To Be Argued By:
EDWIN G. SCHALLERT
Time Requested:25 Minutes

APL-2016-00129
New York County Clerk's Index No. 151162/15

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 PLAINTIFFS-APPELLANTS

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November 15, 2016

CORPORATE DISCLOSURE STATEMENT

Plaintiff-Appellant End of Life Choices New York is an independent non-profit organization with no parents, subsidiaries, or affiliates.

Dated: November 15, 2016
New York, New York

Respectfully submitted,

DEBEVOISE & PLIMPTON LLP

By: _____

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Plaintiffs-Appellants ("Plaintiffs") appeal from the June 3, 2016 order of the Appellate Division, First Department (the "Order"), which affirmed, and modified on the law, the order of the Supreme Court, New York County (Joan M. Kenney, J.) granting the pre-answer motion to dismiss the Complaint of Defendant-Respondent Attorney General ("Defendant").

PRELIMINARY STATEMENT

This action was brought by mentally-competent, terminally-ill patients and by medical professionals who regularly treat such patients. The patients seek to exercise control and avoid loss of dignity and unbearable suffering in the final stages of dying by having the option to obtain from their physicians a prescription for medication they could ingest to achieve a peaceful death – a practice known as aid-in-dying. The Complaint sought a declaration that a physician who provides aid-in-dying does not violate New York's Assisted Suicide Statute.[1] Alternatively, if the Assisted Suicide Statute applies to aid-in-dying, the Complaint sought a declaration that its application would violate the Due Process Clause and the Equal Protection Clause of New York's Constitution.

[1] New York Penal Law Sections 120.30 and 125.15(3) (the "Assisted Suicide Statute" or the "Statute") provide that "promoting a suicide attempt" by "intentionally caus[ing] or aid[ing] another person to attempt suicide" or "to commit suicide" constitute felonies.

The Appellate Division committed multiple legal errors in affirming dismissal of the Complaint. *First*, the Appellate Division erroneously held as a matter of law that the Assisted Suicide Statute prohibits aid-in-dying. In misinterpreting the Statute, the Appellate Division employed a dictionary definition of "suicide" that the Legislature repealed, and it applied a "literal" approach to the Statute that would make criminal many other end-of-life treatments that are lawful and practiced routinely in New York. It construed the Statute in a manner that is inconsistent with its purpose and finds no support in its legislative history.

The Appellate Division's interpretation of the Statute also improperly resolved numerous factual issues. The Complaint and supporting affidavits alleged that aid-in-dying is distinct from suicide; that it is a medically and ethically appropriate treatment option for patients facing unbearable suffering in the final stages of the dying process; that it is indistinguishable from other lawful medical practices that result in a patient's death, such as terminal sedation; and that the death of a person who chooses aid-in-dying is caused by the patient's underlying terminal illness. Giving Plaintiffs "the benefit of every possible favorable inference," the facts as alleged fit within a "cognizable legal theory." *Leon v. Martinez,* 84 N.Y.2d 83, 87-88 (1994).

Second, the Appellate Division erred in dismissing Plaintiffs' claim that application of the Assisted Suicide Statute to aid-in-dying would violate their rights under the Due Process Clause of New York's Constitution. New York has long recognized a broad fundamental right to self-determination with respect to one's body and to control the course of one's medical treatment. This Due Process right encompasses a patient's right to choose aid-in-dying, just as it encompasses a patient's right to choose other end-of-life options. The Complaint alleged that the choice of aid-in-dying is a final autonomous act of a patient who otherwise faces unbearable suffering or must surrender all consciousness and languish with loss of control and dignity until death arrives. This choice directly implicates the fundamental right. Accordingly, the prohibition on aid-in-dying must be subject to strict scrutiny.

The Appellate Division, however, relied on the U.S. Supreme Court's holding nearly twenty years ago that a state's ban of aid-in-dying did not violate a due process right under the *federal* Constitution, which did not encompass the same right to self-determination.[2] Since that ruling, the Supreme Court has recognized that evolving societal views influence the content of fundamental rights. To the extent federal jurisprudence informs the interpretation of New

[2] When the Supreme Court ruled, there was no open practice of aid-in-dying in the United States. Twenty years later, abundant data demonstrate that no harm arises when aid-in-dying is an option. *See infra*, Section II.B.

York's Constitution, Plaintiffs detail how evolving views support aid-in-dying. Rather than crediting these allegations, the Appellate Division improperly weighed the "evidence" of this evolution on a motion to dismiss.

Even absent a fundamental right, the Appellate Division erred in ruling as a matter of law that aid-in-dying was rationally related to a legitimate government interest. The Complaint and supporting affidavits amply demonstrated that experience with aid-in-dying in states where it is practiced reveal there is no legitimate government interest in prohibiting the practice. Indeed, all of the asserted government interests are promoted when this end-of-life option is available.

Third, the Appellate Division erred in rejecting on a motion to dismiss Plaintiffs' claim for violation of the Equal Protection Clause of the New York Constitution. The lower court failed to credit allegations of a fundamental right that encompasses aid-in-dying. In any event, the Complaint adequately alleged that there is no rational basis for differentiating patients who choose aid-in-dying from other patients in the final stages of dying who choose other forms of medical care that precipitate death.

The facts alleged in the Complaint, and the affidavits submitted in opposition to Defendant's motion to dismiss, more than suffice to state a statutory claim as well as claims under the Due Process and Equal Protection Clauses of

New York's Constitution. Plaintiffs' claims should proceed so Plaintiffs have their day in court to present the profoundly important issues raised by this lawsuit.

QUESTIONS PRESENTED

1. Did the lower court err in holding on a motion to dismiss that the Assisted Suicide Statute applies to physicians who provide aid-in-dying?

2. Did the lower court err in holding on a motion to dismiss that application of the Assisted Suicide Statute to aid-in-dying does not violate the Due Process Clause of the New York Constitution when it (i) held that New York's broad fundamental right to self-determination with respect to one's body and to control the course of one's medical treatment does not encompass the option of aid-in-dying; and (ii) held that a ban on aid-in-dying is rationally related to a legitimate government interest, notwithstanding Plaintiffs' well-supported allegations to the contrary?

3. Did the lower court err in rejecting on a motion to dismiss Plaintiffs' claim under the Equal Protection Clause of the New York Constitution?

STATEMENT OF THE CASE

The Complaint

On February 4, 2015, Plaintiffs filed in New York Supreme Court, New York County a Complaint seeking a declaration that "the Assisted Suicide Statute does not encompass the conduct of a physician who provides aid-in-dying to a

mentally-competent, terminally-ill individual who has requested such aid." Compl. ¶ 3 (R. 23). In the alternative, the Complaint sought a declaration that the application of the Assisted Suicide Statute to aid-in-dying would violate the Due Process and Equal Protection provisions of the New York State Constitution. *Id.* [3]

The 26-page Complaint included detailed factual allegations. To begin with, aid-in-dying is "a recognized term of art for the medical practice of providing a mentally-competent, terminally-ill patient with a prescription for medication that the patient may choose to take in order to bring about a peaceful death if the patient finds his or her dying process unbearable." Compl. ¶ 38 (R. 36). For some patients, "providing aid-in-dying is, in the professional judgment of a physician, a medically and ethically appropriate course of treatment." *Id.* ¶ 45 (R. 38). Moreover, aid-in-dying is indistinguishable from other end-of-life options that are openly practiced in New York. For example, a terminally-ill patient suffering from overwhelming physical pain may choose "terminal" sedation – "the administration of drugs to keep the patient continuously in deep sedation, with food and fluid withheld until death arrives." *Id.* ¶ 1 (R.22). Patients also may choose to have

[3] The Complaint named as defendants the New York State Attorney General and the District Attorneys for each district in which a Plaintiff resides or has an office. Rather than burdening the Court with additional filings, Plaintiffs and the District Attorneys entered into a stipulation that they would be bound by any result reached in the litigation between Plaintiffs and the Attorney General. As part of the stipulation, this action was discontinued without prejudice as to the District Attorney defendants. Order at 4-5 (R. 465-66).

ventilators unplugged or feeding tubes withheld, or may choose to stop eating or drinking until death arrives. *Id.* ¶¶ 40, 42 (R. 36, 37).

"Public health, medical, and mental health professionals . . . recognize that the choice of a dying patient for a peaceful death through aid-in-dying is not suicide, just as withholding or withdrawal of treatment or the choice of terminal or palliative sedation is not suicide." *Id.* ¶ 44 (R. 38). The Complaint alleges that "[i]t is recognized that what is causing the death of a patient choosing aid-in-dying is the underlying terminal illness." *Id.* ¶ 38 (R. 36). Rather than "destroying himself or herself," the choice of aid-in-dying is "a final autonomous act of a patient who chooses to avoid the final ravages of disease in the face of impending death, thereby preserving the coherence and integrity of the life the patient has lived." *Id.* ¶ 44 (R. 38).

The Complaint particularized these facts with the experiences of individual patient and physician plaintiffs. For example, Sara Myers was a 60-year old terminally-ill, mentally-competent patient suffering from amyotrophic lateral sclerosis ("ALS"), also known as Lou Gehrig's disease. *Id.* ¶ 22 (R. 26). She was enduring "progressive and inexorable loss of bodily function and integrity." *Id.* ¶ 23 (R. 26). Her disease caused "constant pain," and she felt "trapped in a torture chamber of her own deteriorating body." *Id.* ¶ 24 (R. 27). She wished "not to have

to endure a horrible, slow death that would, in her considered judgment, deprive her of the integrity and dignity she has left." *Id.*

Plaintiff Steve Goldenberg was 55 years old and suffered from AIDS, coronary artery disease, "hypertension, diabetes mellitus, macular degeneration, chronic pain, arthritis, vascular disease – which necessitated amputation of part of his foot and a bypass in his leg – chronic obstructive pulmonary disease and chronic bronchitis, hyperlipidemia, hypothyroidism and recurring candida esophagitis." *Id.* ¶ 27 (R. 28). As a result of cancer in the vocal chords and radiation treatment, he could not swallow food and submitted to surgical insertion of a gastric feeding tube in 2014. He depended on supplemental oxygen supply and was tethered to it most of the day. He slept about 19 hours a day and took 24 medications in his waking hours. He wished not to have to choose between "continuing the painful, lingering decline to death" and the undignified and torturous "route of starving or dehydrating himself to death." *Id.* ¶ 28 (R. 29).[4]

[4] Sara Myers and Steve Goldberg both passed away during this litigation. Because the rights sought to be enforced survive as to the remaining Plaintiffs, "the action does not abate" and "shall proceed." CPLR § 1015(b). One of the remaining Plaintiffs is Eric Seiff, a practicing attorney who was diagnosed with bladder cancer in 2013. He watched his mother "endure a protracted and excruciating dying process" and is "concerned about the devastating emotional consequences for him and his family from a needlessly protracted death." Compl. ¶ 30 (R. 30).

Each of the patient Plaintiffs viewed it as "critical to [their] sense of dignity, autonomy and personal integrity that the option of aid-in-dying be an available end-of-life option." *Id.* ¶ 30 (R. 30). Each of the physician Plaintiffs believe that, without such medical assistance, "these patients cannot achieve a peaceful death in a certain and humane manner." *Id.* ¶¶ 31-35 (R. 31-34). However, uncertainty about the application of the Assisted Suicide Statute deters them from exercising their best professional judgment to provide aid-in-dying. *Id.*

Defendant's Motion To Dismiss

On April 13, 2015, Defendant Schneiderman filed a pre-answer motion to dismiss the Complaint pursuant to CPLR § 3211 (a)(7) on the ground that the Complaint failed to state a cause of action, and pursuant to CPLR § 3211(a)(2) on the ground that the Complaint does not present a justiciable controversy. (R. 46). Plaintiffs opposed the motion and, in accordance with settled law, submitted affidavits buttressing the allegations of the Complaint. *Leon*, 84 N.Y.2d at 88 (on a motion to dismiss, the court may "freely consider affidavits submitted by the plaintiff").

Plaintiffs set forth additional facts in more than 300 pages of supplementary submissions, including:

- One of the physician Plaintiffs is Dr. Timothy Quill, a preeminent palliative care doctor, former President of the American Academy of Hospice and

Palliative Medicine, and Professor in the Palliative Care Division within the Department of Medicine at the University of Rochester Medical Center. Dr. Quill submitted an affidavit explaining his personal experience in providing aid-in-dying to a patient in 1990. He wrote about the experience in an article published in the March, 1991 issue of the *New England Journal of Medicine,* which prompted the Monroe County District Attorney to seek an indictment under the Assisted Suicide Statute. (The grand jury eventually declined to indict Dr. Quill, and the New York State Medical Board decided not to revoke his medical license.) Affidavit of Dr. Timothy E. Quill (Apr. 27, 2015) ("Quill Aff.") ¶¶ 14-17 (R. 430-31). Dr. Quill explained how the practice could be used for "a small number of patients" who are "terminally-ill, suffering intolerably from their disease despite receiving state-of-the-science palliative care, and who have requested aid-in-dying." *Id.* ¶ 23 (R. 433). He also noted that "[p]hysicians in New York are allowed to take terminally-ill patients off of a ventilator, to heavily sedate them to unconsciousness, and to withhold food and fluid to precipitate death in response to severe, otherwise unrelievable suffering." *Id.* ¶ 24 (R. 433).

- Policies adopted by the American Public Health Association and other major national associations of medical professionals recognize that aid-in-dying is *not* assisted suicide. Affirmation of Edwin G. Schallert Aff. (Apr. 28, 2015) ("Schallert Aff.") Exs. 1-4 (R. 144-57). These organizations described how the

practice of aid-in-dying operates in states where the practice is available – either by virtue of statute or court rulings. For example, studies have shown that an open practice of aid-in-dying has "galvanized significant improvement in the care of the dying in Oregon." *Id.,* Ex. 1 (R. 145). Studies also have found that aid-in-dying has no adverse impact on end-of-life care but rather it "in all probability has enhanced the other options." *Id.* Moreover, having the option of aid-in-dying "gives the terminally ill autonomy, control and choice," which physicians had identified as "the overwhelming motivational factor behind the decision" to seek the option. *Id.*

- Two physicians submitted affidavits about their experience providing aid-in-dying in states where the option is available.[5] Both physicians described why aid-in-dying is a compassionate end-of-life treatment option, how it differs from suicide, how it is indistinguishable from various other end-of-life options that precipitate death in terms of the intent of patient and physician, and how the practice has provided enormous comfort to patients and their families. Affidavit of Dr. Eric Kress (Apr. 24, 2105) ("Kress Aff.") (R. 435); Affidavit of Dr. Katherine Morris (Apr. 24, 2015) ("Morris Aff.") (R. 441).

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[5] In Montana, the State Supreme Court held that nothing in the state's statutes indicates that physician aid-in-dying is against public policy. *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009). In Oregon, a statute has permitted the practice since 1994. OR. REV. STAT. § 127.800 et seq.

The Rulings Below

On October 23, 2015, the Supreme Court (Joan M. Kenney, J.) (the "IAS Court") issued a decision and order granting Defendant's pre-answer motion to dismiss pursuant to CPLR § 3211 (a)(7). Although the IAS Court held that it had jurisdiction because Plaintiffs "successfully pled that they are entitled to judicial review of the statutes in question," (IAS Order at 6) (R. 11) the Court concluded that the Complaint failed to state a cause of action. The IAS Court's decision neither addressed nor credited the factual allegations of the Complaint. The IAS Court also failed to address Plaintiffs' cause of action alleging a violation of Plaintiffs' Due Process rights.

Plaintiffs timely filed a notice of appeal to the Appellate Division. (R. 459). On May 3, 2016, the Appellate Division affirmed the IAS Court's dismissal of the Complaint and modified it on the law to declare that (1) the Assisted Suicide Statue provides a valid statutory basis to prosecute physicians who provide aid-in-dying, and (2) to the extent the Assisted Suicide Statute prohibits a physician from providing aid-in-dying, such an application does not violate the New York State Constitution. Order at 24 (R. 485).

In addressing the constitutional claims, the Appellate Division viewed Plaintiffs as "start[ing] from a position of relative weakness" because of decisions by the U.S. Supreme Court in 1997. Order at 12 (R. 473). In *Washington v.*

Glucksberg, 521 U.S. 702 (1997), the Court held that Washington's ban on assisted suicide did not violate substantive due process under the U.S. Constitution. In *Vacco v. Quill*, 521 U.S. 793 (1997), the Court held that New York's prohibition on assisted suicide did not violate the Equal Protection Clause of the Fourteenth Amendment when applied to a physician who provides aid-in-dying.[6] However, the Supreme Court made clear that it was not "foreclose[ing] the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom," *id.* at 809 n.13 (quoting Stevens, J., concurring), nor was it "foreclose[ing] the possibility that an individual plaintiff . . . could prevail in a more particularized challenge." *Glucksberg*, 521 U.S. at 734 n.24 (quoting Stevens, J., concurring).

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[6] In *Quill*, the federal courts addressed only the constitutional question and never construed the reach of the New York Statute. The federal district court in *Quill* specifically noted that the complaint *assumed* that the Assisted Suicide Statute applied to aid-in-dying. *See Quill v. Koppell*, 870 F.Supp. 78, 80 (S.D.N.Y. 1994) ("The original complaint alleged . . . that . . . New York Penal Law makes it a crime to render [aid-in-dying] . . . ."). A majority of the Second Circuit then addressed the statute "to the extent" that it prohibited aid-in-dying, *Quill*, 80 F.3d 716, 718 (2d Cir. 1996), notwithstanding serious doubts that the Assisted Suicide Statute was "ever meant to apply to a treating physician." *Id*. at 732 (Calabresi, C.J., concurring). The Supreme Court thus reached the constitutional issues even though the Statute "had never been interpreted by the state courts" and "despite the concession of the parties that, under certain interpretations, the statutes would avoid constitutional challenge." *Tunick v. Safir*, 209 F.3d 67, 74 (2d Cir. 2000).

Plaintiffs timely filed a Notice of Appeal to this Court on June 3, 2016 (R. 459), and now seek a reversal of the lower court's decision and order.

STATEMENT OF JURISDICTION

Plaintiffs appeal to this Court from each and every part of the Order of the Appellate Division, which affirmed dismissal of the Complaint and held, in part, that application of the Assisted Suicide Statute to prohibit aid-in-dying "does not violate the New York State Constitution." Order at 24 (R. 485). This Court has jurisdiction to hear this appeal pursuant to CPLR § 5601(b)(1), which provides that "[a]n appeal may be taken to the court of appeals as of right . . . from an order of the appellate division which finally determines an action where there is directly involved the construction of the constitution of the state or of the United States." The appeal raises substantial questions under the New York State Constitution concerning fundamental liberties and equal protection under the law with respect to the autonomy, privacy, bodily integrity, and self-determination of a patient near death to control that patient's choice of medical treatment, how much suffering the patient must endure prior to death, and how that patient will cross the threshold to

death. No court has previously addressed these constitutional issues that were necessarily decided by the lower courts and are directly involved in this appeal.[7]

ARGUMENT

I. THE APPELLATE DIVISION ERRED IN HOLDING, AS A MATTER OF LAW, THAT THE ASSISTED SUICIDE STATUTE PROHIBITS AID-IN-DYING.

The Appellate Division properly framed the statutory issue in observing that "[t]he paramount goal in interpreting a statute is to effectuate the intent of the legislature." Order at 8 (R. 469); *see People v. Ryan,* 274 N.Y. 149, 152 (1937) ("The legislative intent is the great and controlling principle."). However, the lower court misinterpreted the Assisted Suicide Statute in this instance by employing a dictionary definition of "suicide" and a "literal" approach to the law, and it ignored factual issues raised by its interpretation of the Statute that could not be resolved on a motion to dismiss. Moreover, the Appellate Division's application of the Assisted Suicide Statute to aid-in-dying is inconsistent with the purpose of the law and finds no support in the Statute's legislative history.

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[7] Plaintiffs' letter to the Chief Clerk and Legal Counsel of the Court dated June 24, 2016, explained in detail why substantial constitutional questions are directly involved in this appeal.

A. The Appellate Division's "Literal" Interpretation Of The Assisted Suicide Statute Is Flawed And Does Not Justify Dismissal of the Complaint.

The Appellate Division relied on a dictionary definition in interpreting the Assisted Suicide Statute, but that definition is virtually identical to a definition that the New York Legislature *repealed* nearly a hundred years ago. Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193, repealing Act of July 26, 1881, ch. 676, § 172, 1881 N.Y. Laws (defining suicide as "the intentional taking of one's own life"); *see* Order at 9 (R. 470) (quoting Merriam Webster's Collegiate Dictionary (11th ed. 2003)) (defining suicide as "the act or instance of taking one's own life voluntarily and intentionally"). The Legislature could not have intended that courts would interpret a statute using a definition it repealed.

In any event, the dictionary definition recited by the Appellate Division raises a factual issue that should not have been decided on a motion to dismiss: whether a physician who prescribes medication for aid-in-dying is assisting "the intentional taking" of a life. The Complaint alleges that the patient plaintiffs' lives are being "taken" by terminal diseases. "It is recognized that what is causing the death of a patient choosing aid-in-dying is the underlying terminal disease." Compl. ¶ 38 (R. 36). Expert opinions are in accord. Kress Aff. ¶ 12 (R. 439-40); Morris Aff. ¶ 12 (R. 444). Indeed, in states where aid-in-dying is practiced openly, death certificates list the underlying terminal disease as the cause of death. *E.g.*,

WASH. REV. CODE ANN. § 70.245 ("the patient's death certificate . . . shall list the underlying terminal disease as the cause of death"); Schallert Aff. Ex. 8 at 48-49 (Oregon) (R. 326-27) ("the attending physician [should] complete the death certificate with the underlying terminal condition(s) as the cause of death, and the manner of death as 'natural'").

Moreover, the Complaint alleged that the intent of patients who choose aid-in-dying is not to take their lives. "Rather than destroying himself or herself, this choice is a final autonomous act of a patient who chooses to avoid the final ravages of disease in the face of impending death, thereby preserving the coherence and integrity of the life the patient has lived." Compl. ¶ 44 (R. 38). Affidavits supporting the Complaint confirm that a physician prescribing the medication for aid-in-dying provides a patient with peace of mind, helps preserve the patient's integrity and dignity, and helps avoid unbearable suffering and prolonged and unrelieved anguish. *See, e.g.*, Kress Aff. ¶ 7 (R. 437-38); Quill Aff. ¶ 19 (R. 431). Plaintiffs' allegations were entitled to "the benefit of every possible favorable inference" at the pleading stage and were thus more than sufficient to support Plaintiffs' claim that aid-in-dying is not assisted suicide. *See Leon*, 48 N.Y.2d at 87.

The Appellate Division nonetheless held that aid-in-dying fits the "literal description" of assisting suicide "since there is a direct causative link between the

medication proposed to be administered by plaintiff physicians and their patients' demise." Op. at 9-10 (R. 470-71). This "literal" approach would make criminal several accepted end-of-life options that are practiced routinely in New York – an absurd result the Legislature could not have intended. *See* N.Y. STAT. § 145 ("A construction which would make a statute absurd will be rejected.").[8]

The Complaint and supporting affidavits explain why as a factual matter aid-in-dying is similar to other end-of-life options where a patient requests medical care that precipitates death. Compl. ¶¶ 40-44 (R. 36-38); Kress Aff. ¶ 9 (R. 438-39); Morris Aff. ¶ 17 (R. 466); Quill Aff. ¶ 24 (R. 433). For example:

- When a physician at the request of a patient turns off a ventilator, there is a "direct causative link" between the physician's act and the patient's demise through asphyxiation. *See* Compl. ¶ 40 (R. 36). But-for turning off the machine, the patient would remain alive. Yet the physician's act is not deemed "assisted suicide."

- When a physician at the request of a patient sedates the patient to unconsciousness, while food and fluid are withheld, there is a "directive causative link" between the physician's act and the patient's death. *See id.* ¶ 41 (R. 37). The use of sedatives themselves can cause a patient's death. *See* Kress Aff. ¶ 9 (R. 438-39). Yet this medical practice of "terminal sedation" is not deemed "assisted suicide."

- When a physician at the request of a patient orders withdrawal of nutrition or hydration, there is a "direct causative link" between that

[8] *Surace v. Danna*, 248 N.Y. 18, 21 (1928) (Cardozo, Ch. J.) ("Few words are so plain that that the context or the occasion is without capacity to enlarge or narrow their extension. The thought behind the phrase proclaims itself misread when the outcome of the reading is injustice or absurdity.").

act and the patient's death through starvation or dehydration. *See* Compl. ¶ 42 (R. 37). Yet the physician's act is not deemed "assisted suicide."

The Legislature could not have intended the Assisted Suicide Statute to apply to aid-in-dying in light of the acceptance in both law and medicine of these other end-of-life options. Writing a prescription empowering a suffering, dying patient with the option of a peaceful death involves a *less* active role for the physician than is required for other end-of-life options that precipitate death. Withdrawal of life support requires physicians, or those acting at their direction, physically to remove equipment; terminal sedation requires the intravenous administration of sedating drugs by the physician.[9] Moreover, while there is a direct link between other end-of-life options and a patient's death, the link between aid-in-dying and a patient's death is more attenuated and often nonexistent. A multi-year study in Oregon – where aid-in-dying has been practiced for nearly two decades – found that nearly 40% of patients ultimately did not ingest the aid-in-dying medication they were prescribed. *See* Schallert Aff. Ex. 9, at 3 (R. 408). Aid-in-dying allows patients a crucial sense of control, providing great comfort even when there is no link between the medication and their death. *See* Richard A.

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[9] The Appellate Division committed a factual error in describing aid-in-dying because a physician does not "administer" medication (Decision at 9) (R. 470), but rather prescribes medicine that a patient can choose to take or not. *See* Compl. ¶ 38 (R. 36).

Posner, AGING AND OLD AGE 239-40 (1995) ("Knowing that if life becomes unbearable one can end it creates peace of mind and so makes life more bearable."); Schallert Aff. Ex. 1, at 1 (In Oregon, "a significant number of patients obtain the medications but do not go on to take them, reflecting that these patients are comforted to have this option").

Although the Complaint explains why aid-in-dying is not assisted suicide, the Appellate Division found that this Court had "obliquely" addressed aid-in-dying in *People v. Duffy*, 79 N.Y.2d 611 (1992), in a manner that "suggests" that the Statute prohibits aid-in-dying. Order at 10 (R. 471). However, the facts of *Duffy* stand in stark contrast to the situation of a mentally-competent, terminally-ill patient suffering inexorable deterioration before an inevitable death. *Duffy* involved a severely depressed, inebriated, physically healthy teenager distraught at breaking up with his girlfriend. 79 N.Y.2d at 613. The teenager met defendant on the street and told him of his desire to kill himself. *Id.* Defendant invited the boy to his apartment, where the teenager continued to express suicidal thoughts and begged the defendant to shoot him. *Id.* In response, the defendant gave the boy more alcohol, encouraged him "to jump headfirst off the porch of his second-story apartment," and finally handed him a gun and ammunition, urging him to "put the gun in his mouth and blow his head off." *Id.* The youngster did so. *Id. Duffy*

exemplifies an appropriate application of the Assisted Suicide Statute on facts that are starkly different from those presented in this case.

The Staff Notes cited in *Duffy*, to which the Appellate Division referred (Op. at 11 (R. 472)), make no reference to a terminally-ill, mentally-competent patient under the care of a physician. Rather, they mention a hypothetical involving a husband who brings a lethal drug to his terminally-ill wife. The hypothetical addresses an entirely different situation involving a lay person with no medical training who is not authorized to practice medicine. By contrast, physicians who prescribe medication for aid-in-dying are empowered by the State to take a variety of actions that may precipitate death – such as terminal sedation, or withdrawing a ventilator – and they are bound by professional and ethical standards, which apply equally to aid-in-dying. *See* Kress Aff. ¶ 12 (R. 439-40); Morris Aff. ¶ 16 (R. 445-46).

B. The Appellate Division's Interpretation Of The Statute Is At Odds With Its Purpose And Legislative History.

The Appellate Division's interpretation of the Assisted Suicide Statute also is flawed because it is inconsistent with the purpose of the Penal Laws and finds no support in the Statute's legislative history. As this Court has held, "[i]n 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.'" *Ryan,* 274 N.Y. at 152 (citation omitted); *Cabell v. Markham,* 148 F.2d 737, 739 (2d Cir. 1945) (L. Hand, C.J.) ("it is one of the surest indexes of a mature and developed jurisprudence not to make a fortress out of the dictionary; but to remember that statutes always have some purpose or object to accomplish, whose sympathetic and imaginative discovery is the surest guide to their meaning."), *aff'd*, 326 U.S. 404 (1945).[10]

A fundamental purpose of the Penal Law is "[t]o prescribe conduct which unjustifiably and inexcusably causes or threatens substantial harm to individual or public interests." N.Y. PENAL LAW § 1.05(1). Aid-in-dying does not unjustifiably and inexcusably threaten harm to individuals. To the contrary, aid-in-dying avoids the brutal harm of forcing a dying patient to endure suffering they find unbearable before their inevitable death arrives. As alleged in the Complaint and supporting affidavits, aid-in-dying is a "medically and ethically appropriate course of

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[10] *See also Matter of Jacob*, 86 N.Y.2d 651, 658 (1995) (in "strictly construing" adoption statute to permit unmarried partners of biological mothers to adopt respective mothers' children, "[the court's] primary loyalty must be to the statute's legislative purpose"); *In the Matter of Alison D. v. Virginia M.*, 77 N.Y.2d 651, 659 (1991) ("in the absence of express legislative direction [we] have attempted to read otherwise undefined words of the statute so as to effectuate the legislative purposes") (Kaye, J., dissenting), *overruled*, *Brooke S.B. v. Elizabeth A.C.C.*, 28 N.Y.3d 1 (2016) (adopting Judge Kaye's dissent and holding the statutory term "parent" under the Domestic Relations Law is not limited to a biological parent; "We agree that, in light of more recently delineated legal principles, the definition of 'parent' established by this Court 25 years ago in *Alison D.* has become unworkable when applied to increasingly varied familial relationships.").

treatment" for terminally-ill patients who otherwise face the prospect of "a horrible, slow death" and believe this option is critical to their "sense of dignity, autonomy and personal integrity." Compl. ¶¶ 45, 24, 30 (R. 38, 27, 30). The distinguished physician Plaintiffs assert that it is "consistent with the highest standards of medical practice" to provide aid-in dying. *Id.* ¶¶ 31-33, 35 (R. 30-33).

The Complaint's allegation that aid-in-dying benefits individuals raises factual issues that implicate the opinions of medical professionals, which cannot be adjudicated on a motion to dismiss.

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

Matter of Eichner (Fox), 73 A.D.2d 431, 462 (2d Dep't 1980) (citations omitted), *order modified by*, *Matter of Storar*, 52 N.Y.2d 363 (1981).

The Appellate Division's interpretation of the Statute is inconsistent with the purpose of the Penal Law because it causes substantial harm to individuals. The Supreme Court of Canada concluded, based on a fully developed trial record, that a prohibition on a physician-assisted death risks substantial harm. The Court observed that "the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be

incapable of doing so when they reached the point where suffering was intolerable." *Carter v. Canada (Attorney General),* 2015 SCC 5, ¶ 57 (2015) (Schallert Aff. Ex. 6) (R. 206). As the Court noted, a person who is grievously and irremediably ill who cannot seek a physician's assistance "has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes." *Id.* ¶ 1 (R. 180).[11] Obviously, both options harm the patient.[12]

Nor does the Appellate Division's interpretation of the Assisted Suicide Statute advance the public interest. There is ample evidence of a "time-honored

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[11] A patient who finds herself trapped in unbearable suffering may inflict a fatal gunshot while the patient still has the strength to do so, as was movingly recounted by Dr. Marcia Angell, whose father did this. *See* Marcia Angell, *No Choice but to Die Alone*, THE WASHINGTON POST (Feb. 24, 2002). This experience led Dr. Angell, a physician and the first woman Editor-in-Chief of the New England Journal of Medicine, to become a leading proponent for aid-in-dying. *See id.*

[12] The loved ones of such patients suffer as well. This has been recounted in amicus briefs of survivors of those who wanted to choose aid-in-dying, but could not access it. *See* Brief for Amicus Curiae Surviving Family Members, *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009), 2009 WL 1967450, at *16. In contrast, loved ones of patients whose wish for aid-in-dying is honored experience positive mental health outcomes. *See* Linda Ganzini, et al., *Mental Health Outcomes of Family Members of Oregonians who Request Physician Aid In Dying*, 38 J. PAIN AND SYMPTOM MGMT. 807, 811-12 (2009) ("family members of Oregonians who received a lethal prescription were more likely to believe that their loved one's choices were honored and less likely to have regrets about how the loved ones died . . . and felt more prepared and accepting of the death than comparison family members.").

but hidden practice of physicians helping terminally ill patients to hasten their deaths." *Compassion in Dying v. Washington*, 79 F.3d 790, 811 (9th Cir. 1996), *rev'd on other grounds*, *Glucksberg*, 521 U.S. 702 (1997). *See, e.g.,* Note, *Physician Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2021 (1992) ("many physicians privately admit that 'they helped patients with incurable illnesses by injecting overdoses or writing prescriptions for drugs potent enough to end their patients' suffering'"); The Lancet, vol. 347, No. 9018 (June 29, 1996) (Nearly one in seven oncologists had carried out aid-in-dying); Richard A. Posner, AGING AND OLD AGE 251 (1995). The possibility of criminal prosecution thus drives underground practices that would benefit from being in the open, where professional standards of care would apply. *See* Stephen W. Smith, END OF LIFE DECISIONS IN MEDICAL CARE: PRINCIPLES AND POLICIES FOR REGULATING THE DYING PROCESS 218 (2012); Schallert Aff. Ex. 1, at 2 (Legality of aid-in-dying in Oregon "prevents real and significant harms inherent in the ongoing, covert, back alley practices of aid-in-dying . . . . The evidence shows that complications are more likely when this occurs in a covert, unsanctioned and unregulated practice.").

Moreover, New York has long recognized a liberty interest in bodily integrity. As described by then-Judge Cardozo, "every human being of adult years and sound mind has a right to determine what shall be done with his own body" in

relation to his medical needs. *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30 (1914). A prohibition of aid-in-dying undermines this important public interest. Because application of the Assisted Suicide Statute would raise substantial constitutional doubts, *see infra* Sections II and III, the statute should be construed not to apply to aid-in-dying. *See People v. Correa*, 15 N.Y.3d 213, 232 (2010) (quoting *Matter of Jacob*, 86 N.Y2d at 667)). In a similar case, the Montana Supreme Court found that the option of aid-in-dying was supported by the public policy of the state and ruled that criminal prosecution of a physician providing aid-in-dying would not be consistent with such policies. The Montana court's decision thus established an open practice on statutory grounds, avoiding the need to reach constitutional issues. *Baxter*, 224 P.3d at 1222.[13]

The Appellate Division's interpretation of the Assisted Suicide Statute also is inconsistent with its history, which contains no suggestion that the Legislature intended it to apply to aid-in-dying. Dating back to the first codification of the law in 1828, the legislative history does not contain a single reference to the act of a physician. Aid-in-dying was not even a recognized concept in 1965, when the current version of the Statute became law. The Statute was enacted more than 25

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[13] The lower court had decided the case in plaintiff's favor on constitutional grounds. One of the Justices of the Montana Supreme Court wrote a concurrence expressing the view that if the constitutional issues were reached, the state constitution would protect the choice for aid-in-dying. *Baxter*, 224 P.3d at 252 (Nelson, J., concurring).

years before the option of aid-in-dying was first discussed openly in the medical community.[14]

Evolutions in medicine affect the end of our lives. Americans rarely die quickly as was common in the past. We now die from recurring cancers, failures of our immune system or muscular degenerations that impose progressive and inexorable deterioration of bodily function and integrity. Modern medicine can draw out the dying process so long that patients may find themselves trapped in an inexorably deteriorating body with a cumulative burden of suffering they find unbearable. *See* Schallert Aff. Ex. 7 (R. 252) (A. Gawande, The New Yorker) ("For all but our most recent history, dying was typically a brief process . . . . These days, swift catastrophic illness is the exception; for most people, death comes only after a long medical struggle with an incurable condition."); Quill Aff. ¶ 22 (R. 432). The notion that when the Legislature last addressed the Assisted Suicide Statute 50 years ago it intended to reach the conduct of a physician

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[14] No physician has been convicted in New York for assisting suicide. Indeed, "[t]here is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." *Compassion in Dying*, 79 F.3d at 811; Richard A. Posner, AGING AND OLD AGE 252 (1995) ("I have found only four American cases, other than those involving Kevorkian, in which a physician was prosecuted for assisting a patient to commit suicide."). Only after Plaintiff Dr. Quill wrote an article in the *New England Journal of Medicine* describing a specific instance of aid-in-dying was a grand jury convened in Rochester, although no charges resulted. Quill Aff., ¶¶ 14-16 (R 430-31).

providing a suffering, dying patient with the option of a more peaceful death through aid-in-dying is implausible.

II. THE APPELLATE DIVISION ERRED IN DISMISSING PLAINTIFFS' CLAIMS UNDER THE DUE PROCESS CLAUSE OF NEW YORK'S CONSTITUTION.

The Complaint alleged that if the Assisted Suicide Statute were construed to reach aid-in-dying, its application would violate Plaintiffs' rights to privacy and other fundamental liberties under the Due Process Clause of the New York Constitution, article I, § 6. *See* Compl. ¶¶ 66-73 (R. 43-44). When a statute burdens a fundamental right, it is subjected to strict scrutiny, "meaning that it will be sustained only if it is narrowly tailored to serve a compelling state interest." *Hernandez v. Robles*, 7 N.Y.3d 338, 375 (2006) (citation and quotation marks omitted). This Court has long recognized a broad fundamental right to self-determination with respect to one's body and to control the course of one's medical treatment. The Appellate Division erred in holding that the right does not encompass aid-in-dying. Plaintiffs would have presented compelling evidence to establish that the decision of how much suffering to bear in the final stages of terminal illness is deeply and profoundly personal and that it is critically important to individuals to be empowered to exercise this last bit of autonomy at the very end of their life in a way that preserves the coherence and integrity of their entire life. As noted by the legal philosopher Ronald Dworkin:

> [W]e live our whole lives in the shadow of death, we die in the shadow of our whole lives. . . . [W]e worry about the effect of life's last stage on the character of life as a whole, as we might worry about the effect of a play's last scene or a poem's last stanza on the entire creative work.

Ronald Dworkin, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM 199 (1993).

Even if aid-in-dying were found not to implicate a fundamental right, Plaintiffs may succeed on their Due Process claim if they can prove that a prohibition on aid-in-dying is not rationally related to a legitimate government interest. *Hernandez*, 374 N.Y.3d at 375. This inquiry necessarily requires development of a factual record, the resolution of which is wholly improper on a pre-answer motion to dismiss. However, the Appellate Division expressly weighed evidence Plaintiffs presented in opposition to the motion and prematurely rejected its sufficiency.

A. Application Of The Assisted Suicide Statute To Aid-In-Dying Would Burden A Fundamental Right.

In *Rivers v. Katz*, 67 N.Y.2d 485, 492 (1986), this Court held that "[i]t is a firmly established principle of the common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his own body and to control the course of his medical treatment." (citations and quotation marks omitted)). *Rivers* recognized that the "common-law right is co-extensive with the patient's liberty interest protected by the due process clause of

our State Constitution." *Id.* at 493. The Court broadly described the right to self-determination:

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

Id. at 493 (citations and quotation marks omitted).

The fundamental right as articulated by this Court encompasses a patient's deeply and profoundly personal choice about how much suffering to endure in the final ravages of the dying process, just as it encompasses a patient's right to choose other end-of-life options that precipitate death. *See Delio v. Westchester Cty. Med. Ctr.*, 129 A.D.2d 1, 16 (2d Dep't 1987) ("The primary focus evident in the Court of Appeals analysis is upon the patient's desires and his right to direct the course of his medical treatment rather than upon the specific treatment involved."). The Complaint and supporting affidavits establish that aid-in-dying is an appropriate medical option for terminally-ill patients confronting a dying process they find unbearable, involving progressive and inexorable loss of bodily function and integrity, and increasing pain and other distressing symptoms, in the final throes of terminal illness. For example, the physician Plaintiffs regularly encounter "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." Compl. ¶ 43 (R. 37). For some patients, even symptomatic relief is impossible to achieve without resorting to surrender of all consciousness in terminal sedation. *Id.* "The only choice available to such patients, therefore, is prolonged and unrelieved anguish on the one hand, or unconsciousness and total loss of control and perceived dignity on the other." *Id.*

Under these circumstances, aid-in-dying allows the patient "to make a rational, informed, autonomous choice." Compl. ¶ 44 (R. 38); *see* Schallert Aff. Ex. 1, at 2 (R. 145) (option of aid-in-dying "gives the terminally ill autonomy"). Where aid-in-dying is an available option, "loss of autonomy" is cited by an overwhelming 93% of patients as motivating their choice. Schallert Aff. Ex. 9, at 31 (R. 408). In light of the Complaint's allegations, it would be consistent with this Court's jurisprudence protecting medical decision-making to conclude that a patient should be allowed to exercise his fundamental right to self-determination by choosing aid-in-dying. *See Eichner*, 73 A.D.2d at 459 ("Individuals have an inherent right to prevent pointless, even cruel, prolongation of the act of dying." (citations and quotation marks omitted.)); *see also Carter*, 2015 SCC 5, ¶ 66 (R. 210) ("An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.").

Notwithstanding this Court's robust and broad protection of the fundamental right to self-determination, the Appellate Division held that it applied only to "a patient's right to refuse medical treatment" and "let nature take its course," rather than to an "affirmative act of taking one's own life." Op. at 15, 16 (R.466-67). Plaintiffs' factual allegations demonstrate that this distinction is indefensible and specious in the context of aid-in-dying.

Several lawful end-of-life medical options involve "affirmative acts" that precipitate a patient's death. For example, terminal sedation involves the intravenous administration of medication, and withholding of nutrition and hydration, which will inevitably result in death. Removing a ventilator is an affirmative act that precipitates death by asphyxiation; the withdrawal of hydration precipitates death by dehydration. These acts would be murder if done without the patient's consent. It cannot be said that a death precipitated by any of these acts is the result of "nature" or the natural progression of an illness or its complications. Moreover, "the patient's interest in dying cannot . . . be divided into an interest in 'refusing' and an interest in 'receiving' treatment. The patient has a single, undivided interest in controlling what happens to her body."[15]

[15] Note, *Physician Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2029 (1992).

The Appellate Division's reliance on *Matter of Bezio v. Dorsey,* 21 N.Y.3d 93 (2013), to support a distinction between refusing treatment and aid-in-dying is misplaced. *Bezio* addressed whether the rights of an inmate on a hunger strike were violated by a judicial order permitting the State to force feed him by nasogastric tube after his health deteriorated to a point that was life-threatening. *Id.* at 96. Although the Court rejected the prisoner's constitutional claims, it specifically distinguished his situation from that of "terminally-ill patients or those in irreversible incapacitated condition as a result of illnesses or injuries beyond their control," observing that "[i]n those circumstances, unlike this one, the patients were suffering from direct medical conditions that were not of their own making." *Id.* at 102-03 (citations omitted). That is precisely the reality that the patient Plaintiffs face. They would choose life if that were possible; indeed, they have fought long and hard to cure their illnesses, or slow their advance through surgery, radiation therapy, chemotherapy and other measures. Despite such efforts, their inexorable decline into the final ravages of terminal illness, from conditions that are not of their own making, is beyond their control.

The Appellate Division also pointed to the Supreme Court's failure to recognize a due process right to aid-in-dying under the *federal* constitution nearly twenty years ago in *Washington v. Glucksberg*, 521 U.S. 702 (1997). The fundamental right to self-determination under the State Constitution is broader than

the right to privacy recognized under the Federal Constitution, so *Glucksberg* is inapposite.[16] Moreover, although the Supreme Court declined to find a federal constitutional right to choose aid-in-dying at that time, it carefully reserved the possibility it might do so in future, and it invited the states to grapple with the issue. *See Glucksberg*, 521 U.S. at 737 ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues.") (O'Connor, J., concurring) (citation and internal quotation marks omitted)); *see also id.* at 735.

To the extent this Court finds the U.S. Supreme Court's federal jurisprudence persuasive in independently interpreting the New York State

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[16] This Court's interpretation of the State Constitution is independent of the U.S. Supreme Court's interpretation of the Federal Constitution. Indeed, it is axiomatic that "this court is bound to exercise its independent judgment and is not bound by a decision of the Supreme Court of the United States limiting the scope of similar guarantees in the Constitution of the United States." *People v. Barber,* 289 N.Y. 378, 384 (1943); *see People v. LaValle*, 3 N.Y.3d 88, 129 (2004) ("It bears reiterating here that 'on innumerable occasions this [C]ourt has given [the] State Constitution an independent construction, affording the rights and liberties of the citizens of this State even more protection than may be secured under the United States Constitution." (citation omitted)); *People v. Scott*, 79 N.Y.2d 474, 495-96 (1992) ("we – consistent with well-settled principles of federalism – are not bound by decisions of the Supreme Court construing similar provisions of the Federal Constitution"); *Cooper v. Morin*, 49 N.Y.2d 69, 79 (1979) ("We have not hesitated when we concluded that the Federal Constitution as interpreted by the Supreme Court fell short of adequate protection for our citizens to rely upon the principle that that document defines the minimum level of individual rights and leaves the States free to provide greater rights for its citizens through its Constitution, statutes, or rule-making authority.").

Constitution, its jurisprudential process for considering fundamental liberties has changed materially since it decided *Glucksberg* and *Quill*. As reflected in more recent cases including *Lawrence v. Texas*, 539 U.S. 558 (2003) and *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), the Supreme Court recognizes that the inquiry into the existence of fundamental rights properly calls for consideration of evolving societal views. *See Obergefell*, 135 S. Ct. at 2602 ("[Fundamental rights] rise, too, from a better informed understanding of how constitutional imperatives define a liberty that remains urgent in our own era."); *Lawrence*, 539 U.S. at 571-72 ("In all events we think that our laws and traditions in the past half century are of most relevance here.").

The Complaint expressly alleged that evolving public views support aid-in-dying. Compl. ¶ 50 (R. 39-40). If the Supreme Court today were faced today with the issues that were presented in *Glucksberg*, it would have the benefit of extensive evidence of this evolution. As described in the Complaint and supporting affidavits, this evidence includes polls showing growing public support for aid-in-dying (*id.*), the adoption of policies by leading medical associations that support aid-in-dying (Schallert Aff. Exs. 1-4) (R. 144-57), positive experiences with aid-in-dying in states where it is practiced, and developments in other countries that have recognized the right of a patient to aid-in-dying. *See*, *e.g.*, *Carter*, 2015 SCC 5

(2015) (R. 162) (striking down Canada's assisted suicide statute as impinging on liberty).

1. The Appellate Division Improperly Weighed Evidence Relevant To The Existence Of A Fundamental Right.

Rather than crediting Plaintiffs' allegations concerning evolving social views for purposes of a motion to dismiss, the Appellate Division quibbled with them. For example, Plaintiffs had pointed to Gallup and Pew Research polls conducted in 2013 finding substantial support for doctors to provide aid-in-dying. Compl. ¶ 50 (R. 39-40). The Appellate Division asserted that "there is no indication that the questions underlying these polls were specifically about aid-in-dying, as opposed to more passive end of life choices such as withdrawal of hydration and nutrition." Order at 19 (R. 480). This assertion reflects a questionable reading of the polls.[17] In any event, a Gallup Poll conducted in 2015 expressly asked whether a doctor should be allowed by law to assist a patient with an incurable condition living in severe pain "to commit suicide if the patient

[17] 60% of those polled by Pew said that a person suffering from a great deal of pain with no hope of improvement has a moral right to commit suicide. Pew Research Center, *Views on End-of-Life Medical Treatments* (Nov. 21, 2013), *available at* http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/. 70% of those in the Gallup poll said that when a person has a disease that cannot be cured, doctors should be allowed by law to end the patient's life by some painless means, if the patient requests it. Lydia Saad, *U.S. Support for Euthanasia Hinges on How It's Described*, GALLUP (May 29, 2013), *available at* http://www.gallup.com/poll/162815/support-euthanasia-hinges-described.aspx.

requests it."[18] Despite this pejorative characterization of aid-in-dying, 68% of the public supported it, and only 28% opposed. These are precisely the type of refinements that a developed record could have provided.

The Appellate Division also stated that "plaintiffs fail to allege whether public polling . . . has changed significantly over the past 20 years." Order at 20 (R. 481). The Complaint and supporting affidavits did allege "evolving" public views. Compl. ¶ 50 (R. 39-40). Public polling on the issue has in fact changed materially. The 2015 Gallup poll showed an increase in support for aid-in-dying from 52% to 68% over the past twenty years. The Appellate Division raised yet another criticism: "plaintiffs fail to allege whether those public polls reflect the opinion of people who are fully informed of the arguments espoused by those who caution against permitting aid-in-dying." Order at 19-20. (R. 480-81). The simple answer is that public opinion polls are not limited to a portion of the public that is "fully informed," and the U.S. Supreme Court credited evolving views on issues like same-sex marriage without questioning whether supporters were fully

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[18] The question Gallup posed was: "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?" Andrew Dugan, *In U.S., Support Up for Doctor-Assisted Suicide*, GALLUP (May 27, 2015), *available at* http://www.gallup.com/poll/183425/support-doctor-assisted-suicide.aspx.

informed of the arguments by those who opposed same-sex marriages. *See Obergefell*, 135 S. Ct. 2584.

In a similar vein, the Appellate Division discounted the adoption of policies by several major national public health and medical associations that support availability of aid-in-dying by stating that "this evidence does not sufficiently demonstrate a societal evolution on the question of aid-in-dying." Order at 18 (R. 479). The weighing of such "evidence," however, was inappropriate in the context of a motion to dismiss. The fact that two of the organizations "acknowledge in their policies that a wide range of views continues to exist within their own memberships concerning end of life treatment options" (Order at 18-19 (R. 479-80) (italics omitted)) is no different from supporters of same-sex marriage who acknowledge that some have religious or other opposition to such marriages.

In short, Plaintiffs more than sufficiently alleged that aid-in-dying implicates a fundamental right under the Due Process Clause of the New York Constitution. Because the lower courts did not subject the Statute to strict scrutiny, reversal of the dismissal of the Complaint is warranted on this ground alone.

B. In Any Event, A Prohibition on Aid-In-Dying Cannot Survive Rational Basis Scrutiny.

Even if aid-in-dying does not implicate a fundamental right, the Appellate Division erred in ruling as a matter of law that a ban on aid-in-dying is rationally related to a legitimate government interest. *See* Order at 17 (R. 478). The

Appellate Division pointed to the U.S. Supreme Court's holding that a ban on aid-in-dying was rationally related to a State's "interest in preserving human life, protecting the integrity and ethics of the medical profession, and ensuring the welfare of vulnerable groups." *Id.* at 14 (R. 475). However, when the Supreme Court decided *Vacco* and *Glucksberg,* it did so in a vacuum without information about the practice of aid-in-dying because at the time there was no open practice in the United States.[19] The experience in the intervening decades demonstrates that the concerns expressed about the potential for adverse impacts of aid-in-dying have not materialized. Accordingly, a prohibition on aid-in-dying cannot be shown to be rationally related to the State's purported interests. Plaintiffs are entitled to present evidence and have the issue addressed on a fully developed record.[20]

The Complaint expressly alleged that prohibition of aid-in-dying is not rationally related to any State interest, and – although not required in the context of

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[19] Indeed, the lack of any information about how an open practice of aid-in-dying might impact patient care and the practice of medicine was undoubtedly a factor in the Court's decision to invite the States to grapple with the issue in the first instance, invoking the "laboratory of the states." *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring); *id.* at 786 ("The day may come when we can say with some assurance which side is right, but for now it is the substantiality of the factual disagreement, and the alternatives for resolving it, that matter.") (Souter, J., concurring).

[20] The importance of evidence and a fully developed record is exemplified by the *Carter* decision where the Canadian Supreme Court cited fifty times to facts found in the proceedings below.

a motion to dismiss – Plaintiffs provided ample evidence to support this allegation. For example, experience has demonstrated that the availability of aid-in-dying, rather than adversely impacting patient care, has allowed some patients with terminal illnesses to live longer lives. *See* Quill Aff. ¶ 19 (R. 431). Studies show that where aid-in-dying is available, end-of-life care improves in measurable ways: referrals to hospice care occur more often and earlier, and palliative care and communication between patient and physician improve. *See id.*; Morris Aff. ¶ 15 (R. 445); Schallert Aff. Ex. 9, at 4 (R. 409). As for adverse impact on vulnerable populations, studies have repeatedly shown "no evidence of heightened risk for the elderly, women, the uninsured, people with little education, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses, or racial or ethnic minorities." Schallert Aff. Ex. 9, at 6 (R. 411).

The Appellate Division acknowledged Plaintiffs' argument that "they have presented sufficient allegations to at least develop a full evidentiary record as to whether aid-in-dying is rationally related to a legitimate government interest." Order at 18 (R. 479). For example, the Court noted two studies with "empirical evidence" that Oregon's Death with Dignity Act "has not invited the fears articulated by people opposed to aid-in-dying." *Id.* at 21 (R. 482). The Court nonetheless refused to permit the development of a full evidentiary record, asserting that "the issue before us transcends mere practical concerns" and that a

state's interest in preserving human life "'is symbolic and aspirational as well as practical.'" *Id.* (quoting *Glucksberg*, 521 U.S. at 729).

In recognizing a right of its citizens to choose physician-assisted dying, the Supreme Court of Canada responded to this asserted state interest:

> [W]e do not agree that the existential formulation nor the right to life requires an absolute prohibition on assistance in dying, or that individuals cannot 'waive' their right to life. That would create a 'duty to live,' rather than a 'right to life,' and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment.

Carter, 2015 SCC 5, ¶ 63 (R. 208).

Judge Posner also has addressed such aspirational concerns:

> Respect for human life must have *something* to do with perceptions of the value, not wholly metaphysical, of that life. The spectacle of . . . hospital wards crowded with dying people so heavily sedated as to be barely sentient or so twisted with pain as to be barely recognizable, might be thought rather to undermine than to enhance a sense of the preciousness of life. The better the quality of lives, the greater the perceived value of preserving them. Doctors and nurses who talk about 'watering the vegetables' on their rounds have not been made sensitive, by their exposure to the practical consequences of sacrificing quality of life, to the desire to prolong life regardless.

Richard A. Posner, AGING AND OLD AGE 241 (1995) (emphasis in original).

As Plaintiffs have alleged, a prohibition on aid-in-dying undermines the preservation of life because it can lead terminally-ill patients to take action to precipitate death prematurely, while they still have ability to do so. Moreover,

there is evidence from states where aid-in-dying is available that "some patients may even survive longer because they have the option of dying on their own terms. Freed of anxiety over loss of control and unbearable suffering, patients' remaining days are of higher quality." Quill Aff. ¶ 19 (R. 431). Only a perverse notion of "preserving" life would force terminally-ill patients to choose death by dehydration or through sedation to unconsciousness, instead of aid-in-dying. This Court should permit the development of a full evidentiary record before deciding whether a "symbolic and aspirational" interest is rationally related to a ban on aid-in-dying.

III. THE APPELLATE DIVISION ERRED IN DISMISSING PLAINTIFFS' CLAIMS UNDER THE EQUAL PROTECTION CLAUSE OF THE NEW YORK CONSTITUTION.

The Complaint alleged that applying the Assisted Suicide Statute to physicians providing aid-in-dying would violate the Equal Protection Clause of the New York Constitution, article I, § 11, because the Assisted Suicide Statute would not treat equally all similarly situated patients who are in the final stages of a fatal illness. *See* Compl. ¶¶ 58-65 (R. 41-43). Some terminally-ill patients have the autonomy to request medical assistance that precipitates death: for example, those eligible for terminal sedation, or those who have a life-prolonging apparatus that can be removed. However, patients who are dying but are not eligible for terminal sedation or do not have a life-prolonging intervention that can be removed are unable to do so if they do not have the option to request aid-in-dying.

The Appellate Division's dismissal of Plaintiffs' equal protection challenge was erroneous in two independent respects. First, because the Complaint adequately alleged that aid-in-dying implicates a fundamental right under the New York Constitution, as discussed in Section II.A above, any disparate treatment of mentally competent, terminally-ill patients would have to be the least restrictive means of advancing a compelling state interest in order to survive an equal protection challenge. *See In re Burns*, 55 N.Y.2d 501, 507 (1982). Whether a measure challenged as imposing disparate treatment is the least restrictive means of advancing a compelling state interest is an intensely factual determination inappropriate for resolution on a motion to dismiss. The lower courts failed to apply this heightened scrutiny.

Second, even under rational basis scrutiny, different treatment of similarly situated patients who are in the final stages of a fatal illness is irrational. The Appellate Division erroneously viewed the U.S. Supreme Court's decision in *Vacco v. Quill,* 521 U.S. 793 (1997) as a bar to finding that the Assisted Suicide Statute violates the equal protection guarantee of the New York Constitution. *Quill* found that a distinction between aid-in-dying and refusing "unwanted lifesaving medical treatment" was "certainly rational." Order at 13 (R. 474) (quoting *Vacco*, 521 U.S. at 800, 801). The Court stated that "[t]he distinction

comports with fundamental legal principles of causation and intent." *Vacco*, 521 U.S. at 801.

The Supreme Court nonetheless recognized that some lawful forms of end-of-life treatment do not involve a mere withdrawal or refusal of life-sustaining treatment. For example, the Court addressed terminal sedation in a footnote at the end of its opinion. "Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death." *Id.* at 808 n. 11. The Court quoted the New York Task Force's statement that "the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death, *if the medication is intended to alleviate pain and severe discomfort, not to cause death.*" *Id.* (quoting New York Task Force at 163) (emphasis added).

The U.S. Supreme Court's discussion of terminal sedation puts into sharp focus the inherently factual issues raised by the Complaint. Any distinction that hinges upon "causation and intent" (*Vacco,* 521 U.S. at 800) implicates factual issues that cannot be decided on a motion to dismiss. *See, e.g.*, *PMJ Capital Corp. v. PAF Capital, LLC,* 98 A.D.3d 429, 430 (1st Dep't 2012) (issues of intent were factual in nature, "preventing dismissal of the complaint at this stage"). Similar to the Supreme Court's description of terminal sedation, the Complaint alleges that

aid-in-dying is intended to "avoid the final ravages of disease" and to preserve "the coherence and integrity of the life the patient has lived" (Compl. ¶ 44) (R. 38) – not to cause death. Indeed, "what is causing the death of a patient choosing aid-in-dying is the underlying terminal illness." Compl. ¶ 38 (R. 36).[21]

Justice Stevens elaborated on why there is no meaningful distinction between aid-in-dying and other end-of-life medical options in terms of intent or causation:

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

[21] This is true even if the patient ingests the medication, which occurs in only 60% or so of cases (Schallert Aff. Ex. 9, at 3 (R. 408)), because what has brought the patient to the threshold of death is her underlying disease and the only question is whether the patient will be forced to endure a bit more torturous suffering before crossing that threshold.

> when it is clear that the time of death will be advanced. The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes, and the actual cause of death is the administration of heavy doses of lethal sedatives. This same intent and causation may exist when a doctor complies with a patient's request for lethal medication to hasten her death.

Glucksberg, 521 U.S. at 750-51 (Stevens, J., concurring). Plaintiffs should be permitted to demonstrate on a full record why a prohibition on aid-in-dying disparately treats similarly situated patients who are in the final stages of a fatal illness and why this treatment is not rationally related to a legitimate government interest.

CONCLUSION

For the foregoing reasons, this Court should reverse the Appellate Division's order affirming dismissal of Plaintiffs' Complaint.

Dated: November 15, 2016
New York, New York

Respectfully submitted,

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CERTIFICATION

I certify pursuant to 500.13(c)(1) that the total word count for all printed text in the body of the brief, exclusive of the statement of the status of related litigation; the corporate disclosure statement; the table of contents, the table of cases and authorities and the statement of questions presented required by subsection (a) of this section; and any addendum containing material required by subsection 500.1(h) of this Part is 11,365 words.

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Respectfully submitted,

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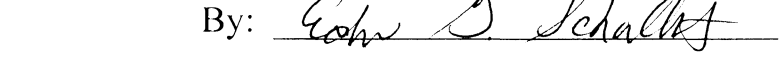
By: 

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