

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST JUDICIAL DEPARTMENT

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TIMOTHY E. QUILL, M.D.,
JUDITH K. SCHWARZ, PH.D.,
CHARLES A. THORNTON, M.D., and
END OF LIFE CHOICES NEW YORK,

Plaintiffs-Appellants,

v.

Index No. 151162/15

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as Attorney General of the State of New York,

Defendant-Respondent.

**AMICUS BRIEF OF DISABILITY RIGHTS AMICI: NOT DEAD YET, ADAPT,
ASSOCIATION OF PROGRAMS FOR RURAL INDEPENDENT LIVING,
AUTISTIC SELF ADVOCACY NETWORK, CENTER FOR DISABILITY
RIGHTS, DISABILITY RIGHTS CENTER, DISABILITY RIGHTS EDUCATION
AND DEFENSE FUND, NATIONAL COUNCIL ON INDEPENDENT LIVING,
NEW YORK ASSOCIATION ON INDEPENDENT LIVING, REGIONAL
CENTER FOR INDEPENDENT LIVING, AND UNITED SPINAL ASSOCIATION**

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STATEMENT OF ISSUES PRESENTED

Plaintiffs-appellants (“appellants”) seek a court order prohibiting prosecution of physician assisted suicide under New York penal laws, as well as a court declaration that New York penal laws against physician assisted suicide are unconstitutional violations of due process and equal protection provisions. The Supreme Court of the State of New York, County of New York, dismissed appellants’ case against the State of New York on October 16, 2015, finding that appellants’ request “to prohibit a district attorney from prosecuting an alleged violation of the penal law, would . . . exceed this Court’s jurisdiction” (*Myers v. Schneiderman*, Memorandum of Decision (“*Decision*”), page 9) and that “the case at bar is factually and legally indistinguishable from *Vacco*” v. *Quill*¹ (*Decision*, page 10), in which the U.S. Supreme Court ruled against precisely the same constitutional claims. Not Dead Yet, ADAPT, Association of Programs for Rural Independent Living, Autistic Self Advocacy Network, Center for Disability Rights, Disability Rights Center, Disability Rights Education and Defense Fund, National Council on Independent Living, New York Association on Independent Living, Regional Center for Independent Living and United Spinal Association (collectively the “Disability Rights Amici”), organizations with members in New York, support

¹ 117 US 2293 (1997); see also *Bezio v. Dorsey*, 21 N.Y.3d 93 (2013).

the New York Supreme Court's ruling and Attorney General's position that Sections 125.15(3) and 120.30 do not violate any New York constitutional provisions.

As noted by Judge Joan Kenney, this case does not concern the settled issue of the individual's right to refuse treatment, even if it might result in death. *Decision*, pages 7, 10-11. Certainly, people have a "right to die" by removing their life supports, refusing life supports, and letting nature take its course. This case concerns only whether there is a New York constitutional right to receive active physician assisted suicide or, as appellants rename it, "physician aid in dying".

Were this Court to reverse the Supreme Court's decision, it would soon face a number of related issues in future cases, including the following:

- Why should a constitutional right be limited to people who have a disabling condition that is labeled "terminal"? Why not any disabling condition? Why not a firm decision to commit suicide by any competent person?
- Why should the constitutional right be limited to providing only lethal medications? Why not lethal injections?
- If such a constitutional right exists, why should a person's right be limited to "aid" only from doctors? What about family members, friends, or advocates?

BACKGROUND

Plaintiff/appellants claim that prohibiting "mentally competent, terminally ill"

people from obtaining a lethal dose of drugs from a third party violates their equal protection and due process rights under the New York Constitution.

The Supreme Court dismissed the case, finding that the Court of Appeals has previously stated that “the right to refuse medical treatment is not the equivalent of a right to commit suicide.” (*Decision at 11*). They referred to the U.S. Supreme Court’s ruling in *Vacco v. Quill* where the Court said that there has been a long time “distinction between a right to refuse medical treatment and a right to commit suicide (or receive assistance in doing so).” 521 US 793, (1997). The State Supreme Court found this case indistinguishable from *Vacco* in which they unanimously held the New York State Penal law prohibiting assistance of a suicide was not arbitrary under the due process standard and did not violate the equal protection clause. *Id.*

Whether there is a constitutional right in New York to physician-assisted suicide must be addressed and understood from the perspective of the class of people who will be most adversely affected and impacted were such a right to be found: people with disabilities, whether their conditions are terminal or not. The Disability Rights Amici represent a very broad spectrum of people with disabilities, including people with physical, developmental, and/or mental disabilities, and people whose disabilities existed from birth or were acquired during their lifetimes. Many are now, or at some point have been, erroneously labeled "terminal" by a physician. Many have had doctors threaten to remove life sustaining treatment on an involuntary basis

and have had to fight to receive continued care.

In fact, although pain (or the fear of pain) is often cited as the primary reason for enacting assisted suicide laws, doctors actually report that the top five reasons they issue lethal prescriptions are because of patients' "loss of autonomy," "less able to engage in activities," "loss of dignity," "loss of control of bodily functions," and "feelings of being burden,"² and that "[p]atients' interest in physician-assisted suicide appeared to be more a function of psychological distress and social factors than physical factors."³

Major issues include the inadequacy of symptom control, difficulties in the person's relationships with family, and psychological disturbances – especially grief, depression, and anxiety.

The desire for euthanasia or assisted suicide resulted from fear and experience of two main factors: disintegration and loss of community. These factors combined to give participants a perception of loss of self [...] Symptoms and loss of function can give rise to dependency on others, a situation that was widely perceived as intolerable for participants: 'I'm inconveniencing, I'm still inconveniencing other people who look after me and stuff like that. I don't want to be like that. I wouldn't enjoy it, I wouldn't. I wouldn't. No. I'd rather die.'⁴

² Oregon's Death With Dignity Act – 2014, page 5, Oregon Public Health Division (<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

³ William Breitbart, MD et al, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, Am. J. Psychiatry 153, 238-242 (1996). See also Robert Pear, *A Hard Charging Doctor on Obama's Team*, N.Y. Times, April 18, 2009, at A14 (noting that pain is "a common stereotype of patients expressing interest in euthanasia. In most cases... the patients were not in excruciating pain. They were depressed and did not want to be a burden to their loved ones").

⁴ Block SD & Billings JA, *Patient Requests to Hasten Death. Evaluation and Management in Terminal*

These are quintessential disability issues. The Disability Rights Amici's members know that these feelings are not inevitable, that their causes are and have been successfully addressed and that, most importantly, these emotions do not justify a lethal response.

Assisted suicide laws authorize doctors to decide who is eligible – i.e., whose condition is "terminal" and whose desire to commit suicide is "rational." In the context of our current healthcare system, with profit motives of insurance and managed care companies, and financial and other pressures on family members and individuals, the risks of subtle and even blatant coercion are great. These are precisely the issues and concerns described in the seminal report issued by the New York State Task Force on Life and the Law in 1994⁵ and discussed by the U.S. Supreme Court in *Vacco*.

No one is immune from the pervasive societal assumptions surrounding the disability label. Fear, bias, and prejudice against disability are inextricably intertwined in these assumptions and play a significant role in assisted suicide. Our

Care, Archives of Internal Medicine, 154(18):2039-47 (Sept. 26, 1994).

⁵ "When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context", New York State Task Force on Life and the Law, May 1994 (https://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/)

society values and desires “healthy” bodies and minds. The idea that any person with a disability could be a happy, contributing member of society is outside the experience or thinking of most non-disabled persons. Severe disability is viewed as worse than death, thus justifying the deadly exception to laws for suicide prevention and laws against homicide. These views and assumptions are strongly opposed by people with disabilities.

The appellants use the term “dignified death” to justify assisted suicide, but when asked what "indignities" concern them, nondisabled (and some newly disabled) people invariably describe the need for assistance in daily activities like bathing, toileting, and other disability realities. These should never be the basis for a societal double standard for providing suicide assistance only to people with disabilities, including those labeled “terminal,” but suicide prevention to the rest of society.

SUMMARY OF ARGUMENT

The Supreme Court is correct - there is no fundamental right, under the New York or United States Constitutions, to assistance from a doctor or any other third party in committing suicide. Moreover, there are compelling State interests in prohibiting assisted suicide for all, including people with disabilities, terminal and nonterminal. State-sanctioned assisted suicide degrades the value and worth of

people with disabilities and violates the antidiscrimination rights, protections and mandates of the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.*

ARGUMENT

STANDARD OF REVIEW

An appeal is properly before the Court of Appeals when it concerns the constitutionality of a statute “from a judgment of a court of record of original instance which finally determines an action where the only question involved on the appeal is the validity of a statutory provision of the state or of the United States under the constitution of the state or of the United States.” *NY CPLR § 5601(b)(2)* (2012).

New York Law sets out no standard of review for any court, leaving the Court broad discretion to decide its own standard. In fact, commentators have noted the court’s broad discretion to use whatever standard they choose and even make new findings of their own in nonjury cases. *Jill Paradise Botler, M. Christine DeVita, Stephen John Kallas, and William J. Ruane, The Appellate Division of the Supreme Court of New York: An Empirical Study of Its Powers and Functions as an Intermediate State Court, 47 Fordham L. Rev. 929, 972 (1979).*

In the lower court ruling it is stated that the decision whether to bring charges against an individual is properly that of a district attorney, and a court either

prohibiting or compelling prosecution of an individual would be beyond its jurisdiction in violation of separation of powers. (*Decision at 10*). Because ruling this statute unconstitutional would impinge on the separation of powers and because it would deny equal protection (e.g. equal suicide prevention) to people with disabilities, this statute's constitutionality must be upheld. The appropriate basis of review for this statute is a rational basis one because this statute does not apply a suspect classification or burden a fundamental right.

The U.S. Supreme Court held in *Vacco* that assisted suicide was not a fundamental right. *Id. at 799*. While an individual may have a right to choose whether to live or die there is no right to engage a physician in this process. Even if this statute were subject to strict scrutiny it must be upheld because of the compelling governmental interest in not having physicians violate the Hippocratic oath and assist the suicides of any class of persons.

II. ASSISTED SUICIDE DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES

A. Assisted Suicide Is Part of the Long and Tragic History of Discrimination Against People with Disabilities

Assisted suicide must be viewed against the backdrop of the United States' long and tragic history of state-sanctioned discrimination against the disabled. The U.S. Supreme Court has acknowledged that at least one of the forms of such

discrimination – the practice of withholding lifesaving medical assistance by medical professionals from children with severe disabilities – demonstrates a "history of unfair and often grotesque mistreatment" arising from a legacy in this country of "prejudice and ignorance," and continuing well into the 20th century. *City of Cleburne, Texas v. Cleburne Living Center*, 105 S. Ct. 3249, 3262, 3266. (1985) (Stevens, J., joined by Burger, C.J., concurring), (Marshall, J., joined by Brennan & Blackmun, JJ., concurring).

Such attitudes, unfortunately, are not completely in the past. Prominent Ethicists, such as Peter Singer of Princeton University,⁶ have advocated the killing of infants with severe disabilities based on a belief that they will not lead a "good" life and will burden their parents and society.

B. Appellants Advocate a Public Policy That Denies People with Disabilities the Benefit of the State's Suicide Prevention Protections

Assisted suicide singles out some people with disabilities, those labeled "terminal" or very severely impaired, for different treatment than other suicidal people receive. This lethal discrimination is viewed as justified based on the mistaken belief that a severe disability – which may cause, for example, use of a wheelchair or incontinence, or may require assistance bathing, eating, toileting, or

⁶ See Peter Singer, *Taking Life: Humans*, in PRACTICAL ETHICS, 175-217 (2d ed. 1993)

other activities of daily living – is worse than death.

The appellants' quest to immunize physicians for assisting the suicides of persons with "terminal" disabilities or conditions, turns on its head the general assumption that suicide is irrational and is a "cry for help." Appellants seek to invalidate long standing protections of old, ill and disabled people and permit doctors to affirmatively facilitate suicide, an act that would be a crime but for the person's disability and a label of "terminal." Persons with severe health impairments would be denied the benefit of New York's suicide prevention laws and programs. Indeed, the appellants' proposal would guarantee that these suicide attempts would result in death – unlike those of the majority of other persons with suicidal ideation who attempt suicide and are not disabled. A practice that the State would otherwise expend public health resources to prevent is instead actively facilitated based on a "terminal" label, however unreliable and slippery such predictions may be, however effectively the person's concerns can be addressed short of active measures to cause death, and however great the risk of non-consensual death through mistake, coercion and abuse.

The United States Supreme Court has recognized that suicide is a practice that States throughout the country actively discourage through laws and prevention programs. *See Washington v. Glucksberg*, 521 U.S. 702, 711 (1997). By asserting that it is irrational for a non-disabled person to end his or her life, but rational for a

disabled person to do so, appellants argue that the non-disabled person's life is intrinsically more valuable and worthwhile than a disabled person's life.

Perhaps no attitude strikes closer to the heart of the disability civil rights movement. Central to the civil rights of people with disabilities is the idea that a disabling condition does not inherently diminish one's life; rather, stereotypes, barriers preventing assistance with activities of daily living, and prejudices do so. In contrast, assisted suicide gives official sanction to the idea that life with a disabling condition is not worth living. As the U.S. Supreme Court has recognized:

The State's interest here [in prohibiting assisted suicide] goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference ... " The State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same as everyone else's.

Glucksberg, 521 U.S. at 732.

Appellants attempt to justify a double standard regarding suicide prevention based on the notion that people with disabilities who have a terminal prognosis are going to die soon anyway. There are several reasons why this argument fails.

First, terminal predictions by doctors are uncertain and unreliable.⁷ The

⁷ E.B. Lamont et al., "Some elements of prognosis in terminal cancer," *Oncology (Huntington)*, Vol. 9, August 13, 1999, pp. 1165-70; M. Maltoni, et al., "Clinical prediction of survival is more accurate than the Karnofsky performance status in estimating lifespan of terminally-ill cancer patients," *European Journal of Cancer*, Vol. 30A, Num. 6, 1994, pp. 764-6; N.A. Christakis and T.J. Iwashyna, "Attitude and

Disability Rights Amici include many people with disabilities who have been given a terminal prognosis by mistake and then pulled through. This medical uncertainty and potential for an unduly grim prognosis is a particularly serious concern on behalf of people with severe new injuries or unexpected severe medical declines such as a stroke or major heart attack. These are times when knowledgeable and genuine suicide prevention is essential.

Second, it is clear from the Oregon State Health Division's assisted suicide data that non-terminal people with disabilities are receiving lethal prescriptions in Oregon, presumably based on mistaken prognoses. The state reports reveal that some people outlived the six-month prognosis every year, based on the time lapse between the person's request for assisted suicide and their death, with a reported time lapse of up to 1009 days.⁸

Self-Reported Practice Regarding Prognostication in a National Sample of Internists," *Archives of Internal Medicine*, Vol. 158, Num. 21 November 23, 1998, pp. 2389-95; J. Lynn et al., "Prognoses of seriously ill hospitalized patients on the days before death: implications for patient care and public policy," *New Horizons*, Vol. 5, Num. 1, February 1997, pp. 56-61. Also: "17 percent of patients [outlived their prognosis] in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses. ... When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*." See Nina Shapiro, "Terminal Uncertainty," *Seattle Weekly*, January 14, 2009, available at <http://www.seattleweekly.com/content/printVersion/553991/> (accessed July 13, 2009).

⁸ Oregon's Death With Dignity Act – 2014, page 6, Oregon Public Health Division (<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

Third, the Oregon state reports reveal that the overwhelming majority of the people who receive lethal prescriptions have disabilities, based on the reported reasons for requesting assisted suicide. Ninety-one percent reportedly made their request due to “loss of autonomy,”⁹ which indicates physical dependence on others for activities previously undertaken without assistance. In fact, the top five reasons are disability related. The Disability Rights Amici have direct knowledge and experience in addressing these issues, which would be the crux of meaningful suicide prevention.

Professionals in the field of suicide prevention also view these issues as treatable. The most extensive literature addresses elder suicide prevention.¹⁰ The U.S. Administration on Aging and Substance Abuse and Mental Health Services Administration state in an issue brief entitled “Preventing Suicide in Older Adults”:

There are several important risk factors for suicide in older adults. These include, among others: • Depression, • Prior suicide attempts, • Marked feelings of hopelessness, • Co-morbid general medical conditions that significantly limit functioning or life expectancy, • Pain and declining role function (e.g., loss of independence or sense of purpose), • Social isolation, • Family discord or losses (e.g., recent death of a loved one), • Inflexible personality or marked difficulty adapting to change¹¹

⁹ *Id.*, Page 5.

¹⁰ See Older Adult Suicide Prevention Resources

(<http://www.sprc.org/sites/sprc.org/files/OlderAdultSuicidePreventionResources.pdf>);

¹¹ OLDER AMERICANS BEHAVIORAL HEALTH Issue Brief 4: Preventing Suicide in Older Adults (http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Issue%20Brief%204%20Preventing%20Suicide.pdf)

The State of Connecticut has included suicide prevention for people with chronic conditions and disabilities in its Suicide Prevention Plan 2020,¹² discussing risk factors as follows at page 44:

Living with chronic or terminal physical conditions can place significant stress on individuals and families. As with all challenges, individual responses will vary. Cancer, degenerative diseases of the nervous system, traumatic injuries of the central nervous system, epilepsy, HIV/AIDS, chronic kidney disease, arthritis and asthma are known to elevate the risk of mental illness, particularly depression and anxiety disorders.

In these situations, integrated medical and behavioral approaches are critical for regularly assessing for suicidality. Disability-specific risk factors include: a new disability or change in existing disability; difficulties navigating social and financial services; stress of chronic stigma and discrimination; loss or threat of loss of independent living; and institutionalization or hospitalization.

In a letter to the New York legislature concerning assisted suicide bills pending in New York State, Dr. Herbert Hendin, CEO and Medical Director of Suicide Prevention Initiatives based in New York City, specifically discussed “the inadequacy of safeguards ostensibly designed to ensure a patient’s psychiatric health and the voluntariness of the decision” in assisted suicide as implemented in Oregon.¹³

Finally, lobby groups that support a public policy of assisted suicide,

¹² State of Connecticut, Suicide Prevention Plan 2020, page 44, <http://www.preventsuicidect.org/files/2015/04/Suicide-Prevention-Plan-2010.pdf>.

¹³ Letter by Dr. Herbert Hendin, MD, <http://noassistedsuicideny.org/wp-content/uploads/2015/03/SPI-memo-2015-16-session.pdf>

including some appellants, have openly advocated expanding eligibility for assisted suicide beyond those with a six-month terminal prognosis. From the Harvard Model Act¹⁴ nearly twenty years ago, to repeated introductions of bills in New Hampshire with expansive definitions of “terminal”,¹⁵ to writings by appellant Quill¹⁶ it is clear that broad assisted suicide eligibility for people with non-terminal disabilities is a goal. Their incremental strategy is “Politics 101,” despite any claims or implications to the contrary in the context of this case.

C. Denying People with Disabilities the Benefit of Both State Suicide Prevention Laws and the Enforcement of Homicide Laws Violates the ADA

Responding to the long and tragic history of discrimination against people with disabilities, in 1990 Congress enacted the Americans With Disabilities Act (“ADA”), 42 U.S.C. § 12101 *et seq.*, the basic civil rights statute for people with

¹⁴ Charles H. Baron, Clyde Bergstreser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg, and Sidney H. Wanzer. "A Model State Act to Authorize and Regulate Physician-Assisted Suicide." *Harvard Journal on Legislation* 33, (1996): 1-34. (<http://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1013&context=lsfp>)

¹⁵ New Hampshire Death With Dignity Act, HB 1325, Section 137 L2 XIII, providing that “Terminal condition” means an incurable and irreversible condition, for the end stage²² for which there is no known treatment which will alter its course to death, and which, in the opinion²³ of the attending physician and consulting physician competent in that disease category, will result in²⁴ premature death.” <http://www.gencourt.state.nh.us/legislation/2014/HB1325.pdf>

¹⁶ Franklin G. Miller, Ph.D., Timothy E. Quill, M.D., Howard Brody, M.D., Ph.D., John C. Fletcher, Ph.D., Lawrence O. Gostin, J.D., and Diane E. Meier, M.D., "Regulating Physician-Assisted Death," *N Engl J Med* 1994; 331:119-123 (July 14, 1994) (<http://www.nejm.org/doi/pdf/10.1056/NEJM199407143310211>)

disabilities. To address and remedy the “serious and pervasive social problem” of discrimination against individuals with disabilities, 42 U.S.C. § 12101(a)(2), Congress substantively required that "no qualified individual with a disability shall . . . be excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity...." 42 U.S.C. § 12132; *See* 28 C.F.R. § 35.130(b) (discrimination includes denying or not affording an opportunity for people with disabilities to benefit from services either equal to or as effective as those afforded nondisabled persons).

Sanctioning assisted suicide only for people with disabilities, and denying them suicide prevention services based on a doctor's prediction of terminal status or other justification violates the ADA because the presence or absence of disability determines whether New York:

- Enforces its laws requiring health professionals to protect individuals who pose a danger to themselves;
- Responds to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities; and
- Investigates and enforces its abuse and neglect and homicide statutes in cases reported as assisted suicides.

A doctor's determination of someone's eligibility for assisted suicide confers

absolute legal immunity on the doctor and other participants in the death, and all State suicide-related procedures are set aside. The existence of a disability should never be the basis for these distinctions.

II. Assisted Suicide Poses Serious, Unavoidable Threats to People with Disabilities That New York Has a Significant State Interest in Preventing

As the U.S. Supreme Court has recognized, assisted suicide is contrary to well-established medical ethics. *See Glucksberg*, 521 U.S. at 731 (quoting American Medical Association, Code of Ethics section 2.211 (1994)); *see also Vacco v. Quill*, 521 U.S. 793, 801 n.6 (1997) (discussing medical profession's distinction between withholding treatment and assisted suicide). This rejection is firmly grounded in the potential harm that appellants' proposed public policy poses to the lives of people with disabilities.

A. The Difficulty in Ensuring Decisions to Die Are Not Coerced or Made by Others Is a Critical State Interest

Some persons killed under assisted suicide laws may "choose" suicide under pressure from others, and New York has a significant State interest to ensure that does not happen. There is no way to ensure that persons are not unduly pressured by family members, because of financial, emotional, or other reasons.

Similarly, given the extraordinarily high cost of health care, there is no way to ensure that health providers, whether insurance companies, health maintenance organizations, or others, are not unduly pressuring a person to request "aid in dying" for financial reasons. Doctors must not be immunized for active measures to cause death.

B. The Assumption that Suicide is "Rational" When Committed by a Person with a Disability Is Not Valid

As the *Glucksberg* decision recognized, "those who attempt suicide – terminally ill or not – often suffer from depression or other mental disorders." 521 U.S. at 730. The Court continued, "Research indicates ... that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated." *Id.* A study of cancer patients showed that those with depression were four times more likely to want to die.¹⁷ Pain is rarely the reason people consider assisted suicide. Many people do so because they fear they will be a burden on their families. The Oregon Reports indicate that 40% of assisted suicide requests involved this factor.¹⁸

¹⁷ See William Breitbart et al., *Depression, Hopelessness and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA 2907, 2909 (Dec. 13, 2000).

¹⁸ Oregon's Death With Dignity Act – 2014, page 5, Oregon Public Health Division (<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

In the most recent reporting year, 2014, physicians referred only 2.9% of persons who requested assisted suicide for a consultation to determine whether their judgment was impaired, and only 5.5% were referred over all the reported years.¹⁹ In a survey of psychiatrists, over half were "not at all confident" they could assess in a single consultation whether a psychiatric condition impaired a person's judgment; only six percent were "very confident."²⁰ This is because such assessments are inherently subjective and unreliable. As one research analysis concluded:

There is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting [physician-assisted suicide]... There are no clinical criteria to guide such an assessment - just as there are no criteria to assess the rationality of any person's decision to commit suicide.²¹

C. The Uncertainty of Diagnosing a "Terminal Illness"

As noted above, the diagnosis and prognosis of a "terminal condition" is inherently uncertain. Because terminal conditions are so often misdiagnosed, the policy that appellants advocate opens the door to assisted suicide for many

¹⁹ *Id* at page 5.

²⁰ Linda Ganzini et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 AM. J. PSYCHIATRY, 595 (Apr. 2000).

²¹ Brendan D. Kelly et al., *Euthanasia, Assisted Suicide and Psychiatry: A Pandora's Box*, 181 British J. Psychiatry 278, 279 (2002).

people with disabilities who are not “terminally ill” within any predictable time frame. The risks to newly disabled people, such as those with significant spinal cord injuries and strokes, are particularly great. As the National Council on Disability has reported, "people with disabilities are aware of enough instances of dramatic mistakes that many of them have a healthy skepticism of medical predictions, particularly as it relates to future life quality."²² Evan Kemp, Director of the Equal Employment Opportunity Commission under President George H.W. Bush, wrote:

As a disabled person, I am especially sensitive to the "quality of life" rationale that is frequently introduced in the debate [over assisted suicide]. For the past 47 years I have lived with a progressive neuromuscular disease that first began to manifest itself when I was 12. My disease, Kugelberg Weylander Syndrome, has no known cure, and I have no hope for "recovery." Upon diagnosis, my parents were informed by the physicians treating me that I would die within two years. Later, another group of physicians was certain that I would live only to the age of 18. Yet here I am at 59, continuing to have an extraordinarily high quality of life.²³

D. The Appellants’ Assumption that Disability Intrinsicly Deprives Life of Dignity and Value Is Not Valid

Many people identified as candidates for assisted suicide could benefit

²² National Council on Disability, *Assisted Suicide: A Disability Perspective* at 27- 28, available at <http://www.ncd.gov/publications/1997/03241997>.

²³ Evan J. Kemp, *Could You Please Die Now?*, Wash. Post, Jan. 5, 1997, at C1.

from supportive care or treatment, such as counseling, pain medication, or in-home consumer-directed personal assistance. These measures lessen their pain and suffering, perceived burden on family members, or lack of independence and choice. The National Council on Disability has found that "improving laws, policies, programs, and services for people with disabilities . . . would go a long way toward assuring that any self-assessment or decision about the quality of life of an individual with a disability would be made in an optimal context of independence, equality of opportunity, full participation, and empowerment."²⁴

Research demonstrates the lack of this type of assistance and support, rather than any intrinsic aspect of a person's disability, is the primary motivation for suicide. Assisted suicide, however, assumes that a medical condition inherently makes life unworthy of continuation. As a doctor at New York's Memorial Sloan-Kettering Cancer Center has observed, assisted suicide "runs the risk of further devaluing the lives of terminally ill patients and may provide the excuse for society to abrogate its responsibility for their care."²⁵

The question how to address the psychological and social needs that underlie the desire to die, however, is typically lost in a simplistic mental

²⁴ National Counsel on Disability, *supra* note 9, at 13.

²⁵ Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED 54 (Jan. 2, 1997).

"competency" determination. One study noted that "the focus on competence may distract from adequate attention and resources on the person and their circumstances"²⁶ Another study concluded that competency determinations "do not provide a framework to address social circumstances that contribute to the desire for euthanasia or assisted suicide."²⁷

III. THE CREATION OF A NEW YORK CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE FOR A CLASS OF PEOPLE BASED ON THEIR HEALTH AND DISABILITY STATUS IS A LETHAL FORM OF DISCRIMINATION

A. People with Disabilities Are the Class of People Who Will Be Affected If a Right to Assisted Suicide Is Found

The issue before the Court goes far beyond the 1980's cases in which courts dismissed the state interest in protecting the lives of these disabled individuals and found a "right to die" through the withdrawal of routine life-sustaining treatment. See *e.g.*, *Bouvia v. Superior Court*, 179 Ca. App. 3d 1127, 255 Cal. Rptr. 297 (1986), *review denied* (June 5, 1986); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989). With appropriate

²⁶ Ganzini et al., *supra* note 7, at 600.

²⁷James V. Lavery, et al, *Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study*. LANCET, 358 (9279), 366 (2001).

treatment and services, many of them would be alive today, as was later admitted in an apology by one of the leading bioethicists who addressed these cases.²⁸ However, even in those cases, the courts specifically distinguished any right involving active physician-assisted suicide. Before this Court is the request to obliterate this distinction. It is against the backdrop of these and other cases that your *amici* request protection from the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

B. Adequate State Safeguards Cannot Be Adopted to Protect People with Disabilities from Assisted Suicide Threat

1. Any Purported Limitation of the Right to Assisted Suicide to Terminally Ill Persons Will Not Protect People with Disabilities

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected, 42 U.S.C. § 12101 (a)(7), assisted-suicide "safeguards" cannot prevent abuse against people with disabilities. History demonstrates that assisted suicide has not and will not be limited to terminally ill persons.²⁹ Moreover,

²⁸ H Brody, A bioethicist offers an apology, Lansing City News, October 6, 2004 (<http://dredf.org/public-policy/assisted-suicide/a-bioethicist-offers-an-apology/>).

²⁹ See H. Hendin and K. Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613 (2008).

terminally ill persons who request assisted suicide are or fear they will become disabled, and are a demographic subset of people with disabilities.

At issue is nondisabled peoples' intense fear of becoming disabled. The wish to die is based on the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids. Medical professionals, jurists and the public consistently ignore underlying treatable depression, lack of health care, in-home long term care services or other supports, and exhaustion from confronting interpersonal, societal and systemic discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless," "suffering needlessly," and "quality versus quantity of life," purportedly in a humanistic and compassionate way, they are really expressing fear of severe disability and a very misguided condemnation, "I could never live like that." Society translates these emotions into a supposedly rational social policy of assisted suicide. The wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from the same emotional disturbance or illogical despair that nondisabled persons face.

The medical profession is not immune to these erroneous assumptions. Research shows that doctors frequently project the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-

prolonging treatment."³⁰ It is particularly important to note that research on suicidal feelings among people with terminal illnesses demonstrates that such feelings are remediable through other means, including pain management, hospice services and counseling.³¹ As long as physicians believe that a person with a severe disability has a "life unworthy of living," lethal errors and abuses will occur.

Safeguards cannot protect one from family pressures due to financial burdens which may accompany a disability, especially when the health care system may not pay for assistance in daily living activities. Nor can safeguards stop families from doctor-shopping when one doctor says the person is not "terminal" or acting "voluntarily," to find another doctor who will say otherwise. Doctor shopping for assisted suicide "friendly" doctors is common in Oregon. The majority of Oregon assisted suicides involve doctors referred to patients by Compassion and Choices, the leading lobby group for assisted suicide bills.³²

³⁰ S. Miles, *Physicians and Their Patients' Suicide*, 271 JAMA 1786 (1994).

³¹ Most death requests, even in terminally ill people, are propelled by despair and treatable depression. H. Hendin and Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. OF PSYCH. 143 (Jan. 1993).

³² Kenneth R. Stevens, Jr., M.D., *The Proportion of Oregon Assisted Suicides by Compassion & Choices Organization*, Physicians for Compassionate Care Educational Foundation, March 4, 2009, available at <http://www.pccf.org/DOWNLOADS/AssistedSuicidesbyCC2009report.pdf>

2. Any Purported Limitation of a Right to Assisted Suicide Only in Cases of "Voluntary" Requests Will Not Protect People with Disabilities from Abuse

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary. The Disability Rights Amici are profoundly disturbed by the appellants' advocacy of a constitutional right for assisted suicide in a society which refuses to find a concomitant right to adequate health care to stay alive. Now managed health care, with its emphasis on cost containment, further abridges the choices and endangers the lives of people with disabilities. Until society is committed to providing life supports, including in-home personal assistance services and technology supports, there is not voluntary choice.

Without health care and consumer-directed personal care services, people with disabilities do not receive what they need to live as independently and with as much autonomy as possible. Appropriate health care includes competent palliative care. Without the professional commitment to help make living worthwhile for people with disabilities, which is the core of suicide prevention, people with disabilities, including those whose conditions are terminal, will not receive the support necessary for informed and voluntary decisions. There are no safeguards that can protect against these prejudices and realities.

Finally, no system of safeguards can control conduct which results in the

death of the primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all persons equally.

C. People With Disabilities, Whether Terminal or Nonterminal, Should Receive Equal Protection of Laws Pertaining to Suicide Prevention and Homicide

Appellants urge this Court to minimize and ignore the risks of abuse impacting vulnerable people. There is already ample evidence of non-voluntary and involuntary withholding and withdrawal of treatment. For example, in a study published in 2011 in the *Journal of Emergency Medicine*ⁱ, University of Pittsburgh researchers found that over 50% of physician respondents misinterpreted a living will as having a "do not resuscitate" (DNR) order. About the same percentage of respondents over-interpreted DNR orders as meaning "comfort care" or "end-of-life" care only.³³ The study shows clearly that having a living will and/or a DNR order makes it much more likely that physicians will withhold treatments that a patient actually wants. Even more clearly involuntary are futility policies that grant immunity to physicians who deny care that the patient or surrogate expressly

³³ F Mirarchi, et al., TRIAD III: Nationwide Assessment of Living Wills and Do Not Resuscitate Orders, *Journal of Emergency Medicine*, Volume 42, Issue 5, pages 511-520 (May 2012) ([http://www.jem-journal.com/article/S0736-4679\(11\)00853-5/abstract?cc=y](http://www.jem-journal.com/article/S0736-4679(11)00853-5/abstract?cc=y)).

wants.³⁴ Legalizing assisted suicide will make matters worse than they already are by expanding the population of people who are eligible to have their lives ended by medical professionals. The Disability Rights Amici have a great deal of experience with incorrect terminal prognoses, and the involuntary denial of care and self-fulfilling prophesy that can result from a “terminal” label.

The more vulnerable members of the disability and aging communities should not be viewed as expendable. And that is the crux of the Disability Rights Amici’s disagreement with appellants. There are at least three responses to the petitioners’ frequent claim that the dangers of assisted suicide have been disproven by the experience in Oregon and Washington: 1) the language of the Oregon and Washington assisted suicide statutes, which leave gaping holes in patient protection but provide a blanket of immunity based on a claim of “good faith” to participants in the death; 2) the common sense factual and legal analyses by numerous courts that have considered the issue; and 3) cases of mistake and abuse which have come to light despite the law’s minimal reporting requirements, the admitted lack of investigation by Oregon state authorities,³⁵ and the impact of strict health care confidentiality laws.

³⁴ Fine & Mayo, Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act, *Ann Intern Med* 2003; 138: 743-746.
(http://portal.mah.harvard.edu/templatesnew/departments/MTA/MAHEthics/uploaded_documents/Texas%20Advance%20Directive%20Act.pdf)

³⁵ DHS News Release: *No authority to investigate Death with Dignity case, DHS says*, March 4, 2005

First, nothing in the provisions of the Oregon and Washington assisted suicide statutes³⁶ prohibits an heir or caregiver from suggesting assisted suicide to an ill person, or taking the person to the doctor to make a request. If the person has a speech impairment, such as due to a stroke, or speaks another language, the laws provide that a patient may communicate “through a person who is familiar with the patient’s manner of communicating.” *See, e.g.*, Oregon DWD Act, 127.800 § 1.01(3). The statutes allow an heir to be a witness to the assisted suicide request as long as the second witness is not an heir. In addition, both witnesses can be complete strangers who merely check the patient’s identification. In either case, the witnesses’ certification that the patient is not being coerced is seriously lacking in foundation and persuasive value. Moreover, the physicians’ ability to detect coercion is similarly in doubt. The median duration of the physician-patient relationship in Oregon is reported as 13 weeks.³⁷ The majority of doctors who prescribe under the Oregon assisted suicide law are referrals by Compassion and Choices, the leading lobby group for these laws.³⁸ In addition, once the prescription for lethal drugs is

(<http://www.oregon.gov/dhs/pages/news/2005news/2005-0304a.aspx>)

³⁶ Oregon Death With Dignity Act, ORS 127.865, Washington Death With Dignity Act, RCW 70.245

³⁷ Oregon’s Death With Dignity Act – 2014, page 6, Oregon Public Health Division

(<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

³⁸ See footnote 34 and additional authorities discussed in M Golden, Why Assisted Suicide Must Not Be Legalized, Part C.1. Safeguards in Name Only/Doctor Shopping, <http://dredf.org/public-policy/assisted-suicide/why-assisted-suicide-must-not-be-legalized/#marker43>

issued, there are no further witness requirements, including at the time of ingestion of the lethal drugs and death. As Washington elder law attorney Margaret Dore has written:

Without witnesses, the opportunity is created for someone other than the patient to administer the lethal dose to the patient without his consent. Even if he struggled, who would know? The lethal dose request would provide the alibi. . .³⁹

The Oregon Reports include data on whether the prescribing doctor or other health care provider was present when the lethal dose was ingested or at the death. In about half the cases, no such person was present.⁴⁰ Assuming for the sake of discussion that healthcare provider witnesses would report a lack of consent or intentional self-administration, in the other half of the cases, there is no evidence of consent or intentional self-administration.

Second, a recent California assisted suicide case granting a demurrer without leave to amend provides a comprehensive and persuasive review of previous court rulings, *O'Donnell v. Harris*, San Diego Superior Court Case No. 37-2015-00016404-CU-CR-CTL (July 24, 2015), giving realistic weight to the many dangers

³⁹ Margaret Dore, Esq., “‘Death with Dignity’: A Recipe for Elder Abuse and Homicide (Albeit Not by Name),” 11 Marquette Elder’s Advisor 387, 2010, available at <http://www.choiceillusion.org/p/the-oregon-washington-assisted-suicide.html>.

⁴⁰ Oregon’s Death With Dignity Act – 2014, page 6, Oregon Public Health Division (<https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>)

that legalizing assisted suicide poses, particularly in an aging population in which, according to federal estimates, one in ten elders are abused.⁴¹

Since "Aid in Dying" is quicker and less expensive, there is a much greater potential for its abuse, e.g., greedy heirs-in-waiting, cost containment strategies, impulse decision-making, etc. Moreover, since it can be employed earlier in the dying process, there is a substantial risk that in many cases it may bring about a patently premature death. For example, consider that a terminally ill patient, not in pain but facing death within the next six months, may opt for "Aid in Dying" instead of working through what might have been just a transitory period of depression. Further, "Aid in Dying" creates the possible scenario of someone taking his life based upon an erroneous diagnosis of a terminal illness, which was, in fact, a misdiagnosis that could have been brought to light by the passage of time. After all, doctors are not infallible.

Furthermore, "Aid in Dying" increases the number and general acceptability of suicide, which could have the unintended consequence of causing people who are not terminally ill (and not, therefore, even eligible for "Aid in Dying") to view suicide as an option in their unhappy life. For example, imagine the scenario of a bullied transgender child, or a heartsick teenaged girl whose first boyfriend just broke up with her, questioning whether life is really worth living. These children may be more apt to commit suicide in a society where the terminally ill are routinely opting for it.

Id. at 8. This is wholly consistent with the issues discussed in the report of the New York Task Force on Life and the Law (see footnote 6 of this brief).

⁴¹ Mark S. Lachs, M.D., M.P.H., and Karl A. Pillemer, Ph.D., "Elder Abuse," *N Engl J Med* 2015; 373:1947-1956, November 12, 2015 (<http://www.nejm.org/doi/full/10.1056/NEJMra1404688>); See D. Heitz, "U.S. Official: Elder Abuse is 'Broad and Widespread'," *Healthline News* (Jan. 27, 2014), available at <http://www.healthline.com/health-news/senior-elder-abuse-more-common-than-you-think-012714>.

Additional deficiencies of patient protections in the Oregon and Washington assisted suicide laws include the fact that no treatment for depression is required.⁴² Moreover, as previously noted, the top five reasons that prescribing physicians report for assisted suicide requests are psycho-social reactions to disability. Two of them are loss of autonomy (92%) and feelings of being a burden on others (40%).⁴³ Nevertheless, neither the Oregon nor Washington laws require disclosures about consumer directed home care options that could alleviate these feelings, nor do they ensure that such home care will be provided if desired. The Disability Rights Amici's experience is that most doctors know little or nothing about home and community based long-term care.

Moreover, under the statute, the state has no authority (or resources) to investigate abuses. The blanket immunities granted to participants in the death, and the impact of patient confidentiality laws, present formidable barriers to uncovering mistakes, coercion and abuse. Despite these obstacles, some cases have come to light.⁴⁴ These further emphasize the critical importance of applying equal protection

⁴² See L. Ganzini, et al., *Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists*, 157 Am. J. Psych., 595, 598 (April 2000); L. Ganzini, et al., *Attitudes of Oregon Psychiatrists Towards Assisted Suicide*, 153 AM. J. PSYCH, 1469 – 75 (1996).

⁴³ See Oregon Public Health Division Reports, *available at* <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>.

⁴⁴ The Disability Rights Education & Defense Fund has compiled brief descriptions of some of these cases, with citations to source materials, entitled "Oregon and Washington State Abuses and Complications." (<https://dredf.org/wp-content/uploads/2015/04/Revised-OR-WA-Abuses.pdf>)

principles to protect people with disabilities, whether terminal or not, from the dangers inherent in a public policy of legalized assisted suicide.

CONCLUSION

People with disabilities in New York are seriously threatened by physician-assisted suicide. The Disability Rights Amici request this Court to recognize that, cloaked in the false rhetoric of “death with dignity,” and “aid in dying,” physician-assisted suicide threatens the civil rights, and the lives, of a profoundly oppressed and marginalized minority.

The Disability Rights Amici are aware that our members have not been declared a “suspect class” entitled to strict scrutiny analysis of statutes that discriminate against us. However, we hope that the time will come when old, ill and disabled people are recognized as a class entitled to strict scrutiny protection. That is the expansion of constitutional rights that we hope to see. As we have argued above, people with disabilities, whether those disabilities are terminal or nonterminal, deserve equal protection under the laws and professional standards pertaining to suicide prevention and homicide law enforcement. We urge this Court to give compelling and dispositive weight to protecting old, ill and disabled people from the risks of mistake, coercion and abuse inherent in a public policy of assisted suicide, and to uphold the Supreme Court’s ruling in this important case.

Respectfully submitted,

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