SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

SARA MYERS, STEVE GOLDENBERG, 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, -against- ERIC SCHNEIDERMAN, in his official capacity as ATTORNEY-GENERAL OF THE STATE OF NEW YORK, 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.	Index No. 151162/15 Hon. Joan M. Kenney IAS Part 8 NYSCEF CASE Motion Sequence 002

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

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Plaintiffs respectfully submit this memorandum in opposition to the motion of Defendant Eric T. Schneiderman ("Defendant") to dismiss the Complaint and in response to Defendant's Memorandum of Law in Support of His Motion to Dismiss. ("Def. Br.")[1]

PRELIMINARY STATEMENT

This action was brought by mentally-competent patients with terminal illnesses and by medical professionals who regularly care for or counsel such patients. Complaint ("Compl.") ¶ 2. The patient Plaintiffs seek to exercise control, avoid a loss of dignity and reduce unbearable suffering as they approach death by obtaining a prescription from their physicians for medication they could ingest to achieve a peaceful death – a practice known as aid-in-dying. *Id.* ¶¶ 3-4, 38. Plaintiffs seek a declaration that a physician who provides aid-in-dying to a patient who has requested such aid does not violate New York Penal Law §§ 120.30 and 125.15 (the "Assisted Suicide Statute" or "Statute"), which provide that "promoting a suicide attempt" by "intentionally caus[ing] or aid[ing] another person to attempt suicide" and "intentionally caus[ing] or aid[ing] another person to commit suicide" constitute felonies. *Id.* ¶ 3. Plaintiffs further allege that the application of the Assisted Suicide Statute to aid-in-dying would violate the Due Process and Equal Protection provisions of New York's Constitution. *Id.*

Defendant's motion is a singularly inappropriate procedure for addressing this lawsuit. The facts alleged in the Complaint, which the accompanying affidavits elaborate, more than suffice to state justiciable statutory and constitutional claims. Defendant fails to credit the Complaint's allegations and ignores a host of intensely factual issues. Moreover, the motion is

[1] The Complaint also named as defendants the District Attorneys for each district in which a Plaintiff resides. 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. *See* NYSCEF Doc. No. 27.

based on a series of suspect or wholly inaccurate legal propositions. Plaintiffs deserve their day in Court to present the profoundly important issues raised by this lawsuit.

STANDARD OF REVIEW

On a motion to dismiss under CPLR § 3211(a)(7), the Court's inquiry is "narrowly circumscribed." *P.T. Bank Cent. Asia v. ABN Amro Bank N.V.*, 301 A.D.2d 373, 375 (1st Dep't 2003). A complaint "must be construed liberally," and "the court must accept as true not only the complaint's material allegations but also whatever can be reasonably inferred therefrom in favor of the pleader." *Id.* at 375-76 (citations and quotation marks omitted). Plaintiffs must be accorded "the benefit of every possible favorable inference," and the Court's analysis is limited to determining "only whether the facts as alleged fit within any cognizable legal theory." *Leon v. Martinez*, 84 N.Y.2d 83, 87-88 (1994). Moreover, the court "may freely consider affidavits submitted by the plaintiff to remedy any defects in the complaint." *Id.* at 88.

Similarly, on a motion to dismiss under CPLR § 3211(a)(2) for lack of subject matter jurisdiction, the Complaint must be liberally construed, and its allegations must be accepted as true. *See Vidal Corp. v. Langley Aviation Corp.*, 48 N.Y.S.2d 824, 827 (Sup. Ct. N.Y. Cnty. 1944) ("The complaint must be liberally construed to give it, if possible, such a construction as will bring its demands within the scope of the jurisdiction of this Court which is presumed to have jurisdiction of a cause unless the contrary plainly appears."); *see also Strassman v. State*, 3 Misc.2d 723, 724 (N.Y. Ct. Cl. 1956) ("For the purposes of this motion, made by the Attorney-General to dismiss this claim for lack of jurisdiction, all of the allegations of the pleading are assumed to be true."), *aff'd*, 6 A.D.2d 926 (3d Dep't 1958).

"The sole consideration in determining a pre-answer motion to dismiss a declaratory judgment action is whether a cause of action for declaratory relief is set forth, not the question of whether the plaintiff is entitled to a favorable declaration." *M.H. Mandelbaum Orthotic &*

Prosthetic Svcs., Inc. v. Werner, 126 A.D.3d 857, at *2 (2d Dep't 2015) (citation and quotation marks omitted). A motion to dismiss a declaratory judgment action should be denied "where a cause of action is sufficient to invoke the court's power to render a declaratory judgment . . . as to the rights and other legal relations of the parties to a justiciable controversy . . . ." *DiGiorgio v. 1109-1113 Manhattan Ave. Partners, LLC*, 102 A.D.3d 725, 728 (2d Dep't 2013) (citation and quotation marks omitted) (alteration in original); *see also Wolff v. 969 Park Corp.*, 86 A.D.2d 519, 520 (1st Dep't 1982) ("In a declaratory judgment action, the material facts and circumstances should be fully developed before the rights of the parties are adjudicated.").

ARGUMENT

I. THE COMPLAINT PLEADS A JUSTICIABLE CONTROVERSY.

The Complaint explicitly alleges that Plaintiffs have been deterred from providing aid-in-dying "due to fear of potential prosecution under the Assisted Suicide Statute if the patient did ultimately self-administer life-ending medication." Compl. ¶ 47. Accepting this allegation and its reasonable inferences, the Complaint pleads a justiciable controversy that clearly satisfies the standard articulated by the decision Defendant primarily relies upon. Plaintiffs "have some reasonable fear, which is not purely 'imaginary' or 'speculative' that they will be prosecuted under this statute in the future." Def. Br. 7 (quoting *Cherry v. Koch,* 126 A.D.2d 346, 350 (2d Dep't 1987)).

Defendant seeks to impose a more demanding requirement that a Plaintiff must have been "prosecuted or threatened with prosecution under" the Assisted Suicide Statute. *Id.* Even if that were the standard, one of the Plaintiffs – Dr. Timothy Quill – has in fact been threatened with criminal prosecution under the Assisted Suicide Statute. *See* Affidavit of Dr. Timothy E. Quill (Apr. 27, 2015) ("Quill Aff.") ¶ 15. Dr. Quill is a nationally renowned palliative care specialist and former President of the American Academy of Hospice and Palliative Medicine. *Id.* ¶ 1-3;

Compl. ¶ 33. In an article published in 1991 in *The New England Journal of Medicine*,[2] Dr. Quill recounted his experience in prescribing a terminally-ill leukemia patient enough barbiturates to enable her to achieve a peaceful death, as she wished. Quill Aff. ¶ 14. A grand jury in Rochester subsequently considered whether to indict Dr. Quill for violation of the Assisted Suicide Statute. *Id.* ¶ 15. An assistant district attorney in Monroe County presented evidence to the grand jury, and Dr. Quill testified before the grand jury for three hours, explaining the wishes of the patient and his views in treating her. *Id.* Although the grand jury decided not to return a criminal indictment, the prosecutor announced that the decision was specific to that case and that "it would be irresponsible for anyone to take the grand jury's decision on these specific facts as any type of directive involving medical or legal conclusions involving terminally-ill patients." *See* Affirmation of Edwin G. Schallert (Apr. 28, 2015) ("Schallert Aff.") Ex. 5 (*N.Y. Times* article); Quill Aff. ¶ 16.

Plaintiffs thus satisfy even the artificially demanding standard articulated by Defendant, since Dr. Quill was indeed "threatened with prosecution" under the Assisted Suicide Statute. Def. Br. 7. Moreover, in light of Dr. Quill's grand jury experience and the public statements of the prosecutor, Plaintiffs manifestly satisfy the applicable legal standard of having "some reasonable fear" that is "not purely 'imaginary' or 'speculative'" that they will be prosecuted under the Assisted Suicide Statute.

Defendant's reassurance that "[a]ny defendant charged with" a crime "may raise as a defense the unconstitutionality of the statute" (Def. Br. 8) provides little comfort. Under settled law Plaintiffs need not subject themselves to criminal prosecution, with all of its attendant burdens and consequences, to challenge the construction and constitutionally of a statute.

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[2] Timothy E. Quill, *Death and Dignity, A Case Study of Individualized Decision Making*, NEW ENG. J. OF MED. 324(10):691-4 (Mar 7, 1991).

Rather, a declaratory judgment action is an entirely appropriate vehicle. *Bunis v. Conway*, 17 A.D.2d 207, 208 (4th Dep't 1962) (declaratory judgment action appropriate "where the plaintiff is in doubt as to his legal rights and wishes to avoid the legal hazard of taking action in advance of the determination of such rights."); *De Veau v. Braisted*, 5 A.D.2d 603, 607 (2d Dep't 1958) ("One of the very purposes of a declaratory judgment is to settle a serious question of law as to the validity of a statute which would be the basis of a threatened prosecution for crime, without requiring, as a prerequisite to judicial entertainment of the question, that interested parties first commit the very acts which are involved in the dispute and thereby run the risk of such prosecution.").

The irony of Defendant's justiciability argument should not escape the Court's attention. Defendant is "the highest ranking law enforcement officer for the State," according to the Attorney General's website, and Defendant explicitly argues in the pending motion that the "plain language of the Assisted Suicide Statute" prohibits the precise conduct in which Plaintiffs wish to engage. *See* Def. Br. 8-10. Yet, at the same time, Defendant claims that Plaintiffs cannot show that they have "some reasonable fear" of prosecution. Def. Br. 7. Defendant cannot have it both ways.

II. THE COMPLAINT STATES A CLAIM THAT NEW YORK'S ASSISTED SUICIDE STATUTE DOES NOT APPLY TO A PHYSICIAN PROVIDING AID-IN-DYING.

The Complaint raises myriad, mixed questions of fact and law as to whether the Assisted Suicide Statute can possibly be considered to reach aid-in-dying. Defendant's motion either ignores or fails to credit the relevant facts while making several unsupported factual assertions. On that basis alone, the motion to dismiss should be denied. In addition, the motion rests upon fatally flawed legal premises.

A. The Complaint Raises Many Factual Issues Relevant to the Potential Application of the Assisted Suicide Statute to Aid-in-Dying.

Whether the Assisted Suicide Statute applies to aid-in-dying implicates a host of factual issues. Defendant's motion to dismiss is plainly an improper procedure for resolving them, although the ultimate determination of whether the Assisted Suicide Statute applies to Plaintiffs' proposed actions is a legal question.

First, the definition of suicide in the context of end-of-life care inherently involves facts as to a patient's condition and appropriate medical treatment. The Complaint states that "[i]n some cases, providing aid-in-dying is, in the professional judgment of a physician, a medically and ethically appropriate course of treatment." Compl. ¶ 45. Moreover, the Complaint expressly alleges that "[p]ublic health, medical, and mental health professionals, including the physician Plaintiffs, recognize that the choice of a dying patient for a peaceful death through aid-in-dying is not suicide." Compl. ¶ 44.

Rather than crediting these allegations, Defendant gives them no weight because the medical professionals are "unnamed" and the allegations are purportedly "vague." Def. Br. 10. Of course, the Complaint need not include the names of professionals to survive a motion to dismiss, but to remove any doubt Plaintiffs have provided the Court with additional details to support the Complaint's allegations.

For example, while noting "the importance of using accurate language to describe care options," the American Public Health Association ("APHA") "[r]ejects the use of inaccurate terms such as 'suicide' or 'assisted suicide' to refer to the choice of a mentally competent terminally ill patient to seek medications to bring about a peaceful and dignified death." Schallert Aff. Ex. 1 (APHA Policy No. 20086). Other professional organizations – such as the American Medical Women's Association, the American Medical Student Association and the

American College of Legal Medicine – have reached a similar conclusion and determined that aid-in-dying is an appropriate medical option for mentally-competent, terminally-ill patients facing unbearable suffering in the final stages of the dying process. *Id.* Exs. 2, 3, 4.

The accompanying expert affidavits of Dr. Eric Kress and Dr. Katherine Morris reinforce these conclusions. *See* Affidavit of Dr. Eric Kress (Apr. 24, 2015) ("Kress Aff."); Affidavit of Dr. Katherine Morris (Apr. 24, 2015) ("Morris Aff."). Based on his experience in Montana, where the Montana Supreme Court held that physicians providing aid-in-dying are not subject to criminal prosecution,[3] Dr. Kress opines that aid-in-dying is "one compassionate medical treatment option for dying patients" that should not be considered suicide (Kress Aff. ¶ 9), that patients choosing aid-in-dying are "not suicidal" (*Id.* ¶ 10), that survivors of patients who choose aid-in-dying do not experience the adverse impact known to afflict survivors of someone who commits suicide (*Id.* ¶ 13), and that the practice is governed by professional standards. *Id.* ¶¶ 5, 12. Based on her experience in Oregon and New Mexico, where the practice is also lawful, Dr. Morris opines that she does not consider the deaths of her patients who choose aid-in-dying to be "any sort of 'suicide'" (Morris Aff. ¶ 12), that she attributes the cause of death of such patients to their underlying illnesses (*Id.*), and that aid-in-dying is governed – as is all of medical practice – by professional practice standards, also referred to as "best practices" and "standard of care." *Id.* ¶ 17.

Second, the Complaint and the accompanying affidavits of Dr. Kress, Dr. Morris and Dr. Quill also explain why as a factual matter aid-in-dying is indistinguishable from other medical options such as the removal of life-sustaining treatments or palliative sedation that are not considered "suicide," even when the patient clearly chooses the option in order to precipitate

[3] *Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009).

death. Compl. ¶¶ 40-44; Kress Aff. ¶ 9; Morris Aff. ¶ 17; Quill Aff. ¶ 24. Defendant asserts that these other options are "distinguishable on the basis of causation and intent" (Def. Br. 16), but issues of causation and intent are intensely factual and ill-suited to resolution on a motion to dismiss. *See Petrosky v Brasner*, 279 A.D.2d 75, 78 (1st Dep't 2001) (causation is a "factual issue[ ] to be resolved on a case-by-case basis by the fact finder"); *PMJ Capital Corp. v. PAF Capital, LLC*, 98 A.D.3d 429, 431 (1st Dep't 2012) (issues of intent were factual in nature, "preventing dismissal of the complaint at this stage"). Indeed, the Supreme Court of Canada recently upheld the findings of a trial judge, after considering "the evidence of physicians and ethicists," that "there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death." *Carter v. Canada (Attorney General)*, 2015 SCC 5, ¶ 23 (2015) (attached as Exhibit 6 to the Schallert Affirmation).

Justice Stevens' concurrence in *Washington v. Glucksberg*, 521 U.S. 702, 750-51 (1997) (Stevens, J., concurring), similarly rebuts any such distinctions:

> 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 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.

Third, Defendant's own arguments and authorities in support of his motion raise several factual issues involving the application of the Assisted Suicide State to aid-in-dying. The following are illustrative:

- Defendant asserts that, to qualify as suicide, "the patient must 'want to die.'" Def. Br. 9 (quoting *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 227 n.2 (1990)). The patient Plaintiffs in this case, like the patients of the physician Plaintiffs who want the comfort of knowing that aid-in-dying is an option, do *not* want to die. They enjoyed full lives before their illnesses and have struggled valiantly to withstand their terminal illnesses. *See, e.g.*, Compl. ¶¶ 22-24 (patient Plaintiff Sara Myers), ¶¶ 25-28 (patient Plaintiff Steve Goldenberg). They would choose life if that were an option for them. They want to exercise autonomy at the end of life and achieve a death less brutal than the inexorable progression of their illness allows, "thereby preserving the coherence and integrity of the life the patient has lived." *Id.* ¶ 44.

- Defendant's statutory argument relies upon *In re Eichner on behalf of Fox,* 73 A.D.2d 431 (2d Dep't 1980). Def. Br. 9-10. However, when the Court of Appeals subsequently reviewed that decision, the Court stated that the State's concerns in preventing suicide were "inapplicable" because the patient's "condition was not self-inflicted." *Matter of Storar*, 52 N.Y.2d 363, 377 n.6 (1981). The Complaint makes clear that the patient Plaintiffs' conditions are not self-inflicted either. *See* Compl. ¶¶ 22-30.

- Defendant argues that the withdrawal of life support is not assisted suicide because "a patient who refuses life-sustaining treatment may fervently wish to live." Def. Br. 18

(citation and quotation marks omitted). However, the patient Plaintiffs, and the terminally-ill patients of the physician Plaintiffs, also "fervently wish to live."

- Defendant asserts that the withdrawal of life-sustaining treatment is not suicide because "the cause of death is the patient's disease or pathology." Def. at Br. 17. However, 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" (Compl. ¶ 38) – yet another allegation Defendant fails to credit. Moreover, in states where aid-in-dying is available, the death certificates of the patients who choose it state the cause of death as the underlying disease. *See, e.g.*, Wash. Rev. Code Ann. § 70.245 ("the patient's death certificate . . . shall list the underlying terminal disease as the cause of death") (Washington); Schallert Aff. Ex. 8 at 48-49 (Oregon). Expert opinions are in accord. Kress Aff. ¶ 12; Morris Aff. ¶ 12.

The Complaint readily satisfies "[t]he sole consideration in determining a pre-answer motion to dismiss a declaratory judgment action," by having set forth "a cause of action for declaratory relief." *M.H. Mandelbaum*, 126 A.D.3d 857, at *2 (citation and quotation marks omitted). Plaintiffs have alleged ample facts for this case to move forward. Whether those facts ultimately will be disputed remains to be seen.

B. Defendant's Motion Rests Upon Fatally Flawed Legal Premises.

Defendant's motion argues that the Assisted Suicide Statute is "unambiguous," that the Statute has "consistently been interpreted to apply" in similar circumstances, that the legislative history of the Statute "confirms the prohibition" on aid-in-dying, that the U.S. Supreme Court "has already addressed and rejected Plaintiffs' claims," and that Plaintiffs are asking this Court to rewrite the Statute. Def. Br. 1, 8, 10-12. None of these legal propositions can withstand scrutiny. Thus, even in the absence of the factual issues raised by the Complaint, Defendant

cannot carry his burden of demonstrating that, as a matter of law, the Assisted Suicide Statute applies to aid-in-dying.

First, Defendant asserts that the Assisted Suicide Statute is unambiguous and relies on a Black's Law Dictionary definition of suicide: "the act of taking one's own life." Def. Br. 9. It is remarkable that Defendant claims this is the authoritative definition of suicide when the New York Legislature long ago *repealed* virtually an identical definition. Until the early Twentieth Century, New York law defined suicide as "the intentional taking of one's own life." Act of July 26, 1881, ch. 676, § 172, 1881 N.Y. Laws, *repealed by* Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193. Because "a statutory term should be defined by the context of the statute rather than by the dictionary," *Spota ex rel. Unkechaug Indian Nation v. Jackson*, 10 N.Y.3d 46, 51 (2008), the dictionary definition in this instance hardly provides clarity in light of the Legislature's repeal of a similar formulation.

The ambiguity of the Statute is reinforced by the fact that, even after repealing the criminal suicide statute, the New York Legislature stated that suicide is a "grave public wrong." Act of July 26, 1881, ch. 676, § 173, 1881 N.Y. Laws; Consolidated Laws of the State of New York of 1909 § 2301, 1909 N.Y. Laws. Determining whether a practice is a "public wrong" – let alone a "grave" one – is hardly an unambiguous exercise. Here, as the Complaint makes clear, aid-in-dying does not remotely qualify; to the contrary, it empowers a dying patient with means to avoid the horrific harm of a brutal death laden with suffering the patient finds unbearable.

Second, any suggestion that the Assisted Suicide Statute has "consistently been interpreted to apply" to aid-in-dying (Def. Br. 8) is preposterous. The Statute has been in place – in different variations – for roughly 200 years. *See* Def. Br. 3. During this time, however, not

one New York Court has *ever* applied the Statute to a physician providing aid-in-dying. The cases that Defendant relies upon are completely inapposite.

In *People v. Minor*, 111 A.D.3d 198 (1st Dep't 2013), cited at Def. Br. 9, assisted suicide was asserted as an affirmative defense to the murder of a man in financial crisis who wanted to kill himself to appear as if he was murdered so that his family would be able to collect life insurance. *Id.* at 200. The healthy victim invited a stranger into his car, explained his plan and requested that the stranger hold a knife steady while he lunged into it repeatedly to kill himself. *Id.* at 200-01. Not only are these facts starkly different from the present case, but the issues at stake in *Minor* are also inapplicable. The Court in *Minor* addressed only whether the stranger had "aided" the decedent in committing suicide.

People v. Duffy, 79 N.Y.2d 611 (1992), cited at Def. Br. 11, is easily distinguished. The case involved a severely depressed, suicidal, inebriated, physically healthy teenager distraught at the breakup with his girlfriend. *Id.* at 613. The teenager met defendant on the street and immediately let him know of his desire to kill himself. *Id.* Defendant invited the youth to his apartment, where the teenager continued to express suicidal thoughts and entreated the defendant to shoot him. *Id.* In response, the defendant gave the teenager more alcohol, challenged him several times "to jump headfirst off the porch of his second-story apartment," and finally handed the teenager a gun and ammunition urging him to "put the gun in his mouth and blow his head off." *Id.* The teenager "loaded the rifle, pointed the barrel at himself and pulled the trigger." *Id.* The facts and issues considered in *Duffy* (whether the Assisted Suicide Statute applied to reckless conduct resulting in another's suicide) are not remotely relevant to this case. Cases like *Duffy* show that the Statute has appropriate applications but do nothing to suggest it applies to aid-in-dying.

Fosmire v. Nicoleau, 75 N.Y.2d 218 (1990), cited at Def. Br. 9, does not show that the Assisted Suicide Statue is unambiguous. The case involved a Jehovah's Witness to whom a hospital gave a blood transfusion against her express instructions. *Id.* at 221. The issue was whether the woman's refusal of treatment was protected by her statutory and common-law right of bodily self-determination and by the fundamental right of personal privacy guaranteed by the United States Constitution (*Id.* at 225-26) – not whether aid-in-dying is "suicide."

Defendant also cites (at 10) to *Matter of N.Y. City Asbestos Litig.*, 32 Misc.3d 161 (Sup. Ct. N.Y. Cnty. 2011). The language Defendant relies upon, however, is simply the Court's summary of an argument made by a party in that case – *not* a holding or analysis of the Court. *See id.* at 166 ("Defendant's central argument points are as follows: . . . physician-assisted suicide is otherwise a crime in New York . . . .").

Third, Defendant asserts that the legislative history of the Assisted Suicide Statute confirms that it "encompass[es] physician-assisted suicide." Def. Br. 11. However, the support Defendant offers consists of a hypothetical example included in a Practice Commentary from 1967. *See id.* The hypothetical posits that the Statute applies to a husband who brings a lethal drug to his terminally-ill wife upon her request, to end her "tortured existence." *See id.* That hypothetical addresses a markedly different situation involving a lay person with no medical training. Physicians are entirely different. They are empowered to cut into human bodies to remove and replace vital organs. They are empowered by the State to take a variety of actions that precipitate death, including withdrawing life-sustaining treatment and providing terminal

sedation. They are bound by professional and ethical standards, which apply to aid-in-dying. *See* Kress Aff. ¶ 12; Morris Aff. ¶¶ 9, 16.[4]

When considering the history of the Assisted Suicide Statute, it is clear that "[t]he statutes at issue were born in another age." *Quill v. Vacco*, 80 F.3d 716, 732 (2d Cir. 1996) (Calabresi, C.J., concurring). The first codification of the statute was enacted nearly two hundred years ago, in 1828, as part of the law of homicide.[5] At the time, the statute punished "[e]very person deliberately assisting another in the commission of self-murder," and such prohibition was grounded on the crime of suicide. Act of Dec. 10, 1828, ch. 20, § 4 1828 N.Y. Laws 19 (codified at N.Y. Rev. Stat. pt. 4, ch.1, tit. 2, art. 1, § 7, p. 661 (1829)). This enactment was incorporated into future codifications and underwent some revisions: first in the New York's Penal Code of 1881 § 175 ("A person who willfully, in any manner, advises, encourages, abets, or assists another person in taking the latter's life, is guilty of manslaughter in the first degree"), and later in New York's Penal Law of 1909 § 2304. The Assisted Suicide Statute obtained its current wording in 1965 with the enactment of the present New York Penal Code.

In all of these revisions and re-codifications, there is nothing to suggest that legislators intended to reach aid-in-dying. None of the different versions of the statute include any specific language describing aid-in-dying, and nothing in the legislative history suggests that legislators even considered the potential act of a physician. Indeed, aid-in-dying was not a recognized concept in 1965, when the current version of New York's Assisted Suicide Statute became law.

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[4] Defendant cites Staff Notes of the Commission on Revision of Penal Law and Criminal Code, Def. Br. 11, but those notes do not make any reference to terminally-ill, mentally competent patients in the care of physicians.

[5] Defendant cites the Act of Feb. 21, 1788, ch. 37, § 2, 1788 N.Y. laws 664, 665 as the first prohibition of assisting suicide (Def. Br. 3); however, the Act does not make any reference to suicide or assisting suicide.

The statute was enacted more than 25 years before the option of aid-in-dying was first discussed openly in the medical community.

Evolutions in medicine affect how we approach the end of our lives. As a society we rarely die from the nasty, brutish, and short infections of the past. We now die from recurring cancers, failures of our immune system, or muscular degenerations that slowly suffocate us. Deaths in modern America are often tortured, unnatural, and lingering. Modern medicine can draw out the dying process so long that a patient may find himself trapped in a progressively, inexorably deteriorating body, in a cauldron of cumulative suffering. *See generally* Schallert Aff. Ex. 7 (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 long medical struggle with an incurable condition."); *see* Quill Aff. ¶ 22. The notion that when the Legislature last addressed the Assisted Suicide Statute 50 years ago it intended to bar aid-in-dying is utterly implausible.

Fourth, Defendant repeatedly refers to the U.S. Supreme Court decision in *Vacco v. Quill*, 521 U.S. 793 (1997), as a precedent purportedly demonstrating that aid-in-dying comes within the scope of the New York Assisted Suicide Statute. *E.g.*, Def. Br. 1, 9. However, *Quill* did not involve a prosecution under the Assisted Suicide Statute, and the Supreme Court addressed only the constitutional questions raised by the two laws. It never construed the New York Statute. Indeed, that is not the province of the Supreme Court. *See BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 577 (1996) ("[O]nly state courts may authoritatively construe state statutes.")

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 at 718, and notwithstanding serious doubts that the Assisted Suicide Statute was "ever meant to apply to a treating physician." *Id.* at 732 (Calabresi, C.J., concurring). Thus, the Supreme Court 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) (Calabresi, C.J.).

For the same reason, Defendant's repeated reliance on the U.S. Supreme Court's decision in *Washington v. Glucksberg*, 521 U.S. 702 (1997), is misplaced. As in *Quill*, the Court in *Glucksberg* never analyzed whether the Washington statute at issue applied to aid-in-dying, but merely assumed that it did, as the district court had done. *See Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1455-56 (W.D. Wash 1994) (noting that plaintiffs challenged the constitutionality of Washington's assisted suicide statute, without analyzing whether aid-in-dying came within its scope).

Finally, Defendant seeks to interpret the meaning of the Assisted Suicide Statute based on the fact that the Legislature has not amended it. Def. Br. 11-12. A legislature's failure to act is quite different from its enactment of a law, and drawing inferences from legislative *inaction* is always a perilous exercise. *See, e.g.*, *Cricchio v. Pennisi*, 90 N.Y.2d 296, 308 n.5 (1997) ("We decline to attribute any definitive meaning to the Legislature's failure to enact any of the proposed amendments . . . ."). Any inference is particularly suspect here because, unlike several

other states, New York has no law that purports to address aid-in-dying.[6] By contrast, some states like Arkansas, South Carolina and Idaho unequivocally prohibit aid-in-dying. *See* Ark. Code Ann. § 5-10-106(b) (making illegal the act of a "physician or health care provider to commit the offense of physician-assisted suicide by (1) [p]rescribing any drug, compound, or substance to a patient with the express purpose of assisting a patient to intentionally end the patient's life"); S.C. Code Ann. § 16-3-1090(G) (explicitly applying the assisted suicide criminal statute to "a licensed health care professional who assists in a suicide"); Idaho Code Ann. § 18-4017(1) (explicitly applying the assisted suicide statute to "a health care professional").

Moreover, Defendant's assertion that Plaintiffs are asking the Court to "rewrite" the Statue (Def. Br. 12) is meritless. The Complaint asks the Court to decide whether the Statute applies to the underlying facts and, if necessary, to determine Plaintiffs' rights under the State Constitution. These are quintessentially judicial functions. As the Second Department observed in *Eichner*, "when appropriate litigants present the court with a vital problem involving private rights as well as public policy, we would be remiss if we declined to act. . . . [T]his power of interpretation must be lodged somewhere, and the custom of the constitution has lodged it in the judges." 73 A.D.2d at 452-53.

[6] For the same reason, the 20-year-old New York Task Force Report cited by Defendant (Def. Br. 5), is not relevant and in any event sheds no light on legislative intent. The Task Force simply concluded in 1994 that there was not enough evidence concerning aid-in-dying at that time to recommend any changes to the law to reflect the practice. See Quill Aff. ¶ 17.

III. THE COMPLAINT ADEQUATELY PLEADS THAT THE ASSISTED SUICIDE STATUTE, IF APPLIED TO A PHYSICIAN PROVIDING AID-IN-DYING, VIOLATES THE DUE PROCESS AND EQUAL PROTECTION CLAUSES OF THE NEW YORK CONSTITUTION.

A. The Complaint Pleads A Violation Of The Due Process Clause.

Plaintiffs have alleged that applying the Assisted Suicide Statute to physicians providing aid-in-dying to their mentally-competent, terminally-ill patients violates patient Plaintiffs' rights (and the rights of physician Plaintiff's mentally-competent, terminally-ill patients, and of Dr. Schwarz's and EOLCNY's mentally-competent, terminally-ill clients) to privacy and other fundamental liberties without due process of law in violation of the Due Process Clause of the New York Constitution, article I, § 6. *See* Compl. ¶¶ 66-73. Plaintiffs have properly pled this claim, and Defendant's motion should be denied.

The United States Supreme Court has repeatedly recognized that due process protects individuals' right to privacy and bodily integrity. *See, e.g.*, *Roe v. Wade*, 410 U.S. 113 (1973) (recognizing the right of privacy protects a woman's right to choose whether to terminate a pregnancy); *Cruzan v. Director, Mo. Dep't Of Health*, 497 U.S. 261 (1990) (suggesting the Due Process Clause protects an interest in refusing medical care, even if that precipitates the individual's death); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 849 (1992) ("It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity."). In *Roe*, the Supreme Court also "stressed the importance of the relationship between the patient and physician." *Glucksberg*, 521 U.S. at 778 (Souter, J., concurring) (citing *Roe*, 410 U.S. at 153, 156). The U.S. Supreme Court has "assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Glucksberg*, 521 U.S. at 720 (citing *Cruzan*, 497 U.S. at 278-79).

Although the Supreme Court has not yet recognized that aid-in-dying is encompassed within the right to privacy and other fundamental liberties under the Due Process Clause of the Federal Constitution, this Court can interpret the State Constitution more broadly. *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)); *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."). Indeed, the Court of Appeals has recognized that the Due Process Clause under the State Constitution is broader than its federal counterpart, and provides greater protection to individual liberties. The Court of Appeals has explained that "[t]he historical differences between the Federal and State due process clauses make clear that they were adopted to combat entirely different evils." *Sharrock v. Dell Buick-Cadillac*, 45 N.Y.2d 152, 160 (1978).

To define the scope of the State Constitution, New York courts examine preexisting statutory or common law defining the scope of the individual right in question; the history and traditions of the state in its protection of the individual right; any identification of the right in the state Constitution as being one of peculiar state or local concern; and any distinctive attitudes of state citizenry toward the definition, scope or protection of the individual right. *People v. P.J. Video*, 68 N.Y.2d 296, 303 (1986).

Not only do these issues require a fully developed record, but New York has recognized a fundamental common law right to self-determination with respect to one's body and to control the course of his medical treatment. *See Rivers v. Katz*, 67 N.Y.2d 485, 492 (1986) ("It is a firmly established principle of the common law of New York that every individual of adult years and sound mind has a right to determine what shall be done with his own body and to control the course of his medical treatment." (citations and quotation marks omitted)); *Delio v. Westchester Cnty. Med. Ctr.*, 129 A.D.2d 1, 13 (2d Dep't 1987) ("The right to self-determination with respect to one's body has a firmly established foundation in the common law."). The Court of Appeals has broadly described this right:

> 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.

Rivers, 67 N.Y.2d at 493. This fundamental right to self-determination is recognized in New York, but not under the federal Constitution. This right is broader than the privacy rights provided under the Federal Constitution and is broad enough to encompass aid-in-dying.

Patients who seek aid-in-dying have the same stake as others in the autonomy, privacy, bodily integrity, and self-determination protected by the fundamental liberties recognized in New York. *See Eichner*, 73 A.D.2d at 459 ("Individuals have an inherent right to prevent pointless, even cruel, prolongation of the act of dying. . . . [A] competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity."). Prohibiting patients from choosing aid-in-dying would severely infringe these rights. Without having access to this medically and ethically appropriate end-of-life care, patients for whom aid-in-dying would be an appropriate option likely face further severe suffering and the fear of an

impending death over which the State has chosen to prevent them from exerting any control. *See, e.g.*, Compl. ¶¶ 43; Quill Aff. ¶ 6, 24. They face the real possibility that their death will be drawn out, unbearable, and lacking in dignity and peace (*see, e.g.*, Compl. ¶ 33), which no person should be forced to endure because of an abstract government interest in preserving life, regardless of the situation of the person living the life at issue.

Patients who seek aid-in-dying are exercising a fundamental right to privacy and self-determination. Any law prohibiting them from exercising that right is a violation of the due process guarantees of the New York Constitution, unless the State can show that it is narrowly tailored to achieve a compelling state interest. *See Hernandez v. Robles*, 7 N.Y.3d 338, 368 (2006). Defendant cannot meet that burden.

Instead, Defendant argues that "assisted suicide" is not a fundamental right, and that the State has a legitimate interest in preventing suicide. *See* Def. Br. 20-28. Defendant's argument is flawed for several reasons. First, Defendant's articulation of the privacy right at issue is circular and assumes a factual conclusion: that aid-in-dying is "assisted suicide." The Complaint specifically alleges that aid-in-dying is not "assisted suicide" (Compl. ¶ 38), and at this stage of the proceedings, the Court must credit that allegation.

Second, the Complaint alleges that the State's prohibition on aid-in-dying has no rational basis. Compl. ¶ 71. Defendant argues that the State has an interest in preserving life, protecting the integrity and ethics of the medical profession, protecting vulnerable patients, and maintaining clear rules regarding assisted suicide. *See* Def. Br. 26-28. These interests were advanced by the State of Washington in *Glucksberg*, but Defendant's reliance on that case is misplaced for the reasons discussed in Section III(C), *infra*. More importantly, a court evaluating aid-in-dying today stands in a starkly different position than the Court deciding *Glucksberg* eighteen years

ago because there is a vast amount of data about how an open practice of aid-in-dying affects patients and physicians. For example, there is abundant evidence from Oregon (and more recently other states) that, since aid-in-dying became available, end-of-life care has improved in measurable ways: referrals to hospice care occur more often and earlier, and palliative care and communication between patient and physician have improved. All of these developments improve terminally-ill patients' quality of life. *See, e.g.*, Quill Aff. ¶ 19; Morris Aff. ¶ 15; Schallert Aff. Ex. 9, at 4.

Extensive experience has also shown that where there is an open practice of aid-in-dying life may be extended. The Supreme Court of Canada recently upheld a trial court's factual finding, based on hearing extensive testimony from witnesses and experts, 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*, 2015 SCC 5, at ¶ 57. In states where aid-in-dying is openly practiced, "there is evidence that some patients may even survive longer because they have the option of dying on their own terms. Freed of the anxiety over loss of control and unbearable suffering, patients' remaining days are of higher quality." Quill Aff. ¶ 19.

In a similar vein, extensive experience from Oregon and other states has refuted concerns about the effect of aid-in-dying on "vulnerable populations." A great body of authoritative literature and testimony of witnesses regarding the practice shows that there is no harm to vulnerable populations. This evidence was extensively reviewed by the court in New Mexico (Schallert Aff. Ex. 10) and by the *Carter* Court in Canada, and factual findings were made by the trial courts, persuasive to the higher courts, that none of the harms speculated about in *Quill* and *Glucksberg* actually arise when aid-in-dying is available. *See, e.g.*, Schallert Aff. Ex. 9, at 6 (no

evidence that aid-in-dying negatively impacts vulnerable populations). These data raise issues that must be determined on a developed factual record, not a motion to dismiss.

All of this evidence would undermine Defendant's argument that a prohibition on aid-in-dying is rationally related to a legitimate State interest. Ultimately, questions regarding whether there is a legitimate State interest in prohibiting aid-in-dying require development of an evidentiary record. With the changed landscape and understanding of aid-in-dying, Defendant's summary references to the interests relied upon in *Glucksberg* (Def. Br. 26-29) cannot be determinative of Plaintiffs' claims here. Plaintiffs have asserted that the violation of their right (or of their patients' or clients' right) to due process is not rationally related to any legitimate state interest, does not further an important state interest, nor is it the least restrictive means of advancing any compelling state interest. Compl. ¶ 71. These facts must be credited on this motion to dismiss, and Plaintiffs have properly pled a legally sufficient claim for the violation of their right to due process.

B. The Complaint Pleads A Violation Of The Equal Protection Clause.

Plaintiffs have alleged that applying the Assisted Suicide Statute to physicians providing aid-in-dying to their mentally-competent, terminally-ill patients violates the Equal Protection Clause of the New York Constitution, article I, § 11, because the Assisted Suicide Statute does not treat equally all competent persons who are in the final stages of fatal illness. *See* Compl. ¶¶ 58-65. Plaintiffs have properly pled this claim and Defendant's motion should be denied.

The Equal Protection Clause "is essentially a direction that all persons similarly situated should be treated alike." *Hernandez*, 7 N.Y.3d at 375 (citation and quotation marks omitted). When a statute burdens a fundamental right protected under the Due Process Clause, it is subjected to strict scrutiny, "meaning that it will be sustained only if it is narrowly tailored to

serve a compelling state interest." *Id.* As described in Section III(A), *supra*, the Assisted Suicide Statute, if construed to encompass aid-in-dying, burdens patient Plaintiffs' fundamental right to privacy and self-determination, and the Complaint plainly alleges that this unequal treatment of mentally-competent, terminally-ill patients is not narrowly tailored to serve a compelling state interest. Compl. ¶ 64.

Even if the Statute did not burden a fundamental right, Plaintiffs may still succeed on their Equal Protection claim if the distinctions made by the Assisted Suicide Statute do not further a legitimate state interest. *See Hernandez*, 374 N.Y.3d at 375. Defendant clearly has not credited the Complaint's allegation that the Assisted Suicide Statute creates a classification that can be challenged on equal protection grounds. Def. Br. 14-16. The Complaint plainly alleges that mentally-competent, terminally-ill patients who wish to choose aid-in-dying as an end-of-life treatment are similarly situated to mentally-competent, terminally-ill patients who choose other end-of-life treatments that Defendant accepts are lawful (and indeed, constitutionally protected), such as terminal sedation, stopping eating and drinking, and the withdrawal of life-sustaining intervention. *See* Compl. ¶¶ 58-65. Whether these classes are similarly situated for the purposes of an Equal Protection claim is a question of fact that requires further development of the record. That the Supreme Court in *Quill* may have reached contrary conclusions on the facts before it is irrelevant here. Questions about whether Plaintiffs' situations are "distinguishable on the basis of causation and intent" from patients who receive artificial life support or palliative sedation (Def. Br. 16) is a question of fact for this Court. This is particularly so in light of the affidavits of Drs. Quill, Morris, and Kress, which all describe the ways in which patients such as Plaintiffs are similarly situated to those on artificial life support or who receive palliative sedation. Crediting the Complaint and affidavits as the Court must on

this motion, Plaintiffs have adequately pled that the law treats similarly situated individuals differently.

The Complaint also alleges that treating these classes differently does not have any rational relationship to a legitimate state interest. Compl. ¶ 64. Whether the distinctions drawn by the Assisted Suicide Statute are rationally related to a legitimate State interest requires further factual development. In particular, and as set out in Section III(A), *supra*, whether the legislature's distinction between the termination of life support and the prescription of lethal medications remains "both important and logical" (Def. Br. 17 (quoting *Quill*, 521 U.S. at 800-01, 808-09) today is a question of fact that requires assessment of multiple important developments over the past twenty years, including the experience with an open practice of aid-in-dying in Oregon Washington, Vermont, New Mexico and Montana, and evolving public attitudes to aid-in-dying.

C. The U.S. Supreme Court Did Not Foreclose A Successful Constitutional Challenge To The Assisted Suicide Statute.

Defendant wrongly relies on *Quill* and *Glucksberg* to argue that Plaintiffs have not stated a due process or equal protection claim. *Quill* and *Glucksberg* are not dispositive for two reasons. First, Plaintiffs do not bring claims under the United States Constitution. Instead, Plaintiffs bring claims under the Equal Protection Clause and Due Process Clause of the New York State Constitution.

Second, although the Supreme Court declined to find a federal constitutional right to choose aid-in-dying in *Quill* and *Glucksberg*, it left the matter open for states to determine the legality for themselves. *See Glucksberg*, 521 U.S. at 735 ("Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a

democratic society."); *id.* at 737 ("States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. . . . In such circumstances, the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . ." (O'Connor, J., concurring) (second and third omissions in original) (citation and internal quotation marks omitted)).

The Supreme Court also carefully reserved the possibility that it might in the future find that a prohibition on aid-in-dying violated the Due Process Clause and Equal Protection clause of the federal constitution. *See Quill*, 521 U.S. at 809 n.13 ("Justice Stevens observes that our holding today 'does not foreclose the possibility that some application of the New York statute may impose an intolerable intrusion on the patient's freedom.' This is true . . . ."); *Glucksberg*, 521 U.S. at 735 n.4 ("We emphasize that we today reject the Court of Appeals' specific holding that the statute is unconstitutional 'as applied' to a particular class. Justice Stevens agrees with this holding, but would not foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge.' Our opinion does not absolutely foreclose such a claim." (citations omitted)). Accordingly, the decisions in *Quill* and *Glucksberg* present no barrier to this Court finding that the Assisted Suicide Statute violates the State Constitution.

Evidence that reflects growing societal acceptance for aid-in-dying, and experience from states that have an open practice of aid-in-dying – which require a developed factual record – both provide strong bases for this Court to recognize a right to aid-in-dying. The significance of evolving societal views to constitutional analysis is recognized in *Lawrence v. Texas*, 539 U.S. 558 (2003), which revisited after only seventeen years the constitutionality of anti-sodomy statutes that had been upheld in *Bowers v. Hardwick*, 478 U.S. 186 (1986). In *Lawrence*, the

Supreme Court reversed its earlier decision in *Bowers*, emphasizing the importance of relatively recent history and evolving social understanding of the conduct at issue to its decision to do so. *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.").

Changing societal views towards aid-in-dying are reflected by other states' recognition of the practice as an end-of-life choice and by other indicators, including, for example, the adoption of policies by various medical associations that support aid-in-dying. *See* Compl. ¶ 50; Schallert Aff. Exs. 1, 2, 3, 4. Oregon, Washington and Vermont have enacted statutes that permit aid-in-dying (Or. Rev. Stat. § 127.800 et seq.; Wash. Rev. Code § 70.245 et seq.; Vt. Stat. Ann. tit. 18, § 5281 et seq.), and courts in Montana and New Mexico have recognized the right to aid-in-dying, establishing an open practice in those states. *See Baxter v. Montana*, 224 P.3d 1211 (Mont. 2009) (physician aid-in-dying not against public policy); Schallert Aff. Ex. 10 (*Morris v. Brandenburg*, No. D-202-CV 2012-02909, slip op. (N.M. Dist. Ct. Jan 13, 2014) (aid-in-dying protected under New Mexico constitution)).

Other examples of changing societal views are illustrated by polls reflecting acceptance of aid-in-dying (*see* Compl. ¶ 50), and developments in other countries that have recognized the right of a patient to physician assistance in achieving a peaceful death. *See, e.g.*, *Carter v. Canada (Attorney General)*, 2015 SCC 5 (2015) (striking down Canada's assisted suicide statute). At the very least, changing societal views, both domestic and international, towards aid-in-dying raise issues that require further record development.

Experience also demonstrates that concerns speculated about by the States, which gave the U.S. Supreme Court pause in *Quill* and *Glucksberg,* have not materialized. When the Supreme Court considered *Quill* and *Glucksberg* in 1997, it had to do so in a vacuum without

information about how the practice of aid-in-dying would affect patients and end-of-life care because, at that time, there was no open practice in the United States. In contrast, this Court stands in a strikingly different position than the Supreme Court when it confronted the issue eighteen years ago: it stands in a landscape rich with data to inform consideration of whether any of the speculated concerns are well founded. A court reviewing such concerns today would find an overwhelming body of evidence establishing that there is no harm to patients when an open practice of aid-in-dying is available. *See* Schallert Aff. Ex. 9, at 6.

Finally, even if one were to consider some of the inapposite cases cited by Defendant as adverse precedent, courts recognize that rigid application of precedent may not be appropriate: "even the venerable doctrine of *stare decisis* becomes ineffectual in that it suggests institutional reliance on old answers at a time when the questions themselves have passed beyond the imagination of the judicial sages who formulated the precedents." *Eichner*, 73 A.D.2d at 447 (holding that a Catholic priest had the right to direct the withdrawal of life support from a comatose Catholic clergy member upon sufficient evidence that the latter did not wish to be kept alive by artificial means).

Defendant asserts that only the Legislature can address aid-in-dying because it would require "a detailed, comprehensive statutory scheme." Def. Br. 29. However, medical practice in New York and elsewhere in the United States demonstrates that "comprehensive statutory scheme[s]" are *not* required in order to "to protect terminally ill individuals from abuse." Def. Br. 29.

First, if this premise were accepted, statutory safeguards would be equally necessary for other medical conduct that precipitates death, such as terminal sedation, stopping eating and drinking, and withdrawal of life-sustaining treatment. Yet, the New York Legislature has not

established "comprehensive statutory schemes" in these contexts. Instead, it has left the development of safeguards to the medical profession. *See, e.g.*, N.Y. Pub. Health Law § 2966 ("If no surrogate is reasonably available . . . to make a decision regarding issuance of an order not to resuscitate on behalf of an adult patient who lacks capacity and who had not previously expressed a decision regarding cardiopulmonary resuscitation, *an attending physician [ ] may issue an order not to resuscitate the patient, provided that the attending physician determines, in writing, that, to a reasonable degree of medical certainty, resuscitation would be medically futile, and another physician . . . reviews and concurs in writing . . . .*" (emphasis added)). The best practices or standards of care developed in these contexts can be readily transferred, with any appropriate adjustments, to aid-in-dying. *See* Kress Aff. ¶ 12; Morris Aff. ¶ 16, 17.

Second, the medical profession appropriately can establish safeguards through evolving best practices. For example, when the Vermont legislature enacted a permissive statute for aid-in-dying in 2013, it established regulatory requirements for a period of only three years. In 2016, the regulatory provisions sunset, leaving the practice to be governed by best practices, also referred to as standard of care. Act 39 of the Vermont General Assembly §§ 2, 3 (2013). Moreover, in New Mexico and Montana, where aid-in-dying became openly available following court decisions, neither state has enacted any regulatory scheme governing the practice. Best practices, accordingly, are left to the medical profession, as is the case for all of medical practice. *See* Kress Aff. ¶ 12; Morris Aff. ¶ 16, 17. It is aberrant for medical practice to be governed by statute. Medical practice evolves organically, as physicians discover more efficacious modalities and treatments; this is as it should be, allowing practice the flexibility to improve over time as discoveries and refinements are made.

There are proper respective roles here for the Court and Legislature: it is this Court's responsibility to determine the reach of the challenged statute and whether it impinges on constitutional rights under our State Constitution. Thereafter, subject to the Court's ruling, there might possibly be a role for the Legislature.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court deny Defendant's motion to dismiss in its entirety.

Dated: New York, New York
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