APL-2016-00129
New York County Clerk's Index Nos. 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. SCHWARTZ, PhD., 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,

– and –

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 *AMICUS CURIAE*
NEW YORK STATE CATHOLIC CONFERENCE
IN SUPPORT OF DEFENDANT–RESPONDENT

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Corporate Disclosure Statement

The New York State Catholic Conference is an independent nonprofit organization with no parents, subsidiaries, or affiliates.

Dated: New York, New York
December 30, 2016

Respectfully submitted,

By: _____

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Did the Appellate Division correctly hold that so-called "aid in dying" is in fact assisted suicide?

Did the Appellate Division correctly hold that there is a legitimate state interest in preventing suicides?

Would the legalization of assisted suicide violate the State's interest and duty to protect vulnerable persons?

Preliminary Statement[1]

This case arises from a long-standing campaign to legalize assisted suicide in New York State. A previous attempt, which sought to have assisted suicide ruled as a federal constitutional right, failed in the Supreme Court of the United States. Attempts to convince the New York State Legislature to legalize assisted suicide have also failed. The effort has now changed tactics to asking the courts to legalize assisted suicide by declaring it a state constitutional right or, in the alternative, by adopting a novel and unprecedented interpretation of the Penal Law. Two lower courts have now reviewed this claim, and have unanimously

[1] Counsel would like to express his gratitude for the invaluable assistance of Alexis N. Carra (M.A. in Ethics and Society, Fordham University) for her significant contributions to the writing of this brief.

rejected it.

This Court should do the same. *Amicus Curiae* New York State Catholic Conference ("the Catholic Conference") files this brief to urge this Court to affirm the rulings of the lower courts. This Court should reject the Appellant's artificial and self-serving attempt to re-define the word "suicide". And this Court should also find that the current ban is rational and is supported by a compelling state interest in preventing suicide and protecting vulnerable citizens.

Interest Of The *Amicus Curiae*

The Catholic Conference has been organized by the Roman Catholic Bishops of New York State as the institution by which the Bishops speak cooperatively and collegially in the field of public policy and public affairs. The Catholic Conference promotes the common good of society based on the social teaching of the Catholic Church in such areas as education, family life, respect for human life, health care, social welfare, immigration, civil rights, criminal justice, the environment, and the economy.

The Catholic Conference carries out advocacy with legislative and

executive officials of the New York State government on public policy matters that relate to these areas of interest. When permitted by court rules and practice, the Catholic Conference participates as a party and files briefs as *amicus curiae* in litigation of importance to the Catholic Church and the common good of the people of the State of New York.

This action involves issues of great interest to the Catholic Church. The Catholic Conference has consistently opposed any legislative or judicial initiative to legalize assisted suicide, because of the threat it poses to vulnerable members of society. For a number of years, the Catholic Conference has conducted extensive advocacy in the New York State Legislature and with the Executive Branch towards that end. When Appellant Timothy Quill filed a federal action in 1994, seeking to legalize assisted suicide in New York, the Catholic Conference filed *amicus* briefs in opposition. When the matter reached the United States Supreme Court in 1997, the interests of the New York State Catholic Conference were represented by the United States Catholic Conference, which filed an *amicus* brief.

The Catholic Church has always taught that the direct, intended taking of an innocent human life is gravely immoral. Pope John Paul II,

Evangelium Vitae (The Gospel of Life) (1995), par. 57. This is not a mere sectarian dogma, but is part of the "unwritten law which man, in the light of reason, finds in his own heart". *Id.* Suicide and assisted suicide are violations of this natural moral law since they involve the deliberate taking of an innocent human life. *Id.,* par. 66.

The Church also holds that there is an intrinsic relationship between the natural moral law and civil law: "the acknowledgment of an objective moral law which, as the 'natural law' written in the human heart, is the obligatory point of reference for civil law itself." *Id.*, par. 70. This relationship is essential to guarantee that fundamental human rights are protected, and not subject to transitory majority opinions. Most importantly,

> civil law must ensure that all members of society enjoy respect for certain fundamental rights which innately belong to the person, rights which every positive law must recognize and guarantee. First and fundamental among these is the inviolable right to life of every innocent human being.

Id., par. 71

Any threat to vulnerable people is a matter of particular concern to the Catholic Church. The bishops of the United States have stated,

> While the common good embraces all, those who are weak, vulnerable, and most in need deserve preferential concern. A

> basic moral test for any society is how it treats those who are most vulnerable.

United States Conference of Catholic Bishops, *Forming Consciences for Faithful Citizenship* (2015), par. 53.

In addition to concerns about the common good and the health of society as a whole, this issue is particularly important to the Catholic Church. The Church in New York State operates the largest network of non-governmental health care providers. Catholic health-care institutions provide holistic health services in an atmosphere of respect for the value and dignity of all human life, with special attention to poor, vulnerable and marginalized persons. Our ministries include hospitals, nursing homes, hospice programs, home health agencies, and long-term home health care programs. The vast majority of these institutions care for elderly and terminally ill patients who are regularly making end-of-life decisions, and who would be directly impacted by the legalization of assisted suicide.

Catholic health care institutions operate under principles set out by the Catholic bishops of the United States:

> The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have

> absolute power over life… Suicide and euthanasia are never morally acceptable options.

United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* Part V, Introduction (2009).

Catholic institutions are directly bound by the Ethical and Religious Directives never to cooperate with assisted suicide:

> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way.

Id., par. 60; *see also* par. 70.

The bishops of New York State, who are the constituent members of the Catholic Conference, are responsible for teaching these religious beliefs in the best interests of the common good of society as a whole, and ensuring that they are adhered to in all Catholic institutions.

Argument

I. The Appellate Division Correctly Held That So-called "Aid In Dying" Is Assisted Suicide

The Appellants' entire case rests on the argument that what they term as "aid in dying" is not assisted suicide, and is thus outside of the

ambit of the current Penal Law prohibitions. Both the Appellate Division and the Supreme Court correctly rejected this effort at verbal engineering.

A. The Appellate Division Correctly Gave The Term "Suicide" Its Ordinary Meaning

It is axiomatic that "Words of ordinary import in a statute are to be given their usual and commonly understood meaning, unless it is clear from the statutory language that a different meaning was intended". *We're Associates Co. v. Cohen, Stracher & Bloom, P.C.*, 65 N.Y.2d 148, 151 (1985). The relevant section of the Penal Law is very plain in defining the crime as when one "intentionally... aids another person to commit suicide". N.Y. Penal Law §125.15(3). There is nothing in that clear language that suggests in any way that the Legislature intended anything other than that the words should be "construed according to [their] natural and most obvious sense". *Frank v. Meadowlakes Dev. Corp.*, 6 N.Y.3d 687, 692 (2006).

Moreover, there is every indication that the Legislature intended to include doctors within the prohibition of assisted suicide by prescribing lethal doses of medication. In fact, the drafters of the Penal Law specifically envisioned that the statute would encompass those who

gave assistance in "the more sympathetic cases (e.g., suicide pacts, assistance rendered at the request of a person tortured by painful disease, and the like)." *Commission Staff Notes on the Proposed New York Penal Law, §130.25.* That would naturally and logically include doctors.

The lower courts were thus entirely justified in holding the "usual and commonly understood meaning" of "assisted suicide" encompasses the act of providing a patient with lethal doses of medicine so that they may end their life.

Indeed, it is strange that the Appellants would argue otherwise. Appellant End of Life Choices, Inc. supports legislation that belies their argument that the physician's conduct is not involved directly in causing the patient's death. The bill defines "medical aid in dying" as "the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer *to bring about death*.". A. 10059/S. 7579, proposed § 2899-d(8) (2015-2016 Regular Session, emphasis added). The physician also has to certify that he informed the patient of "the probable result of taking the medication", *Id.*, at 2899-d(7)(c), and the patient has to make a specific

request for "medication for the purpose of ending his or her life". *Id*., at 2899-e. There is no other reason for the doctor to provide the medication, and much of the bill's procedural provisions are designed to ensure that everyone involved clearly understands it.

So the Appellant's own favored bill makes clear that the physician is directly in the line of causation that brings about a patient's death -- he is providing a patient with the instrumentality that he knows the patient will use to commit suicide. Their own bill, in short, provides a clear instance of the "natural and most obvious sense" of the word "assisted suicide."

The definition accepted by the lower courts was also entirely in keeping with the meaning given the term throughout our legal history. As the Supreme Court has noted, "for over 700 years, the Anglo American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide". *Washington v. Glucksberg,* 521 U.S. 702, 711 (1997). The Supreme Court also related that "the prohibitions against assisting suicide never contained exceptions for those who were near death", including 'those who [were] hopelessly diseased or fatally wounded'". *Glucksberg* at 714 (quoting *Blackburn v.*

State, 23 Ohio St. 146, 163 (1872)).

The lower courts were thus on very solid ground in their rejection of the Appellant's tendentious neologism of "aid in dying".

B. The Appellate Division Correctly Understood The Causal Connection Between The Prescription Of Deadly Medicine And The Death Of The Patient

Appellants also seek to evade the plain meaning of the statute by conflating the withholding of medical treatment with the prescribing of a lethal dosage of medication. In doing so, they blur the distinction between action and omission, and they disregard the importance of causality and intent – elements that are indispensable in any proper application of the law.

Although they both may result in death, forgoing medical treatment (such as declining a ventilator) and administering lethal medication are not the same and cannot be treated as such. The physician who prescribes the lethal dosage of medication is committing a particular action, whereas the physician who does not administer life support is omitting a particular action. This distinction between action and omission must be upheld – and has always been upheld – in order to properly apply the law in this and in many other contexts. This key

distinction was clearly recognized by the Supreme Court: "when a patient refuses life-sustaining medical treatment [omission of an act], he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician [commission of an act], he is killed by that medication." *Vacco v. Quill,* 521 U.S. 793, 802 (1997).

This act/omission distinction makes the issue of causality very clear. In the first scenario, the omission scenario, *the cause of death is the underlying illness*, but in the second scenario, the commission scenario, *the cause of death is the lethal medication*. This is a logical distinction. And the Supreme Court recognized that this distinction has explicit legal significance because "[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide." *Id.,* at *800.*

Similarly, with regards to intent, there is a significant difference between intentionally and unintentionally causing death: "[t]he law has long used actors' intent or purpose to distinguish between two acts that may have the same result." *Id*., at 803. For example, under the Penal Law unintentional killings would typically be considered manslaughter,

whereas intentional killings are usually considered murder. *See, e.g.,* N.Y. Penal § 125. When applied to medicine, the physician who prescribes lethal medication to a patient explicitly intends the death of the patient. He thereby participates in an intentional killing. However, in the case of the physician who declines to provide optional treatment at the end of life, he does not intend that this action will cause the death of the patient, but accepts that the death may still occur as a result of the patient's underlying condition. In other words, the intention of the action or omission is fundamentally different, and the law recognizes this by declaring that intentionally causing death is always impermissible.

The Appellants' confusion over causation is evident in their own argument. In attempting to sever the physician's action from the cause of death, Appellants argue "in states where aid-in-dying is practiced openly, death certificates list the underlying terminal disease as the cause of death." Brief for Appellants, 16. But the fact that other state legislatures have authorized doctors to make manifestly false statements on death certificates does not change reality -- the deadly dose of medicine causes the patient's death so that he or she does not

have to wait for the underlying condition to reach its conclusion. That is the entire point of the Appellants' case.

The Appellants' self-serving re-definition of words and confusion about causation and intent cannot defeat the common-sense reading of the statute. The Appellate Division and the Supreme Court were thus correct in treating so-called "aid in dying" as assisted suicide within the meaning of the Penal Law.

II. Overturning New York State's Ban On Assisted Suicide Would Violate A Clear And Strong State Interest To Prevent Suicides

Petitioners claim that the current ban on assisted suicide lacks a sufficient legitimate basis. They argue in the alternative that the ban fails either the compelling state interest standard or the rational basis standard. Regardless of which standard this Court applies, the ban certainly is supported by a well-established and strong state interest in preventing suicides and protecting vulnerable people.

A. The Appellate Division Correctly Found That There Is A Legitimate State Interest In Preventing Suicides

The state interest in preventing suicides has always been recognized as a legitimate governmental objective. In 1994, the New

York State Task Force on Life and the Law unanimously recommended against the legalization of assisted suicide. In their report, the Task Force eloquently summarized society's interest in maintaining a ban on assisted suicide:

> We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). Remarkably, the petitioners' brief does not even mention this landmark report.

The Supreme Court of the United States, in upholding the very same statute that the Appellants now challenge, also recognized this interest:

> prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia... These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.

Vacco, supra at 808-9.

Nothing has changed since either 1994 or 1997. The state interest in maintaining the ban on assisted suicide is just as strong, clear and legitimate today as it was then.

B. Legalizing Assisted Suicide Would Undermine The Extensive Current Efforts To Prevent Suicides

New York State has long pursued programs and policies to implement its interest in preventing suicides. The legalization of assisted suicide, even for a small class of persons, would send a dangerous mixed message that would inevitably undermine that clear state interest.

Suicide is a major public health problem. It is among the top ten causes of death in New York for all age groups from age 10 through 64, it is in the top five causes of death for age groups from 10 through 44,

and it is the second highest cause of death for teenagers and the highest non-accidental cause of death for that age group. New York State Department of Health, *Leading Causes of Death, New York State, 2012*, https://www.health.ny.gov/statistics/vital_statistics/docs/leading_causes_of_death_nys_2012.pdf.

The New York State Office of Mental Health (OMH) recognizes suicide as a serious public health problem and considers suicide prevention a top priority. *See* New York State Office of Mental Health, *Suicide Prevention,* https://www.omh.ny.gov/omhweb/suicide_prevention/ (last visited Dec. 26, 2016). Just this year, the Department issued a comprehensive and detailed strategic plan to prevent suicides across the state. New York State Office of Mental Health, *1,700 Too Many: New York State's Suicide Prevention Plan 2016-2017* (September 2016), https://www.omh.ny.gov/omhweb/resources/publications/suicde-prevention-plan.pdf. In conjunction with the Suicide Prevention Center of New York, which operates with funding from OMH, New York State spends millions of dollars each year on efforts to reduce suicide attempts. New York State also collaborates with numerous private organizations whose mission is to prevent suicides. Local governments

likewise spend a great deal of energy and resources to deter suicide, particularly among young people.

Clear and unequivocal messages to discourage suicide are ubiquitous in New York. It is very common to see signs on bridges, posters in mass transit, and billboards urging people who are contemplating suicide that "life is worth living". Schools at all levels devote a great deal of resources to identify suicide risks and to intervene to prevent it. For example, suicide prevention is a component of a major state initiative, aimed at elementary and high schools. New York State Department of Education, *New York State's Safe Schools*, https://safeschools.ny.gov/sites/default/files/Suicide.pdf. Similar initiatives are also found at public colleges. See, e.g., The University at Albany, *Suicide Prevention*, http://www.albany.edu/counseling_center/suicide_prevention.shtml (last visited December 26, 2016).

Legalizing assisted suicide would also undermine current legal mandates that extensive efforts be expended to prevent suicides. The Mental Hygiene Law requires evaluation and even authorizes involuntary hospitalization and treatment for anyone who is likely to cause "serious harm to himself or others". N.Y. Mental Hyg. § 9.39(a).

The statute explicitly includes "threats of or attempts at suicide" under this definition of harm. *Id.* This practice is followed in numerous hospitals around the state, and involves the efforts of doctors, nurses, lawyers, and judges. It represents a substantial investment of resources by the state in preserving the lives of those who are contemplating suicide.

If assisted suicide were to be legalized, however, the message would be sent that in the eyes of the law some lives would matter more than others. Namely, the state would have an interest against suicide "downstairs" (e.g., for the patient in the emergency room who expresses a desire to kill himself), but not "upstairs" (i.e., for the terminally ill patient in a ward upstairs who expresses the same desire). This is an irrational distinction -- both patients have expressed their desire to commit suicide and there is no reason to treat them differently. The fact that the patient upstairs has a terminal illness does not render his life any less valuable than that of the patient downstairs, and the state should not treat his life as unworthy of protection.

The legalization of assisted suicide would also likely lead to an increase in suicides. Studies have shown that when assisted suicide is

legalized, overall suicide rates are higher than in the general population. David Albert Jones and David Paton, *How does legalization of physician assisted suicide affect rates of suicide?* South. Med. J., October 2015, 108:599. The World Health Organization has warned that media coverage of suicide can lead to "imitative suicidal behaviours" – a phenomenon that has been called "suicide contagion" -- especially among young or depressed people. World Health Organization, *Preventing Suicide: A Resource for Media Professionals,* 6 - 8 (2008), www.who.int/mental_health/prevention/suicide/resource_ media.pdf (last visited Dec. 26, 2016). It is common practice, for example, for vigorous intervention and prevention efforts when a suicide takes place in a school, in order to prevent "copycats".

The concern that legalizing assisted suicide will lead to an increase in overall suicide rates is demonstrated by the experience of states that have already taken that step. In Oregon, which the petitioners consistently point to as their ideal case, the overall suicide rate is 42% higher than the national average. Oregon Health Authority, *Suicides in Oregon and Associated Factors 2003-2012*, 3, http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/

Documents/NVDRS/Suicide%20in%20Oregon%202015%20report.pdf. Rates have also risen in Washington over the past decade. Health of Washington State, *Suicide* (2013) http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2015-DU.pdf. And suicide rates are significantly higher in Vermont than the national average across all age groups. Vermont Suicide Prevention Coalition, *Vermont Suicide Prevention Platform* (2015), http://vtspc.org/wp-content/uploads/2015/06/VSPP_2015_Interactive.pdf. While correlation is not necessarily proof of causation, this pattern cannot be easily dismissed as coincidence.

New York State's strong policy to prevent suicide is consistent and unequivocal. If assisted suicide were to be legalized, the credibility and effectiveness of the State's anti-suicide messages and efforts would be undermined. In effect, the State would be sending a tragic mixed message – some lives are worth preserving, while others are disposable. And more lives are likely to be lost as a result.

C. The Legalization Of Assisted Suicide Cannot Be Limited To Terminally Ill Persons

The petitioners assert that they seek only a ruling on behalf of

those who are terminally ill and experiencing unbearable suffering. But there is every reason to believe that a newly-found right to assisted suicide will inevitably be expanded to include other persons as well.

As other courts have already found, the standards for defining the eligible population cannot be limited. For example, adopting the Appellant's class definition would lead to drawing a "line between terminally ill patients who can self-administer lethal drugs and those who cannot. Yet this would arguably amount to discrimination based upon physical disability." *Sampson v. State*, 31 P.3d 88, 97 (Alaska 2001). Further, the purported "right" to assisted suicide would hinge on a "vague, unverifiable, and subjective standard" since the "mental competency of terminally ill patients is uniquely difficult to determine." *Id.*. Indeed, the criteria proposed by the Appellants are so vague that they could be expanded to permit even mature children to commit assisted suicide, so long as they are terminally ill and mentally competent.

The inevitability of expansion can be seen in the logic of the Appellants' own argument. They have insisted that assisted suicide should be a viable option for patients who have determined that their

suffering has become "unbearable". Yet there is no definition of what constitutes "unbearable suffering". The views of different patients and different doctors will inevitably vary with regards to the nature and extent of suffering. This raises concerns as to *who* decides what suffering qualifies, and *what kinds* of suffering actually qualify, and any type of suffering could potentially be cited as grounds for assisted suicide. Indeed, advocates have openly and repeatedly stated that their ultimate goal is to permit assisted suicide for anyone who desires it, regardless of their medical condition. *See, e.g.*, *Assisted Suicide and Euthanasia: Beyond Terminal Illness, supra.* (quotations from advocates cited therein).

These concerns have already become reality in the European nations that have legalized assisted suicide. Belgium, the Netherlands, and Switzerland have all seen assisted suicide extend to those who "feel old" (Switzerland) or people who experience "psychic suffering" (the Netherlands). United States Conference of Catholic Bishops Secretariat of Pro-Life Activities, *Assisted Suicide and Euthanasia: Beyond Terminal Illness*, http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/Assisted-Suicide-

and-Euthanasia-Beyond-Terminal-Illness.pdf (last visited Dec. 26, 2016). Both Belgium and the Netherlands have gone so far as involuntary euthanasia -- killing people who did not even ask for death, including children. United States Conference of Catholic Bishops Secretariat of Pro-Life Activities, *Assisted Suicide and Euthanasia: From Voluntary to Involuntary*, http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted-suicide/to-live-each-day/upload/assisted-suicide-from-voluntary-to-involuntary-edits.pdf (last visited Dec. 26, 2016).

The inevitable expansion of assisted suicide is also happening in Canada. Prior to the enactment of the law by the Parliament, a task force of medical professionals and ethicists recommended that, "Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits." Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report, 34* (November 30, 2015), http://www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf. And now, just months after legalization, this expansion is already begun. On December 14, 2016, the Canadian Federal Department of Health requested that the Council of Canadian

Academies to "examine three particularly complex types of requests for medical assistance in dying that were identified for further review and study by the legislation passed by Parliament in 2016. These cases include requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition." Council of Canadian Academies, *Council of Canadian Academies to Undertake Studies Related to Medical Assistance in Dying* (December 14, 2016), http://www.scienceadvice.ca/en/news.aspx?id=186. Appellants repeatedly hold out Canada as their exemplar, so this Court should look upon these developments as a harbinger for New York.

Concern about the expansion of assisted has led the American Psychiatric Society to adopt a new ethical rule. The rule bans participation by their professionals in participation in any assisted suicide involving a non-terminal patient. American Psychiatric Association, *Position Statement on Medical Euthanasia* (December 2016), https://psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2016-Medical-Euthanasia.pdf. In announcing the rule, the head of the APA ethics committee is quoted as stating:

> So far, no other country that has implemented physician-assisted suicide has been able to constrain its application solely to the terminally ill, eventually including non-terminal patients as legally eligible as well. This is when psychiatric patients start to be included.

Michael Cook, "American Psychiatric Association takes historic stand on assisted suicide and euthanasia", *BioEdge* (December 16, 2016), https://www.bioedge.org/bioethics/american-psychiatric association-takes-historic-stand-on-assisted-suicide-a/12137.

It is thus clear that if the petitioners receive the relief they request, there will be no limiting principles that can restrict assisted suicide to the terminally ill, and assisted suicide will inevitably be pushed to include many more categories of patients.

III. Legalizing Assisted Suicide Would Violate The State's Interest And Duty To Protect Vulnerable Persons

The ban on assisted suicide is supported by a clear, well-established and legitimate state interest in protecting vulnerable persons. This policy is embodied in the New York State Constitution, which states that, "The aid, care and support of the needy are public concerns and shall be provided by the state." N.Y. Const. art. XVII § 1. This Court has said, "care for the needy is not a matter of 'legislative

grace'; it is a constitutional mandate." *Fayad v. Novello*, 96 N.Y.2d 418, 428 (2001). It is "an expression of the existence of a positive duty on the state to aid the needy" and "fundamental part of the social contract." *Tucker v. Toia*, 43 N.Y.2d 1, 7 (1977).

The State's duty to care for the needy would be betrayed by legalizing assisted suicide. The Task Force on Life and the Law prominently stressed the risk to poor and vulnerable persons in legalizing assisted suicide:

> In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

They went on to warn:

> No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.

When Death is Sought, Executive Summary.

These structural problems in the American medical system have certainly not been corrected in the years since the Task Force's report. Studies consistently show that disparities exist in access to and quality of healthcare across numerous demographic categories, particularly race, sex, socioeconomic status, and geographic location. *See, e.g.,* Centers for Disease Control and Prevention, *2014 National Healthcare Quality and Disparities Report,* http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf.

These inequities are exacerbated by the economic pressures of the current medical system, where cost containment is a priority. In this environment, pressure will inevitably be felt by low-income patients to choose suicide rather than putting an economic burden on their families. In fact, there have been several reported cases where insurance companies have denied coverage for life-sustaining treatments, only to offer to cover suicide drugs instead. *See, e.g.,* Katerina Tinko, "How California's New Assisted Suicide Law Could Especially Hurt the Poor", *The Daily Signal* (October 6, 2015), http://dailysignal.com/2015/10/06/how-californias-new-assisted-suicide-law-could-especially-hurt-poor/ (last visited Dec. 26, 2016).

The risks presented by the suicide option would present a special danger for vulnerable older people. The widespread and under-reported problem of elder abuse highlights the risk of undue influence in end-of-life decisions. Lifespan of Greater Rochester, et al., *Under the Radar: New York State Elder Abuse Prevalence Study* (May 2011), p. 2-3, http://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf ("141 out of 1,000 older New Yorkers have experienced an elder abuse event since turning age 60").

People with mental illness are also at a higher risk. A large number of people who request assisted suicide are suffering from treatable depression. "Mental illness raises the suicide risk even more than physical illness. Nearly 95 percent of those who kill themselves have been shown to have a diagnosable psychiatric illness in the months preceding suicide. The majority suffer from depression that can be treated." Herbert Hendin, *Seduced by Death: Doctors, Patients, and Assisted Suicide* 34-35 (1998). Yet in Oregon, shockingly few patients who request assisted suicide are referred to mental health professionals for evaluation -- only 3.8% in 2015, and only 5.5% since 1998. Oregon Public Health Division, *Oregon's Death with Dignity Act – 2015*,

https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf (February 4, 2016).

It has been long recognized that the elderly and poor are not adequately served in their mental health needs, which would make them vulnerable to suicide. Geriatric Mental Health Alliance of New York, *Barriers to Meeting the Mental Health Needs of Older Adults,* http://www.networkofcare.org/library/Barriers%20to%20Meeting%20the%20Mental%20Health%20Needs%20of%20Older%20Adults,.pdf (last visited Dec. 26, 2016). The lesson from the Netherlands should thus be sobering. A recent study showed that patients are granted assisted suicide despite having complex psychiatric histories and diagnoses, and amidst disagreement by treating physicians and psychiatrists over whether cases meet the criteria for "unbearable suffering". Scott Y.H. Kim et al., *Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014*, JAMA Psychiatry, 2016;73(4):362-368.

Institutionalized persons would also be at risk because of their inherent isolation and stressful lives. For example, the New York State

prison system has seen a significant increase in suicides in recent years. The rate of suicides among prisoners is 60% higher than the national average for prisoners and over 100% higher than the national average for the general population. Correctional Association of New York, *Suicide Rate 60% Higher in New York State Prisons*, (November 13, 2014), http://www.correctionalassociation.org/news/suicide-rate-60-higher-in-new-york-state-prisons-2. The problem is so serious that the Commissioner has ordered an extensive program to screen inmates and train staff. New York State Department of Correction and Community Services, *Inmate Suicide Prevention*, (January 12, 2016), http://www.doccs.ny.gov/Directives/4101.pdf. Legalizing assisted suicide for those with "unbearable suffering" would certainly undermine these efforts, and communicate to despondent prisoners that they are without hope.

These threats would be particularly severe if assisted suicide were to be legalized by judicial action, rather than by the Legislature, since there would be no standards or regulations to govern how it will actually take place. This would be markedly different from comparable medical situations, where New York law clearly sets forth protective

requirements. For example, there would be no way to assure that patients are competent to make such a momentous decision either at the time of the request or when they are taking the medicine. *See, e.g.*, N.Y. Pub. Health § 2994-c(2) (a physician must make a determination that the patient lacks capacity "to a reasonable degree of medical certainty" prior to the appointment of a health care surrogate). There would be no guarantee by independent witnesses that the patient was making the decision or taking the medicine free of compulsion or pressure. *See, e.g.,* N.Y. Pub. Health § 2981(2) (witness requirements for the valid execution of an appointment of a health care proxy). There would be no requirement that a patient receive psychiatric evaluation for depression or other mental health problems. *See, e.g.,* N.Y. Mental Hyg. § 9. There is no way to be sure that only the patient is taking the deadly medicine. *See, e.g.,* N.Y. Pub. Health § 3351 (strict limits on dispensing and administering controlled substances to addicts). And there would be no way for public health and law enforcement authorities to ensure that there are no abuses. *See, e.g.,* N.Y. Pub. Health § 230-d(4) (requiring office-based surgery practices to report all "adverse events" to the Department of Health).

These factors taken together create a grave risk to many vulnerable people. Experience in Oregon shows that the reasons that people ask for assisted suicide are primarily social, and not because of unbearable pain. The top five reasons for asking for suicide in that state are decreasing ability to participate in activities that made life enjoyable (96.2%), loss of autonomy (92.4%), loss of dignity (75.4%), burden on family, friends/caregivers (48.1%), and losing control of bodily functions (35.7%). *Oregon's Death With Dignity Act – 2015*, at 6.

Legalizing assisted suicide in New York would send to such people a dangerous message that their worst fears are justified: that they are viewed as a burden to their families and society, that their suffering has no meaning and they are hopeless, that their disabilities make their lives less worthy of love, and that they will be abandoned by medical professionals and their families. In short, the likelihood is that what would begin as a "right to die" would inevitably be heard by patients as a "duty to die".

There would be a further negative impact on needy and vulnerable New Yorkers, since legalization of assisted suicide could force Catholic institutions and providers out of the health care field. Catholic doctrine

is unequivocal in prohibiting assisted suicide under any circumstances, and forbids any Catholic institution or individual from participating in it in any way. *Evangelium Vitae*, *supra*, at par. 66; see also *Ethical and Religious Directives*, *supra*, par. 60. The Catholic faith and assisted suicide are utterly incompatible.

But if assisted suicide were legalized, current New York law would likely require every hospital, nursing home, and physician to tell every patient with a terminal diagnosis how patients can kill themselves. For example, the Palliative Care Information Act requires hospitals and practitioners to provide information, access or referrals for all "end of life options" that are "appropriate", which would likely be interpreted to include assisted suicide. N.Y. Pub. Health § 2997-c. The Palliative Care Access Act, which requires hospitals to enact policies that guarantee patients access to "palliative care", may also be construed to force Catholic health institutions to participate in assisted suicide as "end-of-life-care… to prevent or relieve pain and suffering." *Id.*, at § 2997-d.

Legalization of assisted suicide would thus place Catholic individuals and institutions in an irreconcilable dilemma -- either obey

the civil laws and violate the doctrines of their faith, or go out of business. This would force many Catholic institutional and individual providers to withdraw from the health care field, which would directly and severely impact the needy people who are principally served by Catholic health care.

By prohibiting assisted suicide, current New York law fulfills the compelling state interest in protecting the needy, as promised by Article XVII of the New York State Constitution. It embodies the special concern for the poor that has been a hallmark of New York public policy dating at least back to the Progressive Era. Overturning the ban would betray this proud tradition.

Conclusion

The Appellate Division, and the Supreme Court before it, correctly rejected the Appellant's effort to have assisted suicide legalized in New York State. This court should affirm that judgment.

Dated: New York, New York
December 30, 2016

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 6,174 words.

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