteriorating body." Compl. ¶ 24 (R. 27). It is error to fail to consider the justice of an interpretation that required extending Ms. Myers's life to the last agonizing hours before death.

Similarly, justice does not demand punishment of a physician who uses his or her medical judgment to grant the request of a mentally-competent terminally-ill patient for a more peaceful death by prescribing medication the patient could ingest to achieve this. Physicians are granted great latitude in the application of their judgment to the needs of their patients. Under the lower court's formulation of the statute, a physician is faced with the dilemma that no effective treatment exists, but the patient could, with aid-in-dying medication, shorten his or her

suffering. And yet the patient must suffer a prolonged painful death regardless. A statute based on justice should not require a physician to choose between, on the one hand, the physician's and patient's decision of the proper medical course, and, on the other, possible incarceration.

As to the consideration of the objects of the law, there too the lower court decisions failed to provide a full and fair analysis both as to the statute as written and more generally within the context of the laws of this State. The Appellate Division in particular performed a similar analysis when assessing whether the State had a legitimate government interest. Order at 17 (R. 478). Determining whether the State has a plausible interest, however, is distinct from construing a statute based on its objects. There is nothing in the language of the statute itself that reflects that it is a specific objective of the State to force those in the active process of dying to prolong their suffering. To the contrary, the following scenarios show quite the opposite.

First, under the laws of the State, a mentally-competent terminally-ill patient is permitted to refuse lifesaving medical treatment. As Judge Cardozo explained in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129 (1914), "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." In fact, beyond merely refusing treatment, a patient has the right to demand the active cessation of such treatment. *Matter of Storar*, 52

N.Y.2d 363, 376 (1981). As explained in the Complaint, that right extends to demanding the removal of a feeding tube or intravenous fluids so that death arrives from starvation or dehydration. Compl. ¶ 42 (R. 37). That right also encompasses commanding a physician to switch off a respirator. In those circumstances physicians are given immunity for their role in the foreseeable death of the patient, N.Y. Pub. Health Law § 2986 (McKinney's), despite taking specific actions that will precipitate death. That death, though earlier than modern medicine could procure, is considered benign under the law—consisting of neither murder nor suicide, but instead the natural result of the disease.

Second, and similarly, the same result must surely follow if the patient actively removes his or her own life saving treatment rather than leaves the task to a physician. The act of a patient who manages to turn off his or her own respirator or withdraw his or her own feeding tube or IV could no more be considered a suicide than the same acts with the assistance of a physician. To hold otherwise would require the physician to ignore the patient's decision and reverse the active steps taken, which the law does not permit. *Matter of Storar*, 52 N.Y.2d at 376.

Third, as explained by the U.S. Supreme Court in *Vacco v. Quill*, 521 U.S. 793, (1997), New York practice permits physicians to provide "double effect" medications that will hasten a patient's death. *Id.* at 808 n.11. In other words, medication that will foreseeably lead to death is permitted to alleviate suffering. *Id.*

Here again, the act, conducted with the active participation of a physician and the knowing consent of the patient, is considered neither murder nor suicide.

Fourth, and finally, the scenario contemplated in this action—providing a patient with access to medication via prescription that, if taken by the patient, will foreseeably lead to death. According to the State, the mere writing of a prescription is a criminally culpable act of assisting suicide, whereas removing a feeding tube or IV, shutting off a respirator, or providing terminal sedation are all acts condoned to minimize the suffering of patients. The lack of justice in this position is highlighted by the fact that attempting suicide has long been decriminalized. *Eichner v. Dillon*, 73 A.D.2d 431, 467 (N.Y. App. Div. 1980). A physician, therefore, can be held criminally liable as, in effect, an accomplice to an underlying act that is no longer a crime.

Amici assert that, when taken together, these four scenarios show that requiring suffering to the last possible breath is not consonant with the object of the law. The distinction between these scenarios is more religious than substantive or logical. *See, generally,* Edward Rubin, *Assisted Suicide, Morality, and Law: Why Prohibiting Assisted Suicide Violates The Establishment Clause*, 63 Vand. L. Rev. 763 (2010).

More generally, the lower courts' interpretation of the Assisted-Suicide Statute to apply to medical aid in dying for a mentally-competent terminally-ill

patient simply cannot be squared with New York State's treatment of health care. As discussed above, the State rightly gives great deference to its patients and its medical practitioners in deciding if, how, or when to treat disease. Moreover, New York's government has yet to commit the resources to guarantee universal health care; our government leaves most of us to fend for ourselves. With that background, any suggestion that New York has shown a direct object of its laws to draw out each life to its fullest extent is ahistorical.

Moreover, the people of this State regularly participate in activities with a significant likelihood of cutting short their lives, including those related to obesity, alcohol abuse, smoking, and, of importance here, refusing medical treatment. We do not, as a State, forbid adults from making informed or even uninformed decisions that may and often do hasten death.

Although not necessary to the Court's resolution of this matter, *amici* assert that consideration of the categorization of medical aid in dying as *malum prohibitum* rather than *malum in se* should ease the Court's decision. As conceded by the Respondent, five states have enacted laws to allow medical aid in dying. Resp. Br. at 40-41. At least one other state, Montana, allows the practice under a court decision. *Id.* at 40 n.17. Under those circumstances, it cannot be said that medical aid in dying is *malum in se*—an act that is evil in itself rather than because it is prohibited. *Lloyd Capital Corp. v. Pat Henchar, Inc.*, 80 N.Y.2d 124, 128

(1992); *People v. Cole*, 219 N.Y. 98, 101 (1916) ("[Unlicensed p]racticing medicine, when unaccompanied by acts that are in themselves evil, vicious, and criminal, is not a crime at common law. Practicing medicine is not malum in se. It is important in the interest of public health and public welfare that a person holding himself out as a physician or healer of diseases should have the education, training, skill, and knowledge adequate for such purposes."). Because medical aid in dying would be—if it is criminal at all—*malum prohibitum*, the Court's precedent permits application of a strict construction. *Vetri*, 309 N.Y. at 405-406.

Under that standard, the argument for applying the Assisted-Suicide Statute to the acts of a physician seeking to ease the suffering of a mentally-competent terminally-ill patient are all the weaker. As discussed above, nothing in the statute itself suggests application to professional medical practice similar in practice and result to others conducted legally in this State. The distinction at that point is, as discussed above, more religious rather than substantive—the impending death will occur regardless.

D. The Evolution of New York Law and Medical Practice Make It Inappropriate to Apply the Penal Law Term "Suicide" to Providing Medical Aid in Dying to a Mentally-Competent Terminally-Ill Patient Who Requests It

As discussed above, it is well established that a physician may lawfully perform acts that would be criminal if done by a layperson. In recent decades, New York law has recognized that the century-old doctrine that a patient may refuse

treatment includes the right to refuse life-sustaining treatment and requires that health care professionals take affirmative actions to withdraw such treatment upon demand. A competent patient may appoint a health care agent to make such decisions if and when the patient loses capacity. N.Y. Public Health Law § 2980-94 (McKinney). And in the absence of a health care agent, a family member (surrogate) may do so. *Id.* § 2994 A-U. Moreover, as discussed above, permitted end-of-life medical practice extends beyond merely withdrawing treatment to include the active administration of "double effect" medications (for example, high doses of morphine) that will foreseeably depress the patient's breathing and hasten death.

Except for the health care agent and surrogate decision-making statutes, all of the above practices rely on judicial recognition that they do not come within the meaning of the homicide provisions (including those relating to suicide) of the Penal Law. This is appropriate, because the Penal Law declares that its purpose is to "proscribe conduct which unjustifiably and inexcusably causes or threatens substantial harm to individual or public interests," N.Y. Penal Law §1.05[1] (McKinney), and that it "must be construed according to the fair import of [its] terms to promote justice and effect the objects of the law," *id.* § 5.00.

This understanding of the autonomy rights of patients and professional medical practice may not have been well-recognized fifty-three years ago when the

"Staff Notes of the Commission on Revision of the Penal Law and Criminal Code," cited by the court below, were written. Decisions such as *Eichner v. Dillon* and *Matter of Storar* were yet to come.

The term "suicide" must not, under applicable law and professional medical practice, be construed to include medical aid in dying. There is no legal or moral difference between a physician acting in response to a patient's demand to switch off a respirator and writing the patient a prescription for aid-in-dying medication. The former act is well recognized as not constituting murder or assisting suicide. The latter must not be treated differently.

II. APPLYING THE ASSISTED-SUICIDE STATUTE TO THE CONDUCT AT ISSUE HERE SHOULD REQUIRE LEGISLATIVE ACTION

An important part of the Appellate Department's analysis in this case relied on the Court of Appeal's analysis in *Duffy*. Order at 10 (R. 471). There, the Court cited to the "Staff Notes of the Commission on Revision of the Penal Law and Criminal Code, released in 1964":

> An individual who--like defendant--consciously disregards a substantial and unjustifiable risk that his actions will lead to another person's killing him- or herself and thereby causes that person's death may be just as culpable as one who intentionally causes or aids another to commit suicide (*see,* Staff Notes, *op. cit*., at 339 [noting 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]). In the absence of a clear indication to the contrary, we are simply unwilling to ascribe to the

> Legislature an intent to criminalize the latter conduct while at the same time subjecting the former to no penal sanction at all.

Duffy, 79 N.Y.2d at 615. The relevant portion of the legislative history provides:

> Subdivision 3 substantially restates a former Penal Law section, which defined the crime of "abetting and advising suicide" and classified it as manslaughter in the first degree (§ 2304).
>
> Since such conduct also amounted to murder (§§ 1044[1], 1046), it would certainly have been prosecutable as such under the former law in the absence of any specific suicide provision. Whether the presence of the indicated suicide section (§ 2304) rendered the latter exclusively applicable to such conduct, and outlawed a murder prosecution therefor is not determinable either from the former suicide section itself (§ 2304) or from any judicial decisions.
>
> The question is recognized and explicitly resolved in the Revised Penal Law. All cases of causing or aiding a suicide are prosecutable as second degree manslaughter under the instant provision, but those in which "duress or deception" is used by the defendant are also prosecutable as murder (§ 125.25[1b]). This rule is designed to restrict the more sympathetic cases to manslaughter and, at the same time, to permit the more heinous ones to be prosecuted as murder. Thus, a man who, upon the plea of his incurably ill wife, brings her a lethal drug in order to aid her in ending a tortured existence, is guilty at most of second degree manslaughter. On the other hand, a man who, in order to rid himself of an unwanted wife, deceitfully embarks upon an alleged suicide pact with her and then extricates himself according to plan, leaving her to die, is guilty of murder as well as of second degree manslaughter.

(R. 61). Nothing in the foregoing suggests an intent to either exclude or include physicians within the ambit of the law.

The absence of any discussion of physicians in the legislative history of the act was addressed in the People's brief with the truisms that "omissions from a statute 'are to be remedied by the Legislature,' . . . and 'that courts are not to

legislate under the guise of interpretation.'" Resp. Br. at 27. That argument, however, *assumes* that the Legislature necessarily intended to include within its ambit the actions of physicians. The issue raised by Appellants below, however, was not simply whether the relevant statute should be interpreted to carve out physicians, but instead, whether the statute as written was intended to encompass physicians at all, or can be read to do so now.

The distinction between these two formulations (positive requirement for a legislative carve-out or rational interpretation to exclude) is not merely rhetorical, but instead is a generally unstated but necessary carve-out to many criminal laws. Physicians acting within the scope of their profession are permitted to perform acts that would be criminal if performed by a non-physician. For example, a person who consents to the amputation of a limb is consenting to an act that, if performed by someone other than a physician, would be a criminal act. N.Y. Penal Law § 120.10 (McKinney) ("A person is guilty of assault in the first degree when . . . [w]ith intent to disfigure another person seriously and permanently, or to destroy, amputate or disable permanently a member or organ of his body, he causes such injury to such person or to a third person."). The people of this State, quite literally, place their lives in the hands of their physicians. And, as discussed throughout this *amicus* brief, when applying their professional judgment to the lives and deaths of their patients, physicians are not held to the same standards by which the rest of us

must abide. This result is both logical and pragmatic, as the Legislature is not in a position to approve by statute every act that could conceivably be carried out by a physician with patient consent.

Therefore, *amici* assert that the lower courts failed to adequately consider the special position of physicians in matters of patient life and death. This is not remotely to argue that physician conduct is unfettered, but instead, that when such limitations are interpreted to limit the scope of physician conduct, care should be taken. Given the broad scope of discretion accorded to treating physicians in this State when providing medical care with patient consent, rules of general application that may be interpreted to cabin that discretion should be interpreted narrowly. And, if practicable, where threat of criminal prosecution is to be applied to foreclose physicians from certain consented-to practices, the Legislature should make that application clear in either the statutory language or legislative history as was done in Arkansas. *See* Ark. Code Ann. § 5-10-106 (West).

III. THE OPPONENTS OF MEDICAL AID-IN-DYING RELY ON SLIPPERY SLOPE AND PARADE OF HORRIBLES ARGUMENTS TO SUPPORT THE *STATUS QUO*

The Attorney General of New York, the New York State Catholic Conference, the Disability Rights *Amici*, and the 39 Physicians *Amici* all express their disagreement with the Appellant using the same well-worn rhetorical forms: the slippery slope and the parade of horribles. We are told that providing access to

medical aid-in-dying to mentally-competent terminally-ill patients will inevitably lead to incalculable societal harms beyond measure. They argue that medical aid-in-dying will be targeted at the poor and disabled. *See*, *e.g.*, Resp't Br. 12; Catholic Conference Br. at 29; Disability Rights Br. at 16-17. They argue that non-terminal patients or even physically healthy people will be drawn to suicide because they heard media reports that mentally-competent terminally-ill people were able to end their suffering. Catholic Conference Br. at 19; Disability Rights Br. at 20-21. And all subtly or not so subtly bring in the wholly distinct and unrelated concept of euthanasia to make their case. Resp't Br. at 50, 39 Physicians Br. at 8; Catholic Conference Br. at 23; Disability Rights Br. at 18. Indeed, both the 39 Physician *Amici* and the Respondents argue that "'aid-in-dying' is the same as euthanasia" (Resp't Br. at 30; 39 Physician Br. at 8)—a conclusion for which neither provides a shred of evidence. Black's Law Dictionary, Abridged Sixth Ed. (1997), defines euthanasia as "[t]he act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy," suggesting a third-party act rather than self-determination, as is at issue here. *See In re Zornow*, 31 Misc. 3d 450, 456 (N.Y. Sup. Ct. 2010); *People v. Minor*, 28 Misc. 3d 278, 280 (N.Y. Sup. Ct. 2010).

Beneath these rhetorical arguments, four threads of argument may be teased out: (1) the taking of one's own life has been disfavored for centuries; (2) the role

of doctors is to heal rather than harm; (3) the State has an interest in preserving all human life; and (4) there is a risk that patients will consider monetary concerns and inadequate access to care.

As to historical practice, none of those citations to the past are argued to have been directed to the specific acts of a physician using medical judgment to permit a mentally-competent terminally-ill patient to determine his or her own fate. *See* Resp't Br. at 34 (referring generally to the prohibition against suicide); Catholic Conference Br. at 9 (same). Reliance upon general historical statements provide little guidance today, where patients are already given the ability to shorten their lives by refusing or terminating life-sustaining treatment and receiving pain medication at levels that knowingly hasten death. And as correctly stated by Appellants, those arguments give no credence to the fundamental shifts in people's perceptions over that span. Appellant Br. at 35 (citing *Obergefell v. Hodges*, 135 S. Ct. 2584, 2602 (2015)).

Next, as to the argument that a physician's only role is to heal, currently accepted medical practice belies this limited characterization. Physicians in this State are called upon to take actions that will hasten patient deaths, for example, turning off a respirator or providing conscious sedation. A telling disposition on the flaw in the opposition's reasoning is provided by the Catholic Conference in straining to distinguish "between action and omission." Catholic Conference Br. at

10. The Catholic Conference considers acceding to a refusal of medical treatment as merely an act of omission rather than action. *Id.* This false distinction is founded in the fiction that removing life-extending treatment at a patient's request is somehow passive. Sedating someone into unconsciousness while withdrawing food and water is not passive. "Pulling the plug" is not passive. These are affirmative acts, though no doubt difficult, that are now an intrinsic part of medical care.

The argument that the State is interested in preserving all life is similarly flawed. As an initial matter, as discussed in the preceding paragraph, that argument conflicts with legally-recognized professional medical reality. More generally, this State permits its adult citizens to make a vast array of decisions that are likely to foreshorten their lives including smoking, drinking alcohol, and overeating. The state has policies to discourage these and other life-shortening practices, but they are not forbidden. In addition, the State does not provide universal access to health care. The State has not, in practice, evinced a specific interest in drawing out each and every life to the fullest extent.

Finally, the allusions to the unfair burden that access to medical aid-in-dying would place on those without access to proper health care is mystifying. Terminal illnesses are not confined to any one economic slice of the populace. Indeed, it is at least as plausible that aid in dying would be utilized more fully by those with the means to access that form of care. The logic applied by those in opposition, in

effect, is that it would be unfair to give a mentally-competent terminally-ill patient access to medical aid in dying precisely because that patient lacks access to proper care. Regardless of the merits of this logic, the statistics published annually by the State of Oregon for their Death with Dignity Act contradicts these false assumptions. *See*, *e.g.*, Oregon Death With Dignity Act: 2015 Data Summary 5 (2016), https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf (noting that the vast majority of relevant patients possessed health insurance).

CONCLUSION

The lower courts ruled based on a strictly literal construction and without a complete record. The resulting construction is contrary to the law's objectives and the promotion of justice. The consented-to actions of a physician to a mentally-competent terminally-ill patient are not fairly within the reach of the Penal Law as written. For the foregoing reasons, *amici* respectfully request that the judgment of the Appellate Division be reversed.

Dated: April 17, 2017
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Respectfully submitted,

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Certification

I certify pursuant to § 500.13(c) of the Rules of Practice of this Court that the total word count for all printed text in the body of the brief is 5,117.

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